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

Teaching Patients Self-Help Skills to Replace Self-Medication

Part III: Managing Comorbidities, Crises, Relapses

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“Bridge” from Webinar #2

- The case conceptualization is an ever-evolving roadmap to understanding the patient’s subjective world, and targeting interventions.
- Specific CBT techniques can be used in session and for homework.
- CBT techniques aim to modify beliefs, raise the standard of behavior, improve coping skills, and provide practice.
- [Now for a few slides from the end of Webinar #2 as a pathway to the new slides of Webinar #3].

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.

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.*

Managing…

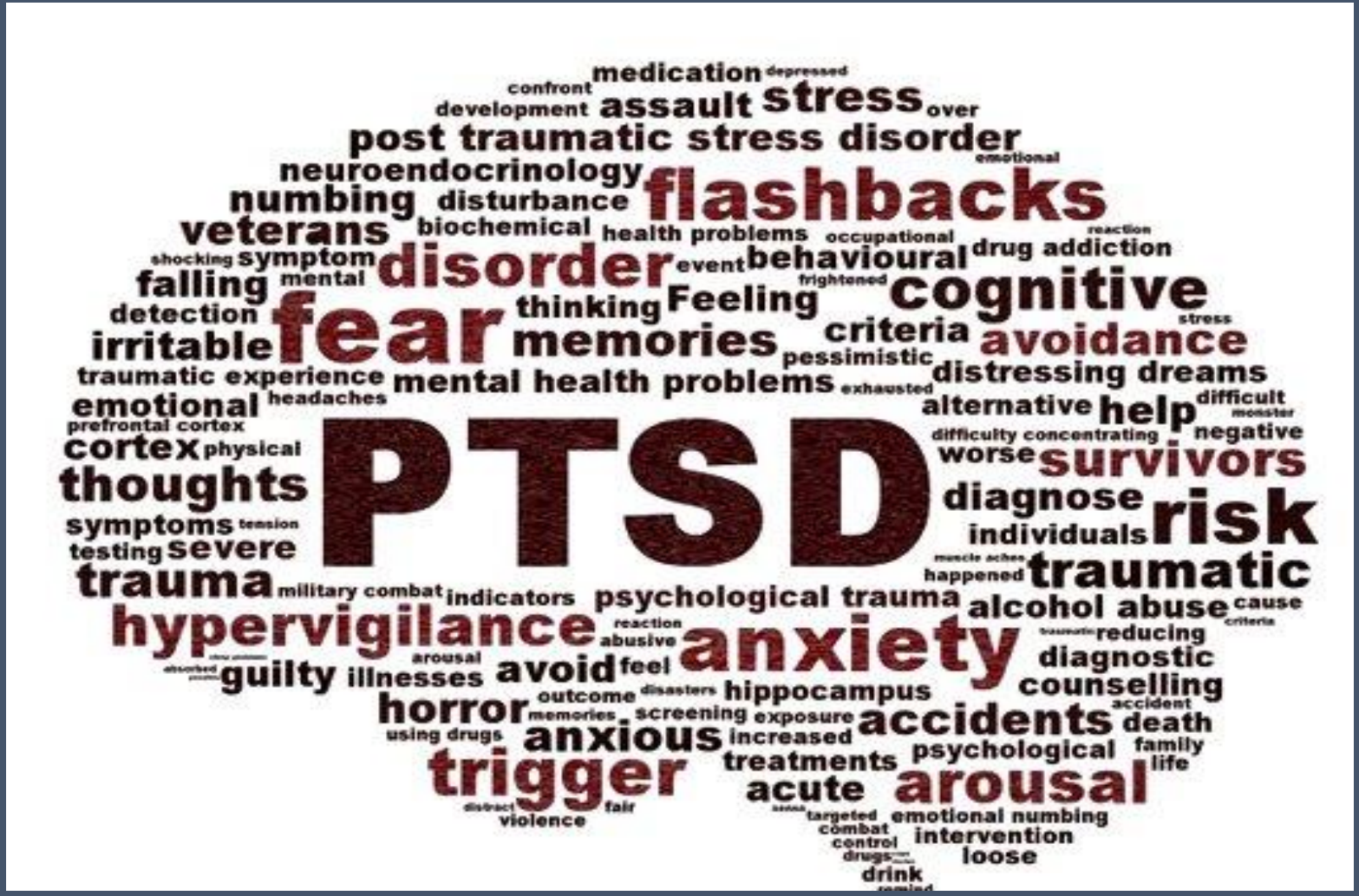
Complexity, High-Risk, Crises, & Relapses

(The intersection of CBT with critical case management)

Defining “Complexity” and “High-Risk”

- Multiple diagnostic features (“comorbidity”).
- Long history of dysfunction; previous treatments.
- Many factors maintain the patient’s problems.
- Frequent and/or serious crisis situations.
- Difficulties in the therapeutic relationship.

Also, medical problems, poor response to pharmacotherapy, etc.


PTSD
flashbacks
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disorder
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using drugs
anxious
increased
psychological
family
life
trigger
treatments
acute
arousal
distract
fair
violence
targeted
emotional numbing
combat
intervention
control
drugs
loose
drink

Crisis Prevention/Intervention
(e.g., suicidal ideation and/or intent)

- Elevated suicide risk is always the top-priority agenda item for discussion in a session.
- Inquire about suicide risk early in the session to give yourself enough time to intervene.
- Ask guided discovery questions first (i.e., do not feel rushed to produce immediate interventions).
- Remain calm, non-defensive, and empathic.

Outpatient Management of Patients with Elevated Suicide Risk

- If possible, increase the frequency of appointments.
- *Schedule* phone contacts. (Much better than answering spontaneous crisis calls.)
- Coordinate care with other professionals who may be on the case.
- Assess the need for hospitalization.
- Seek an outside consultation if necessary.

Create a Safety Plan (1)

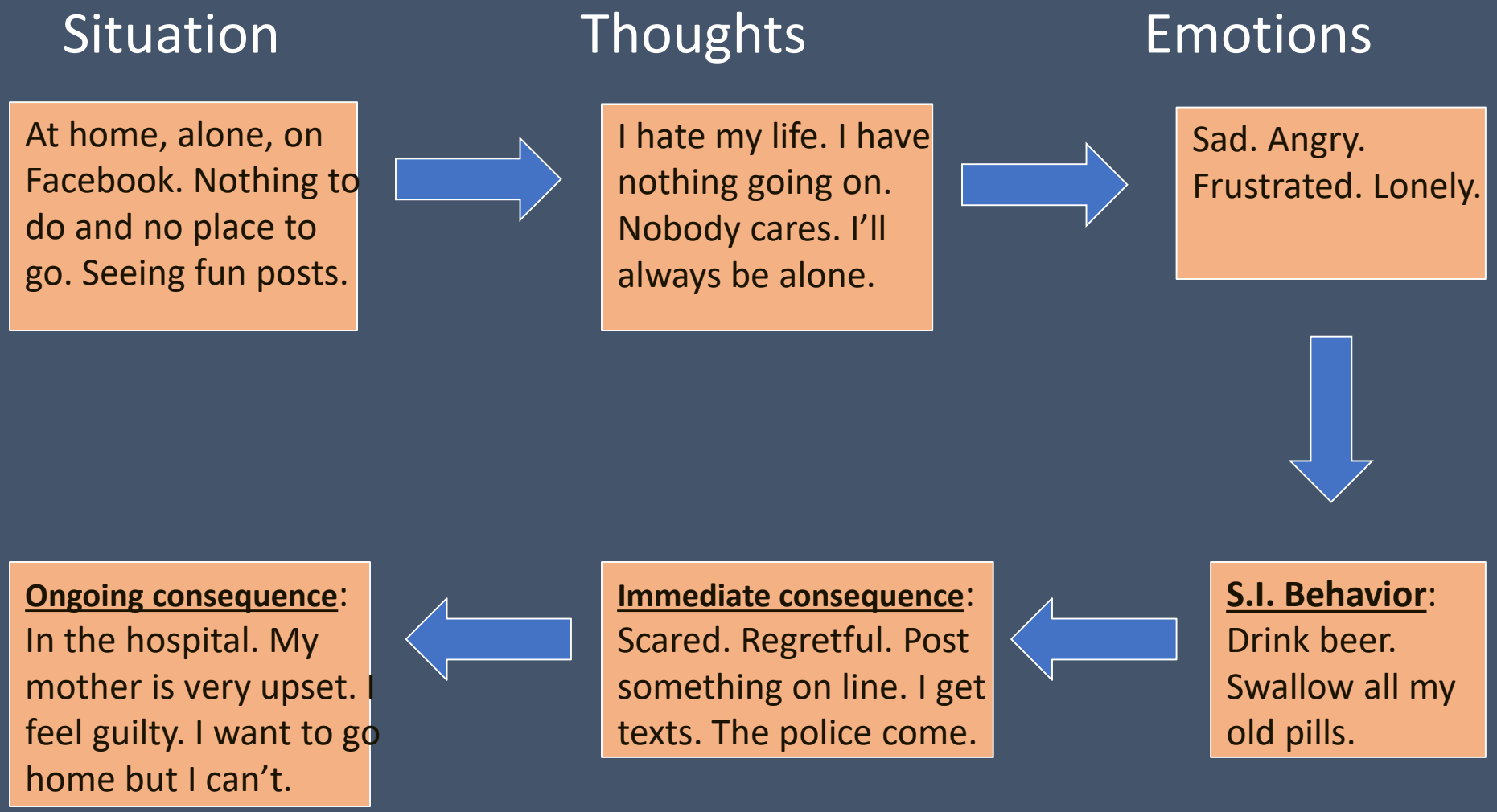
- **Recognize "early warning signs."**
  - Thoughts and feelings of hopelessness.
  - Self-isolation.
  - Warning: Schema activation can create rapid decline.
- **Use social support.**
  - Facilitate communication.
  - List of family, friends, support group members, sponsor.
- **Contacting mental health professionals.**
  - Therapist; Psychopharmacologist; Crisis Center.

Stanley, B., & Brown, G. (2012).

Create a Safety Plan (2)

- **Make use of well-practiced coping skills.**
  - Physical activity.
  - Self-soothing (not self-medicating). Example: music, warm shower, fragrance, “comfort food.”
  - Writing and rational responding.
  - Mindfulness exercises.
- **Reduce access to lethal means.**
  - Ask a family member to be in charge of distributing the patient’s medication (to prevent overdose).
  - Ask the patient to give up possession of a weapon.

Chain Analysis of the Suicidal Behavior



Understand the Crisis Situation(s)

- Crises can be conceptualized.
- Therefore, they can be “educational.”
- Which part of the crisis is an “objective” crisis (i.e., most people would respond similarly)?
- Which part of the crisis is about schema activation (i.e., the reaction seems “magnified” and idiosyncratic)?

Crisis Prevention/Intervention:
Relationship Discord (1)

- Is the patient's partner also abusing substances?
- Is the patient's partner trying to "escape" from your patient? If so, be careful not to blindly assist your patient in trying to reconcile with the partner.
- Is there violence or threat of violence?
- Be careful about "triangulation."

Crisis Prevention/Intervention:
Relationship Discord and Co-Dependency (2)

- Discuss the relationship problem as a “high-risk situation” for drug use.
- How trustworthy is the patient in his/her relationship?
- The patient’s descriptions of the relationship are a good measure of his/her/their degree of “externalization.”

Crisis Prevention/Intervention:
Medical and General Health Problems

- Neglect of health is common. Assess eating, sleeping habits.
- Patients may fail to take their prescribed medications.
- Gain permission to establish communication with the patient's family and primary care physician, if possible.
- Discuss the relationship between the patient's medical problems and his/her/their addictions.
- Examine impact of the patient's drug abuse on his/her/their sexual behavior.
- Be prepared to discuss the issue of sexually-transmitted disease. Openly discuss what constitutes "safe sex."

Crisis Prevention/Intervention:
Legal Difficulties

- Is the patient at risk for going (back) to jail?
- Understand and communicate the limits of confidentiality.
- Establish a policy about your involvement that is consistent with your legal responsibilities (reporting to the court?).
- Be prepared to defuse the patient's anger. Express commitment to help, but also set limits (empathically).
- Is the patient a danger to others? To *you*?
- Consult and document!

Crisis Prevention/Intervention:
Trauma and Loss

- Loss, regret, and past trauma all can increase the patient's hopelessness and vulnerability to relapse and self-harm.
- Be aware of anniversaries of the deaths of the patients' loved ones. This is a time of special risk for your patient.
- If a patient is actively abusing alcohol and/or other drugs, always be aware of the risk for suicide.

Depression, Anxiety, and Self-medication

- Define the patient's dysphoria, anxiety, anger, guilt, and other negative emotions as "internal, high-risk situations."
- Patients may believe that they can feel better only if they use alcohol and other drugs.
- Patients may choose to discontinue the "wrong chemical" (e.g., they stop taking their anti-depressants, but they continue to drink heavily).
- Teach the patient the methods of relaxation and mindfulness (and other standard CBT methods for mood and anxiety problems).

Video (Excerpts of a role-play):

Patient self-medicates his anxiety/panic

- Patient (a law student portrayed in a role-play by his real-life therapist) identifies his anxiety/panic as the problem.
- He minimizes his drinking (and smoking cannabis).
- He expresses irritation at the idea of “collecting data” on himself.
- Therapist tries to find a way to make the assignment acceptable.
- Therapist highlights relevant drug-related beliefs.
- Pros and cons.
- Therapist appeals to the patient’s strengths to gain collaboration.
- Anticipating upcoming challenges.

Co-morbid Personality Disorders (1)

- Patients with ***borderline*** features may view alcohol and other drug use as their form of mood management, or even as a deliberate form of self harm.
- The alcohol and drugs cause even *more* dis-inhibition, acting out, and consequences.
- They may believe that they are hopeless, incompetent, and unlovable; thus, they feel unworthy of treatment or improvement.
- Suicidality is a constant problem in treatment.

Comorbid Personality Disorders (2)

- Patients with ***anti-social*** features may view the therapist as an “authority” whose rules are meaningless. Thus, they may not adhere to a therapeutic contract.
- They may try to take advantage of their therapist’s kindness and positive regard.
- Watch out for “special requests” they ask of you in an attempt to make you collude with their counter-therapeutic agenda.
- If they don’t get their way, they will leave.

Comorbid Personality Disorders (3)

- Patients who demonstrate ***avoidant*** and ***dependent*** personality traits may choose to drink and use drugs rather than face the tasks of therapy.
- They may be at risk for being under the control of family or love partners who are using alcohol and other drugs.
- They may not wish to attend sessions, but they do not want you to end their treatment!

Responses to Relapse into Drinking/Using (1)

- If the patient keeps an appointment, that is already a good sign.
- Routinely ask about any possible lapse/relapse episodes since the previous session. (It's *not* an accusation to ask!)
- If the patient fails to keep an appointment, reach out.
- If you cannot reach the patient, leave a caring, concerned message.
- If you get no response, consider contacting the patient's family in the manner of a safety check (inform the patient with a message).
- When the patient returns, process the absence as a clinical issue, not just as an administrative issue.

Responses to Relapse into Drinking/Using (2)

- Remember the *Abstinence Violation Effect* (the patient may turn a slip-up into full-fledge binge-drinking and/or binge-using).
- Be willing to discuss the seriousness of the situation, while reaffirming a commitment to help, and expressing hope.
- Increase vigilance in monitoring (including the patient's self-monitoring).
- Create a plan of action for the coming days (e.g., avoiding high-risk situations, planning healthy activities, identifying social support persons who are sober).

Therapist “Fight or Flight” Responses (1)

- High-risk patients, owing to their sometimes extreme behaviors, can trigger “fight or flight” responses in other people.
- Unfortunately, therapists may be tempted to respond with “fight or flight” as well (e.g., engaging in an argument; prematurely ending the session or treatment).
- Therefore, we as therapists need to find a healthier alternative to “fight or flight.”

Therapist “Fight or Flight” Responses (2)

- Engaging in a **power struggle** with the patient.
  - Example: Insisting on a given intervention as a requirement for being in treatment (e.g. exposures).
  - Example: Spending too much time addressing the patient’s choice not to fill out questionnaires.
  - Example: Arguing over the patient’s failure to do therapy homework.
- **Disengaging** from the patient.
  - Ending a session too early when the patient is passive.
  - Being too quick to terminate.

Therapist “Fight or Flight” Responses (3)

Healthy alternatives to “fight or flight” include:

1. Acknowledge the patient’s feelings.
2. Express a willingness to try to understand.
3. Express a willingness to work things out.
4. Being willing to look at ourselves and taking ownership of part of the issue.
5. Providing constructive feedback.

Responding Competently to the Patient's Expressions of **Anger**

- **Stay composed**. Keep your voice low and somber.
- Listen and reflect. Validate what you can.
- You may not be able to "solve" the problem right then and there, but your empathic, constructive words may at least **stabilize** the situation until such time as the patient is in a better frame of mind and you can process the situation calmly.
- Remember the motto, *"It's all data!"* (Let's conceptualize.)
- Communicate an attitude that says, *"We can work it out."*

Therapist Self-Reflection
("Using Yourself" in Session)

- Explain your intentions and rationale.
- What do my reactions tell me about the reactions this patient may elicit in others?
- Address the session ***process*** (what is happening "between you and me right now").
- Carefully, tactfully tell the patient what is going through ***your*** mind right now, including your own automatic thoughts and attempts at responding rationally.

Helpful reminders when treating patients with high levels of comorbidity and complexity

- Difficult experiences are “teaching moments,” and this is true of treating the most difficult-to-treat patients. Stay focused on the opportunity for professional growth.
- Remember, even if you are having trouble making progress with a given patient, your earnest efforts are preparing you to succeed with many *other* patients.
- Find the patient’s strengths. Mention them. Appreciate them.
- Sometimes patients give up on themselves. Show them that you are not going to join them!
- Remember that helping just one patient also helps others in their lives who are affected by the patient’s problems.

A Hopeful Message

You are not responsible for your patients' decisions to drink or use drugs, but you may be partly responsible for their recovery.

Although some of your patients who misuse alcohol and other drugs may not respond optimally to therapy, many others will experience partial remissions, and some will achieve long-term remissions.

For every patient you help, you also will help his/her/their family, and others!

THANK YOU! (It's Q & A time)

If you would like further information, please feel free to contact me at the following e-mail address:

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