



# Addiction Messenger

SERIES 38 - April 2010 Volume 13, Issue 4

Ideas for Treatment Improvement

## Cognitive Behavioral Therapy

### Part 1 - An Overview

**C**ognitive Behavioral Therapy (CBT) is a general classification of psychotherapy, based on social learning theory, which emphasizes how our thinking interacts with how we feel and what we do. It's based on the view that when a person experiences depression, anxiety, or anger that these stressors can be exacerbated (or maintained) by exaggerated or biased ways of thinking and that these patterns can be modified by reducing erroneous and maladaptive beliefs. A counselor using CBT helps a client to recognize their style of thinking and to modify it through the use of evidence and logic.

#### Principles and Elements of CBT

There are several different types and/or applications of CBT. They focus on cognitive restructuring, modifying behavior, and/or developing alternative coping skills. Most share some common principles and elements, such as:

**Brief and Time-Limited** - yields positive results for a client in a relatively short period of time. The average number of sessions clients receive is approximately 16. CBT is brief because it is instructional and makes use of homework assignments.

**Present Centered** - What is happening with the client in the "here and now?"

**Thought Focused** - Helps client recognize and understand personal thoughts that can lead to irrational fears and worries. Cognitive distortions, such as those listed on page 3, are explored by the client and counselor collaboratively.

**Practice and Homework** - Develops new skills by teaching different ways to understand situations and their responses. The counselor acts as a teacher and coach. Home work (including reading assignments) encourages the client to practice the techniques learned.

**Sound Therapeutic Relationship** - Establishes a trusting relationship and builds rational self-counseling skills in the client that helps the client learn to think differently. The counselor's role is to listen, teach, and encourage, while the client's role is to express concerns, learn, and implement that learning.

The advantages of using CBT include:

- Structure that reduces the possibility that sessions will become "chat sessions", and more therapeutic work may be accomplished,
- An emphasis on getting better by learning how to recognize and correct problematic assumptions, the root cause of many problems, and
- Clearly defined goals and methods that can be evaluated using scientific methods.

*"Man's mind,  
once stretched by  
a new idea, never  
regains its  
original  
dimensions."*

~ Oliver Wendell Holmes  
(1841 - 1935) ~

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Next Issue:

Concepts  
&  
Skills

## Components of CBT

There are 2 critical components of CBT - Functional Analysis and Skills Training.

**Functional Analysis** - plays a critical role in helping the client and counselor assess high-risk situations that are likely to lead to substance use and providing insights into what may trigger or stimulate the client's substance use (e.g., interpersonal difficulties, opportunities to take risks or feel euphoria not otherwise available in the patient's life, etc.). Later in treatment, functional analysis of substance use episodes helps identify those situations or states in which the individual still has difficulty coping.

Initially, the counselor conducts a functional analysis of a recent episode of substance use with the client. An example might look like this as the counselor asks a series of questions aimed at eliciting insights into the client's thinking and recollections:

- To get an idea of how all this works, let's go through an example. Tell me all you can about the last time you used cocaine.
- Where were you and what were you doing?
- What happened before?
- How were you feeling?
- When was the first time you were aware of wanting to use?
- What was the high like at the beginning?
- What was it like later?
- Can you think of anything positive that happened as a result of using?
- What about negative consequences?

**Skills Training** - can be viewed as a highly individualized training program to help the client unlearn old habits associated with substance use and learn or relearn healthier skills. In CBT, the goal is to identify and reduce habits associated with a drug-using lifestyle by substituting more enduring, positive activities and rewards. The client learns to recognize and cope with urges to use substances. In addition, the skills can improve interpersonal functioning, enhance social supports, and help clients learn to tolerate feelings like depression and anger.

The highly individualized nature of CBT requires the counselor to be sensitive in matching the *content*, *timing*, and *presentation* of new skills and behaviors to the client's readiness for change.

## Critical Tasks

The primary objectives of CBT are to:

- *Foster motivation for abstinence.* CBT methods such as functional analysis, which clarifies what the client stands to lose or gain by using substances, can enhance the client's motivation to stop use.
- *Teach coping skills.* This is the core of CBT - to help clients recognize the high-risk situations in which they are most likely to use substances and to develop other, more effective, means to cope.
- *Change reinforcers.* CBT focuses on identifying and reducing habits associated with drug use by substituting positive activities and rewards.
- *Foster management of painful feelings.* CBT skills help the client recognize and cope with urges to use substances and learn to tolerate other strong feelings such as depression and anger.
- *Improve interpersonal relationships and social supports.* CBT trains the client in interpersonal skills and strategies to help them increase their support networks and build healthy relationships.

## Structure and Format of CBT Sessions

The NIDA publication, *A Cognitive-Behavioral Approach: Treating Cocaine Addiction* (<http://www.drugabuse.gov/txmanuals/cbt/CBT5.html>), suggests that since CBT focuses on a great deal of work in each session (ie. review practice exercises, debrief any problems that have occurred, skills training, feedback on skills training, in-session practice, and plans for the next session) that a "20/20/20 Rule" be applied by the counselor to the flow of the session. An example for a typical 60-minute session is:

### First 20 minutes

- Assess substance abuse, craving, and high-risk situations since last session,
- Listen for/elicited patient's concerns, and
- Review and discuss the homework practice exercise

### Second 20 minutes

- Introduce and discuss the session topic, and
- Relate the session topic to the client's current concerns

### Third 20 minutes

- Explore the client's understanding of and reactions to the topic,
- Assign a practice exercise for the next week, and

- Review plans for the week and anticipate potential high-risk situations.

### Getting Started

Clients typically participate in approximately 16 CBT sessions over a 12 week period. There is, however, great variability. CBT can be delivered in individual or group counseling settings. Whichever you use there are some tasks to accomplish in the beginning to properly orient the client to CBT and set the stage for productive work. In getting started the counselor assesses the client as a candidate for CBT. The counselor:

- Reviews all assessment information,
- Begins establishing a relationship,
- Works to enhance client's motivation for change,
- Presents the CBT model,
- Introduces functional analysis,
- Negotiates treatment goals and specific objectives, and
- Provides a rationale for homework practice assignments.

The first session is the most important and may need to be scheduled for a longer period than usual because several issues need to be addressed:

- Building rapport to establish a relationship with client,
- Assessing the client's substance use and other problems that may be important to address during treatment,
- Provide a rationale for CBT treatment,
- Review the structure for the following sessions, and
- Begin skills training.

The next issue of this AM series on CBT will provide more details on individual session topics and skills-building development.

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### Cognitive Distortions

- 1. Mind reading:** You assume that you know what people think without having sufficient evidence of their thoughts.
- 2. Fortune telling:** You predict the future—that things will get worse or that there is danger ahead.
- 3. Catastrophizing:** You believe that what has happened or will happen will be so awful and unbearable that you won't be able to stand it.
- 4. Labeling:** You assign global negative traits to yourself and others.
- 5. Discounting positives:** You claim that the positives that you or others attain are trivial.
- 6. Negative filter:** You focus almost exclusively on the negatives and seldom notice the positives.
- 7. Overgeneralizing:** You perceive a global pattern of negatives on the basis of a single incident.
- 8. Dichotomous thinking:** You view events, or people, in all-or-nothing terms.
- 9. Shoulds:** You interpret events in terms of how things should be rather than simply focusing on what is.
- 10. Personalizing:** You attribute a disproportionate amount of the blame to yourself for negative events and fail to see that certain events are also caused by others.
- 11. Blaming:** You focus on the other person as the *source* of your negative feelings and you refuse to take responsibility for changing yourself.
- 12. Unfair comparisons:** You interpret events in terms of standards that are unrealistic—for example, you focus primarily on others who do better than you and find yourself inferior in the comparison.
- 13. Regret orientation:** You focus on the idea that you could have done better in the past, rather on what you can do better now.
- 14. What if?** You keep asking a series of questions about "What if" something happens and fail to be satisfied with any of the answers.
- 15. Emotional reasoning:** You let your feelings guide your interpretation of reality.
- 16. Inability to disconfirm:** You reject any evidence or arguments that might contradict your negative thoughts.
- 17. Judgment Focus:** You view yourself, others and events in terms of evaluations of good-bad or superior-inferior, rather than simply describing, accepting, or understanding. You are continually measuring yourself and others according to arbitrary standards, finding that you and others fall short. You are focused on the judgments of others as well as your own judgments of yourself. (Leahy, 1996)

### Sources

NIDA Publication: *A Cognitive-Behavioral Approach: Treating Cocaine Addiction*. Downloaded from the World Wide Web at: <http://www.drugabuse.gov/txmanuals/cbt/CBT1.html>

R.. L. Leahy, *Cognitive Therapy: Basic Principles and Applications*. Jason Aronson Publishing Co., 1996. <http://www.352express.com/wpm/files/40/aronson02INTRO-2.pdf>

# NFATTC WORKSHOPS

## May - June 2010 Course Schedule

NFATTC Trainings in Alaska, Hawai'i, Oregon and Washington

### Developing Effective Treatment Plans ("Treatment Planning MATRS")

May 3, 2010 – Anchorage, AK

May 7, 2010 – Salem, OR

June 21-22, 2010 - Honolulu, HI

**1-day Course (7 CE Hours)** - designed to help counselors develop treatment plans that are individualized, strength-based, and oriented toward specific client needs. Course is focused on using assessment information effectively in treatment planning and ongoing case management.

### Buprenorphine Treatment for Young Adults

May 21, 2010 – Portland, OR

**3-hour Course (3 CE Hours)** - aims to increase understanding of the role of Buprenorphine in medication-assisted treatment of opioid dependence in young adults. Content is focused on treatment strategies and philosophy, the role of Buprenorphine in recovery, and the value of coordinated client care.

### Advanced Motivational Interviewing

May 24-25, 2010 – Honolulu, HI

**2-day Course (14 CE Hours)** - designed for those who have had introductory MI training and want to further develop and refine their MI skills in the areas of identifying and eliciting change talk and using strategies to decrease resistance.

### Cognitive Behavioral Therapy

May 4-5, 2010 – Anchorage, AK

June 9-10, 2010 - Honolulu, HI

**1.5 -day Course (10 CE Hours)** – focuses on building skills in the use of cognitive behavioral therapy for counseling interventions. Participants will have the opportunity to develop or improve skills in the use of CBT appropriate for those clients with substance use disorders and mental health issues.

### Clinical Supervision I: Building Chemical Dependency Counselor Skills

May 13-14, 2010 – Seattle, WA

June 3-4, 2010 - Seaside, OR

**2-day Course (14 CE Hours)** - designed to increase understanding and skill in assessing the clinical skills of counselors in addiction treatment settings and building learning plans for their continued professional growth and development. Focused on the teaching and mentoring aspects of clinical supervision in the context of the Addiction Counseling Competencies. Topics include the importance of observation, performance evaluation, negotiation of learning plans, and the structuring of supervisory interviews.

### Clinical Supervision II: Managing Supervisory Dilemmas

June 18-19, 2010 – Portland, OR

June 24-25, 2010 – Spokane, WA

**2-day Course (14 CE Hours)** - builds upon "Clinical Supervision I", taking participants to the next level in supervisory skill development by adding a conceptual framework and practice in correcting counselor performance problems.

### Working Effectively with Latinos

May 12-13, 2010 – Salem, OR

**1.5 -day Course (10 CE Hours)** - training is designed for addiction professionals, and others, who want to increase their awareness and build culturally sensitive skills for working with Latino clients.

### Introduction to Using Motivational Incentives ("PAMI - Promoting Awareness of Motivational Incentives")

June 24, 2010 - Honolulu, HI

**3-hour Course (3 CE Hours)** - designed to build awareness of the use of Motivational Incentives as an evidence-based therapeutic strategy to enhance client retention in addiction treatment. Principles, history, research, and suggestions for overcoming implementation barriers are discussed.

### Group Counseling & Facilitation Skills

May 26-28, 2010 - Prineville, OR

June 29 – July 1, 2010 – Honolulu, HI

**3-day Course (21 CE Hours)** - interactive training in how to establish and facilitate productive process-oriented and psycho-educational groups. Content includes stages of group development, resolving conflict in groups, and practicing interventions that facilitate group growth.

To view the entire brochure and to register on-line go to:  
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