Cognitive-Behavioral Therapy (CBT) for Alcohol Misuse and Other Substance Use Problems:

Teaching Patients Self-Help Skills to Replace Self-Medication

Part II: Case Conceptualization and Practical Techniques, in Session and for Homework

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“Bridge” from Webinar #1

- CBT techniques are enhanced by a positive therapeutic relationship. They go hand in hand.
- The methods of creating, nurturing, managing, and sustaining a positive therapeutic relationship are “techniques” in and of themselves.
- A sense of collaboration and teamwork are essential. “Confrontation” must be respectful.
- [Now for a few slides from the end of Webinar #1 as a pathway to the new slides of Webinar #2].

Creating a Better Therapeutic Relationship

- Do not express judgmental attitudes.
- Focus on the patients' subjective distress, not just whether or not they have used drugs.
- Emphasize the goal of trying to help the patients improve their lives, not just to become sober.
- Be willing to continue working with substance abusers who have had a relapse.
- Retention of the patients in treatment is of paramount importance. Be proactive!

Therapeutic alliance enhancement via the case conceptualization*

- Explore the *meaning* and *function* of the patient's seemingly oppositional or self-defeating actions.
- Strive to understand the pain, fear, and ambivalence behind the patient's hostility, resistance, and dishonesty.
- Collaboratively utilize unpleasant feelings in the therapeutic relationship as "grist for the mill."

*More on case conceptualization coming up.

Stay focused on the goals of treatment.

- When you are in disagreement with your patient, stop and review your areas of agreement.
- Remain focused on the patient's personal strengths and admirable qualities.
- Find areas of "compromise" (e.g., when the patient does not wish to stop using drugs entirely).

Positive therapist beliefs to enhance the therapeutic alliance.

- “My patients may or may not accept my clinical judgments, or my good will, but I will offer them just the same.”
- “I can teach my patients to utilize a wide range of self-help techniques, and I can consistently encourage them to use them.”
- “If I help even one patient, I am helping his or her loved ones as well.”

The challenge of understanding

Case Conceptualization

- The “roadmap” to understanding the patient’s subjective world.
- Doubles as a roadmap for understanding how best to select, modify, and target interventions.
- Helps the therapist transcend being generally empathic in order to rise to the level of being *accurately* empathic.
- Not etched in stone. It evolves as new information comes to light.

Case Conceptualization

- What is the “function” of the dysfunction?
- What is the “logic” in the apparent illogic?
- How did these patterns originate?
- What factors maintain these problems?
- What are the obstacles to positive change?
- Which factors can we change/improve?
- What can we predict about the patient’s response to…?
    - A particular intervention?
    - A particular homework assignment?
    - A setback?

Case Conceptualization

Historical & Developmental data

- Family history of mental disorder, substance abuse, suicide.
- Family structure, landmarks, secrets.
- Quality of patient's relationships to parents or caregivers.
- History of emotional, physical, sexual abuse.
- Quality of peer relationships before adulthood (bullying, ostracism, exclusion?)

Case Conceptualization (continued)

Historical & Developmental data

- The family and/or surrounding environment may have been unsafe and unstable.
- The patient may have endured sexual abuse/violence.

Case Conceptualization (continued)

Historical & Developmental data

- The family and/or surrounding environment may have been neglectful and depriving.
- The family and/or surrounding environment may have been punitive and rejecting.
- The family and/or surrounding environment may have been invalidating and subjugating.

Case Conceptualization (continued)

Historical & Developmental data

- Family history of problems with alcohol and other drugs.
- Role of religion in the patient's upbringing.
- Academic and employment history.
- Significant romantic relationships and patterns thereof.
- Patient's medical and legal histories.

Case Conceptualization (continued)

- **Current Life Situation**
  - Typical daily activities.
  - Patient's personal strengths.*
  - Patient's current mood state.
  - Patient's current level of suicidality.
  - Patient's beliefs about self, others, and future.
  - Environmental factors that maintain dysfunctional patterns and schemas.

*Kuyken, Padesky, & Dudley (2009).

Early Maladaptive Schemas (rapid overview)

(As defined by Jeffrey Young & Janet Klosko; Arnoud Arntz & team)

- Broad, pervasive themes or patterns.
- Comprised of memories, emotions, cognitions, and bodily sensations.
- Regarding oneself and one's relationships with others.
- Developed during childhood or adolescence.
- Dysfunctional, especially when elaborated over time and generalized across contexts.
- **Schemas interact with specific beliefs about alcohol and other drugs.**

All of us have “schemas,” but…

In chronic, serious psychological disorders the schemas are more maladaptive, more severe, and in greater numbers.

In chronic, serious psychological disorders the *coping strategies* are more extreme and cause more problems (e.g., self-medicating; morbid avoidance)

Early Maladaptive Schemas

(Disconnection and Rejection)

- Abandonment / Instability.
- Mistrust / abuse.
- Emotional deprivation.
- Defectiveness/ “Badness”/ Shame.
- Social isolation / Alienation / Unlovability.

Early Maladaptive Schemas

(Impaired Autonomy and Performance)

- Dependence / Incompetence.
- Vulnerability to harm.
- Enmeshment / Undeveloped sense of self.
- Failure.

Early Maladaptive Schemas
(Impaired Limits)

- Entitlement / Insufficient limits.

- Insufficient self-control or self-discipline.

Early Maladaptive Schemas
(Overvigilance and Inhibition)

- Unrelenting standards / Hyper-criticalness
- Negativity / Pessimism.
- Punitiveness.

Specific Techniques (1)

- Thought Records (and similar methods for rational responding)
  - Rational responding to automatic thoughts, against "permission-giving", etc.
  - Constructive self-talk instead of self-medication.
  - Constructive ideas against helplessness, hopelessness, and catastrophizing.

THOUGHT RECORD

Directions: When you notice your mood getting worse, ask yourself, **"What's going through my mind right now?"** and as soon as possible jot down the thought or mental image in the Automatic Thought Column.

DATE/ TIME	SITUATION 1.What actual event or stream of thoughts, or daydreams, or recollection led to the unpleasant emotion? 2.What (if any) distressing physical sensations did you have?	AUTOMATIC THOUGHT(S) 1.What thought(s) and/or image(s) went through your mind? 2.How much did you believe each one at the time?	EMOTION(S) 1.What emotion(s) (sad, anxious, angry, etc.) did you feel at the time? 2.How intense (0-100%) was the emotion?	ALTERNATIVE RESPONSE 1.(optional) What cognitive distortion did you make? (e.g., all-or-nothing thinking, mind-reading, catastrophizing, etc.) 2.Use questions at bottom to compose a response to the automatic thought(s). 3.How much do you believe each response?	OUTCOME 1.How much do you now believe each automatic thought? 2.What emotion(s) do you feel now? How intense (0-100%) is the emotion? 3.What will you do ? (or did you do?)

Questions to help compose an alternative response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? Could I live through it? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of changing my thinking? (5) What should I do about it? (6) If _____ (friend's name) was in the situation and had this thought, what would I tell him/her?

Thought Record (Sample content)

Automatic Thought/Belief:

"If I use cocaine only on Saturday nights, I won't become addicted, and nothing bad will happen."

[This belief may interact with a schema of *entitlement* and *insufficient limits*.]

Thought Record (Sample content)

Questions

How else can I view this situation?

What is the evidence, for and against?

What would I advise a friend to do?

What constructive action can I take?

Thought Record (Sample content)

Rational Responses (using the questions)

I am setting myself up for a full relapse.
I am giving myself permission to use.
Whenever I start using, I can't stop.
I would tell a friend he is lying to himself.
I can go to a 12-step meeting on Saturday.
I can watch a hockey game at home.

Thought Record (Sample content)

Automatic Thought/Belief:

"I can't socialize unless I'm drunk or high."

[This belief may also reflect a schema of social *isolation, alienation, unlovability*, and/or a schema of *dependence, incompetence*].

Thought Record (Sample content)

Questions

How else can I view this situation?

What is the evidence, for and against?

What would I advise a friend to do?

What constructive action can I take?

Thought Record (Sample content)

Rational Responses (using the questions)

It would be difficult to socialize while straight, but I would be showing I'm serious about my recovery.

It has been a long time since I hung out with others without at least drinking. But I remember the time I went to a "sober New Year's Eve Party." I can do it if others are also sober.

I would tell a friend to be herself, and give it a try.

I can tell one or two friends that I need their support.

Thought Record (Sample content)

Automatic Thought/Belief:

"If I want to use, nothing can stop me."

[This belief may interact with a schema of *insufficient self-control or self-discipline*].

Thought Record (Sample content)

Questions

How else can I view this situation?

What is the evidence, for an against?

What would I advise a friend to do?

What constructive action can I take?

Thought Record (Sample content)

Rational Responses (using the questions)

That's just an excuse to use. I am responsible for stopping myself. Just don't start.

I used to let myself do whatever I wanted. However, now I want to work my program of recovery.

I would tell a friend to reach out to others, go to a meeting, or go for a run. Anything but use alone.

I can say no to myself and ride it out while doing something else I need to do. I can call my sponsor.

Specific Techniques (2)

- Activity Monitoring / Planning
  - Assess how patients spend their time.
  - Plan new activities to fill the new time void left by the avoidance of drinking/using other drugs.
  - Maximize activities that create a sense of *mastery* and *accomplishment*.
  - Utilize activities that involve sober *enjoyment*.

Activity Schedule (Daytime)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6:00	Asleep	Asleep	Asleep	Asleep	Asleep	Asleep	Go home
7:00			Breakfast	Gym			Asleep
8:00			E-mails	Breakfast			
9:00			Class	Study			
10:00			Class	Study	Breakfast		
11:00		Class	Class	Class	Errands		
12:00		Class	Lunch	Class	Errands		
13:00	TV	Lunch	You Tube	Lunch	Music/Study	Lunch	
14:00	Lunch	Study	Class	Video games	Music/Study	Watch sports on TV	
15:00	Video games		Class	Video games	Gym		
16:00	Drink		Friends	Friends	Gym		Sick

Activity Schedule (night)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
17:00	Drinking	Study	Friends	Friends	Out to dinner	Video games	TV
18:00	TV / food	Dinner	Dinner	Dinner	Out to dinner	Video games	
19:00		Attend game	Library	TV sports	Sports bar	Friends	
20:00		Attend game	Library			Out to dinner	
21:00		Drinking	TV sports			Out to dinner	Food
22:00	Web surfing and video games		TV sports			Dancing and other things	Study
23:00			Web surfing and video games	study			Video games
0:00		Video games	Asleep		Friends and other things		Talking to friends
1:00		Asleep					Talking to friends
2:00 – 6:00	Asleep	Asleep		Asleep			Asleep

Specific Techniques (3)

- The "D & D" technique (*delay* and *distraction* in response to craving).
  - Craving comes in waves.
  - "Ride out the wave" via "D&D".
  - "Procrastinate" drinking/drugging.
  - "Starve the monster" (do ***not*** feed it).
  - Utilize sober activities to facilitate D&D.
  - ***Mindfulness methods can be used here!***

Specific Techniques (4)

- **Advantages – Disadvantages Analysis.**
  - 2x2 table (pros and cons; using and not).
  - For self vs. for loved ones.
  - For now vs. for the future.
  - Use the “pros for using drugs” box to spot dysfunctional beliefs that can be rationally re-evaluated via the use of Daily Thought Records.

"Pro's for using drugs"
(Items to be evaluated and modified on Thought Records)

"I feel self-confident when I'm high."

"I can forget about my problems for a bit."

"My medical pain goes away for a while."

"Drinking fills up my empty time."

"Using drugs relieves my cravings."

Therapists should give empathy for the patient's feelings as part of the process of re-evaluating and modifying these dysfunctional beliefs.

Pros of using	Cons of using
I feel more self-confident. **I can forget about my problems.** **My medical pain feels better.** **Drinking fills up my empty time.** **I can satisfy my cravings.**	**My confidence is an illusion.** **My problems actually get worse.** **I am killing myself slowly.** **I create more things to worry about in reality.** **My cravings get stronger next time.**
Pros of NOT using	Cons of NOT using
I may earn the trust of my family. I will save money. I will be able to keep my promises. I will be able to look at myself in the mirror without being ashamed. I will look better and feel better. I will be able to study and work. I will have more self-respect.	I will have withdrawal symptoms. I will have to confront all my problems. I will still have to admit that I am addict, but I won't be getting high. I will feel pressure to stay free of drugs. People will expect more of me.

Therapist Video Demonstration

Patient demonstrates good grasp of the treatment model, describing a high-risk situation and how he used his coping skills to emerge without taking a drink.

Therapist guides and gives positive reinforcement.

Therapist introduces the Thought Record.

Specific Techniques (5)

- **Personal Skills Enhancement**
  - Problem-solving skills.
  - Communication skills (e.g., less profanity).
  - Assertiveness skills (especially for refusing a drink /drug, and to reduce anger).
  - Decision-making skills (especially for mindfully avoiding high-risk situations). Teach patients to ask themselves critical questions! (e.g., “What is my goal?”)

Additional Techniques

- Role-playing.
  - *Practice telling someone the truth.*
  - *Practice rational responses against tempting automatic thoughts.*
  - *How to say "no" to an offer of a drink.*

- Flashcards ("affirmation statements")
  - *"Do the right thing for your children."*
  - *"Be brave. Be wise. Be sober. Be free."*
  - *"Make the call before you fall."*

Additional Techniques

- Create a "higher standard" of behavior.
  - *Don't use profane language.*
  - *Be considerate of other people's feelings.*
  - *Donate your time to help others (e.g., be a 12-step sponsor, be a "Big Brother/Sister," think of others' needs before your own.)*
- Establish new, healthy daily routines.
  - *Early to bed and early to rise!*
  - *Be where you are supposed to be, when you are supposed to be there.*

Homework

- The previously mentioned CBT techniques are readily usable as part or all of the patient's homework assignment(s), including:
  - Thought Records.
  - Activity Tracking and Scheduling. (Including self-monitoring)
  - "Delay and Distract" methods.
  - Weighing pros and cons.
  - Trying healthier forms of communication.
- Homework can also include items such as:
  - Attending meetings.
  - Doing readings.
  - General journaling.
  - (Many others).

Principles of Effective Homework.

- Provide explicit instructions.
- Ask the patients for feedback, including their understanding of the purpose, and intended benefits.
- In general, the benefits are…
  - Learn a new, useful psychological skill.
  - Improve morale and hopefulness.

Principles of Effective Homework (continued)

- Ask the clients how likely they are to do the homework – or how confident they are about doing it (0-100 scale).
- Inquire about potential obstacles that could get in the way of doing the homework.
- Rationally respond to discouraging or avoidance-inducing thoughts about the homework.

Principles of Effective Homework. (Continued)

- **Set up the homework as a "no-lose" situation.**
  - If homework is attempted, this is a triumph over inertia and hopelessness.
  - If homework is not done, it becomes an opportunity to understand "what gets in the way of self-help."
- **Therapist encourages; never judges.**

Q and A time