



Addiction Messenger

SERIES 38 - June 2010 Volume 13, Issue 6

Ideas for Treatment Improvement

Cognitive Behavioral Therapy

Part 3 - Co-Occurring Disorders

CBT strategies are designed to explore client thinking patterns about situations and events, together with their beliefs, values, perceptions, and expectations regarding that experience. CBT approaches in substance use treatment are generally educational, problem-focused, and time-limited. The past two issues of the AM focused on the structure of CBT and the methods and strategies counselors can use to facilitate client changes in thinking and behavior. This issue will highlight tips related to the use of CBT with clients having co-occurring substance use and mental disorders.

CBT and COD

People with co-occurring disorders (COD) often have different, and sometimes more severe, thought distortions than those who have only a substance use disorder. As with other populations, clients with COD are encouraged to engage actively in their treatment, with the counselor's role largely one of educator and coach. CBT is most beneficial and effective with clients who are stabilized and not in acute distress. CSAT's TIP Series 42, *Substance Abuse Treatment for Persons with Co-Occurring Disorders* (2005), emphasizes the value of collaborative efforts between the client and counselor in identifying goals and setting agendas for each therapy session. Initially, clients with COD may need to concentrate on developing very specific coping skills during treatment. Some specific CBT strategies noted in TIP 42 are summarized below.

Adapting CBT for Clients with COD

In brief, it is suggested that counselors:

- Use visual aids, including illustrations and concept mapping (a visual presentation of concepts that makes patterns evident).
- Practice role preparation and rehearse for unexpected circumstances.
- Provide specific *in vivo* feedback on applying principles and techniques.
- Use outlines for all sessions that list specific behaviorally anchored learning objectives.
- Test for knowledge acquisition.
- Make use of memory enhancement aids, including notes, tapes, and mnemonic devices.

*"Do not let what
you cannot do
interfere
with what you
can do"*

*~ John Wooden (1910 -
present) ~*

Northwest Frontier
Addiction Technology
Transfer Center
810 D Street NE
Salem, OR 97301
Phone: (503) 373-1322
FAX: (503) 373-7348

A project of OHSU
Department of Public Health
& Preventive Medicine

Steve Gallon, Ph.D.
Principal Investigator

Mary Anne Bryan, MS, LPC
Program Manager, Editor
bryanm@ohsu.edu

www.attnetwork.org

Next Series:

**Screening, Brief
Intervention, and
Referral to
Treatment**

The District of Columbia, in partnership with the Danya Institute, developed a “best practices” curriculum that provides information for using CBT in a more concrete fashion with COD clients (DC Department of Mental Health, 2007). The curriculum provides the following tips:

Visual Aids - use cartoons, signs, illustrations, and/or pictures that clients draw to illustrate information.

Role Playing - practice target behaviors with clients or have them practice within a group setting. An advantage of role playing in groups is the fostering of group cohesion and energy and the general effectiveness of the role play learning experience.

Coaching - use on-the-spot coaching by recognizing when an opportunity presents itself that will allow the client to practice an adaptive behavior.

Memory Enhancement Aids - use visual aids such as flash cards, tokens, and/or items of a symbolic nature to help make the experience or lesson become more concrete for the client.

Session Outlines - use outlines and lists to anchor specific behavioral learning objectives for each therapy session. Insure retention of objectives by repeating the learning experience in several different ways (worksheets, role play, video).

Test for Knowledge - confirm knowledge gains and client ability to demonstrate learned skills. Repeat objectives and modify learning strategies as needed.

When Not to Use CBT

TIP 42 suggests that CBT not be used when:

- Clients with psychotic or bipolar disorders are not stabilized on medication. Instability can amplify the client’s emotional response.
- Clients do not have stable living arrangements. CBT is not appropriate when the client’s primary needs are a priority.
- Clients are not medically stable.
- Clients have a fixed delusion. Such clients are typically not receptive to cognitive restructuring.

Special Issues with COD Clients

Another publication, “Integrated Services for Substance Use and Mental Health Problems - Cognitive-Behavioral Therapy Curriculum 3: Clinician’s Guide” (McGovern, et al, 2008), highlights

several issues that could be problematic when counselors engage in cognitive restructuring (CR) with COD clients. CR is a method for understanding stressful feelings and moods and reframing negative thinking. Potential obstacles and strategies to address them include:

- Clients are unable to achieve abstinence and want to learn CBT coping skills first to achieve it.

CBT is best suited to clients who have obtained abstinence and/or are actively engaged in addiction treatment.

- Clients address problem thought patterns with only a small reduction in distress.

It’s common for clients to experience modest levels of stress reduction initially; focus on the improvements to gradually shape their ability to use CR. Practice will lead to improvement. If they’re adamant that new thought patterns give little benefit, then enlist them in reconciling this discrepancy rather than trying to “prove” it to them.

- Clients continue to embrace beliefs of self-blame or perfectionist expectations.

Ask clients how others might respond or behave in a similar situation to encourage them to examine their own beliefs and why they hold themselves to a higher standard. In addition, they can be supported in identifying past experiences that may have led to their unrealistic assumption .

- Clients adhere to beliefs that they “know” in the absence of any supporting evidence or logic.

Assure the client that it takes practice and tenacity to change strong belief patterns and replace them with more realistic ones. Collaborate with them on constructing a “payoff matrix” (functional analysis) that will help them identify the costs and benefits of giving up dysfunctional beliefs.

- Clients have difficulty learning the five steps of CR and find them too arduous and complex.

Clients can absorb the essence of CR without fully learning each of the five steps. Another approach is to present CR in three basic steps instead of five (feelings, self-statement, and new thought). The use of significant others to coach the client can also be effective especially if the client has cognitive impairments.

- Clients feel unable to use CR “in the moment.”

It’s often challenging for a client to use CR “in the moment” until they’ve had extensive practice. It may be most advantageous for these clients to first focus on distinguishing

whether their current feelings/thoughts reflect a common pattern of thinking for them that can be quickly modified.

- Clients are able to use CR to address everyday stressors, but not for trauma-related distress.

Reassurance that this is normal and that practicing CR related to traumatic events within the therapy session will enhance their skills in using CR is essential. With graduated steps and practice they'll be able to address trauma related stress on their own.

- Clients are uncertain about which situations to work on with CR.

Encourage the client to use CR whenever they notice distressing thoughts and emotions. The important lesson is to be aware of an upsetting emotion and use it as a cue to use CR to examine and evaluate the thoughts and beliefs that are behind the emotion.

- Clients are unable to generate evidence against a thought.

Consider assisting the client to generate evidence against a particular thought within the therapy session. After they're able to do this with some ease have them practice more through homework assignments and gradually promote doing it "in the moment."

- Clients are unable to identify automatic thoughts.

If the client is able to recognize difficult emotions but isn't able to identify the thoughts/beliefs that are behind the emotions, then practice during the therapy session will help followed by homework assignments.

- Clients generate alternative thoughts but with a low degree of believability.

Support the client in exploring new thoughts that incorporate some of the evidence against the old thoughts. Use questions to prompt clients to identify thoughts that they find more believable. It's important that they understand that their thoughts have probably been reinforced for a long time and will require practice to replace.

- Clients with multiple thoughts and feelings related to an upsetting situation are uncertain about which thoughts to challenge.

Ask the client to concentrate on the most distressing feeling first and then to identify the strongest thought associated with that feeling.

- Clients have upsetting situations that warrant both alternative thoughts and action plans.

Assist clients in developing an action plan to reduce stress after they've identified alternative thoughts regarding the original situation.

- Clients have difficulty generating distressing situations from the past week.

The client may have indeed experienced little stress during the previous week. Explore the potential for suppressed or withheld distress that the client has avoided.

- Despite efforts the client realizes that some situations just cannot be changed, either in thought or action.

Focus and acknowledge that some situations can't be changed and guide the client toward acceptance through a realistic appraisal of circumstances.

CBT and COD Resource

A complete integrated treatment program for working with clients with COD can be found in Hazelden's Co-Occurring Disorders Program which was developed by Dr. Mark McGovern and colleagues at the Dartmouth Medical School. The package of products includes:

- 5 curriculum packages (most have a 3 ring-binder, CD-ROM, Clinician's Guidebook, and client handouts) - \$1,295.00 (Individual curriculums can be purchased separately - \$165.00 - \$325.00)
- 1 DVD (83 min.) - A Guide for Living with Co-occurring Disorders: Help and Hope for Clients and Their Families - \$225.00
- Hazelden Co-Occurring Disorders Program Clinical Administrators Guidebook with CD-ROM - \$85.00.

SOURCES

DC Department of Mental Health (2007). Training Curriculum: Co-Occurring Disorders Clinical Competency Certificate Training. Downloaded from: http://www.danyainstitute.org/files/dc_cosig

Center for Substance Abuse Treatment (2008). Substance Abuse Treatment for Persons with Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42, DHHS Publication No. (SMA) 08-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration.

McGovern, M, Drake, RE, Merrens K, Mueser, K, and Brunette, M. (2008). Hazelden Co-occurring Disorders Program. City Center, MN: Hazelden Administration, 2005

Northwest Frontier ATTC

810 "D" Street NE

Salem, Oregon 97301

Phone: (503) 373-1322

FAX: (503) 373-7348



Finding Hope: Resources for Recovery

July 21 - July 23, 2010

Monarch Hotel and
Conference Center
Clackamas, Oregon

REGISTER AT:

lclark.edu/~ccps/nwais/index.html

Earn 2 Continuing Education hours for \$20 NAADAC Approved

by reading a series of three *Addiction Messengers* (AM)

If you wish to receive continuing education hours for reading the AM:

- fill out the registration form below, and complete the 2-page test on the following pages,
- return both to NFATTC with a fee **payment of \$20** (make checks payable to: NFATTC, please).

You will receive, by return mail, a certificate stating that you have completed 2 Continuing Education hours.

You may complete any of the past series you wish. You can download issues by clicking on the *Addiction Messenger* button on our website: <http://www.attcnetwork.org/regcenters/c1.asp?rcid=10&content=CUSTOM1>

- o **Series 5** Vol. 5, Issues 1-3 "Methamphetamine: Myths & Facts"
- o **Series 6** Vol. 5, Issues 4-6 "Co-Occurring Disorders"
- o **Series 7** Vol. 5, Issues 7-9 "Trauma Issues"
- o **Series 8** Vol. 5, Issues 10-12 "Cultural Competence"
- o **Series 9** Vol. 6, Issues 1-3 "Engagement & Retention"
- o **Series 10** Vol. 6 Issues 4-6 "Co-Occurring Disorders"
- o **Series 11** Vol. 6 Issues 7-9 "Integrated Services for Dual Disorders"
- o **Series 12** Vol. 6 Issues 10-12 "Infectious Diseases"
- o **Series 13** Vol. 7 Issues 1-3 "Contingency Management"
- o **Series 15** Vol. 7 Issues 7-9 "Research and the Clinician"
- o **Series 16** Vol. 7 Issues 10-12 "Recovery Support"
- o **Series 17** Vol. 8 Issues 1-3 "Family Treatment"
- o **Series 18** Vol. 8 Issues 4-6 "Cognitive-Behavioral Therapy"
- o **Series 19** Vol. 8 Issues 7-9 "Counselor As Educator"
- o **Series 20** Vol. 8 Issues 10-12 "Recovery Support"
- o **Series 21** Vol. 9 Issues 1-3 "Problem Gambling"
- o **Series 22** Vol. 9 Issues 4-6 "Treatment Planning"
- o **Series 23** Vol. 9 Issues 7-9 "Methamphetamine"
- o **Series 24** Vol. 9 Issues 10-12 "Using and Building Motivational Interviewing Skills"
- o **Series 25** Vol. 10 Issues 1-3 "Nicotine Cessation"
- o **Series 26** Vol. 10 Issues 4-6 "Improving Agency Process"
- o **Series 27** Vol. 10 Issues 7-9 "Motivational Incentives"
- o **Series 28** Vol. 10 Issues 10-12 "Recovery Oriented Systems of Care"
- o **Series 29** Vol. 11 Issues 1-3 "Family Treatment In Addiction Treatment"
- o **Series 30** Vol. 11 Issues 4-6 "Implementing Recovery Management"
- o **Series 31** Vol. 11 Issues 7-9 "The Returning Veterans Journey"
- o **Series 32** Vol. 11 Issues 10-12 "LGBTQ Issues in Addiction Treatment"
- o **Series 33** Vol. 12 Issues 1-3 "Prescription Medication Abuse"
- o **Series 34** Vol. 12 Issues 4-6 "Conflict Management"
- o **Series 35** Vol. 12 Issues 7-9 "Twelve Step Facilitation"
- o **Series 36** Vol. 12 Issues 10-12 "Integrating SA & MH Services"
- o **Series 37** Vol. 12 Issues 1-3 "Medication-Assisted Treatment"

Registration Form for Series 38 "Cognitive Behavioral Therapy"

Name _____

Address _____

City/State/Zip _____ Phone _____

Email _____

Return your Pre-test and Registration form by mail or FAX at (503) 373-7348

Make checks payable to NFATTC and send to NFATTC, 810 D Street NE, Salem, OR 97301

Name _____

TEST Series 38

1. What are some of the advantages to using Cognitive Behavioral Therapy (CBT) outlined in the overview?

2. There are two critical components of CBT presented in the overview. They are

- a. _____
b. _____

3. The overview of CBT presents five primary objectives of CBT, including:

- a. Teaching of coping skills
b. Fostering motivation for abstinence
c. Changing reinforcers
d. All of the above

4. Which of the following are effective strategies for using CBT:

- a. Focusing on the client's assumptions
b. Recognizing irrational thoughts
c. Using a systematic approach
d. All of the above
e. a and b

5. Clients may feel that their thoughts are invalidated when they are _____
(fill in the blank).

6. Drawing out thoughts and assumptions often lead to a deeper understanding of the client's underlying beliefs and assumptions.

True or False

7. Adapting CBT for clients with COD includes:

- a. Using visual aids
b. Session outlines
c. No role-playing
d. a and b.
e. All of the above.

8. The following CBT methods can open a window into the client's core issues:

1. _____
2. _____
3. _____
4. _____

9. CBT is best suited to clients who have obtained abstinence and/or actively engaged in addiction treatment.

True or False

10. It is best not to use CBT with clients with COD in the following situations:

1. _____
2. _____
3. _____

Mail or FAX your completed test to NFATTC
Northwest Frontier ATTC, 810 D Street NE, Salem, OR 97301 FAX: 503-373-7348
You can register for continuing education hours for Series 1 through 30.
Contact Mary Anne Bryan at 503-378-6001

