

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.

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.