Understanding and Managing Harmful Drinking and Substance Use

THE TALKING THERAPIES UK SELF-HELP SERIES



Understanding and Managing Harmful Drinking and Substance Use

An eight-module programme for people whose own drinking or other substance use has become risky or harmful, built on honest self-monitoring, motivation, and a realistic plan for change

A self-help workbook · 8 modules · about 8 weeks

TALKING THERAPIES UK

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First edition, 2026.

This workbook accompanies the Understanding and Managing Harmful Drinking and Substance Use programme on the Talking Therapies UK self-help platform. Its text is drawn from the programme and is kept current with it: whenever the programme changes, the workbook is set again.

Revision 2. This printing was set on 21 November 2026 from the programme as it stood that day.

A note on using this workbook. It offers self-help based on established psychological approaches for difficulties of mild to moderate severity. It is not a substitute for assessment or treatment by a qualified professional and is not designed for use in a crisis. The examples in it are fictional; no real person appears in them. If you are worried about your safety, or your difficulties are getting worse, the page headed “When self-help is not enough” says where to turn.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this workbook

Harmful and risky substance use sits on a spectrum, and most of that spectrum is never seen by specialist addiction services at all. At one end is use that carries no meaningful risk; further along is hazardous use, a pattern that increases the chance of future harm without having caused it yet; further still is harmful use, where real harm, to physical health, relationships, work, mood, or safety, is already occurring; and at the far end is dependence, a distinct clinical state with its own behavioural, cognitive and physiological features. This programme is built for the hazardous and harmful end of that spectrum, for people whose own drinking or other substance use has become a genuine concern but who are not physically dependent, and it is deliberately not built for dependence, which needs a different kind of help first and is explained fully, with the reasoning behind that boundary, in Module 1. This programme draws on several converging evidence bases. The National Institute for Health and Care Excellence's guidance on alcohol-use disorders, set out in public health guideline PH24 and clinical guideline CG115, establishes screening and brief structured intervention as the appropriate first response to hazardous and harmful drinking, reserving more intensive medical and psychosocial treatment for dependence; this programme is built in that spirit, as a structured brief intervention a person can work through at their own pace. The AUDIT-C screening tool, a shortened three-question version of the World Health Organization's Alcohol Use Disorders Identification Test, gives a quick and well-validated way of placing a person's own drinking on this spectrum, and Module 1 walks through it in full. Marlatt and Gordon's relapse prevention model, developed from the 1980s onward and still the dominant framework in the field, supplies two of this programme's central techniques: urge surfing, a specific way of riding out a craving rather than fighting it or being swept along by it, and a clear-eyed account of what actually happens psychologically after a lapse, named the abstinence violation effect, which this programme works with directly rather than pretending lapses will not happen. Prochaska and DiClemente's stages-of-change model, originally developed by studying how people actually change addictive behaviours successfully, frames readiness to change as something that moves through recognisable stages rather than being simply present or absent, which this programme uses to help you locate yourself honestly and work from where you actually are rather than where you feel you ought to be. The programme is framed primarily, though not exclusively, around alcohol, and it is worth being honest about why. Alcohol is where the validated UK screening tools, the clearest guideline-level evidence for structured self-help, and the largest body of relapse-prevention research all sit most solidly for an adult population working independently. Other substances are not absent from this programme's thinking, and several of the vignettes and much of the underlying psychology throughout, reinforcement, tolerance, cue reactivity, the stages of change, urge surfing, the abstinence violation effect, apply to cannabis, stimulants and other substances in broadly the same way. But some substances carry withdrawal risks that alcohol shares with very few others, and a small number carry risks that are substantially more dangerous again; these differences matter enormously for safety and are set out plainly in Module 1, because the single most important thing this programme can do for some readers is to send them to a GP or a specialist drug and alcohol service before they attempt anything else, rather than to a self-help course. Who this is for. The programme is suitable for adults whose own honest answers to the AUDIT-C screen and the pattern description in Module 1

place them in the hazardous or harmful range, who are experiencing some degree of risk or harm, whether to physical health, mood, relationships, work, finances or safety, from their own drinking or other substance use, and who show no signs of physical dependence: no withdrawal symptoms such as shaking, sweating, nausea or anxiety when use is delayed or stopped, no drinking or using first thing to feel normal or to settle such symptoms, and no history of a withdrawal seizure or delirium. Many adults whose substance use has become a genuine worry fit this description precisely: drinking considerably more than the UK low-risk guideline of fourteen units a week, or using another substance in a way that is clearly causing some harm, without having crossed into the territory where stopping abruptly carries its own medical danger. Who this is not for, and where to go instead. If your own pattern shows any sign of physical dependence as just described, please see your GP before attempting to cut down or stop, even gradually; Module 1 explains exactly why this matters and what a GP or specialist alcohol service can offer that this programme cannot. If your main substance of concern is an opioid, a benzodiazepine, or another substance with a similarly dangerous withdrawal profile, a specialist drug and alcohol service is the right route in place of this programme regardless of how dependent you believe yourself to be, because the risk calculation for these substances is different from alcohol's in ways Module 1 sets out in full. If you are under eighteen, young people's substance misuse services are the age-appropriate route. If your concern is someone else's drinking or substance use rather than your own, a structured self-help course aimed at your own behaviour is the wrong tool for that situation; the practice's separate programme, Supporting Someone Else's Drinking or Substance Use, is written specifically for family members and carers in that position. And if you are experiencing a mental health crisis, including thoughts of suicide or self-harm, please use the safety information in Module 1 and seek urgent help before, or alongside, anything in this programme.

This workbook is the written form of the Understanding and Managing Harmful Drinking and Substance Use programme on the Talking Therapies UK self-help platform. It follows the programme module by module: each part of the book is one module, and each chapter is one piece of the module's teaching, set in the order the programme presents it.

Read the chapters of a part in order, then turn to the worksheets that follow them. The worksheets are the part of the work that changes things, so give them the time they ask for and come back to them as the weeks go on. You may copy or print the worksheets for your own use, as often as you need.

Most people work through one module a week, which takes the whole programme about 8 weeks. Go at the pace that suits you: a module done properly is worth more than two done quickly.

The check-in questionnaires let you see how things are changing. Complete each one when you reach it, note the date and your total, and compare it with the last.

When self-help is not enough

- If you are in danger now, or have seriously harmed yourself, call 999 or go to your nearest accident and emergency department.
- If you need help urgently but it is not an emergency, call NHS 111 or contact your GP surgery.
- Samaritans are there day and night, every day of the year: call 116 123 free from any phone.
- If you would rather not talk, text SHOUT to 85258 for free, confidential support at any hour.

- If your difficulties are getting worse as you work through this book, or you find yourself thinking about ending your life, stop and speak to your GP or a mental health professional. A workbook can be a good start, and some difficulties need more help than a book can give.

What this workbook will help you to do

- Place your own drinking or other substance use accurately on the spectrum from hazardous use through to dependence. Score your own pattern against the AUDIT-C screen and understand what the result means. Recognise the specific signs that mean a GP or specialist service is needed before, or instead of, this programme.
- Understand positive and negative reinforcement, tolerance, and cue reactivity as the mechanisms that maintain harmful substance use. Recognise the self-medication pattern where substance use manages an underlying difficulty such as anxiety, low mood or poor sleep. Locate your own current stage of readiness to change honestly, using the stages-of-change model.
- Keep a structured, honest self-monitoring record of your own use over at least a week. Identify your own specific high-risk situations across people, places, times, and emotional states. Understand why writing the pattern down changes how clearly it can be seen and worked with.
- Understand ambivalence as a normal part of changing a long-standing pattern rather than a sign of insufficient commitment. Work through a decisional balance covering both the costs and the benefits of your current pattern and of changing it. Choose a specific, realistic goal, including an honest assessment of whether moderation or abstinence is the safer and more appropriate choice for you.
- Understand the craving curve and why a craving that is not acted on will reliably fall even though it does not feel that way at its peak. Practise urge surfing as a specific technique for experiencing a craving without being controlled by it. Build concrete when-then plans for your own highest-risk trigger situations identified in Module 3.
- Understand why lasting change requires replacing the function a substance has served, not simply removing the substance itself. Rate your own current confidence and use of a range of alternative coping strategies honestly. Build a concrete, personal alternatives repertoire mapped to your own specific triggers.
- Distinguish clearly between a lapse and a relapse, and understand why treating every lapse as total failure is itself a risk factor. Understand the abstinence violation effect and why it tends to increase, rather than decrease, the likelihood of continued use after a lapse. Use a structured thought record to examine a self-critical thought following a lapse.
- Recognise your own early warning signs of drift back towards the old pattern. Plan specifically for known high-risk periods ahead, such as anniversaries, stressful periods, or social occasions. Write a complete, personal relapse-prevention plan bringing together everything built across the programme.

PART 1

Understanding Harmful and Risky Substance Use

Where hazardous and harmful use sit on the wider spectrum, screening your own pattern honestly, and making sure this programme is the right fit before you start

CHAPTER 1

Welcome to the programme

If you are reading this, some part of you has already noticed that your drinking, or your use of another substance, has become more of a problem than you would like it to be. That noticing is the hardest part for a great many people, and you have already done it. This programme does not ask you to decide, on this page, whether you have a serious problem or a minor one, whether you are an alcoholic or just someone who drinks a bit too much, or any of the other binary, loaded judgements that tend to circle this subject. It asks something more useful: where does your own pattern actually sit, what is keeping it going, and what would a realistic, structured attempt at change actually look like for you.

Across the eight modules, you will screen your own pattern properly rather than guessing at it, understand the psychological mechanisms that keep harmful use going once it has started, map your own specific triggers in detail, work out what you actually want to change and why, learn a specific technique for riding out a craving without being controlled by it, build a wider set of alternatives for the function the substance has been serving, understand what happens psychologically after a lapse and how to stop a single lapse turning into a full return to the old pattern, and put together a written plan for maintaining the change once the structured weeks end.

Before any of that, this first module has one job that matters more than any other: making sure this is safe and appropriate for you to do on your own. Harmful and risky substance use covers an enormous range, from a pattern that is a genuine concern but carries no particular medical danger in addressing it yourself, through to physical dependence, where stopping abruptly or even cutting down quickly can itself be dangerous and needs medical support. Please read the next three sections in full and complete the exercises honestly before continuing, even if you feel confident you already know where you stand.

CHAPTER 2

Hazardous use, harmful use, and dependence: a spectrum, not a label

Public health and clinical guidance in this area, including the National Institute for Health and Care Excellence's guideline PH24 on alcohol-use disorders, uses three terms that are worth understanding properly, because they describe genuinely different situations that call for genuinely different responses, and confusing them is one of the most common reasons people either underestimate a real risk or, just as often, assume the worst about a pattern that is actually very manageable through structured self-help.

Hazardous use is a pattern that increases the risk of future harm without having caused clear harm yet. Regularly drinking well above the UK Chief Medical Officers' low-risk guideline of fourteen units a week, spread over at least three days with several drink-free days, is a hazardous pattern even if nothing has gone visibly wrong as a result so far; the risk is to future health, and the whole point of addressing it at this stage is to act before harm actually arrives rather than waiting for it.

Harmful use is a pattern that is already causing clear harm, physical, psychological, or social, even though it falls short of dependence. This might be liver function beginning to show the effects of sustained heavy drinking, a relationship under strain because of how often or how much someone drinks or uses, missed or underperformed work, a mood that has become harder to manage because a substance is propping it up, or any combination of these. Harmful use is where this programme's title places most of its attention, though hazardous use is equally within scope, because the earlier a hazardous pattern is addressed, the less likely it is to become harmful in the first place.

Dependence is different again, and the difference is not simply a matter of degree. The World Health Organization's International Classification of Diseases and NICE's own clinical guidance describe dependence as a cluster of behavioural, cognitive and physiological features occurring together: a strong, often difficult-to-resist desire to use the substance; difficulty controlling the onset, amount, or ending of use once started; continuing to use despite clear awareness of the harm it is causing; giving the substance a higher priority than other activities and obligations that used to matter; tolerance, meaning a need for increasing amounts to achieve the same effect; and, often most tellingly, a physical withdrawal state when use is reduced or stopped. It is this last feature, physical withdrawal, that creates the genuine medical boundary this programme cannot safely cross, and the next section explains exactly why.

CHAPTER 3

Screening your own pattern: the AUDIT-C

The AUDIT-C is a shortened, three-question version of the World Health Organization's full Alcohol Use Disorders Identification Test, validated for exactly the purpose this module needs: a quick, honest way of placing your own drinking on the hazardous-to-harmful spectrum. It asks three questions, each scored from zero to four, for a total out of twelve.

The first question asks how often you have a drink containing alcohol, scored never (zero), monthly or less (one), two to four times a month (two), two to three times a week (three), or four or more times a week (four). The second asks how many units you typically drink on a day when you are drinking, using UK units, scored zero to two units (zero), three to four (one), five to six (two), seven to nine (three), or ten or more (four). The third asks how often you have six or more units on a single occasion, scored never (zero), less than monthly (one), monthly (two), weekly (three), or daily or almost daily (four).

Adding the three scores together gives a total out of twelve. The banding used across NHS and UK public health screening, and used in this programme, is as follows: zero to four is low risk; five to seven is increasing risk; eight to ten is higher risk; eleven to twelve suggests possible dependence and is itself a signal to see your GP rather than to proceed with this programme alone. A positive screen, meaning a score that warrants some action, is generally taken as five or more.

To make this concrete: someone who drinks four to five times a week, typically has five to six units on a drinking day, and has six or more units on a single occasion weekly would score something close to four plus two plus three, nine in total, placing them in the higher-risk band; a great many people in exactly this position feel, privately, that their drinking is "probably fine" because it is not daily and does not involve obvious drunkenness, and the AUDIT-C's value is precisely that it replaces that private, often overly generous impression with an honest number. If your main substance of concern is not alcohol, the same underlying logic, frequency, typical amount, and frequency of using an amount that itself carries risk, is a reasonable way to think about your own pattern even though the AUDIT-C's specific scoring was built and validated for alcohol.

A NOTE

Please see your GP, rather than continuing with this programme alone, if any of the following apply to you: you notice physical symptoms, such as shaking, sweating, nausea, or anxiety, when you have not had a drink or used for a while, which settle once you do; you have ever drunk or used first thing to feel normal or to stop such symptoms; you have ever had a seizure, or an episode of severe confusion or hallucination, when stopping or cutting down; or your AUDIT-C score is eleven or twelve. These are signs of physical dependence, and for alcohol in particular, stopping or cutting down quickly without medical support can, in genuine dependence, cause a dangerous withdrawal seizure or a state called delirium tremens; this is not a risk this programme is designed to manage, and a GP or specialist alcohol service can arrange safe, often medically assisted, withdrawal where it is needed.

If your main substance of concern is an opioid such as heroin or a diverted prescription painkiller, or a benzodiazepine such as diazepam used outside of how it was prescribed, please see your GP or a specialist drug and alcohol service rather than attempting to cut down using this programme, whatever your own sense of how dependent you are; both drug classes carry withdrawal risks and safe-reduction considerations that are substantially different from alcohol's and need specialist input to manage properly.

If you are having thoughts of suicide or self-harm, please contact the Samaritans on 116 123, available free and at any time, or call 999 if you are in immediate danger, before continuing with this programme.

For support and information in the meantime, Drinkline, the national alcohol helpline, is free and confidential on 0300 123 1110, weekdays 9am to 8pm and weekends 11am to 4pm; for any other drug, FRANK offers free and confidential advice around the clock on 0300 123 6600.

WORKSHEET

Score your own AUDIT-C

Work out your own score using the three questions and the scoring above, then write down the total and which band it falls into. If your substance of concern is not alcohol, describe your own frequency and typical amount in the same terms instead, and use your judgement about which band best describes the level of risk. Be honest rather than generous with yourself; the exercises later in this module and the rest of the programme work far better from an accurate starting point than from a flattering one.

State your three AUDIT-C answers, your total score, which band it falls into, and one honest sentence about whether that number surprised you.

WORKSHEET

Sort each presentation into the right route

Before writing your own honest pattern description, sort eleven short presentations into the three routes described above. Recognising the distinction in other people's examples builds the same discrimination skill you will need when you look at your own pattern in the next exercise, and the distinction matters because the wrong route delays the help that would actually work, or in the case of dependence, could genuinely put someone at risk.

This programme is the right fit for hazardous or harmful patterns of substance use, of the person's own choosing, with no signs of physical dependence and no substance whose withdrawal risk profile rules out self-directed reduction. Seeing a GP first is the right route wherever there are signs of physical dependence, such as withdrawal symptoms, morning use to feel normal, or a history of a withdrawal seizure, even where the person feels ready to act alone. Specialist drug and alcohol or mental health services are needed now wherever there is a dangerous withdrawal profile regardless of dependence severity, a specific medical risk such as pregnancy, an age below eighteen, or a severe psychological comorbidity.

The groups: A This programme is the right fit B See a GP first, before attempting to cut down C Specialist services are needed now

Write the letter of the group each item belongs to in its box.

☐ 1. Drinking most evenings, four to five units at a time, gradually increasing over about two years, no withdrawal symptoms, no morning drinking, a partner has mentioned mild concern

☐ 2. Drinking ten or more units on both Friday and Saturday nights most weekends, little or no drinking during the week, hangovers affecting concentration and performance on Mondays

☐ 3. Opens a can of strong lager immediately on waking because hands are shaking and the shaking settles once the first drink is finished; has tried going a day without drinking and felt sweaty, anxious, and unwell

☐ 4. Drinking daily for several years with a high and still-increasing tolerance, had a seizure two years ago during a previous attempt to stop drinking suddenly, currently still drinking at the same level

☐ 5. Using cannabis most evenings to wind down, a pattern that has grown over the past year, noticing some effect on motivation and short-term memory, no other substance use, no withdrawal symptoms

☐ 6. Taking diazepam most days, obtained outside of a prescription, worried about what would happen if stopping suddenly given what has happened to others in a similar position

☐ 7. Using cocaine on nights out most weekends, a pattern that has increased in frequency over six months and is becoming difficult to afford, no daily use, no physical withdrawal symptoms noticed

☐ 8. Currently pregnant and drinking several times a week

☐ 9. A seventeen-year-old drinking with friends at weekends, noticed and raised by a parent, with no other features of concern

- [ ] 10. Drinking alone most nights to cope with stress from a difficult job, aware the pattern is becoming more frequent, no withdrawal symptoms, keen to address it before it becomes worse
- [ ] 11. Drinking daily for several years, needing a clearly increasing amount to feel the usual effect, has never actually tried stopping and does not know what would happen, a mild tremor has been noticed most mornings

The answers are at the back of the book.

WORKSHEET

Locating your own pattern

Take fifteen to twenty minutes and write an honest description of your own pattern: what you use and how often, your AUDIT-C score and band if alcohol is involved, what tends to trigger use, what the consequences have been so far for your health, mood, relationships, work or finances, and whether any of the dependence or specialist-risk signs set out above apply to you.

Then look honestly at what you have written against the three routes set out in this module. If anything in your description points towards seeing a GP first or towards specialist services, please pause here and take that route instead; it is a sign this programme has done exactly the job this first module was designed to do. If you are confident this programme is the right fit, the next module begins the actual work, starting with understanding why harmful use develops and keeps going once it has started.

Describe your own pattern honestly and check it against the three routes above.

CHAPTER 4

What you have done in this module

You understand the difference between hazardous use, harmful use, and dependence, and why that distinction is not just semantic but genuinely changes what the safe and appropriate next step is. You have scored your own pattern on the AUDIT-C, or described it in equivalent terms, and checked it honestly against the specific signs that mean a GP or specialist service should come before, or instead of, this programme. If you have reached this point and nothing in Module 1 has redirected you elsewhere, the next module moves on to understanding how harmful use actually develops and what keeps it going, which is the foundation for everything the rest of the programme builds on.

CHECK-IN

Mood check-in (PHQ-9)

Before you begin, take a few minutes to complete this short questionnaire. It is the same one used in NHS Talking Therapies and gives us a baseline against which to measure your progress over the programme.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total: _____ **Date: _____**

Add up the numbers you have circled. A total of 0 to 4 suggests minimal symptoms of depression, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe and 20 to 27 severe. Note your total and the date, so you can compare the next check-in with this one.

If you circled anything other than 0 for the last question, please talk to your GP or call NHS 111 today. If you are in danger now, call 999.

The PHQ-9 and GAD-7 were developed by Drs Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission is required to reproduce, translate, display or distribute them.

CHECK-IN

Everyday life check-in (WSAS)

And one more short questionnaire about how things are affecting everyday life: work, home, social life, relationships and leisure. Functioning often recovers on a different timetable to symptoms, and it matters just as much.

This check-in uses the WSAS (Work and Social Adjustment Scale). If you are using the online programme, complete it there, where your scores are kept and compared for you. If you are working from this book alone, your GP or therapist can give you a copy.

WORKSHEET

Taking this forward

Before you move on, take two minutes to make this module harder to lose. Skills fade fastest in exactly the moments they are needed most, so the work here is to decide now, while things are steady, what you will reach for when they are not.

If things ever feel much worse rather than better, that is a signal to reach out rather than push on alone: use the messaging button to contact the practice, speak to your GP, or if you feel unsafe right now contact 999 or the Samaritans on 116 123.

Three short answers, in your own words. First: what single idea or skill from this module do you most want to keep? Second: when, realistically, will it be hardest to use, name the actual situation. Third: what exactly will you do in that moment? Write it as a sentence you could follow when stressed.

PART 2

How Harmful Use Develops and Is Maintained

The psychological mechanisms, reinforcement, tolerance, cue reactivity and self-medication, that keep a harmful pattern going, and where you currently sit in your own readiness to change

CHAPTER 5

Why this matters before anything else

It would be easy to assume that harmful substance use continues simply because the person involved lacks willpower or has not yet decided, firmly enough, to stop. This module sets that assumption aside, because it is not well supported by the psychological evidence and because, in practice, it tends to generate shame rather than change. A more accurate and considerably more useful account is that a substance keeps being used because it is doing real psychological work, work that has a specific mechanism, and understanding that mechanism is the foundation for everything the rest of this programme builds, including the urge-surfing technique in Module 5 and the alternatives repertoire in Module 6, both of which only work well once you understand what they are actually replacing.

CHAPTER 6

Reinforcement, tolerance, and cue reactivity

Behaviour that is reinforced tends to continue, and substance use is reinforced in two distinct ways that are worth telling apart. Positive reinforcement means the substance produces a pleasant effect directly: a feeling of relaxation, pleasure, confidence, or social ease that would not otherwise be there. Negative reinforcement means the substance removes or reduces something unpleasant: it quietens anxiety, lifts a low mood briefly, relieves boredom, settles anger, or, once tolerance and dependence-adjacent patterns begin to develop, relieves the early discomfort of simply not having used for a while. Both forms of reinforcement are genuinely powerful, and in practice most people's own pattern involves a mixture of both, though usually with one predominating; telling which is doing more of the work in your own case is one of the more useful things this module's exercise asks you to do, because the two call for different kinds of alternative later in the programme.

Tolerance is the well-documented process by which the body and brain adapt to repeated exposure to a substance, requiring progressively larger amounts to produce the same effect. This is not a character failing; it is a predictable physiological adaptation, and it is part of why a pattern that started as occasional and moderate can, without any single dramatic decision, gradually become daily and heavy. Tolerance also means that stopping or cutting down reveals, by contrast, just how much adaptation has occurred, which is part of why self-monitoring, covered properly in Module 3, matters more than most people expect; the drift is usually too gradual to notice from the inside without writing it down.

Cue reactivity describes how specific people, places, times of day, objects, or emotional states become linked, through ordinary associative learning, to the urge to use. A particular chair, a particular time after work, a particular friend, or a particular feeling of flatness on a Sunday afternoon can each become a learned trigger, producing a craving that feels, in the moment, almost automatic. This is not weakness either; it is how association works in the human brain, and it is precisely why Module 3's trigger-mapping exercise and Module 5's urge-surfing technique both work directly with triggers as identified, specific things rather than treating cravings as a single undifferentiated force to be resisted through general effort.

The end of the sample

This is a free sample of “Understanding and Managing Harmful Drinking and Substance Use”, and it ends here.

Everything you have read here is from the opening of the book, set exactly as it is printed in it. The rest follows in the same way, chapter by chapter, with its worksheets, its examples and its reference list.

The full book is on sale in the Talking Therapies UK shop. A copy is yours to keep, as a PDF and an ebook, licensed to you by name: a short line saying so is printed at the foot of each page of the PDF and on the title page of the ebook.