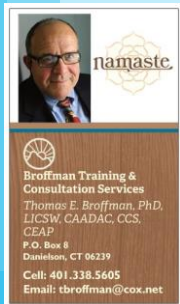


612.W Utilizing Cognitive Behavioral Therapy to Treat Substance Use Disorders (612W)

6-5-19
10:00 AM. – 5:15 PM



1

Working Agreements

1. We will treat others as we'd like to be treated
2. Share the time
3. What is said in the room stays in the room
4. Say **OUCH**, if someone says something that makes you uncomfortable
5. We're in this together
6. Download the humor app & bring it to class
7. Be curious
8. Be open minded

2

Introductions

1. Your current position?
2. Where do you work?
3. Previous training in CBT?
4. Years of experience with CBT?
5. Biggest challenge working with people with SUD?
6. Most rewarding experience working with people with SUD?
7. One thing I want to learn over the next 6 hours?

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Disclaimer: CBT Not Appropriate for:

1. People who are acutely homicidal or suicidal
2. Unstable psychiatrically
3. Having problems meeting their basic human needs (food, clothing, shelter, safety)
4. Impaired or under the influence of alcohol or drugs
5. Traumatic brain injury
6. Memory or cognitive impairment

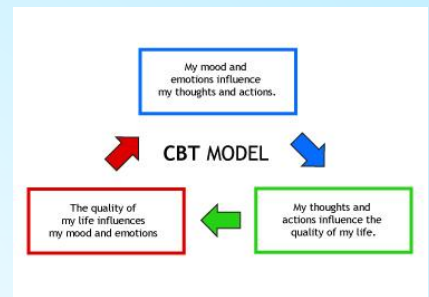
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Brief Intro to CBT

- We react without knowledge of internal processes.
- Core beliefs will generate automatic thoughts.
- Our initial reaction will be felt.
- Our feeling will then dictate our behavior.
- Ineffective behaviors strengthen distortions and core beliefs.



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What is Cognitive-Behavioral Therapy (CBT)?

1. CBT is a therapeutic approach to helping resolve emotional and behavioral disturbance in patients by working with their physical-sensory, cognitive and behavioral responses to internal and external events.
2. CBT is a form of psychotherapy that emphasizes the important role of thinking in how we feel and what we do.
3. Cognitive-behavioral therapy does not exist as a distinct therapeutic technique.
4. The term "cognitive-behavioral therapy (CBT)" is a very general term for a classification of therapies with similarities.
5. There are several approaches to cognitive-behavioral therapy, including Rational Emotive Behavior Therapy, Rational Behavior Therapy, Rational Living Therapy, Cognitive Therapy, and Dialectic Behavior Therapy.

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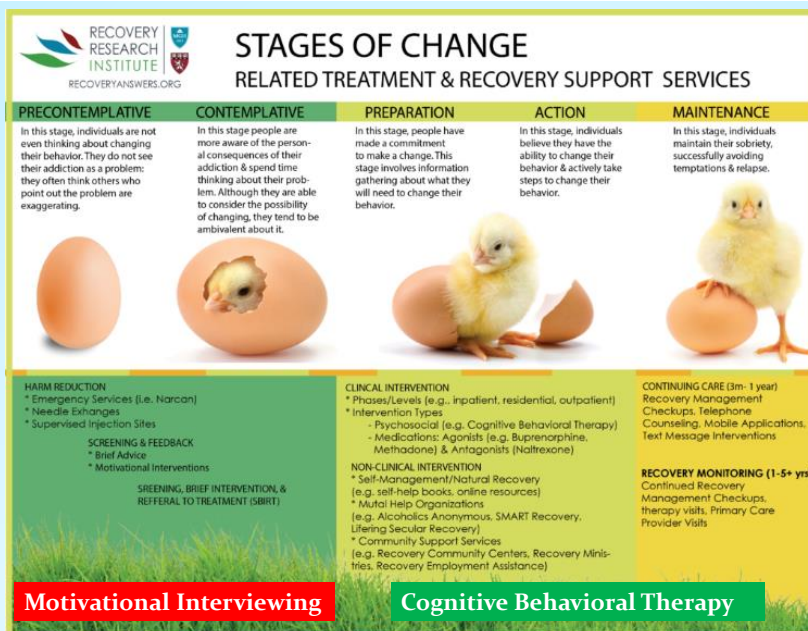
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What Is CBT and Its Assumptions?

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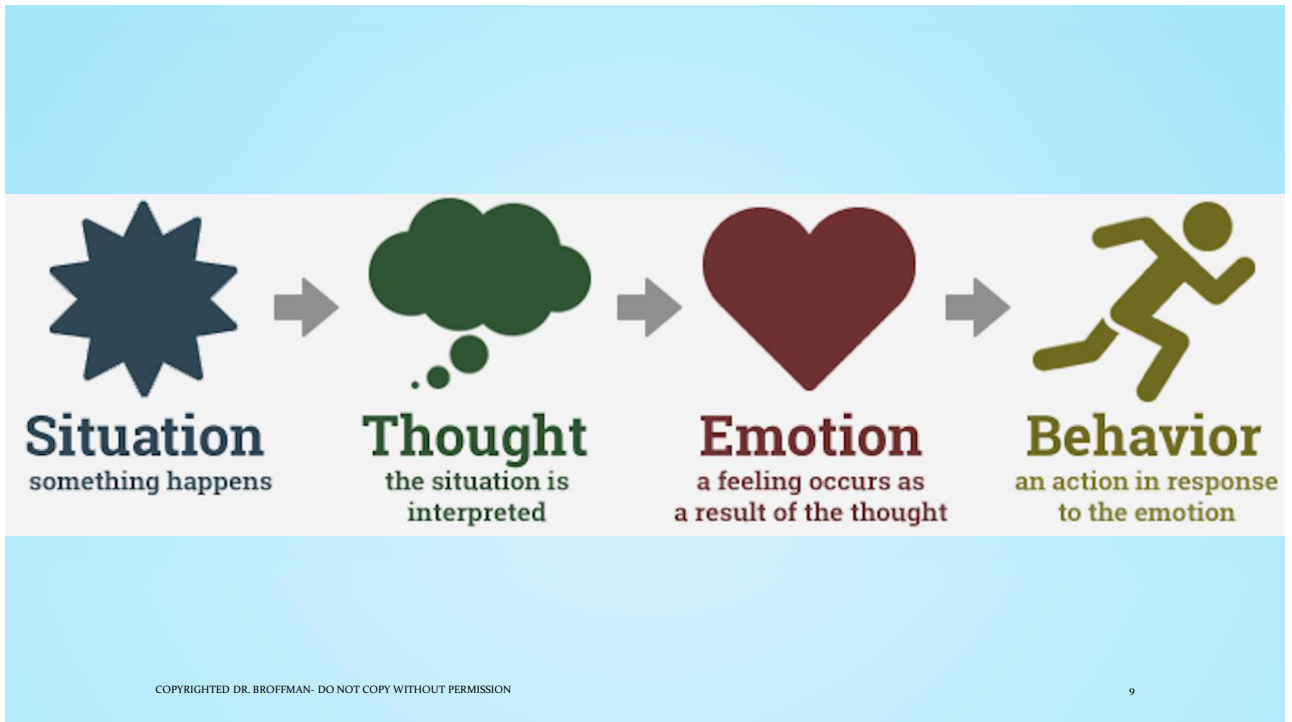
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Cognitive-Behavioral Therapy is...

1. CBT is based on the cognitive model of emotional response.
2. CBT is briefer and time-limited.
3. A sound therapeutic relationship is necessary for effective therapy, but not the focus.
4. CBT is a collaborative effort between the therapist and the client.
5. CBT is based on aspects of stoic philosophy.
6. CBT uses the Socratic Method.
7. CBT is structured and directive.
8. CBT is based on an educational model.
9. CBT theory and techniques rely on the Inductive Method.
10. CBT theory and techniques rely on homework.

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1. CBT Is Based On The Cognitive Model Of Emotional Response

- Cognitive-behavioral therapy is based on the idea that our thoughts cause our feelings and behaviors, not external things, like people, situations, and events.
- The benefit of this fact is that we can change the way we think to feel / act better even if the situation does not change.

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2. CBT is Briefer and Time-Limited

- Cognitive-behavioral therapy is considered among the most rapid in terms of results obtained.
- The average number of sessions clients receive (across all types of problems and approaches to CBT) is only 16.
- Other forms of therapy, like psychoanalysis, can take years.
- What enables CBT to be briefer is its highly instructive nature and the fact that it makes use of homework assignments.
- CBT is time-limited in that we help clients understand at the very beginning of the therapy process that there will be a point when the formal therapy will end.
- The ending of the formal therapy is a decision made by the therapist and client.
- Therefore, CBT is not an open-ended, never-ending process.

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3. A Sound Therapeutic Relationship Is Necessary For Effective Therapy, But Not The Focus

- Some forms of therapy assume that the main reason people get better in therapy is because of the positive relationship between the therapist and client.
- Cognitive-behavioral therapists believe it is important to have a good, trusting relationship, but that is not enough.
- CBT therapists believe that the clients change because they learn how to think differently and they act on that learning.
- Therefore, CBT therapists focus on teaching rational self-counseling skills.

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4. CBT Is a Collaborative Effort Between The Therapist And The Client

- Cognitive-behavioral therapists seek to learn what their clients want out of life (their goals) and then help their clients achieve those goals.
- The therapist's role is to listen, teach, and encourage, while the client's roles is to express concerns, learn, and implement that learning.

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5. CBT Is Based On Aspects Of Stoic Philosophy

- Cognitive-behavioral therapy does not tell people how they should feel.
- However, most people seeking therapy do not want to feel they way they have been feeling.
- The approaches that emphasize stoicism teach the benefits of feeling, at worst, calm when confronted with undesirable situations.
- They also emphasize the fact that we have our undesirable situations whether we are upset about them or not.
- If we are upset about our problems, we have two problems — the problem, and our upset about it. Most people want to have the fewest number of problems possible.
- So when we learn how to more calmly accept a personal problem, not only do we feel better, but we usually put ourselves in a better position to make use of our intelligence, knowledge, energy, and resources to resolve the problem.

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6. CBT Uses the Socratic Method

- Cognitive-behavioral therapists want to gain a very good understanding of their clients' concerns.
- That's why they often ask questions.
- They also encourage their clients to ask questions of themselves, like, "How do I really know that those people are laughing at me?"
- "Could they be laughing about something else?"

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7. CBT Is Structured and Directive

- Cognitive-behavioral therapists have a specific agenda for each session.
- Specific techniques / concepts are taught during each session.
- CBT focuses on the client's goals.
- We do not tell our clients what their goals “should” be, or what they “should” tolerate.
- We are directive in the sense that we show our clients how to think and behave in ways to obtain what they want.
- Therefore, CBT therapists do not tell their clients what to do — rather, they teach their clients how to do.

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8. CBT Is Based On An Educational Model

- CBT is based on the scientifically supported assumption that most emotional and behavioral reactions are learned.
- Therefore, the goal of therapy is to help clients unlearn their unwanted reactions and to learn a new way of reacting.
- Therefore, CBT has nothing to do with “just talking”. People can “just talk” with anyone.
- The educational emphasis of CBT has an additional benefit — it leads to long term results.
- When people understand how and why they are doing well, they know what to do to continue doing well.

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9. CBT Theory and Techniques Rely On the Inductive Method

- A central aspect of Rational thinking is that it is based on fact.
- Often, we upset ourselves about things when, in fact, the situation isn't like we think it is.
- If we knew that, we would not waste our time upsetting ourselves.
- Therefore, the inductive method encourages us to look at our thoughts as being hypotheses or guesses that can be questioned and tested.
- If we find that our hypotheses are incorrect (because we have new information), then we can change our thinking to be in line with how the situation really is.

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10. CBT Theory And Techniques Rely On Homework

- If when you attempted to learn your multiplication tables you spent only one hour per week studying them, you might still be wondering what 5 X 5 equals.
- You very likely spent a great deal of time at home studying your multiplication tables, maybe with flashcards.
- The same is the case with psychotherapy.
- Goal achievement (if obtained) could take a very long time if all a person were only to think about the techniques and topics taught was for one hour per week. T
- hat's why CBT therapists assign reading assignments and encourage their clients to practice the techniques learned.

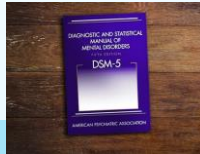
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What are SUD?

- The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual.
- Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.
- According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.



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5 Most Common Substance Use Disorders In The United States

1. Alcohol Use Disorder (AUD)
2. Tobacco Use Disorder
3. Cannabis Use Disorder
4. Stimulant Use Disorder
5. Hallucinogen Use Disorder
6. Opioid Use Disorder

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Role of the Clinician in CBT

1. CBT is a very active form of counselling.
2. A good CBT clinician is a teacher, a coach, a “guide” to recovery, a source of reinforcement and support, and a source of corrective information.
3. Effective CBT requires an empathetic clinician who can truly understand the difficult challenges of addiction recovery.

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Role of the Clinician in CBT

- The CBT clinician has to strike a balance between:
 1. Being a good listener and asking good questions in order to understand the client.
 2. Teaching new information and skills
 3. Providing direction and creating expectations
 4. Reinforcing small steps of progress and providing support and hope in cases of relapse.

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Role of the Clinician in CBT

- The CBT clinician also has to balance:
 1. The need of the client to discuss issues in his or her life that are important.
 2. The need of the clinician to teach new material and review homework.
- The clinician has to be flexible to discuss crises as they arise, but not allow every session to be a allow every session to be a “crisis management session”.

Role of the Clinician in CBT

- The clinician is one of the most important sources of positive reinforcement for the client during treatment
- It is essential for the clinician to maintain a nonjudgmental and non-critical stance.
- Motivational interviewing skills are extremely valuable in the delivery of CBT.

Core Beliefs

- Combination of life interactions.
- The way we make sense of the world.
- Reinforced through experience.
- Different than spiritual beliefs.
- We may not explore our core beliefs.
- Be set during childhood and exist over lifetime.

Thoughts Levels

- **Automatic Thoughts**
 - Transient, superficial, unaware
- **Assumptions**
 - Rules
- **Core Beliefs / Schemas**
 - Absolute



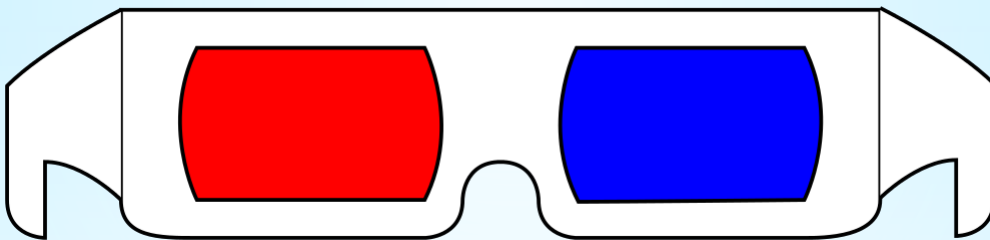
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Core Beliefs

- Like a set of colored glasses, core beliefs will impact the view and interpretation of events.



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Examples Of Negative Core Beliefs

1. I'm ugly
2. I'm not as good as them
3. I'll never amount to anything
4. People don't like me
5. I can't do anything right
6. I'll never get better at this
7. I'm not a confident person
8. There's no way I could do that
9. I'm stuck
10. I'm unlovable
11. There's something wrong with me

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Examples Of Negative Core Beliefs

11. There's something wrong with me
12. I never get things right
13. They'll leave me in the end
14. Everyone just uses me
15. The world is evil
16. People only like interesting people
17. I'm just an anxious person
18. I'm negative
19. I'm different from everyone else
20. I'm stupid

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Beliefs Translated to Thoughts

- Anxiety: “Something bad will happen to me.”
- Depression: “Life is pointless.”
- Paranoia: “People are out to get me.”
- BPD: “Everyone hurts me.”
- Substance use: “Life is too painful.”

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Core Beliefs and Behavior

- 1.Core beliefs molded through lifetime experience.
- 2.Trigger occurs and is interpreted through beliefs.
- 3.Internal feeling arises as a result of the trigger.
- 4.Behavioral response occurs based on thought/ feeling.
- 5.Behavior is viewed as purposeful even if unhelpful.
- 6.The response of behavior enforces core belief.
- 7.Cycle continues.

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Cognitive Processes of Substance Use

- Self efficacy-ones faith in their ability to cope.
 - “I can’t handle this problem.”
 - “There’s no way I can do this.”
- Outcome expectancies of substance.
 - “I don’t have to put up with my problems.”
 - “I will feel better.”
- Attributions of causality: internal or external.
 - “Anyone would use if they lived where I live.”
 - “I have anxiety and alcohol is the only thing that helps.”
- Decision making process: contributing factors of use.
 - Being around triggers as opposed to sober supports.

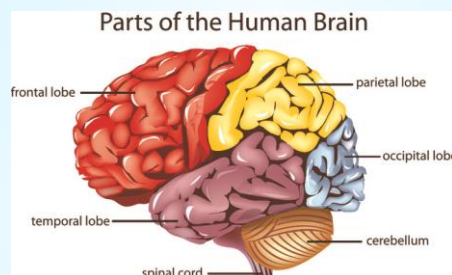
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Clarity, Cravings, and Urges

- Clarity: can see how drug use harms life.
- Craving: automatic thoughts, focus on benefits of use and ignore drawbacks of use.
- Urges: the cravings are turned into an action.



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Modifying Core Beliefs

- Help client become aware of their thoughts.
- Work to assess accuracy of thoughts.
- More accurate thoughts contribute to more manageable emotions.
- Manageable emotions allow for consideration of several behavioral responses.
- More effective response is chosen.
- Improved outcome challenges core belief.

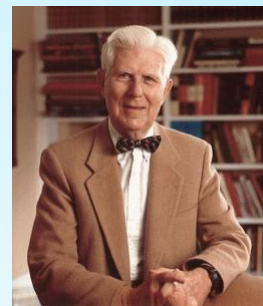
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Therapeutic Relationship

- Built on collaboration and respect.
- The clinician is NOT the expert.
- Warm and empathic.
- Respectful when challenging.
- Built on modification and flexibility.
- Help the client feel better.



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Cognitive Therapy Overview

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Thought Record

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Common Unhealthy Thought Patterns

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Cognitive Distortions

1. •Perfectionism: all or nothing thinking.
2. •Should statements: arbitrarily setting standards.
3. •Over personalization: taking too much responsibility.
4. •Selective attention: focusing only on one aspect.
5. •Denial: Failing to see your own role in a problem.
6. •False-permanence: thinking things are more permanent than they really are.
7. •Overgeneralizing: a single event becomes applied to future events.

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Cognitive Distortions

8. •Catastrophizing: making things out to be worse than they are.
9. •Magical thinking: everything would be better if..
10. •Emotional Reasoning: acting as if emotions are reality.
11. •Mind reading: assuming what others are thinking.
12. •Double standard: being more harsh on yourself than you are to others.
13. •Self Centeredness: only seeing your own perspective.
14. •Fallacy of fairness: believing life must be fair.

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Ways to Challenge Thoughts

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New Responses Worksheet

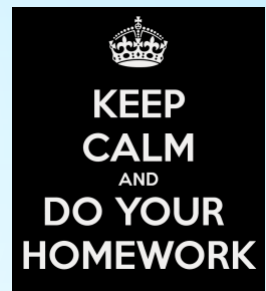
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Homework

1. •Necessary for CBT and helps reduce relapse.
2. •Become aware of/ challenge thought process.
3. •Can list effective and ineffective coping.
4. •Helps to build self efficacy.
5. •Connect to sober and social supports.



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What is CBT for SUD?

- • Based on social-cognitive learning theory
 - – Substance use functionally related to major life problems
 - – Coping deficits (e.g., life stress, substance-related cues) maintain use/relapse
- • Coping skills training addresses and overcomes skill deficits
 - – Enhance identification and coping with high-risk situations/cues
 - – Increase active adaptive behavioral-cognitive coping
 - – Enhance sobriety-based social support

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CBT Addresses Two Major Types Of Learning That Contribute To SUD

- Learning by Association 'Classical' Conditioning
 1. Neutral stimuli become triggers for substance use/cravings, through repeated associations between stimuli and drug (conditioning).
 2. External triggers: People, places, time of day, day of week, things...
 3. Internal triggers: thoughts, emotions, pain/physiological changes

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CBT Addresses Two Major Types Of Learning That Contribute To SUD

- Learning by Consequence ‘Operant’ Conditioning
 1. Substance use is shaped by the consequences of use.
 2. Positive Reinforcement: if after using a substance a person feels more comfortable in social situations or happier etc.
 3. Negative Reinforcement: if substance use reduces anxiety, tension, stress, or depression; future use to reduce or terminate the unpleasant experience

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CBT and Substance Use

1. • Substance use is a coping strategy.
2. • Core beliefs generate automatic responses to triggers.
3. • When we are unaware of or don’t challenge our thoughts, we maintain distortions.
4. • Distortions will exacerbate feelings causing us to cope with substances.
5. • Challenging thoughts improves behaviors which improves mood and modifies beliefs.

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Assumptions of CBT to Treat SUD

- ***Main Assumption: Substance problems arise/continue due to deficits in sober coping skills.***
- Patient is motivated to stop/reduce substance use needs to acquire skills to do so.
- 1. Failure to engage in active coping when encountering precipitants to substance use contributes to relapse.
- 2. CBT is differentially effective in increasing active coping efforts when compared to alternative interventions
- 3. Because problems with coping are attributable to skills deficits, performance-based skill training techniques are necessary to remediate deficits

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Common Components of CBT

1. • Establish good therapeutic relationship
2. • Educate patients: model, disorder, therapy
3. • Assess illness objectively, set goals
4. • Use evidence to guide treatment decisions
5. (collaborative empiricism)
6. • Structure treatment sessions with agenda
7. • Limit treatment length
8. • Issue and review homework to generalize learning

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Major Goals of CBT

1. Provide social-cognitive learning framework
 - Substance use becomes predominant coping response to stress
2. Identify triggers (“functional analysis”)
 - e.g., environmental, cognitive, affective
3. Teach Skills
 - e.g., problem solving, environmental restructuring, social-interpersonal skills, cognitive restructuring, coping with craving/urges, relaxation
4. Consequence control – developing support systems
 - Change positive expectancies about effects of use, access alternative reinforcers
 - Develop social systems to support and reinforce abstinence
5. Reduce relapse risk (Abstinence Violation Effect)

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Model for CBT Treatment (Behavior Chain): Functional Analysis of Substance Use Behavior

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Functional Analysis

1. For each instance of cocaine use during treatment, the therapist and patient do a functional analysis, that is, they identify the patient's thoughts, feelings, and circumstances before and after the substance use.
2. Early in treatment, the functional analysis plays a critical role in helping the patient and therapist assess the determinants, or high-risk situations, that are likely to lead to substance use and provides insights into some of the reasons the individual may be using substances (e.g., to cope with interpersonal difficulties, to experience risk or euphoria not otherwise available in the patient's life).
3. Later in treatment, functional analyses of episodes of substance use may identify those situations or states in which the individual still has difficulty coping.

Functional Analysis / the 5 Functional Analysis / the 5 Ws

- The first step in CBT: How does drug use fit into your life?
1. One of the first tasks in conducting CBT is to learn the details of a client's drug use. It is not enough to know that they use. It is not enough to know that they use drugs or a particular type of drug.
 2. It is critical to know how the drug use is connected with other aspects of a client's life. Those details are critical to creating a useful treatment plan.

The 5 Ws (Functional Analysis)

- The 5 Ws of a person's drug use (also called a functional analysis)
 1. When?
 2. Where?
 3. Why?
 4. With / from whom?
 5. What happened?

The 5 Ws

- People addicted to drugs do not use them at random. It is important to know:
 1. The time periods when the client uses drugs?
 2. The places where the client uses and buys drugs
 3. The external cues and internal emotional states that can trigger drug cravings (why)?
 4. The people with whom the client uses drugs or the people whom the client buys drugs from
 5. The effects the client receives from the drugs the psychological and physical benefits (what happened)

Functional Analysis

Antecedent Situation	Thoughts	Feelings & Sensations	Behavior	Consequences
Where was I?	What was I thinking?	What was I feeling?	What did I do?	What happened after?
Who was I with?		What signals did I get from my body?	What did I use?	How did I feel right after?
What was happening?			How much did I use?	How did other people react to my behavior?
			What paraphernalia did I use?	Any other consequences?
			What did other people around me do at the time?	

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Functional Analysis

What leads up to _____ and the functional relationship of _____ to the consequences

Triggers What sets me up to	My thoughts and feelings <u>before</u>		What did I do?	Positive things that then happened (after)	Negative things that then happened (after)
	What I was thinking	What I was feeling			

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Functional Analysis

<u>Trigger</u> What sets me up ?	<u>Thoughts, and Feelings</u> What was I thinking? What was I feeling?	<u>Behavior</u> What did I do then?	<u>Positive Consequences</u> What positive thing happened?	<u>Negative Consequences</u> What negative thing happened?
1.				
2.				
3.				

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Two Components of CBT

- CBT has two critical components:
 1. Functional analysis
 2. Skills training

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Functional Analysis

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Functional Analysis

Antecedent Situation	Thoughts	Feelings & Sensations	Behavior	Consequences
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Who was I with?		What signals did I get from my body?	What did I use?	How did I feel right after?
What was happening?			How much did I use?	How did other people react to my behavior?
			What paraphernalia did I use?	Any other consequences?
			What did other people around me do at the time?	

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Skills Training

1. CBT can be thought of as a highly individualized training program that helps cocaine abusers unlearn old habits associated with substance abuse and learn or relearn healthier skills and habits.
2. By the time the level of substance use is severe enough to warrant treatment, patients are likely to be using mood altering substances as their single means of coping with a wide range of interpersonal and intrapersonal problems.

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Why Skills Training?

1. The individual may have never learned effective strategies to cope with the challenges and problems of adult life, as when substance use begins during early adolescence.
2. Although the individual may have acquired effective strategies at one time, these skills may have decayed through repeated reliance on substance use as a primary means of coping.
3. These patients have essentially forgotten effective strategies because of chronic involvement in a drug-using lifestyle in which the bulk of their time is spent in acquiring, using, and then recovering from the effects of drugs.
4. The individual's ability to use effective coping strategies may be weakened by other problems, such as cocaine abuse with co-occurring disorders.
5. Because substance abusers are a heterogeneous group and typically come to treatment with a wide range of problems, skills training in CBT is made as broad as possible.

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Why Skills Training?

6. The first few sessions focus on skills related to initial control of substance use (e.g., identification of high-risk situations, coping with thoughts about substance use).
7. Once these basic skills are mastered, training is broadened to include a range of other problems with which the individual may have difficulty coping (e.g., social isolation, unemployment).
8. In addition, to strengthen and broaden the individual's range of coping styles, skills training focuses on both intrapersonal (e.g., coping with craving) and interpersonal (e.g., refusing offers of drugs) skills.
9. Patients are taught these skills as both specific strategies (applicable in the here and now to control substance use) and general strategies that can be applied to a variety of other problems.
10. Thus, CBT is not only geared to helping each patient reduce and eliminate substance use while in treatment, but also to imparting skills that can benefit the patient long after treatment.

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5 Critical Tasks Utilizing CBT

1. ***Foster the motivation for abstinence.*** An important technique used to enhance the patient's motivation to stop substance use is to do a decisional analysis which clarifies what the individual stands to lose or gain by continued cocaine use.
2. ***Teach coping skills.*** This is the core of CBT - to help patients recognize the high-risk situations in which they are most likely to use substances and to develop other, more effective means of coping with them.
3. ***Change reinforcement contingencies.*** By the time treatment is sought, many patients spend most of their time acquiring, using, and recovering from substance use to the exclusion of other experiences and rewards. In CBT, the focus is on identifying and reducing habits associated with a drug-using lifestyle by substituting more enduring, positive activities and rewards.

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Essential and Unique CBT Interventions

- The key active ingredients that distinguish CBT from other therapies and that must be delivered for adequate exposure to CBT include the following:
 1. Functional analyses of substance abuse
 2. Individualized training in recognizing and coping with craving, managing thoughts about substance use, problem solving, planning for emergencies, recognizing seemingly irrelevant decisions, and refusal skills
 3. Examination of the patient's cognitive processes related to substance use
 4. Identification and debriefing of past and future high-risk situations
 5. Encouragement and review of extra-session implementation of skills
 6. Practice of skills within sessions

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Coping With Cravings

1. Understanding craving
2. Describing craving
3. Identifying triggers
4. Avoiding cues
5. Coping with craving

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Understanding Cravings

1. It is important for patients to recognize that experiencing some craving is normal and quite common.
2. Craving does not mean something is wrong or that the patient really wants to resume drug use

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Describing Craving

- It is essential to get a sense of the patients' experience of craving.
- This includes eliciting the following information.
 1. What is craving like for you?
 2. How bothered are you by craving?
 3. How long does craving last for you?
 4. How do you try to cope with it?

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Identifying Triggers

- Therapists should then work with patients to develop a comprehensive list of their own triggers.
- Some patients become overwhelmed when asked to identify cues.
- Again, it may be most helpful to concentrate on identifying the craving and cues that have been most problematic in recent weeks.
- This list should be started during the session; the practice exercise for this session should include self-monitoring of craving, so patients can begin to identify new, more subtle cues as they arise.

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Dr. B's 4 Triggers: PPTT

1. People
2. Places
3. Things
4. Time

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Avoiding Cues

1. Keep in mind that the general strategy of "recognize, avoid, and cope" is particularly applicable to craving.
2. After identifying the patients' most problematic cues, therapists should explore the degree to which some of these can be avoided.
3. This may include breaking ties or reducing contact with individuals who use or supply drugs, getting rid of paraphernalia, staying out of bars or other places where drugs was used, or no longer carrying money

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Coping With Craving

- The variety of strategies for coping with craving include the following.
 1. Distraction
 2. Talking about craving
 3. Going with the craving
 4. Recalling the negative consequences of substance abuse
 5. Using self-talk

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Distraction

- In many cases, an effective strategy for coping with conditioned craving for substance abuse is distraction, especially doing something physical.
- It is useful to prepare a list of reliable distracting activities in conjunction with patients in anticipation of future craving.
- Such activities might include taking a walk, playing basketball, and doing relaxation exercises.
- Preparation of such a list may reduce the likelihood that patients will use substances, particularly alcohol and marijuana, in ill-fated attempts to deal with craving.
- Leaving the situation and going somewhere safe is one of the most effective ways of dealing with craving when it occurs.

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Talking About Craving

- When patients have supportive, abstinent friends and family members, talking about craving when it occurs is a very effective strategy and can help reduce the feelings of anxiety and vulnerability that often accompany it.
- It can also help patients identify specific cues.
- Socially isolated patients, or those who have few non-using friends, will find it difficult to nominate a supportive other who can assist with craving, thoughts about drugs, and other problems.
- This should alert therapists to the need to consider addressing social isolation during treatment.
- For example, therapists and patients can brainstorm ways of meeting new, non-using others, reconnecting with friends and family members, and so on.

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Going With The Craving

- ***Pay attention to the craving.*** This usually involves, first, finding someplace safe to let oneself experience craving (e.g., a comfortable and quiet place at home). Next, relax and focus on the experience of craving itself - where it occurs in the body or mind and how intense it is.
- ***Focus on the area where the craving occurs.*** This involves paying attention to all the somatic and affective signals and trying to put them into words. What is the feeling like? Where is it? How strong is it? Does it move or change? Where else does it occur? After concentrating in this way, many patients find the craving goes away entirely. In fact, the patient may find it useful to rate the intensity of craving before and after the exercise to demonstrate the effectiveness of the technique.

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Critical Tasks Utilizing CBT

4. ***Foster management of painful affects.*** Skills training also focuses on techniques to recognize and cope with urges to use cocaine; this is an excellent model for helping patients learn to tolerate other strong affects such as depression and anger.
5. ***Improve interpersonal functioning and enhance social supports.*** CBT includes training in a number of important interpersonal skills and strategies to help patients expand their social support networks and build enduring, drug-free relationships.

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Recalling the Negative Consequences Of Substance Abuse

- When experiencing craving, many people have a tendency to remember only the positive effects of cocaine; they often forget the negative consequences.
- Thus, when experiencing craving, it is often effective for them to remind themselves of the benefits of abstinence and the negative consequences of continuing to use.
- This way, patients can remind themselves that they really will not feel better if they use.
- To this end, it may be useful to ask patients to list on a 3 x 5 card the reasons they want to be abstinent and the negative consequences of use and to keep the card in their wallet or another obvious place.
- A glimpse of the card when confronted by intense craving for substances or a high-risk situation can remind them of the negative consequences of substance use at a time when they are likely to recall only the euphoria.

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Using Self-talk

- For many patients, a variety of automatic thoughts accompany craving but are so deeply established that patients are not aware of them.
- Automatic thoughts associated with craving often have a sense of urgency and exaggerated dire consequences (e.g., "I have to use now," "I'll die if I don't use," or "I can't do anything else until I use").
- In coping with craving, it is important both to recognize the automatic thoughts and to counter them effectively.
- To help patients recognize their automatic thoughts, therapists can point out cognitive distortions that occur during sessions (e.g., "A few times today you've said you feel like you have to use.
- Are you aware of those thoughts when you have them?").
- Another strategy is to help patients "slow down the tape" to recognize cognitions.
- Once automatic thoughts are identified, it becomes much easier to counter or confront them, using positive rather than negative self-talk.

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Daily Record of Substance Craving

Date/Time	Situation, Thoughts, And Feelings	Intensity of Craving (1-100)	Length of Craving	How I Coped
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7

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Final Thoughts on Coping With Cravings and Urges

- Urges are common and normal. They are not a sign of failure. Instead, try to learn from them about what your craving triggers are.
- Urges are like ocean waves. They get stronger only to a point, then they start to go away.
- If you don't use, your urges will weaken and eventually go away. Urges only get stronger if you give in to them.
- You can try to avoid urges by avoiding or eliminating the cues that trigger them.
- You can cope with urges by -
 1. Distracting yourself for a few minutes.
 2. Talking about the urge with someone supportive.
 3. "Urge surfing" or riding out the urge.
 4. Recalling the negative consequences of using.
 5. Talking yourself through the urge.
- Each day this week, fill out a daily record of cocaine craving and what you did to cope with craving.

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Coping With Thoughts About Substance Use

- There are several ways of coping with thoughts about substance use:
 1. Thinking through and remembering the end of the last high
 2. Challenging your thoughts
 3. Recalling the negative consequences of cocaine use
 4. Distracting yourself
 5. Talking through the thought

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Monitoring Of Thoughts, Plus Recording Of Coping Skills

Before the next session, keep track of your automatic thoughts about cocaine when they occur, and then record a positive thought and coping skills.

Thought About Substance Use	Positive Thought, Coping Skill Used
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8

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Goals Worksheet

1. The changes I want to make during the next __ weeks are:
2. The most important reasons why I want to make those changes are:
3. The steps I plan to take in changing are:
4. The ways other people can help me are:
5. Some things that might interfere with my plan are:

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Managing Availability

- List sources of substances here and what you'll do to reduce availability (for example, people who might offer you substances, places you might get it).

Source	Steps I'll Take To Reduce Availability
1	1
2	2
3	3
4	4
5	5
6	6
7	7

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Substance Refusal Skills

- There are several basic principles in effective refusal of substances.
 - Respond rapidly (not hemming and hawing, not hesitating).
 - Have good eye contact.
 - Respond with a clear and firm "no" that does not leave the door open to future offers of substance.
- Many patients feel uncomfortable or guilty about saying no and think they need to make excuses for not using, which allows for the possibility of future refusals.
- Inform patients that "no" can be followed by changing the subject, suggesting alternative activities, and clearly requesting that the individual not offer substances again in the future. ("Listen, I've decided to stop and I'd like you not to ask me to use with you anymore. If you can't do that, I think you should stop coming over to my house.")

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Within-Session Role-Play Refusal Skills

- After reviewing the basic refusal skills, patients should practice them through role-playing, and problems in assertive refusals should be identified and discussed.\
- Since this maybe the first session that includes a formal role-play, it is important for therapists to set it up in a way that helps patients feel comfortable.
 1. Pick a concrete situation that occurred recently for the patients.
 2. Ask patients to provide some background on the target person.
 3. For the first role-play, have patients play the target individual, so they can convey a clear picture of the style of the person who offers cocaine and the therapist can model effective refusal skills.
 4. Then reverse the roles for subsequent role-plays.

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Drink/Drug Refusal Skills

Tips for responding to offers of substances:

1. Say no first.
2. Make direct eye contact.
3. Ask the person to stop offering substances.
4. Don't be afraid to set limits.
5. Don't leave the door open to future offers (e.g., *not today*).
6. Remember the difference between assertive, passive, and aggressive responses

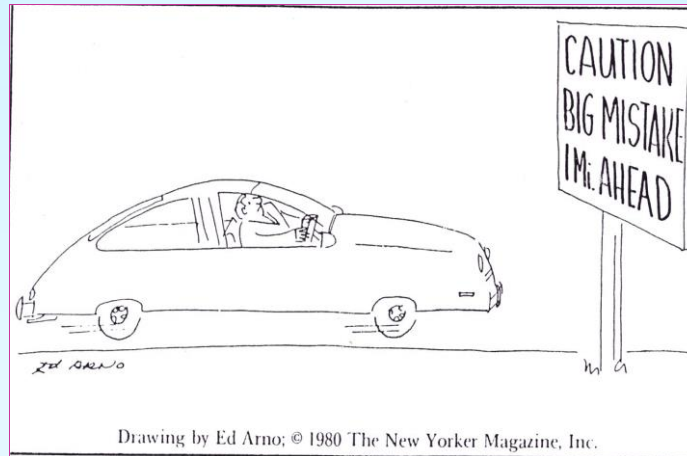
People Who Might Offer Me Substances	What I'll Say To Them
1. A friend I used to use with:	1
2. A coworker:	2
3. At a party:	3
4. Family member	4
5. Partner	5
6. Other	6

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Seemingly Irrelevant Decisions



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Seemingly Irrelevant Decisions

- When making any decision, whether large or small, do the following:
 1. Consider all the options you have.
 2. Think about all the consequences, both positive and negative, for each of the options.
 3. Select one of the options. Pick a safe decision that minimizes your risk of relapse.
 4. Watch for "red flag" thinking - thoughts like "I have to . . .", or "I can handle . . ." or "It really doesn't matter if . . ."

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Monitoring Seemingly Irrelevant Decisions

- Practice monitoring decisions that you face in the course of a day, both large and small, and consider safe and risky alternatives for each.

Decision	Safe Alternative	Risky Alternative
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7

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All-Purpose Coping Plan

- Remember that running into problems, even crises, is part of life and cannot always be avoided, but having a major problem is a time to be particularly careful about relapse.

If I run into a high-risk situation:

1. I will leave or change the situation.

Safe places I can go:

2. I will put off the decision to use for 15 minutes. I'll remember that my cravings usually go away in ____ minutes and I've dealt with cravings successfully in the past.

3. I'll distract myself with something I like to do.

Good distractors:

4. I'll call my list of emergency numbers:

Name:

Name:

Name:

5. I'll remind myself of my successes to this point:

6. I'll challenge my thoughts about using with positive thoughts:

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Problem Solving

- These, in brief, are the steps of the problem solving process.
 1. "Is there a problem?" Recognize that a problem exists. We get clues from our bodies, our thoughts and feelings, our behavior, our reactions to other people, and the ways that other people react to us.
 2. "What is the problem?" Identify the problem. Describe the problem as accurately as you can. Break it down into manageable parts.
 3. "What can I do?" Consider various approaches to solving the problem. Brainstorm to think of as many solutions as you can. Consider acting to change the situation and/or changing the way you think about the situation.
 4. "What will happen if . . .?" Select the most promising approach. Consider all the positive and negative aspects of each possible approach and select the one likely to solve the problem.
 5. "How did it work?" Assess the effectiveness of the selected approach. After you have given the approach a fair trial, does it seem to be working out? If not, consider what you can do to beef up the plan, or give it up and try one of the other possible approaches.

Reminder Sheet For Problem Solving

Select a problem that does not have an obvious solution. Describe it accurately. Brainstorm a list of possible solutions. Evaluate the possibilities, and number them in the order of your preference.

- Identify the problem:

- List brainstorming solutions:

Support Plan

What Is My Goal?	Who Is To Be Contacted? (Phone#, Address)	When Will the Contact Be Made?	What Services Will I Request?	Outcome Sought
Goal 1				
Goal 2				
Goal 3				
Goal 4				

Helpful Resources

- <https://www.getselfhelp.co.uk/>
 - [Therapy Worksheets](#)
 - Download and print therapy worksheets, self help guides and leaflets
 - [Free Downloads](#)
 - Download and print therapy worksheets, self help guides and leaflets
- <https://www.therapistaid.com/>
 - Worksheets
 - Free therapy worksheets.

Thanks for coming!



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Closing Exercise:

1. Something I learned?
2. Something I'll use?
3. This training will help me?
4. Something I wanted more of?

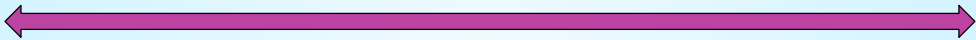
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HELPFULNESS RULER

*On a scale of 1 to 10, how helpful
was today's AM presentation?*



1	2	3	4	5	6	7	8	9	10
Not at all Helpful				Somewhat Helpful					Extremely Helpful