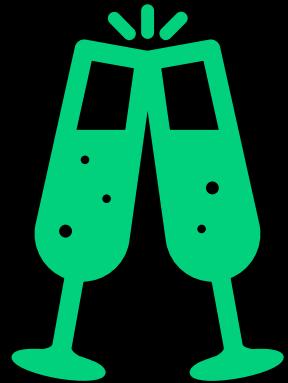


SUBSTANCE USE



What happens when
the host at a party
after 15 minutes say
they are out of the
alcohol?

COGNITIVE BEHAVIORAL THERAPY FOR PEOPLE IN LATER STAGES

- Early Active Treatment: the person is engaged in treatment and has reduced substance use for more than past month, but still meets the criteria for substance use
- Late Active Treatment: The person is engaged in treatment and has not met criteria for substance use for the past 1-5 months

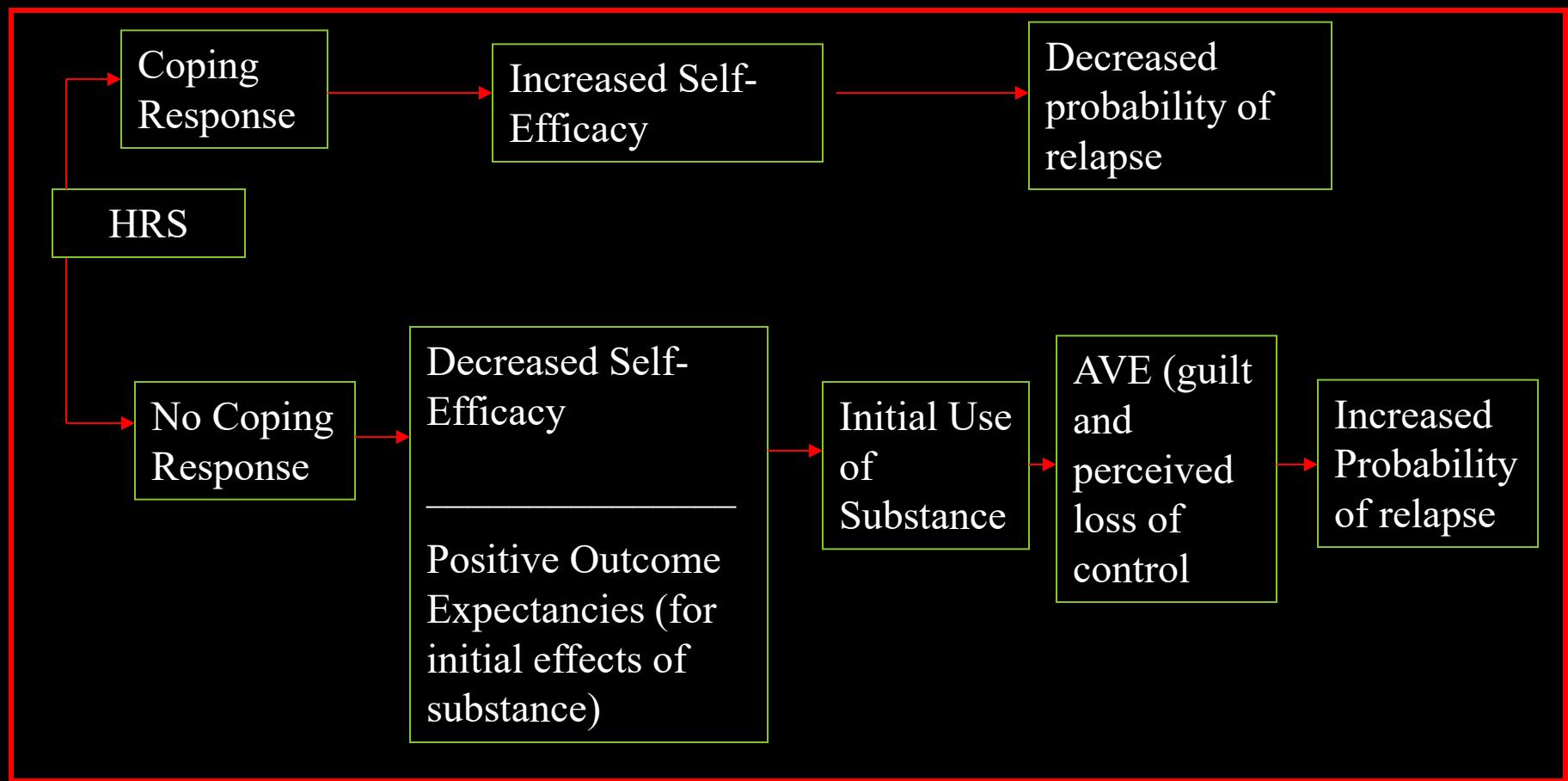
COGNITIVE BEHAVIORAL THERAPY

- Directly addresses potential risk factors for substance use or a return to substance use
- What are some common risk factors for people with co-occurring disorders?

HIGH RISK SITUATIONS (HRS)

- Frequently serve as immediate precipitators of initial use after reduction or abstinence
 - **Negative Thoughts & Negative Emotional States**
 - Anger, anxiety, depression, frustration and boredom
 - Interpersonal Conflict
 - Social Pressure
 - Positive Emotional States, celebrations, exposure to substance related stimuli, testing one's personal control (willpower) and nonspecific cravings.
- Approx. 75% of reported return to use identified with:
 - **Negative emotional states**
 - **Interpersonal conflict**
 - **Social pressure**

MARLATT MODEL OF RELAPSE



COPING SKILLS

- It is the person's response to HRS that determines if she/he will experience a lapse
- A person's coping behavior is a determinant of the outcome
- People who can execute coping strategies (leave the situation, positive self-talk etc.) are LESS likely to relapse
- People who have coped successfully experience a increase sense of self-efficacy (mastery over a HRS)
- People with low self-efficacy perceive themselves lacking motivation or ability to resist HRS.

OUTCOME EXPECTANCIES

If client does not cope effectively then self-efficacy decreases, sense of powerlessness increases, and the positive effects of substance use as coping mechanism activated.

Anticipate only the positive effects and ignore the negative consequences

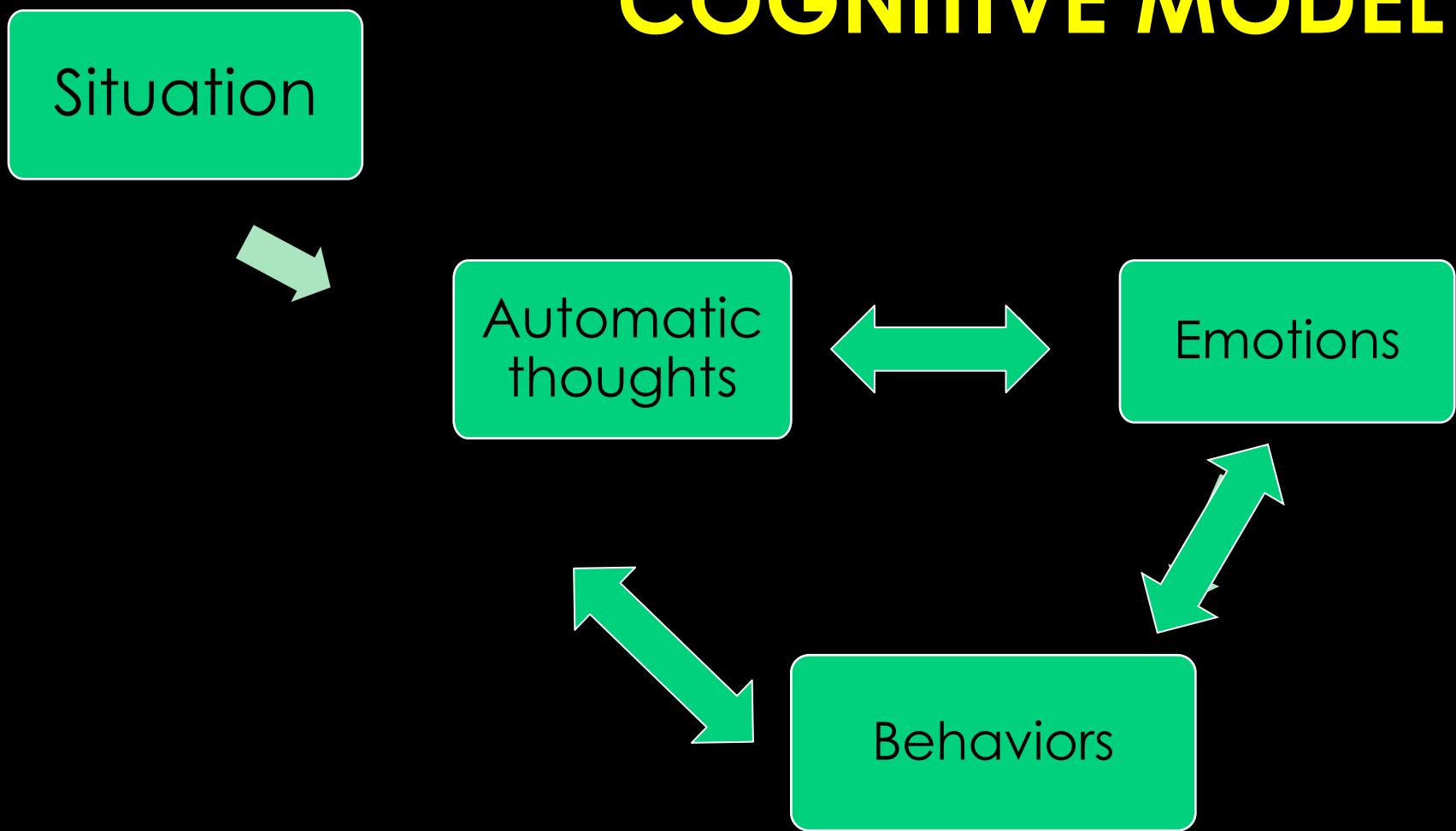
Expects substance to help cope with negative emotions or conflict (self-medication)

Focus is on immediate gratification neglecting delayed negative consequences

THE ABSTINENCE VIOLATION EFFECT

- There is a difference between a lapse (first use) and a prolonged relapse
- Progression from lapse to relapse not inevitable
- The AVE influences whether lapse leads to relapse
- There will be an **increase** potential relapse if:
 - If person feels lapse is due to own personal failure (guilt/negative emotions) “Now that I’ve blown it might as well keep using or
 - Attributes lapse to stable, global internal factors beyond control (“I have no willpower and will never be able to stop using”)

COGNITIVE MODEL



- CBT is based on the theory that the way individuals perceive a situation is more closely connected to their reaction than the situation itself
- Individuals' perceptions are often distorted and unhelpful, particularly when they are distressed.
- Cognitive Behavior Therapy helps people identify their distressing thoughts and evaluate how realistic the thoughts are.
- Then they learn to change their distorted thinking. When they think more realistically, they are less likely to resort of substance use
 - Judith Beck, The Beck Institute

COGNITIVE DISTORTIONS

- What are some types of negative thinking?
- What ones do you use most?
- What are some unhelpful (negative) thoughts you have heard?



MANAGING NEGATIVE THINKING- COGNITIVE RESTRUCTURING

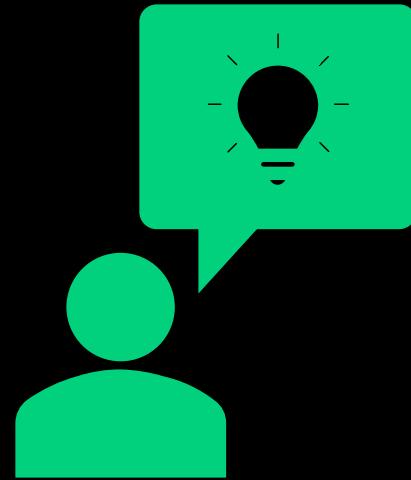


- Is this thought based on emotion or facts?
- What evidence is there that this thought is accurate?
- What evidence is there that this thought isn't accurate?
- What I tell a best friend if she was in this situation?
- What's the worst that could happen?
- What other ways could this information be interpreted?

COGNITIVE BEHAVIORAL THERAPY

Specifically, CBT helps people

- **Recognize** situations in which they are most likely to use
- **Avoid** those situations when appropriate
- **Cope** more effectively with a range of problems and problematic behaviors associated with substance use



FUNCTIONAL ANALYSIS (FA)

How many of you have conducted a FA?

A FA helps a person:

- Recognize why they are using substances
- Recognize the negative consequences of substance use
- Identifies barriers to reducing substance use
- Determines what they need to do to either avoid or cope with whatever triggers their use
- Requires a careful analysis of each episode of use and the skills and resources available to the client

FUNCTIONAL ANALYSIS

The Situation: Where were you? When was it (day/time)? What were you doing?	Thoughts: What did you start thinking?	Feelings What did you start feeling?	Craving or Use? What substance did you crave/use? How much did you use? How did you get it?	Were there any positive Consequences?	Were there any negative Consequences?

FUNCTIONAL ANALYSIS EXERCISE

- Role Play with partners
 - Person: you have had a slip over the weekend and have just reported this to your counselor
 - Counselor: you are going to complete a functional analysis for this slip using the FA format.

INTRAPERSONAL COPING SKILL TRAINING TOPICS

Managing Unhelpful, Negative Thinking

Managing Urges to Drink

Problem Solving

Increasing Pleasant Activities

Anger Management

Seemingly Irrelevant Decisions

Planning Emergencies

INTERPERSONAL SKILL TRAINING TOPICS

- Nonverbal communication
- Assertiveness
- Conversation skills
- Giving and receiving positive feedback
- Listening skills
- Giving constructive criticism
- Receiving Criticism about Drinking
- Drink Refusal Skills
- Resolving Relationship Problems
- Developing Social Support Networks



How do you teach
skills?

TEACHING COPING SKILLS

Structure of Sessions

- Rationale
 - Discusses Benefits of Skills to be taught in that session/meeting
- Skill Guidelines
 - Specific coping strategies related to the global skill
 - Develop with person(s) steps to skill
- Modeling
 - Vignettes used to demonstrate the skill guidelines and modeled by the group facilitator

TEACHING COPING SKILLS

- **Behavioral Rehearsal Role Plays**

- Individually tailored role plays that allow people to practice relevant skills in the context of personal situations they have encountered.
- Feedback on role play

- **Reminder Sheets**

- Written summary of skill guidelines given to people that to review at home and refer to when needed
- Includes practice exercises for people to take home

- **Practice Exercises**

- Structured Experiences that offer opportunities to practice the new coping skills in real-life situations
- People are expected to bring their responses to following session where the practice exercise is reviewed
- Shape behavior by praising even small attempts at working on practice assignments

COPING SKILLS - EXERCISE

Small group

- You are going to design for your co-workers a skill module for refusing offers of drugs/alcohol (an HRS)
- Include the rationale, skill steps, modeling and role play activities, methods for assessing role play performance (feedback) and homework assignments

COPING WITH CRAVING

- Understand the client's experience of craving
- Convey craving as normal, time-limited experience
- Identify craving cues and triggers
- Teach and practice craving and urge control techniques
- Explain conditioned cues via Pavlov's study
- Convey time-limited nature of craving by metaphor of wave – dissipates in less than an hour
- Explain process of extinction of conditioned responses

STRATEGIES FOR COPING WITH CRAVING

- Distraction
 - Flashcards
 - Talking about craving
 - Going with the craving (riding the wave)
 - Recalling negative consequences
 - Using self-talk
 - Any others?

RELAPSE PREVENTION INTERVENTION STRATEGIES

Enhancing Self-Efficacy

- Strategies designed to increase a client's sense of mastery and of being able to handle difficult situations without lapsing.
 - Use a Collaborative relationship
 - Identify successful changes in the past
 - Teach that changing a habit is a process of skill acquisition
 - Break down the overall task into smaller more manageable subtasks
 - Reinforce small increments in performing a skill
 - Give positive feedback on successful performance on tasks even those unrelated to SU.

RELAPSE PREVENTION INTERVENTION STRATEGIES

Lapse Management

Halt lapse/ Damage control

- “If I get into a high-risk situation and use alcohol or drugs, I should STOP DRUG/ALCOHOL EARLY before it does any more damage to my health, relationships and finances
- Provide client with emergency card (what to do in event of a lapse).
 - Bounce Back Into Treatment
 - Call my support person
 - Talk with my doctor
 - Discuss this slip in group and figure out how to prevent it next time

RELAPSE PREVENTION INTERVENTION STRATEGIES

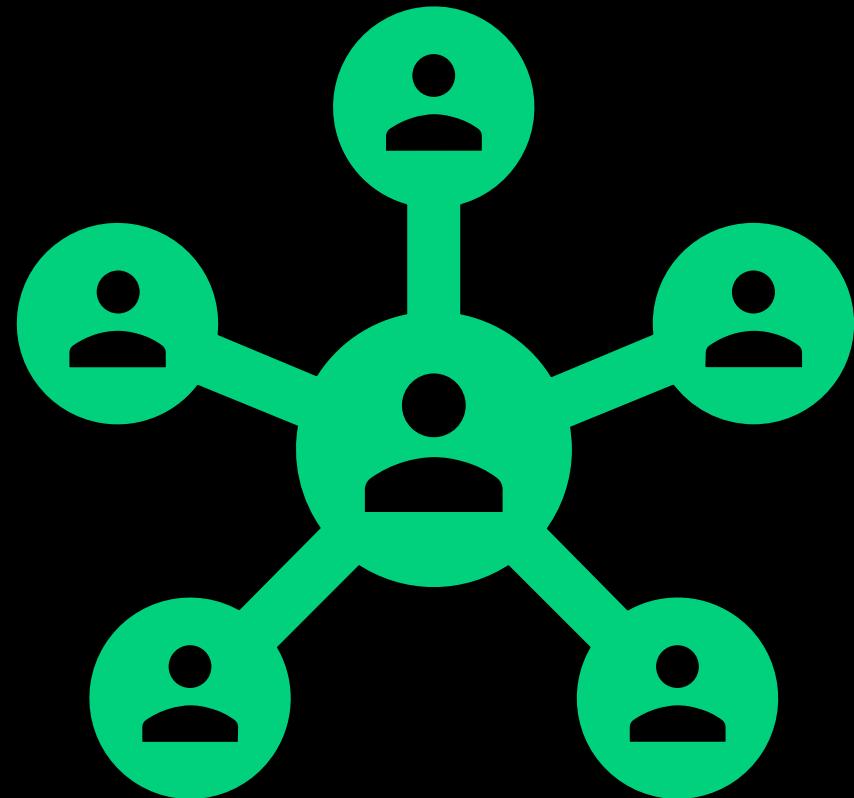
Changes in Lifestyle Self-Control

- Balanced lifestyle and positive addiction
 - Develop Healthy Pleasures (watching TV, reading, listening to music)
 - Develop Healthy Habits (taking medications, saving money, attending meetings, exercising regularly)
 - Engage in positive roles (work, relationships, parent)
 - Involvement in supportive social network of non-users

DEVELOPING A RELAPSE PREVENTION PLAN

- Use functional assessment
- Identify highest risk situations
- Identify ways to avoid or cope with high risk or likely warning signs (U-turns and coping skills)
- List reasons why you desired to quit
- Support person to contact
- Write it down on an emergency card for client and clinician
- Client and clinician review it regularly
- Use relapse as learning experience
- Modify as needed

Group Treatment for Co-Occurring Disorders



RATIONALE FOR GROUP-BASED TREATMENT

- Substance use frequently occurs in a social context
- Opportunity for social support
- Development of a new, healthier social network
- More economical than individual treatment
- Greater variety of feedback to person
- Modeling available from people who have progressed to later stages of treatment
- Research studies of group treatment show positive effect on substance abuse outcomes

COMMON THEMES OF GROUP TREATMENTS FOR CO-OCCURRING DISORDERS

- Education about effects of substance use
- Non-confrontational
- Avoidance of high levels of negative affect in group
- Fostering social support between group members
- Encouraging attendance at self-help groups for substance use
- Addressing problems related to mental health challenges



DIFFERENT TYPES OF GROUP TREATMENT

- Social skills training
- Stage-wise
 - Motivation groups
 - Active treatment groups
- Education/supportive
- 12-step

MOTIVATIONAL GROUPS

Goals:

- 1) Help clients develop understanding of how substance use has affected their lives
- 2) Help clients become motivated to work on reducing substance use

Motivational Groups

Logistical Consideration:

- Leadership: Works best with co-facilitators
- Integration with other Interventions: Case Management, OP, Psychiatrist
- Setting: Can be held in any setting
- Size: 6-12 clients

Timing and Frequency: weekly but can be increased if necessary (during holidays)

MOTIVATION GROUPS

- Logistical Consideration:
 - Duration: Brief to decrease intensity & allow clients with short attention span
 - Admission & Attendance: Acknowledging SA not a prerequisite. Regular attendance encouraged but not required. Group members can attend on drop-in basis.
 - Motivating Clients: Pick non-stigmatizing name. Serve refreshments. Schedule field trips. Provide transportation
 - Open format

MOTIVATION GROUPS

- Group Guidelines:
 - Confidentiality
 - Alcohol and drug use
 - Active psychosis
 - No disruptive behavior
 - Member check-in
 - Others?

MOTIVATIONAL GROUPS

Sample Outline of First Persuasion Group

1. Rationale for Group	5-10 minutes
2. Introductions	15-20
minutes	
3. Discussion of guidelines	15-20
minutes	
4. Wrap-up	5-10
minutes	

MOTIVATIONAL GROUPS

- Possible Topics:
 - Effects of alcohol & drugs
 - Symptoms of MI
 - Stress-vulnerability model
 - Medications
 - Social Skills Training
 - Guest Speakers
 - Dealing with stress
 - Coping with symptoms
 - Activities for relaxation & pleasure
 - Cues associated with cravings
 - Fun Group/Art Projects

ACTIVE TREATMENT GROUPS

- For people interested in working directly on strategies for reducing their use or maintaining abstinence.
- All members have already developed awareness of negative effects of SU on their lives
- For people in Active Treatment or Relapse Prevention Stages.

People whose SA continues to be active and severe not appropriate.

ACTIVE TREATMENT GROUPS

Goals

1. Continued reduction in substance use
2. Movement towards abstinence
3. Prevention of Relapses
4. Minimize severity of relapses.

ACTIVE TREATMENT GROUPS

Therapeutic Principles:

- Involve more directly addressing substance and related problems
- Focus on strategies to promote further reduction of substance use or to maintain abstinence
- More confrontational
- Facilitate Peer to Peer Interaction

ACTIVE TREATMENT GROUPS

Therapeutic Principles:

- Psycho-education
 - Nature and symptoms of specific psychiatric disorders
 - Interactions between SA and MI
 - Management of cravings and HRS
 - Self-help principles
- Teaching Skills & Behaviors
 - Assertiveness
 - Giving and receiving criticism
 - Drink and drug refusal
 - Recognizing HRS and techniques for managing them
- Supporting Abstinence and Self-Help Concepts

ACTIVE TREATMENT GROUPS

Guidelines:

- ✓Respecting Confidentiality
- ✓Not interrupting
- ✓Not being disruptive
- ✓Respect other group members
- ✓SU before group not allowed
- ✓Cannot attend if clearly inebriated

ACTIVE TREATMENT GROUPS

Group Structure:

- Check-in
 - Review with each member HRS encountered during week and how managed
 - Return to 1 or 2 members and facilitate group discussion on management of that particular HRS
- Topic Discussion
 - Sometimes identified from topic raised by clients in check-in
 - Group leader may introduce new topic as focus of group
- Wrap-up

ACTIVE TREATMENT GROUPS

Topics:

- Triggers and high-risk situations.
- Skills training, anger management, assertiveness, coping, etc.
- Relaxation and imagery.
- Stress management.

ACTIVE TREATMENT GROUPS

Group Process:

- Primarily based on Peer to Peer
- Limited input from leaders
 - Stimulate peer interactions to help members share practical advice for dealing with HRS and other problems they encounter
 - Ensure all members contribute to group discussion
 - Leaders use modeling to demonstrate handling HRS.
- Peers can also use modeling

RESOURCES

Miller, W. R., Rollnick, S. (2023) *Motivational Interviewing: Helping People Change and Grow* (4th ed.) Guilford Press

Miller, W. M., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.

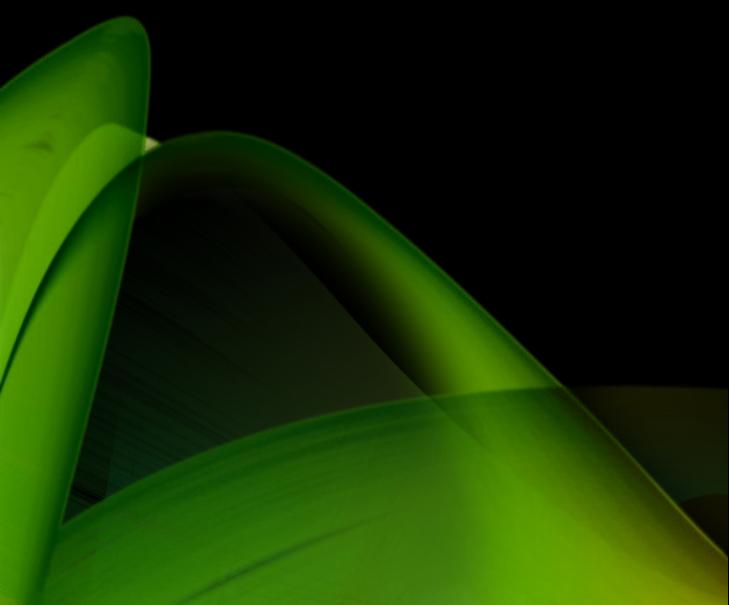
Rosengren, David B. (2018). *Building Motivational Interviewing Skills: A Practitioner Workbook* (2nd ed.). New York, NY: Guilford Press.

Miller, W.R. & T.B. Moyers (2017) Motivational Interviewing and the clinical science of Carl Rogers. *Journal of Consulting and Clinical Psychology*, 85(8), 757-766

Miller & Rollnick (2017) Ten things MI is not Miller, W.R. & Rollnick, S. (2009) Ten things that MI is not. *Behavioral and Cognitive Psychotherapy*, 37, 129-140.

Overcoming Addictions: Skills Training for People with Schizophrenia. (1999) Lisa Roberts, Andrew Shaner and Thad Eckman. W.W. Norton: New York

RESOURCES



- Mueser, K.M., Noordsy, D.L., Drake, R.E., and Fox, L. (2003). Integrated treatment for dual disorders. NY, NY: Guilford Press.
- Monti, Kadden, Rohsenow, Cooney and Abrams (2002). Treating Alcohol Dependence (2nd Edition): New York: Guilford Press.
- Carroll, K.M. (1998) Manual 1: A Cognitive-Behavioral Approach: Treating Cocaine Addiction. Therapy Manuals for Drug Addiction. National Institute on Drug Abuse. NIH Publication Number 98-4308.
- Marlatt, G.A. & Gordon, J.R. ed. (1985). Relapse Prevention New York: Guilford Press.