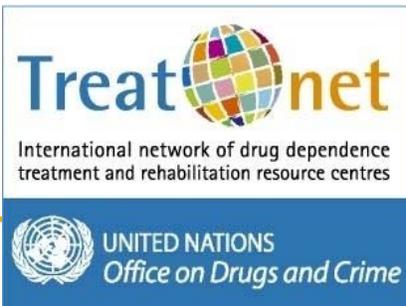


# Leader's Guide Cognitive Behavioural & Relapse Prevention Strategies



Treatnet Training Volume B, Module 3: Updated 18 September 2007

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## Instructions

1. Introduce yourself.
2. Explain the purpose of this series of trainings sponsored by the United Nations Office on Drugs and Crime: “The capacity building programme mission is to transfer technology and knowledge on substance abuse intervention to service providers in the participating local areas. Service providers include managers, physicians and psychiatrists, counsellors, psychologists, social workers, peer educators, outreach workers, and other professionals working in the substance abuse field.”
3. Thank participants for their interest in this series of trainings before starting your presentation.

## Training goals

1. Increase knowledge of cognitive behavioural therapy (CBT) and relapse prevention (RP) strategies and resources.
2. Increase skills using CBT and RP strategies and resources.
3. Increase application of CBT and RP strategies for substance abuse treatment

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### Instructions

1. Read the training goals to your audience.
2. Explain that it is very important for participants in this training module to not only gather new knowledge but also to practise the skills covered in this module and apply them to their work with addicted clients.
3. Explain your training and follow-up plans. Stress that after this training, you will be available to answer questions and provide feedback and advice regarding their demonstrations of the new skills through the role-plays.

## Module 3: Workshops

**Workshop 1:** Basic Concepts of CBT and RP

**Workshop 2:** Cognitive Behavioural Strategies

**Workshop 3:** Methods for Using Cognitive Behavioural Strategies

3

### **Instructions**

1. Read the slide to your audience.
2. Explain that this training module will take approximately 6-7 hours.

## Workshop 1: Basic Concepts of CBT and RP



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### Instructions

1. Introduce Workshop 1, “Basic Concepts of CBT and RP.”
2. Explain that one of the most important ingredients of psychosocial treatment for substance use disorders is teaching people how to stop or reduce their substance use and how to avoid relapsing and returning to dangerous levels of use.
3. Explain that one set of techniques that has been shown to be highly effective for this purpose is based on principles of cognitive behavioural therapy (CBT).

## Pre-assessment

Please respond to the pre-assessment questions in your workbook.

(Your responses are strictly confidential.)



10 minutes

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### Instructions

1. Ask participants to complete the 5 pre-assessment questions. They have 10 minutes to complete these questions.
2. Explain that both the pre-training and post-training assessments are conducted to insure that the training is appropriate for your particular audience, to measure the effectiveness of the training, and to provide opportunities for improving it.
3. The assessments may create tension among audience members. To reduce such tension, explain that both assessments are confidential and that they do not need to provide any personal information.

## Icebreaker

If you had to move to an uninhabited island, what 3 things would you take with you and why? (food and water are provided)



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### Instructions

1. This activity is optional, although recommended.
2. Ask your audience the question on the slide.

### Notes

Icebreakers are meant to create interaction among participants. Feel free to replace the icebreaker with another one if it would be more appropriate for your audience.

## Training objectives

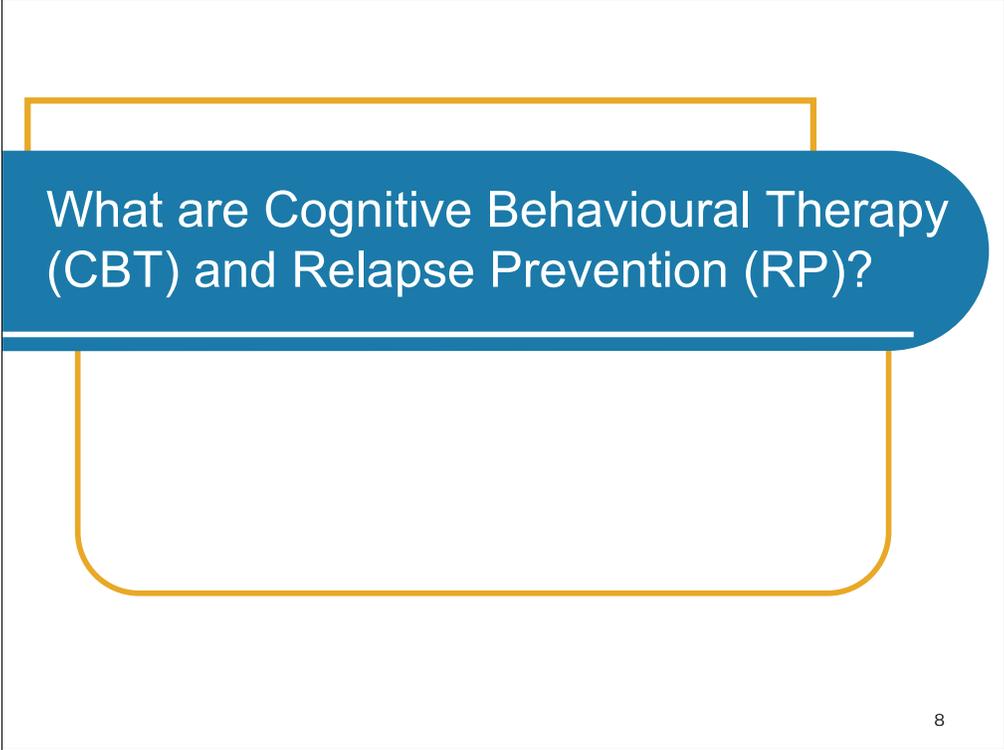
### **At the end of this workshop, you will:**

1. Understand that substance use is a learned behaviour that can be modified according to principles of conditioning and learning
2. Understand key principles of classical and operant conditioning and modelling
3. Understand how these principles apply to the treatments delivered in cognitive behavioural therapy and relapse prevention training
4. Understand the basic approaches used in cognitive behavioural therapy and how they apply to reducing drug use and preventing relapse
5. Understand how to conduct a functional analysis and know about the 5 Ws of a client's drug use

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### **Instructions**

1. Read the training objectives to your audience.
2. Explain that these objectives should be achieved as a team.
3. Encourage participants to ask you questions as needed.



## What are Cognitive Behavioural Therapy (CBT) and Relapse Prevention (RP)?

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### **Instructions**

Read the slide to your audience.

## What is CBT and how is it used in addiction treatment?

- CBT is a form of “talk therapy” that is used to teach, encourage, and support individuals about how to reduce / stop their harmful drug use.
- CBT provides skills that are valuable in assisting people in gaining initial abstinence from drugs (or in reducing their drug use).
- CBT also provides skills to help people sustain abstinence (relapse prevention)

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### Instructions

1. Read the slide to your audience.
2. Explain that the cognitive-behavioural paradigm works under the assumption that substance abuse is a learned maladaptative behaviour rather than caused by an underlying pathology. Under this assumption, therapy for substance abuse takes the form of an educational-learning process in which the clinician becomes a coach and the client has an active learning role throughout the process. The goal is for the individual with an addiction is to re-learn alternative behaviours to substance abuse while the clinician teaches, coaches, and reinforces his or her positive behaviour.
3. Explain that CBT attempts to help clients recognise, avoid, and cope. That is, RECOGNISE the situations in which they are most likely to use drugs, AVOID these situations when appropriate, and COPE more effectively with the range of problems and problematic behaviours associated with substance abuse.

# What is relapse prevention (RP)?

Broadly conceived, RP is a cognitive-behavioural treatment (CBT) with a focus on the maintenance stage of addictive behaviour change that has two main goals:

- To prevent the occurrence of initial lapses after a commitment to change has been made and
- To prevent any lapse that does occur from escalating into a full-blown relapse

**Because of the common elements of RP and CBT, we will refer to all of the material in this training module as CBT**

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## Instructions

1. Read the slide to your audience.
2. Explain that relapse prevention is a cognitive-behavioural treatment that includes a large educational component (Marlatt & Donovan, 2005). Relapse prevention aims to increase the client's awareness of high-risk situations and increase coping skills, self-efficacy, and control of internal and external variables that may make them more vulnerable to relapse. Relapse prevention (RP) combines cognitive and behavioural techniques such as thought-stopping, coping skills, alternative activities, etc.

## Additional Information

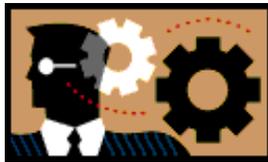
Relapse prevention is a generic term that refers to a wide range of therapeutic techniques to prevent lapses and relapse of addictive behaviours. The term "relapse" was initially employed in the medical context to refer to those people who re-experience a disease stage. Currently, this term is being used for a variety of behaviours including returning to regular substance abuse (Marlatt & Donovan; 2005).

People who make behavioural changes (e.g., smoking cessation, increasing regular exercise, etc.) tend to relapse to previous behavioural repertoires over time (Polivy & Herman, 2002). Similarly, it has been demonstrated that few individuals are able to completely succeed in substance abuse abstinence for the long-term on the first attempt (Addy & Ritter, 2000). Sobriety and relapse are both part of an interactive, complex process in the treatment context. Relapse prevention skills can be improved over time in a lapse/relapse learning curve in which increasing practise of coping skills will decrease the probability of relapse. The main goal of RP is maintaining sobriety over time and preventing the occurrence of lapses and their escalation into a full relapse episode. It is difficult to determine whether a lapse may end up in relapse. It ultimately depends on how the client responds to high-risk situations.

## Foundation of CBT: Social Learning Theory

### Cognitive behavioural therapy (CBT)

- Provides critical concepts of addiction and how to not use drugs
- Emphasises the development of new skills
- Involves the mastery of skills through practise



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### Instructions

1. Read the slide to your audience.
2. Explain that under the cognitive-behavioural paradigm, thoughts, feelings, and behaviours are separate areas of human behaviour and cognitive processing that become associated through learning. For instance, alcohol use is a behaviour that might be linked to thoughts, feelings, and even other behaviours by personal experience and observation. When these associations become stronger over time, they may act as triggers without any substances necessarily being present at the time.
3. Provide some examples. For instance, thinking that a cigarette will help me to relax may become a trigger to smoke. Even behaviours may become triggers for drug use.

## Why is CBT useful? (1)

- CBT is a counseling-teaching approach well-suited to the resource capabilities of most clinical programs
- CBT has been extensively evaluated in rigorous clinical trials and has solid empirical support
- CBT is structured, goal-oriented, and focused on the immediate problems faced by substance abusers entering treatment who are struggling to control their use

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### Instructions

1. Read the slide to your audience.
2. Explain that cognitive-behavioural therapy employs learning principles within a highly structured intervention with clearly defined goals that focus on the individual's current problems. The learning principles are based on classical conditioning and operant conditioning that might occur through observation and direct experience.

## Why is CBT useful? (2)

- CBT is a flexible, individualized approach that can be adapted to a wide range of clients as well as a variety of settings (inpatient, outpatient) and formats (group, individual)
- CBT is compatible with a range of other treatments the client may receive, such as pharmacotherapy

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### **Instructions**

1. Read the slide to your audience.

## Important concepts in CBT (1)

In the early stages of CBT treatment, strategies stress behavioural change. Strategies include:

- planning time to engage in non-drug related behaviour
- avoiding or leaving a drug-use situation.



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### Instructions

1. Read the slide to your audience.
2. Explain that in cognitive behavioural therapy the emphasis is not on being strong, but in teaching clients to be wise and make good decisions.

## Important concepts in CBT (2)

CBT attempts to help clients:

- Follow a planned schedule of low-risk activities
- Recognise drug use (high-risk) situations and avoid these situations
- Cope more effectively with a range of problems and problematic behaviours associated with using



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### Instructions

1. Read the slide to your audience.

## Important concepts in CBT (3)

As CBT treatment continues into later phases of recovery, more emphasis is given to the “cognitive” part of CBT. This includes:

- Teaching clients knowledge about addiction
- Teaching clients about conditioning, triggers, and craving
- Teaching clients cognitive skills (“thought stopping” and “urge surfing”)
- Focusing on relapse prevention



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### Instructions

1. Read the slide to your audience.

## Foundations of CBT

The learning and conditioning principles involved in CBT are:

- Classical conditioning
- Operant conditioning
- Modelling

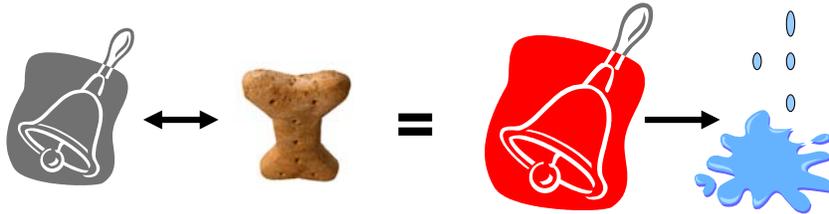
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### **Instructions**

1. Read the slide to your audience.

## Classical conditioning: Concepts

**Conditioned Stimulus (CS)** does not produce a physiological response, but once we have strongly associated it with an **Unconditioned Stimulus (UCS)** (e.g., food) it ends up producing the same physiological response (i.e., salivation).



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### Instructions

1. Read the slide to your audience.
2. Explain to your audience the graphic: Conditioned stimuli (CS) are those stimuli that by their nature do not produce a physiological response in our bodies (e.g., a bell) but that once we strongly associated them with an unconditioned stimulus (UCS; food, in this case) after repeated exposures, they end up producing the same physiological response (salivation) in absence of the UCS (food).
3. Ask participants for examples of stimuli associated with drug use. For instance, tobacco users may have strong associations between a cigarette and smoking friends, types of food or drinks (e.g., coffee), and places (e.g., pubs or bars).

## Classical conditioning: Addiction

- Repeated pairings of particular events, emotional states, or cues with substance use can produce **craving** for that substance
- Over time, drug or alcohol use is paired with **cues** such as money, paraphernalia, particular places, people, time of day, emotions
- Eventually, exposure to cues alone produces drug or alcohol cravings or urges that are often followed by substance abuse

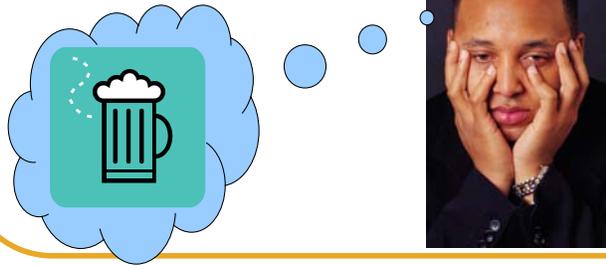
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### Instructions

1. Read the slide to your audience.
2. Explain that classical conditioning is a learning process that has three main components: A conditioned stimulus (CS), unconditioned stimulus (UCS), and a conditioned response (CR).
3. Explain to participants that over time, a repeated stimulus (a bell ringing) paired with another event (the presentation of food) can elicit a reliable response (dog salivation). The same can be said of the addicted person. Certain stimuli or cues, for example, money, boredom, or anxiety, that are associated with use of a drug can, over time, trigger cravings for that drug.

## Classical conditioning: Application to CBT techniques (1)

- Understand and identify “triggers” (conditioned cues)
- Understand how and why “drug craving” occurs



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### Instructions

1. Read the slide to your audience.
2. Explain that clinicians should then work with clients to develop a comprehensive list of the client’s triggers (conditioned stimuli). Some clients become overwhelmed when asked to identify cues (one person reported that even breathing was associated with their drug use). 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 practise exercise for this session should include self-monitoring of craving, so clients can begin to identify new, more subtle cues as they arise.

(Adapted from Carroll, 2002)

## Classical conditioning: Application to CBT techniques (2)

- Learn strategies to avoid exposure to triggers
- Cope with craving to reduce / eliminate conditioned craving over time



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### Instructions

1. Read the slide to your audience.
2. Explain that classical conditioning theories can be applied in two important areas: (1) in learning strategies and skills to avoid being exposed to triggers (friends, locations, money, etc.) and (2) in coping with craving to reduce or eliminate conditioned craving over time.
3. Provide some examples of strategies that can be learned, such as avoiding certain places or people, avoiding having cash, etc.
4. Provide examples of how to cope with cravings, such as exercising, relaxation techniques, calling a non-substance user friend, etc.
5. Ask participants for more examples.

## Operant conditioning: Addiction (1)

Drug use is a behaviour that is reinforced by the positive reinforcement that occurs from the pharmacologic properties of the drug.



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### Instructions

1. Read the slide to your audience.
2. Explain that drug use can also be seen as behaviour that is reinforced by its consequences. Drugs may be used because they change the way a person feels (powerful, energetic, euphoric, stimulated, less depressed), the way they think (I can only get through this if I am high), or the way they behave (less inhibited, more confident)
3. Ask participants for more examples.

## Operant conditioning: Addiction (2)

Once a person is addicted, drug use is reinforced by the negative reinforcement of removing or avoiding painful withdrawal symptoms.



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### Instructions

1. Read the slide to your audience.
2. Ask participants for examples of how withdrawal symptoms can be negative reinforcements for continuing drug use.

### Notes

Please be aware that the confidentiality of clients needs to be maintained. Ask for general examples and not for particular cases.

## Operant conditions (1)

**Positive reinforcement** strengthens a particular behaviour (e.g., pleasurable effects from the pharmacology of the drug; peer acceptance)



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### Instructions

1. Read the slide to your audience.
2. Ask participants for examples of positive reinforcements that can strengthen a behaviour.
3. Explain that positive reinforcement occurs when a particular behaviour increases in occurrence by the consequence of experiencing or observing a positive condition. For example, if I eat when hungry, the consequence will be to feel satisfied; therefore, I will probably repeat this behaviour again in the future.

## Operant conditions (2)

**Punishment** is a negative condition that decreases the occurrence of a particular behaviour (e.g., If you sell drugs, you will go to jail. If you take too large a dose of drugs, you can overdose.)



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### Instructions

1. Read the slide to your audience.
2. Ask for other examples.
3. Explain to your audience that punishment refers to a negative condition that decreases the occurrence of a particular behaviour. For example, if I put my hand in a hot stove, the consequence will be that I will burn my hand (pain – a negative consequence); therefore, I will probably avoid repeating this behaviour again.

## Operant conditions (3)

**Negative reinforcement** occurs when a particular behaviour gets stronger by avoiding or stopping a negative condition (e.g., If you are having unpleasant withdrawal symptoms, you can reduce them by taking drugs.).



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### Instructions

1. Read the slide to your audience.
2. Ask your audience for some other examples.
3. Explain that negative reinforcement occurs when a particular behaviour increases in occurrence by avoiding or stopping a negative consequence. For example, a rat in a cage receives a mild electrical shock on its feet (negative consequence), the rat discovers that pressing a bar stops the shocks; as a consequence, the behaviour of pressing the bar is strengthened.

## Operant conditioning: Application to CBT techniques

- Functional Analysis – identify high-risk situations and determine reinforcers
- Examine long- and short-term consequences of drug use to reinforce resolve to be abstinent
- Schedule time and receive praise
- Develop meaningful alternative reinforcers to drug use

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### Instructions

1. Read the slide to your audience.
2. Explain that you will be discussing each one of these techniques in the upcoming slides.

## Modelling: Definition

**Modelling:** To imitate someone or to follow the example of someone. In behavioural psychology terms, modelling is a process in which one person observes the behaviour of another person and subsequently copies the behaviour.



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### Instructions

1. Read the slide to your audience.
2. Explain that under a cognitive behavioural approach, substance abuse is a learned behaviour that developed through complex interplays of modelled behavior, classical conditioning, or operant conditioning. The same principles can be used to help the client stop substance use (adapted from Carroll, 2002, pp. 18-24).
3. Explain that modelling is a technique that will help clients learn new behaviours and coping skills through observing other people's behaviours. If you employ techniques such as role-playing, observing videos, or observing good models acting in an adaptive way, your client can learn new behaviours. Either in individual or group settings, your conduct (or the model's conduct) will be observed by the client and, ideally, copied by them. For instance, the client will learn to respond in new way by watching you apply techniques to avoid or deal with high-risk situations (e.g., refusing drugs from a friend).
4. Ask your audience for other examples.

## Basis of substance use disorders: Modelling

When applied to drug addiction, modelling is a major factor in the initiation of drug use. For example, young children experiment with cigarettes almost entirely because they are modelling adult behaviour.

During adolescence, modelling is often the major element in how peer drug use can promote initiation into drug experimentation.

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### Instructions

1. Read the slide to your audience.
2. Provide examples such as: children learn language by listening to and copying their parents. Adults can learn to ski by watching accomplished skiers. The same may be true for many substance abusers. By seeing their parents use alcohol to cope with their problems, teenagers may learn to do the same. Teenagers often begin smoking after watching their friends use cigarettes. So to may some drug abusers begin to use after watching their friends or family members use drugs or alcohol.
3. Ask participants for other examples of the effects of modelled behaviour.

## Modelling: Application to CBT techniques

- Client learns new behaviours through role-plays
- Drug refusal skills
- Watching clinician model new strategies
- Practising those strategies

Observe how  
I say "NO!"

NO thanks, I  
do not smoke



30

### Instructions

1. Read the slide to your audience.
2. Explain that just as CBT assumes that substance use is learned behaviour and that some individuals learn to use through modelling, operant conditioning, or classical conditioning, the same learning concepts can be applied to help clients stop using. For example, modelling is used to help clients learn new behaviours, such as refusing drug offers or how to break off from a drug associate. Thus, the client learns to respond in new unfamiliar ways in high-risk situations by watching the clinician model those behaviours and by practising those strategies in role-plays with the clinician.

## CBT Techniques for Addiction Treatment: Functional Analysis / the 5 Ws

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### **Instructions**

Tell participants that you will now discuss the first step in cognitive behavioural therapy for addiction: the functional analysis, or 5 Ws.

## The first step in CBT: How does drug use fit into your life?

- 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 drugs or a particular type of drug.
- 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.

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### **Instructions**

1. Read the slide to your audience.

## The 5 Ws (functional analysis)

### The 5 Ws of a person's drug use (also called a functional analysis)

- When?
- Where?
- Why?
- With / from whom?
- What happened?

33

#### Instructions

1. Read the slide to your audience.

#### Additional Information

Following the cognitive behavioural model previously presented, it is essential in relapse prevention to identify situations and risk factors that maintain the use of drugs over time. These drug maintaining factors are divided into external and internal variables (McCrary, 2001) that make the use of drugs more likely. The clinician may interview the client to identify external and internal antecedents (A) and consequents (C) of the drug use behaviour (B) in what is called a Functional Analysis or ABC Analysis

The maintaining factors are as follows:

External antecedents or circumstances surrounding the use of drugs: place or places where the use of drugs usually happened, the day and time in which use usually occurs, direct or indirect peer pressure (individuals that use drugs with the client), paraphernalia, the drug itself (its sight or smell) and events that happen before and after using substances (i.e., having marital problems, etc.).

Internal antecedents that might be categorized in three cognitive-behavioural levels:

- Physiological sensations and feelings: whether the client is aware of them or not, such as withdrawal symptoms, cravings, emotions (rage, sadness, feeling lonely), etc.
- Cognitions such as thoughts, ideas, positive expectations of the drug effect, planning, etc.
- Behaviours or client conduct repertoires such as copings skills.

Consequences – may include consequences at the individual level such as decreased withdrawal symptoms or cravings, desired drug effects, decrease in negative emotions; or external consequences at a social level such as increased socialization, etc.

## The 5 Ws

People addicted to drugs do not use them at random. It is important to know:

- The time periods **when** the client uses drugs
- The places **where** the client uses and buys drugs
- The external cues and internal emotional states that can trigger drug craving (**why**)
- The people with **whom** the client uses drugs or the people from **whom** she or he buys drugs
- The effects the client receives from the drugs – the psychological and physical benefits (**what happened**)

34

### Instructions

1. Read the slide to your audience.

### Notes

You will need to review the form entitled “Functional Analysis” with your audience.

## Questions clinicians can use to learn the 5 Ws

- What was going on before you used?
- How were you feeling before you used?
- How / where did you obtain and use drugs?
- With whom did you use drugs?
- What happened after you used?
- Where were you when you began to think about using?

35

### Instructions

1. Read the slide to your audience.
2. Explain to your audience that the cognitive-behavioural approach assumes that substance abuse can be better treated if clinicians focus on **current maintaining factors**. The model theorizes that external antecedents of drug use that have been previously conditioned through repeated pairing have an important role in determining subsequent drug use. Cognitions, physiological responses, and emotions mediate the relationship between the external antecedents and the behaviour of using substances and even play a role in determining subsequent use of drugs. In addition to this, the consequences of the use of drugs might be physiological, psychological, or interpersonal in their origin (McCrary, 2001).

### Functional Analysis or High-Risk Situations Record

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

#### Instructions

1. Read the slide to your audience.
2. Explain to your audience how to use the “Functional Analysis” form.

#### Notes

Use next slide to explain the form to your audience

## Activity 3: Role-play of a functional analysis

### Script 1

Conduct a role-play of a functional analysis:

1. Review 5 Ws with client
2. Provide analysis of how this information will guide treatment planning



25 minutes

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### Instructions

1. Read the slide to your audience.
2. Ask participants to get their Functional Analysis form. They will have to write some notes on them.
3. Divide the group into pairs.
4. Explain that each participant will have the opportunity to practise the use of the Functional Analysis form.
5. Explain that they will need to review the 5 Ws with their partner (client) and explain how this information will guide them through treatment planning.
6. After the first set of participants have finished using the form (10 minutes after) ask them to change roles.
7. Take another 5 minutes to debrief.

Questions?

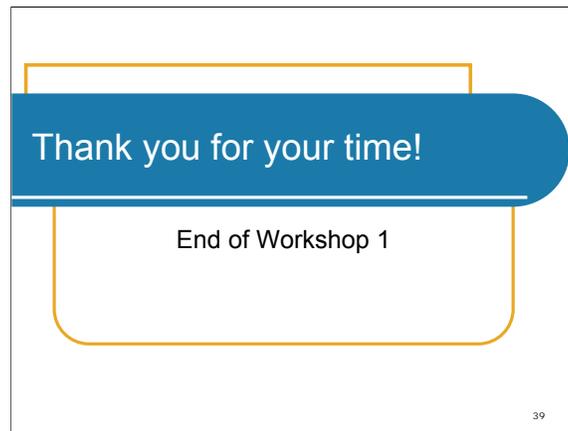


Comments?

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**Instructions**

1. Ask participants if they have questions.
2. Take the time to clarify any areas of the workshop that were unclear to participants.
3. Provide examples and review previous slides, if necessary.



**Instructions**

Give participants a break, if necessary.

## Workshop 2: Cognitive Behavioural Strategies



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### **Instructions**

1. Introduce Workshop 2 by reading the title.

## Training objectives

**At the end of this workshop, you will be able to:**

1. Identify a minimum of 4 cognitive behavioural techniques
2. Understand how to identify triggers and high- and low-risk situations
3. Understand craving and techniques to cope with craving
4. Present and practise drug refusal skills
5. Understand the abstinence violation syndrome and how to explain it to clients
6. Understand how to promote non-drug-related behavioural alternatives

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### Instructions

1. Read the training objectives to your audience.
2. Explain to participants that these objectives should be achieved as a team.
3. Encourage them to ask you questions as needed.

## CBT Techniques for Addiction Treatment: Functional Analysis & Triggers and Craving

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### **Instructions**

1. Introduce CBT Techniques for Addiction Treatment (Functional Analysis & Triggers and Craving) by reading the title.

## “Triggers” (conditioned cues)

- One of the most important purposes of the 5 Ws exercise is to learn about the people, places, things, times, and emotional states that have become associated with drug use for your client.
- These are referred to as **“triggers”** (conditioned cues).

43

### Instructions

1. Read the slide to your audience.
2. As noted previously, clinicians should then work with clients to develop a comprehensive list of the client’s triggers. Some clients become overwhelmed when asked to identify cues (one client reported that even breathing was associated with cocaine use for him). 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 practise exercise for this session should include self-monitoring of craving, so clients can begin to identify new, more subtle cues as they arise.

(Adapted from Carroll, 2002)

## “Triggers” for drug use

- A “trigger” is a “thing” or an event or a time period that has been associated with drug use in the past
- Triggers can include people, places, things, time periods, emotional states
- Triggers can stimulate thoughts of drug use and craving for drugs

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### Instructions

1. Read the slide to your audience.
2. Ask your audience to Keep in mind that the general strategy of “recognise, avoid, and cope” is particularly applicable to craving. After identifying the clients’ most problematic cues, clinicians should explore the degree to which some of these can be avoided. 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 are used, or no longer carrying money.
3. Provide the following example:

“You’ve said that having money in your pocket is the toughest trigger for you right now. Let’s spend some time thinking through ways that you might not have to be exposed to money as much. What do you think would work? Is there an amount of money you can carry with you that feels safe? You talked about giving your check to your mother earlier; do you think this would work? You’ve said that she’s very angry about your drug use in the past; do you think she’d agree to do this? How would you negotiate her keeping your money for you? How could you arrange with her to get money you needed for living expenses? How long would this arrangement go on?”
4. Explain that clinicians should spend considerable time exploring the relationship between alcohol and drugs with clients who use them together to such an extent that alcohol becomes a powerful drug cue. Specific strategies to reduce, or preferably, stop alcohol use should be explored.
5. Explain to your audience that common triggers include being around people with whom one used drugs, having money or getting paid, drinking alcohol, social situations, and certain affective states, such as anxiety, depression, or joy. Triggers for drug craving also are highly idiosyncratic, thus identification of cues should take place in an ongoing way throughout treatment (Carroll, 2002).

## External triggers

- **People:** drug dealers, drug-using friends
- **Places:** bars, parties, drug user's house, parts of town where drugs are used
- **Things:** drugs, drug paraphernalia, money, alcohol, movies with drug use
- **Time periods:** paydays, holidays, periods of idle time, after work, periods of stress

45

### Instructions

1. Read the slide to your audience.
2. Ask participants to provide more examples of external triggers.

## Internal triggers

- Anxiety
- Anger
- Frustration
- Sexual arousal
- Excitement
- Boredom
- Fatigue
- Happiness



46

### Instructions

1. Read the slide to your audience.
2. Ask participants to provide more examples of internal triggers.

## Triggers & Cravings

Trigger → Thought → Craving → Use



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### Instructions

1. Read the slide to your audience.
2. Explain to your audience how a trigger can initiate some thoughts about using drugs which leads the client to have cravings and finally to use the substance.
3. Tell your audience that you will review this sequence in the following slides.

## Activity 3: Role-playing

### Using the Internal and External Trigger Worksheets:

- Observe the role-play and how the clinician identifies triggers.
- Practise the role-play for 10 minutes



35 minutes



48

### Instructions

1. In this client/clinician role-playing session, you will play the clinician. Ask for a volunteer to play the client's role.
2. You will use either the Internal or External Trigger Worksheets in the role-playing to help the client identify the triggers of his/her substance use.
3. Ask your audience to use the forms to take notes on the strategies you have used.
4. Divide the audience into groups of two. Each person in the group will play each of the roles (client and clinician) for 10 minutes.
5. Ask participants to role-play to practise the use of the forms. One participant should use the Internal Trigger Worksheet and the other should use the External Trigger worksheet.
6. Once they have practised their roles, ask participants to give you a report on difficulties or comments on these two forms.
7. Once you are done (10 minutes), ask the audience if they have questions

## CBT Techniques for Addiction Treatment: High-Risk & Low-Risk Situations

49

### **Instructions**

Introduce CBT Techniques for Addiction Treatment (High-Risk & Low-Risk Situations) by reading the title.

## High- and low-risk situations (1)

- Situations that involve triggers and have been highly associated with drug use are referred to as **high-risk situations**.
- Other places, people, and situations that have never been associated with drug use are referred to as **low-risk situations**.

50

### **Instructions**

Read the slide to your audience.

## High- and low-risk situations (2)

An important CBT concept is to teach clients to decrease their time in high-risk situations and increase their time in low-risk situations.



51

### Instructions

Read the slide to your audience.

## Activity 4: Role-playing

Using the “high-risk vs. low-risk” continuum (see Triggers charts), use information from the functional analysis (5Ws) and the trigger analysis to construct a high-risk vs. low-risk exercise. Role-play the construction of a high- vs. low-risk analysis.



35 minutes

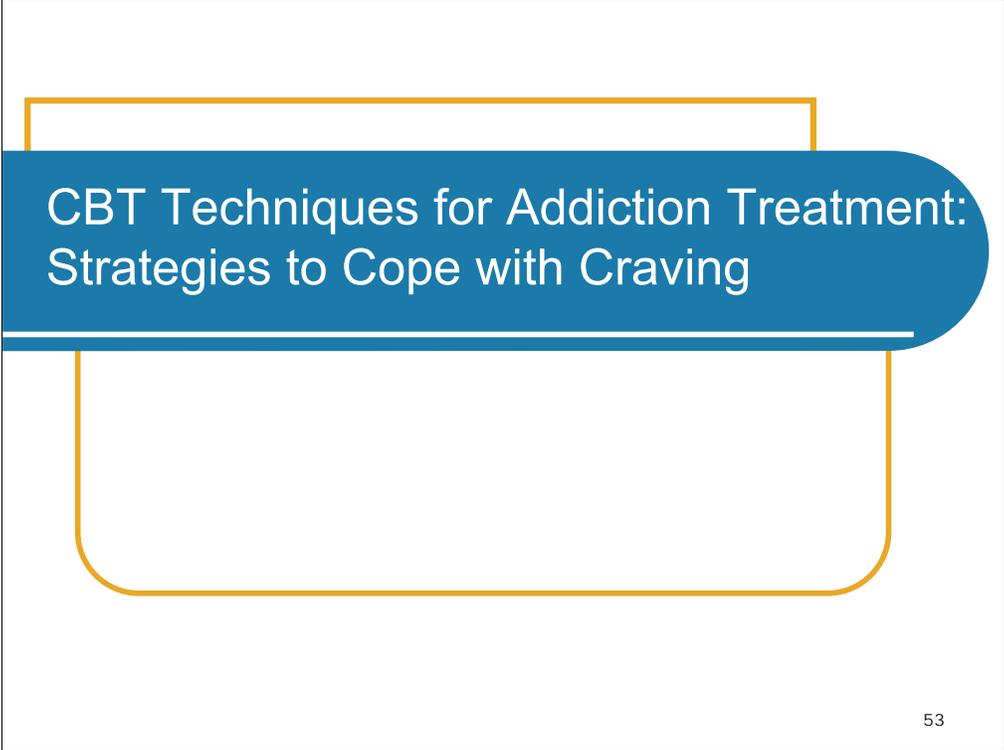


52

### Instructions

This activity is a continuation of Activity 3.

- Again in this client/clinician role-playing session you will play the clinician. Ask the previous volunteer to keep playing the client’s role.
- You will use the Internal or External Trigger Chart in the role-playing to help the client assess the high-risk situations of his/her substance use.
- Ask your audience to use the forms to take notes.
- Divide the audience into the same pairs from Activity 3. Each person in the group will play each of the roles (client and clinician) for 10 minutes.
- Ask participants to role-play to practise their the use of the forms. One participant should use the Internal Trigger Chart and the other should use the External Trigger Chart.
- Once they have practised their roles, ask participants to give you a report on difficulties or comments on these two forms.
- Once you are done (10 minutes) ask the audience if they have questions



## CBT Techniques for Addiction Treatment: Strategies to Cope with Craving

53

### **Instructions**

Introduce CBT Techniques for Addiction Treatment: Strategies to Cope with Craving, by reading the title.

# Understanding craving

## Craving (definition)

- To have an intense desire for
- To need urgently; require

Many people describe craving as similar to a hunger for food or thirst for water. It is a combination of thoughts and feelings. There is a powerful physiological component to craving that makes it a very powerful event and very difficult to resist.

54

### Instructions

1. Read the slide to your audience.
2. Explain that cravings are impulsive urges that have a physiological basis. Cravings will not stop just because the client has decided not to use drugs. Clients will need to learn skills to deal with cravings, such as avoiding triggers and high-risk situations that can lead to cravings.

(Adapted from Carroll, 2002)

## Craving: Different for different people

Cravings or urges are experienced in a variety of ways by different clients.

For some, the experience is primarily **somatic**. For example, “I just get a feeling in my stomach,” or “My heart races,” or “I start smelling it.”

For others, craving is experienced more **cognitively**. For example, “I need it now” or “I can’t get it out of my head” or “It calls me.”

55

### Instructions

1. Read the slide to your audience.
2. Ask your audience for more examples.

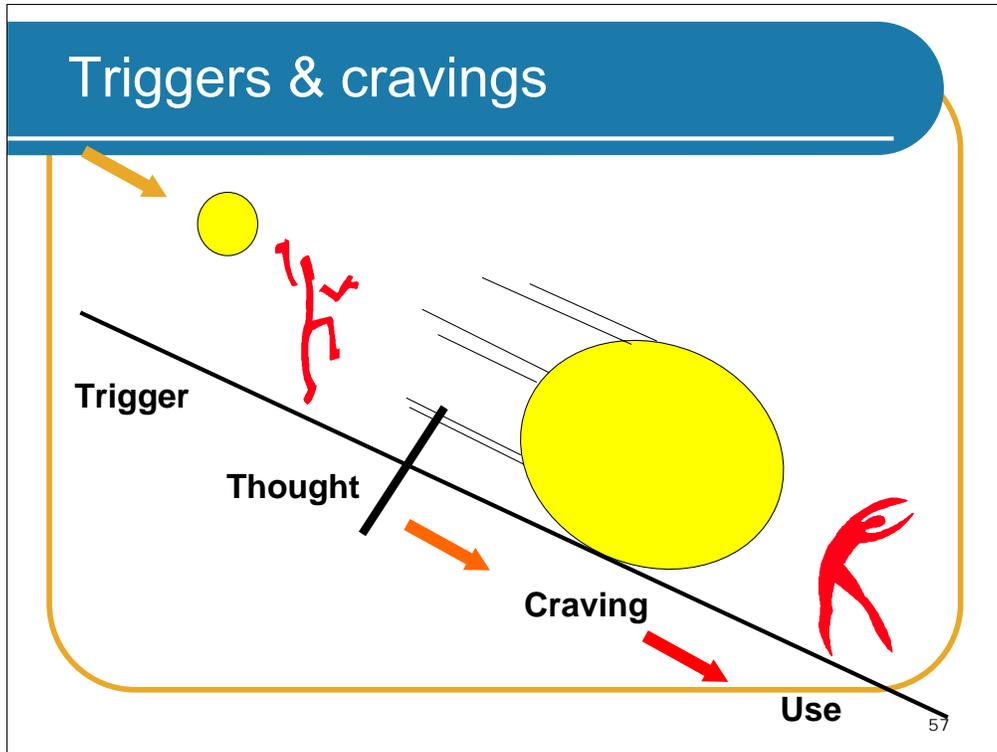
## Coping with craving

- Many clients believe that once they begin to crave drugs, it is inevitable that they will use. In their experience, they always “give in” to the craving as soon as it begins and use drugs.
- In CBT, it is important to give clients tools to resist craving

56

### **Instructions**

Read the slide to your audience.



### Instructions

1. Read the slide to your audience.
2. Explain that clients should learn from clinicians that triggers do not automatically lead them to using. Between the stimuli and the use of the drug there are thoughts that lead to craving.
3. Point to the line in the middle of the graphic. Explain to your audience that if the client learns coping skills to stop those thoughts before he/she starts craving of drugs, it will be easier to stop the behaviour of drug seeking and drug use. They need to stop the thoughts before they turn into craving. If the client does not learn to stop those thoughts, then it will be extremely difficult to stop the behaviour of drug use once he/she starts craving the drug.

# Strategies to cope with craving

## Coping with Craving:

1. Engage in non-drug-related activity
2. Talk about craving
3. “Surf” the craving
4. Thought stopping
5. Contact a drug-free friend or counsellor
6. Pray

58

### Instructions

1. Read the slide to your audience.
2. Explain to your audience each of the following strategies to cope with craving:
  - Engaging in non-drug-related activities that serve as a distraction from cravings and that should be done in low-risk situations, such as walking, going to the movies, going to Alcoholic Anonymous meetings, etc.
  - Talking about craving with another person could help the client to focus on the physiological and emotional sensations of the craving instead of thinking about the drug and how to find it. Clients may also use self-talk and self-instructions to avoid craving and drug-using thoughts.
  - “Surf” the craving means to focus on the physiological and emotional sensations of the craving when it is inevitable. For example, a client needs to learn how to identify craving sensations. He/she may sit in a quiet room and attend to the craving sensations. This is called surfing because of the metaphor of craving as a wave. Clients may also use relaxation techniques while “surfing” the craving to control and modify the craving or wait until it is over.
  - Thought stopping is a very useful skill if clients practise it. Thought-stopping techniques are meant to break the link between thinking of using and cravings. There are different techniques that clients may apply to stop the thoughts once they start, such as snapping their wrist with a rubber-band (clients may wear one all the time and use it whenever they have those thoughts). Other techniques are using relaxation or calling someone, engaging in distracting activities, etc.
  - Contact a drug-free friend or counselor. Talking to another person helps to release feelings and allows clients to hear their own thinking process. Clinicians can help clients to make a list of phone numbers of supportive people that the client can keep with them all times and use them when needed.
  - There are other strategies such as recalling the negative consequences of drug abuse.
3. Explain to your audience that clinicians may wish to point out that these strategies may not stop craving completely. However, with practise, they will reduce the frequency and intensity of craving and make it less disturbing and frustrating when it occurs.

(Source: Center for Substance Abuse Treatment. Counselor’s Treatment Manual: Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders. DHHS Publication No. (SMA) 06-4152. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006. )

(Adapted from Carroll, 2002)

## Activity 5: Role-playing

Use the “Trigger-Thought-Craving-Use” sheet to educate clients about craving and discuss methods for coping with craving. Role-play a discussion of techniques to cope with craving.



20 minutes

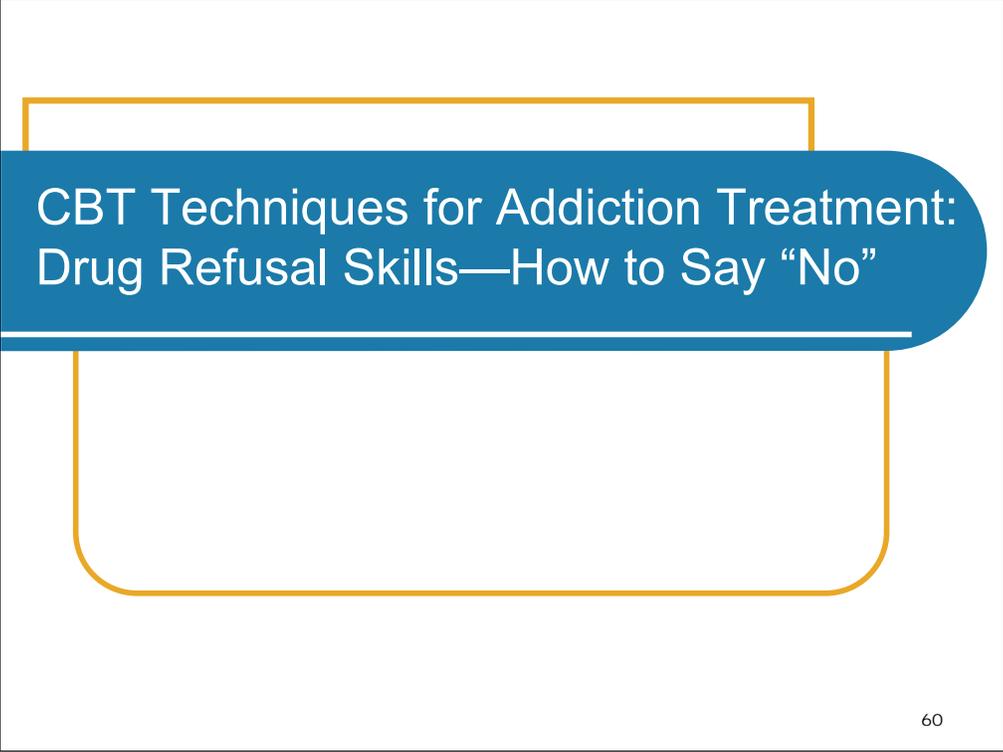


59

### Instructions

This activity is a continuation of Activities 3 and 4.

- Again, in this client/clinician role-playing session you will play the clinician. Ask the previous volunteer to keep playing the client's role.
- You will use the Trigger-Thought-Craving-Use sheet in the role-playing to educate the client about craving and discuss methods for coping.
- Ask your audience to use the sheet to take notes.
- Once you are done (5 minutes), ask the audience if they have questions
- Divide the audience into the same pairs from Activities 3 and 4. Each person in the group will play each of the roles (client and clinician) for 5 minutes.
- Ask participants to role-play to practise the use of this Trigger-Thought-Craving-Use sheet.
- Once they have practised their roles, ask participants to give you a report on difficulties or comments on the Trigger-Thought-Craving-Use sheet.



## CBT Techniques for Addiction Treatment: Drug Refusal Skills—How to Say “No”

60

### **Instructions**

Introduce CBT Techniques for Addiction Treatment (Drug Refusal Skills-How to Say “No”) by reading the title.

## How to say “No”: Drug refusal skills

- One of the most common relapse situations is when a client is offered drugs by a friend or a dealer.
- Many find that they don't know how to say “No.”
- Frequently, their ineffective manner of dealing with this situation can result in use of drugs.



61

### Instructions

1. Read the slide to your audience.
2. Explain to your audience that a major issue for many substance abusers is reducing availability of the drug and effectively refusing offers of the drug. Clients who remain ambivalent about reducing their drug use often have particular difficulty when offered the drug directly. For instance, many drug users' social networks have so narrowed that they associate with few people who do not use drugs, and cutting off contact may mean social isolation. Also, many individuals have become involved in distribution, and extricating themselves from the distribution network is difficult. Many clients lack the basic assertiveness skills to effectively refuse offers of the drug or prevent future offers. Thus, this session includes sections on reducing availability, refusal skills, and a review of general assertiveness skills.
3. Explain that clinicians should carefully direct questions to ferret out covert indicators of ambivalence and resistance to change and the social forces working against change. Failure of clients to take initial steps towards removing triggers and avoiding the drug may reveal a number of clinically significant issues.

(Source: Carroll, 2002)

## Drug refusal skills: Key elements

**Improving refusal skills/assertiveness:** There are several basic principles in effective refusal of drugs:

1. Respond rapidly (not hemming and hawing, not hesitating)
2. Have good eye contact
3. Respond with a clear and firm “No” that does not leave the door open to future offers of drugs
4. Make the conversation brief
5. Leave the situation

62

### Instructions

1. Read the slide to your audience.
2. Explain to your audience that clinicians should review the client’s suppliers and explore strategies for reducing contact with them. In some cases, a clear and assertive refusal, followed by a statement that the client has decided to stop and a request that the drug no longer be offered, can be surprisingly effective. In other cases, clients can arrange to avoid any contact with particular users or suppliers.

### Additional Information

When clients are in a close, intimate relationship with someone who uses and supplies drugs, the problem is more difficult. For example, it may not be easy for a woman to abstain when her partner supplies drugs or continues to use, and she may not be ready to break off the relationship. Furthermore, sometimes only limited change in a client’s stance towards such a relationship can be effectively undertaken in 12 weeks of treatment. Rather than seeing this as an either-or situation (“I can either stop cocaine use or get out of the relationship”), clinicians should explore the extent to which exposure to drugs can be renegotiated and limits set.

“I hear you say that you feel like you want to stay with Bob for now, but he’s not willing to stop using cocaine. Being there is pretty risky for you, but maybe we can think of some ways to reduce the risk. Have you thought about asking him not to bring drugs into the house or use them in the house? You’ve said you know there’s a lot of risk to you while he continues to do that, both in terms of your staying abstinent as well as having drugs around your kids.”

(Source: Carroll, 2002.)

## Drug refusal skills: Teaching methods

After reviewing the basic refusal skills, clients should practise them through role-playing, and problems in assertive refusals should be identified and discussed.

1. Pick an actual situation that occurred recently for the client.
2. Ask client to provide some background on the target person.

63

### **Instructions**

Read the slide to your audience.

(Source: Carroll, 2002.)

## Role-play: Drug-offer situation

- Role-play a situation where a drug user friend (or dealer) makes an offer to give or get drugs. Role-play an ineffective response and role-play an effective use of how to say “No.”

64

### Instructions

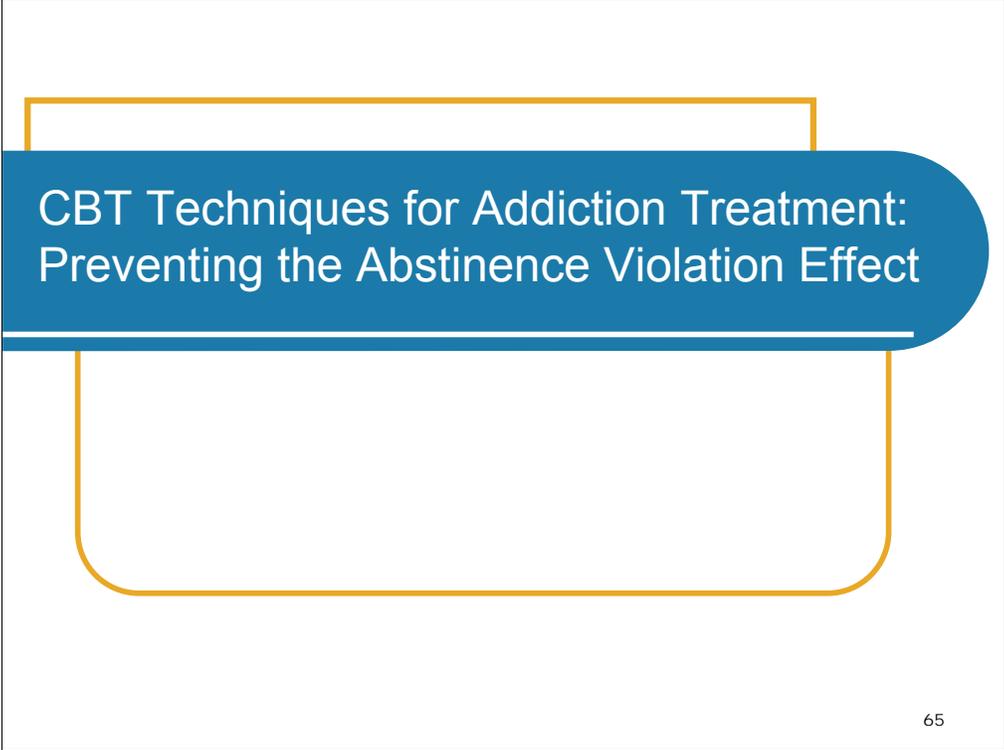
1. Read the slide to your audience.
2. Explain to your audience that after reviewing the basic refusal skills, clients should practise them through role-playing, and problems in assertive refusals should be identified and discussed. Since this is the first session that includes a formal role-play, it is important for clinicians to set it up in a way that helps clients feel comfortable. For the first role-play, have clients play the target individual, so they can convey a clear picture of the style of the person who offers drugs and the clinician can model effective refusal skills. Then reverse the roles for subsequent role-plays. Role-plays should be thoroughly discussed afterward. Clinicians should praise any effective behaviours shown by clients and also offer clear, constructive criticism:

“That was good; how did it feel to you? I noticed that you looked me right in the eye and spoke right up; that was great. I also noticed that you left the door open to future offers by saying you had stopped cocaine ‘for a while.’ Let’s try it again, but this time, try to do it in a way that makes it clear you don’t want Joe to ever offer you drugs again.”

Quite often, the role-plays will reveal that a client doesn’t fully understand what has been covered or has feelings of discomfort with assertive responding. For such individuals, clinicians should devote another session to reviewing and practising assertive responding.

Key areas to review include defining assertiveness, reviewing the differences between response styles (passive, aggressive, passive-aggressive, and assertive), body language and nonverbal cues, and anticipating negative consequences.

(Source: Carroll, 2002.)



## CBT Techniques for Addiction Treatment: Preventing the Abstinence Violation Effect

65

### **Instructions**

Introduce CBT Techniques for Addiction Treatment (Preventing the Abstinence Violation Effect) by reading the title.

## Abstinence Violation Syndrome

If a client slips and uses drugs after a period of abstinence, one of two things can happen.

- He or she could think: “I made a mistake and now I need to work harder at getting sober.

Or

- He or she could think: “This is hopeless, I will never get sober and I might as well keep using.” This thinking represents the **abstinence violation syndrome**.

66

### Instructions

Read the slide to your audience.

## Abstinence Violation Syndrome: What people say

- One lapse means a total failure.
- I've blown everything now! I may as well keep using.
- I am responsible for all bad things.
- I am hopeless.
- Once a drunk / junkie, always a drunk / junkie.
- I'm busted now, I'll never get back to being straight again.
- I have no willpower...I've lost all control.
- I'm physically addicted to this stuff. I always will be.

67

### **Instructions**

Read the slide to your audience.

## Preventing the Abstinence Violation Syndrome

Clients need to know that if they slip and use drugs / alcohol, it does not mean that they will return to full-time addiction. The clinician can help them “reframe” the drug-use event and prevent a lapse in abstinence from turning into a full return to addiction.

68

### **Instructions**

Read the slide to your audience.

## Abstinence violation effect: Examples of “reframing” (1)

I used last night, but I had been sober for 30 days before. So in the past 31 days, I have been sober for 30. That’s better than I have done for 10 years.



69

### Instructions

1. Use the slide as an example of a client “reframing.”
2. Ask another person from the audience to read out loud Anna’s words on the slide.

## Abstinence violation effect: Examples of “reframing” (2)

Learning to get sober is like riding a bicycle. Mistakes will be made. It is important to get back up and keep trying.



70

### Instructions

1. Use the slide as another example of a client “reframing.”
2. Ask another person from the audience to read out loud Anna’s words on the slide.

## Abstinence violation effect: Examples of “reframing” (3)

Most people who eventually get sober do have relapses on the way. I am not unique in having suffered a relapse, it's not the end of the world.



71

### Instructions

1. Use the slide as a third example of “reframing.”
2. Ask another person from the audience to read out loud Anna’s words on the slide.



## CBT Techniques for Addiction Treatment: Making Lifestyle Changes

72

### **Instructions**

Introduce CBT Techniques for Addiction Treatment: Making Lifestyle Changes, by reading the title.

## Developing new non-drug-related behaviours: Making lifestyle changes

- CBT techniques to stop drug use must be accompanied by instructions and encouragement to begin some new alternative activities.
- Many clients have poor or non-existent repertoires of drug-free activities.
- Efforts to “shape and reinforce” attempts to try new behaviours or return to previous non-drug-related behaviour is part of CBT.

73

### Instructions

1. Read the slide to your audience.
2. Ask your audience what lifestyle changes they can suggest to their clients and the steps clients will need to follow in order to make those changes.

Questions?

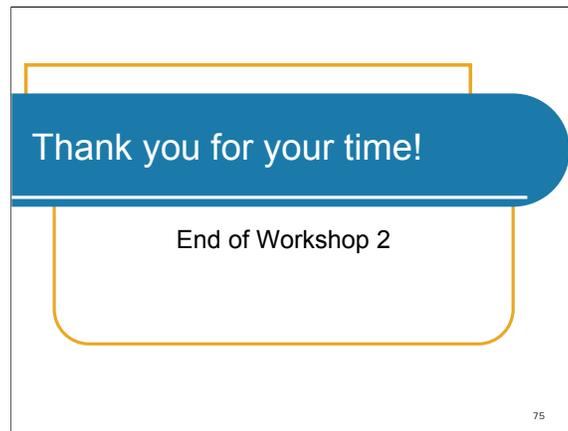


Comments?

74

**Instructions**

1. Ask your audience if they have any questions.
2. Take the time to clarify any areas of the workshop that were unclear to participants.
3. Provide examples and review previous slides, if necessary.



**Instructions**

Give participants a break, if necessary.

## Workshop 3: Methods for Using Cognitive Behavioural Strategies



76

### **Instructions**

Introduce Workshop 3 by reading the title.

## Training objectives

**At the end of this workshop, you will be able to:**

1. Understand the clinician's role in CBT
2. Structure a session
3. Conduct a role-play establishing a clinician's rapport with the client
4. Schedule and construct a 24-hour behavioural plan

77

### **Instructions**

1. Read the training objectives to your audience.
2. Explain that these objectives should be achieved as a team.
3. Encourage participants to ask you questions as needed.

## Role of the Clinician in CBT

78

### **Instructions**

Introduce the workshop by reading the title.

## The clinician's role

To teach the client and coach her or him towards learning new skills for behavioural change and self-control.



79

### Instructions

1. Read the slide to your audience.
2. Explain that the role of the clinician is to teach and coach the client towards learning new skills for behavioural change and self-control. The client ultimately should learn to be his or her own coach in the behavioural change process to achieve abstinence or reduction of drug use (Addy & Ritter, 2000)
3. Explain that the role of the clinician is also to teach the client how to avoid feelings of shame when recurrence or relapse occurs and to encourage him/her to keep seeking help and keep attending the treatment sessions.

## The role of the clinician in CBT

- CBT is a very active form of counselling.
- 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.
- Effective CBT requires an empathetic clinician who can truly understand the difficult challenges of addiction recovery.

80

### Instructions

1. Read the slide to your audience.
2. Explain that the CBT process revolves primarily around the relationship between the counsellor and the client. It is this relationship that leads to growth and change. The counsellor works “with” the client, and a sense of partnership and collaboration prevails. In essence, the counsellor functions as an ally or guide who helps the client change himself or herself, rather than as an expert who “fixes” all the client’s problems (Ranganathan, Jayaraman & Thirumagal)
3. Explain to your audience that the CBT **primary goal** is to initiate abstinence or reduction in substance use and prevent relapse by addressing potential precipitants of relapse and high-risk factors and teaching the individual coping mechanisms and the necessary skills to effectively exercise control. The **secondary goal** is to help the client recover from the damage addiction has caused in his life. The client is encouraged to achieve and maintain abstinence and then to develop the necessary psychosocial skills to continue recovery as a lifelong process.

## The role of the clinician in CBT

The CBT clinician has to strike a balance between:

- Being a good listener and asking good questions in order to understand the client
- Teaching new information and skills
- Providing direction and creating expectations
- Reinforcing small steps of progress and providing support and hope in cases of relapse

81

### **Instructions**

Read the slide to your audience.

## The role of the clinician in CBT

- The CBT clinician also has to balance:
  - The need of the client to discuss issues in his or her life that are important.
  - 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 “crisis management session.”

82

### **Instructions**

Read the slide to your audience.

## The 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 non-judgemental and non-critical stance.
- Motivational interviewing skills are extremely valuable in the delivery of CBT.

83

### **Instructions**

Read the slide to your audience.

## How to Conduct a CBT Session

84

### **Instructions**

Tell participants that you will now discuss how to conduct a CBT session.

## CBT sessions

- CBT can be conducted in individual or group sessions.
- Individual sessions allow more detailed analysis and teaching with each client directly.
- Group sessions allow clients to learn from each other about the successful use of CBT techniques.

85

### **Instructions**

Read the slide to your audience.

## How to structure a session

The sessions last around 60 minutes.



86

### **Instructions**

Read the slide to your audience.

## How to organise a clinical session with CBT: The 20 / 20 / 20 rule

- CBT clinical sessions are highly structured, with the clinician assuming an active stance.
- 60-minute sessions divided into three 20-minute sub-sessions
- Empathy and acceptance of client needs must be balanced with the responsibility to teach and coach.
  - Avoid being non-directive and passive
  - Avoid being rigid and machine-like

87

### Instructions

1. Read the slide to your audience.
2. Explain that Cognitive Behavioural Therapy applied to Relapse Prevention is highly structured and more didactic than other treatment modalities. There will be a great deal of different activities such as reviewing and practising exercises, debriefing problems that may have occurred since the last session, skills training, feedback on skills training, in-session practise, and planning for the next week. This active stance must be balanced with adequate time for understanding and engaging with the client.

(Source: Carroll, 2002.)

## First 20 minutes

- Set agenda for session
- Focus on understanding client's current concerns (emotional, social, environmental, cognitive, physical)
- Focus on getting an understanding of client's level of general functioning
- Obtain detailed, day-by-day description of substance use since last session.
- Assess substance abuse, craving, and high-risk situations since last session
- Review and assess their experience with practise exercise

88

### Instructions

1. Read the slide to your audience.
2. Explain that during the first 20 minutes of each session the clinician will focus on getting a clear understanding of the client's current concerns, level of general functioning, and substance use and craving during the past week. During this section, clients will play a more active role in responding to questions or describing their experiences. The clinician will also get information on the client's experiences in practising exercises learned in previous sessions (except for the first session), a urine test or breath test, and the client response to medication and compliance, if applicable.

(Source: Carroll, 2002.)

## Second 20 minutes

- Introduce and discuss session topic
- Relate session topic to current concerns
- Make sure you are at the same level as client and that the material and concepts are understood
- Practise skills

89

### Instructions

1. Read the slide to your audience.
2. Explain that the second 20 minutes will be devoted to introduction and discussion of a particular skill. Here, the clinician will have a more active role of teaching and explaining the new skills but will also obtain feedback from clients to assess their degree of understanding or agreement on the relevance of the new skills.

(Source: Carroll, 2002.)

## Final 20 minutes

- Explore client's understanding of and reaction to the topic
- Assign practise exercise for next week
- Review plans for the period ahead and anticipate potential high-risk situations
- Use scheduling to create behavioural plan for next time period

90

### Instructions

1. Read the slide to your audience.
2. Explain that the final 20 minutes reverts to being more client dominated, as clients and clinicians agree on a practise exercise for the next week and anticipate and plan for any difficulties the clients might encounter before the next session.

(Source: Carroll, 2002.)

## Challenges for the clinician

- Difficulty staying focused if client wants to move clinician to other issues
- 20 / 20 / 20 rule, especially if homework has not been done. The clinician may have to problem-solve why homework has not been done
- Refraining from conducting psychotherapy
- Managing the sessions in a flexible manner, so the style does not become mechanistic

91

### **Instructions**

Read the slide to your audience.

# Principles of Using CBT

92

## **Instructions**

Introduce Principles of Using CBT by reading the title.

## Match material to client's needs

- CBT is highly individualised
- Match the content, examples, and assignments to the specific needs of the client
- Pace delivery of material to insure that clients understand concepts and are not bored with excessive discussion
- Use specific examples provided by client to illustrate concepts

93

### Instructions

1. Read the slide to your audience.
2. Explain the importance of adapting the materials to the client's needs and that CBT is highly individualized. The clinician should carefully match the content, timing, and nature of presentation of the material to the client. Do not belabour topics or rush through material in an attempt to cover all of it in a few weeks. The pace is determined by the client's needs. Some clients may need several weeks to truly master a basic skill while others may need only a few sessions. It is more effective to slow down and work at a pace that is comfortable and productive for your client than to risk the therapeutic alliance by using a pace that is too fast.

(Source: Carroll, 2002.)

# Repetition

- Habits around drug use are deeply ingrained
- Learning new approaches to old situations may take several attempts
- Chronic drug use affects cognitive abilities, and clients' memories are frequently poor
- Basic concepts should be repeated in treatment (e.g., client's "triggers")
- Repetition of whole sessions, or parts of sessions, may be needed

94

## Instructions

1. Read the slide to your audience.
2. Explain that learning new skills and effective skill-building requires time and practise. Drug users have very defined routines around acquiring, preparing, using the drug, and recovering from it. It is important for the clinician to recognise how difficult it is for them to change these patterns especially when they encounter the withdrawal symptoms. In addition to this, clients usually seek help after long periods of chronic use. Drugs may affect their attention, memory, and other cognitive skills and make it difficult for them to understand, memorize, and use new skills to cope with their drug dependence. Therefore repetition of sessions or parts of sessions may be necessary for clients that do not easily understand the concepts or the rationale of the treatment. Therefore, the clinician should feel free to repeat the sessions as many times as needed.

It is important to recognise how uncomfortable it is to learn new habits and new approaches. Moreover most clients come to treatment after a long period of use and chronic use affects cognitive abilities.

(Source: Carroll, 2002.)

## Practise

Mastering a new skill requires time and practise. The learning process often requires making mistakes, learning from mistakes, and trying again and again. It is critical that clients have the opportunity to try out new approaches.



95

### Instructions

1. Read the slide to your audience.
2. Explain that in cognitive behavioural therapy, practising is a central component since it is an important part of the learning process. Mastering a new skill requires time and practise. The learning process often requires making mistakes and trying again over and over until the skills are mastered. In CBT, practise of new skills is a central, essential component of treatment. The degree to which the treatment is skills *training* over merely skills *exposure* has to do with the amount of practise. It is critical that clients have the opportunity to try out new skills within the supportive context of treatment. Through firsthand experience, clients can learn what new approaches work or do not work for them, where they have difficulty or problems, and so on. CBT offers many opportunities for practise, both within sessions and outside of them. Each session includes opportunities for clients to rehearse and review ideas, raise concerns, and get feedback from the clinician. Practise exercises are suggested for each session; these are basically homework assignments that provide a structured way of helping clients test unfamiliar behaviours or try familiar behaviours in new situations. However, practise is only useful if the client sees its value and actually tries the exercise. Compliance with extra-session assignments is a problem for many clients. Several strategies are helpful in encouraging clients to do homework.

## Give a clear rationale

Clinicians should not expect a client to practise a skill or do a homework assignment without understanding **why** it might be helpful.

Clinicians should constantly stress the importance of clients practising what they learn outside of the counselling session and explain the reasons for it.



96

### Instructions

1. Read the slide to your audience.
2. Explain that giving a clear rationale of the homework or other assignments is critical. Many people do not practise their homework or drop out because they do not understand the importance of the suggested assignments and practising them. It is critical that clients know the reasons why you are making a specific recommendation or assignment. Clinicians should not expect a client to practise a skill or do a homework assignment without understanding why it might be helpful. Thus, as part of the first session, clinicians should stress the importance of extra-session practise.

## Activity 7: Script 1

“It is very important that you give yourself a chance to **try new skills** outside our sessions so we can identify and discuss any problems you might have putting them into **practise**. We’ve found, too, that people who try to practise these things tend to do **better in treatment**. The practise exercises I’ll be giving you at the end of each session will help you try out these skills.”



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### Instructions

1. Use the slide as an example of a clinician explaining why practising newly learned skills is important.
2. Ask another person from the audience to read out loud the clinician’s words on the slide.

## Communicate clearly in simple terms

- Use language that is compatible with the client's level of understanding and sophistication
- Check frequently with clients to be sure they understand a concept and that the material feels relevant to them

98

### Instructions

1. Read the slide to your audience.
2. Explain that clinicians should be careful to use language that is compatible with the client's level of understanding and sophistication. Clinicians should check frequently with clients to be sure they understand a concept and that the material feels relevant to them. Reading your client's signs is also important, for example lack of eye contact, overly brief responses, or failure to come up with examples or homework. These signals may indicate that your client does not understand or is not well suited to the materials that you presented.

## Monitoring

**Monitoring:** to follow-up by obtaining information on the client's attempts to practise the assignments and checking on task completion. It also entails discussing the clients' experience with the tasks so that problems can be addressed in session.

99

### Instructions

1. Read the slide to your audience.
2. Explain that following up on assignments is critical to improving compliance and enhancing the effectiveness of these tasks. Checking on task completion underscores the importance of practising coping skills outside of sessions. It also provides an opportunity to discuss the client's experience with the tasks so that problems can be addressed in treatment.
3. Explain that in general, clients who do homework tend to have clinicians who value homework, spend a lot of time talking about homework, and expect their clients to actually do the homework. The early part of each session must include at least *5 minutes* for reviewing the practise exercise in detail; it should not be limited to asking clients whether they did it. If clients expect the clinician to ask about the practise exercise, they are more likely to attempt it than are clients whose clinician does not follow through.
4. Explain that if any other task is discussed during a session (e.g., implementation of a specific plan to avoid a potential high-risk situation) clinicians need to be sure to bring it up in the following session. For example, "Were you able to talk to your brother about not coming over after he gets high?"

## Praise approximations

Clinicians should try to shape the client's behaviour by praising even small attempts at working on assignments, highlighting anything that was helpful or interesting.

100

### Instructions

1. Read the slide to your audience.
2. Explain that just as most clients do not immediately become fully abstinent upon treatment entry, many are not fully compliant with practise exercises. Clinicians should try to shape the client's behaviour by praising even small attempts at working on assignments, highlighting anything they reveal was helpful or interesting in carrying out the assignment, reiterating the importance of practise, and developing a plan for completion of the next session's homework assignment.

## Example of praising approximations

Well Anna, you could not finish your assignments but you came for a second session. That is a great decision, Anna. I am very proud of your decision! That was a great choice!



I did not work on my assignments...sorry.

Oh, thanks!  
Yes, you are right. I will do my best to get all assignments done by next week.

101

### Instructions

1. Use the slide as an example of a clinician praising approximations.
2. Ask another person from the audience to read out loud Anna's words on the slide.
3. Read the words of the clinician or ask a participant to play that role.

## Overcoming obstacles to homework assignments

Failure to implement coping skills outside of sessions may have a variety of meanings (e.g., feeling hopeless). By exploring the specific nature of the client's difficulty, clinicians can help them work through it.

102

### Instructions

1. Read the slide to your audience.
2. Explain that some clients literally do the practise exercise in the waiting room before a session, while others do not even think about their practise exercises. Failure to implement coping skills outside of sessions may have a variety of meanings: clients feel hopeless and do not think it is worth trying to change behaviour; they expect change to occur through willpower alone, without making specific changes in particular problem areas; the client's life is chaotic and crisis ridden, and they are too disorganized to carry out the tasks; and so on. By exploring the specific nature of client's difficulty, clinicians can help them work through it.

## Example of overcoming obstacles

But it was something very easy.

I could not do the assignments...I am very busy and, besides, my children are at home now so I do not have time....

I understand, Anna. How can we make the assignments easier to complete tomorrow?

Well, I think that if I just start by doing one or two days of assignments...no more.

103

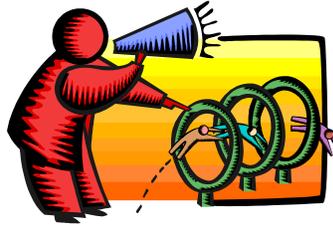
### Instructions

1. Use the slide as an example of a clinician overcoming obstacles.
2. Ask another person from the audience to read out loud Anna's words on the slide.
3. Read the words of the clinician or ask a participant to play that role.
4. Explain that although the clinician was thinking "that the assignment was very easy to do" he did not mention this to the client. On the other hand he tries to find a way to make it easier for the client to complete the assignments for the next day.

## What makes CBT ineffective

Both of the following two extremes of clinician style make CBT ineffective:

- Non-directive, passive therapeutic approach
- Overly directive, mechanical approach



104

### Instructions

1. Read the slide to your audience.

## Activity 6: Observe a role-play

Observe clinician A and clinician B conducting a session with a client:

- How did they do in session?
- What would you do differently and why?



15 minutes



105

### Instructions

1. In this client/clinician role-playing session you will play the role of two different clinicians. Ask for a volunteer to keep playing the client's role.
2. Conduct a role-play that exhibits a non-directive clinician, Clinician A, (who lets the client talk about whatever he/she wants, does not intervene, etc., asks general questions without focusing on important issues, etc.). Play this role for 5 minutes.
3. Now conduct a role-play that exhibits an overly directive clinician, Clinician B (who does not let the client talk, intervenes all the time, orders the client to do certain things, etc.). Play this role over 5 minutes.
4. Ask your audience for feedback on the two clinicians: differences, good and bad things they did during the session.
5. Ask your audience how they would do differently.

## Creating a Daily Recovery Plan

106

### **Instructions**

Introduce Creating a Daily Recovery Plan.

## Develop a plan (1)

Establish a plan for completion of the next session's homework assignment.



107

### **Instructions**

Read the slide to your audience.

## Develop a plan (2)

- Many drug abusers do not plan out their day. They simply do what they “feel like doing.” This lack of a structured plan for their day makes them very vulnerable to encountering high-risk situations and being triggered to use drugs.
- To counteract this problem, it can be useful for clients to create an hour-to-hour schedule for their time.

108

### **Instructions**

Read the slide to your audience.

## Develop a plan (3)

- Planning out a day in advance with a client allows the CBT clinician to work with the client cooperatively to maximise their time in low-risk, non-trigger situations and decrease their time in high-risk situations.
- If the client follows the schedule, they typically will not use drugs. If they fail to follow the schedule, they typically will use drugs.

109

### **Instructions**

Read the slide to your audience.

## Develop a plan (4)

### A specific daily schedule:

- Enhances your client's self-efficacy
- Provides an opportunity to consider potential obstacles
- Helps in considering the likely outcomes of each change strategy

Nothing is more motivating than being  
**well prepared!**

110

### Instructions

1. Read the slide to your audience.
2. Explain that a solid plan for change enhances your client's self-efficacy and provides an opportunity for them to consider potential obstacles and the likely outcomes of each change strategy. Furthermore, nothing is more motivating than being well prepared—no matter what the situation, a well-prepared person is usually eager to get started. A sound plan for change can be negotiated with your client by the following means:
  - Offering a menu of change options
  - Developing a behaviour contract
  - Reducing or eliminating barriers to action
  - Enlisting social support
  - Educating your client about treatment
  - Initiating the plan on a specific date
  - Preparing relatives and friends to move into action

### Notes:

See Module 1 for additional information

(Source: SAMHSA TIP 35, 1999.)

## Stay on schedule, stay sober

- Encourage the client to stay on the schedule as the road map for staying drug-free.
  - Staying on schedule = Staying sober
  - Ignoring the schedule = Using drugs

111

### **Instructions**

Read the slide to your audience.

## Develop a plan: Dealing with resistance to scheduling

- Clients might resist scheduling (“I’m not a scheduled person” or “In our culture, we don’t plan our time”).
- Use modelling to teach the skill.
- Reinforce attempts to follow a schedule, recognizing perfection is not the goal.
- Over time, let the client take over responsibility for the schedule.

112

### **Instructions**

Read the slide to your audience.

## Activity 7: Exercise

Have pairs of participants sit together and practise the creation of a 24-hour behavioural plan using the Daily / Hourly Schedule form.



113

### Instructions

1. Divide the audience into pairs. Each person in the group will play each of the roles (client and clinician) for 10 minutes.
2. Ask participants to role-play to practise the use of the creation of a 24-hour behavioural plan using the Daily/Hourly Schedule form.
3. Once they have practised their roles, ask participants to give you a report on the schedule of their clients and their comments on difficulties in using the Daily/Hourly Schedule form.

Questions?



Comments?

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**Instructions**

1. Ask your audience if they have any questions.
2. Take the time to clarify any areas of the workshop that were unclear to participants.
3. Provide examples and review previous slides, if necessary.

## Post-assessment

Please respond to the post-assessment questions in your workbook.

(Your responses are strictly confidential.)

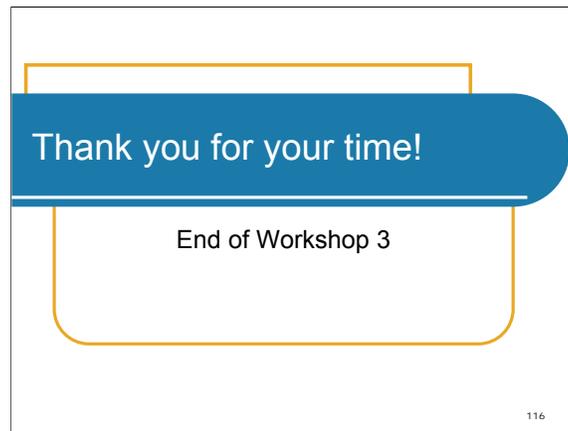


10 minutes

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### Instructions

1. Ask participants to complete the 5 post-assessment questions. They have 10 minutes to complete these questions
2. Remind them that both the pre-training and post-training assessments are conducted so as to insure that the training is appropriate for your particular audience, to measure the effectiveness of the training, and to provide opportunities for improving it
3. The assessments may create tension among audience members. To reduce such tension, explain to participants that both assessments are confidential and that they do not need to provide any personal information.



### **Instructions**

1. Thank your audience for their time.
2. Remind participants to use the forms in clinical settings
3. Encourage your audience to keep in touch with you to resolve any doubts or answer any questions they might have.
4. Facilitate your contact information.