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**Intervention for alcohol, cannabis and amphetamine
use among people with a psychotic illness**

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**INTERVENTION FOR ALCOHOL,
CANNABIS AND AMPHETAMINE
USE AMONG PEOPLE WITH A
PSYCHOTIC ILLNESS**

**Amanda Baker, Sandra Bucci, &
Frances Kay-Lambkin**

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1. INTRODUCTION

1.1 Context

Despite the widespread co-occurrence of psychosis and substance use disorders, and the adverse effects of substance use on functioning and outcome among people with psychosis (Teesson et al., 2000), there have been few randomised controlled trials specifically aimed at reducing substance use among people with psychotic disorders. One-session motivational interventions among psychiatric hospital inpatients with mixed diagnoses and co-existing alcohol and/or other drug use problems have reported promising but short-term intervention effects (Hulse & Tait, 2002, 2003; Baker et al., 2002).

Cognitive behaviour therapy (CBT) has been shown to be effective for alcohol (Shand et al., 2003), cannabis (Copeland et al., 2001) and amphetamine use disorders (Baker et al., in press) and has also shown benefits for psychotic symptomatology (Haddock et al., 2000). In the first RCT to investigate the effectiveness of CBT among people with comorbid schizophrenia and substance use disorder, Barrowclough and colleagues (2001) randomly assigned 36 patient-caregiver dyads to either routine care alone or combined with motivational interviewing and CBT (total 29 sessions) plus a family intervention of 10-16 sessions, over nine months. Eighteen months following entry to the study, the treatment group had significantly superior general functioning (GAF) and negative symptom scores, with no difference in percentage of days abstinent from substances (Haddock et al., 2003). The authors suggested that studies with larger numbers of subjects, examining the efficacy of different components of CBT interventions, are required. The trial this treatment manual was written for investigated whether a 10-session CBT intervention among a large sample of people with psychosis and substance use disorders was more effective than routine treatment in reducing substance use and improving symptomatology and general functioning.

1.2 Organisation of this Manual

This manual has been written for the project "Randomised controlled trial of cognitive-behaviour therapy for alcohol and other drug problems among people with a psychotic illness", funded by the National Health and Medical Research Council (NHMRC) in 2000. The manual is not intended to stand alone. Rather, it is to be accompanied by extensive reading of the research and clinical literature, training in the approaches used and ongoing supervision.

The intervention described in this manual was delivered over 10 weekly, individual sessions. The manual firstly describes some of the theoretical and contextual background information relevant to the treatment delivered to participants, and its evaluation in the randomised controlled trial conducted over 2000-2003. Outcomes of the research are briefly summarised in a subsequent section.

Each subsequent section contains a detailed session-by-session guide to the substance use intervention evaluated in the randomised controlled trial. All handouts, homework activities and therapist and client resources are provided. Each session is preceded by a *Therapist Summary Sheet* that lists all the strategies and information to be covered in the relevant session. Each session description concludes with a *Therapist Checklist* to assist with clinical note taking, and to ensure all the essential components of the therapy session were covered where possible.

Format of therapy

Guidelines for the delivery of the treatment sessions are given for each of the ten sessions in this manual. These guidelines are general, around which a therapist will be able to add his or her own style and experience.

In order to provide clients with effective motivational enhancement and coping skills, the following topics are covered:

- Motivational interviewing (Sessions 1-4 and further sessions if necessary)
- Symptom management (Sessions 1-10 as applicable)
- Thought Monitoring (Sessions 1 and 2)
- Conceptualising treatment: Introduction to CBT, Assessing and Avoiding High Risk Situations (Session 5)
- Seemingly Irrelevant Decisions, Problem Solving, Managing Unhelpful Thoughts (Session 6)
- Coping with Cravings/urges to use AODs, The “Breaking The Rule” Effect, Activity Scheduling (Session 7)
- Drink/Drug Refusal Skills, Lifestyle Issues (Session 8)
- Relapse Prevention/Management (Session 9 and 10)
- Treatment Termination, Follow-Up Appointment (Session 10)

2. BRIEF BACKGROUND TO THE STUDY AND SUMMARY OF RESULTS OF EVALUATION

2.1 Introduction

The present study builds on a pilot study conducted by Baker and colleagues (2001) which evaluated a brief intervention for substance users among people with a major mental illness. The researchers found a modest, short term reduction in polydrug use, although this effect was not sustained over a 12 month period. Baker et al (2001) recommended that a longer term intervention specifically targeting the three primary substances (alcohol, cannabis and amphetamine) be evaluated among people with a psychotic illness.

2.2 Participants and Procedure

Participants in the research project described in this manual consisted of 130 people who were recruited into the study between August 2000 and June 2002 from the Hunter Region, NSW. Participants met ICD-10 diagnostic criteria for psychosis and were regular users of alcohol, cannabis and/or amphetamines at hazardous levels. Hazardous use of alcohol was determined as consumption exceeding recommended guidelines for hazardous use produced by the National Health and Medical Research Committee (NHMRC): four standard drinks per day for men and two standard drinks per day for women (Pols & Hawks, 1992) within the past month. Regular hazardous use of cannabis and amphetamines was classified as meeting at least weekly consumption on the Drug Use Scale of the Opiate Treatment Index (OTI; Darke, Ward, Hall, et al, 1991) in the month prior to interview. Participants were excluded if they were acutely unwell, non-English speakers, had evidence of organic brain impairment and/or were not likely to reside in the geographical area within the next twelve months.

2.3 Measures

Data were collected on demographic characteristics, past and present alcohol, cannabis and/or amphetamine use and mental health, treatment history, stage of change, reasons for using substances, quality of life, personality and cognitive functioning.

Assessments were scheduled at pre-treatment, post-treatment (15 weeks post initial assessment), 6 months and 12 months following the initial assessment and were conducted by interviewers blind to group allocation.

2.4 Design

The study protocol is displayed in Figure 2.1

Participants were randomly allocated to either an active treatment condition (ten sessions of motivational interviewing and CBT) or a control condition (self help booklet and treatment as usual) that occurred over ten weekly sessions. The self help booklet was developed by CEIDA (2000) to address mental health and substance use. The treatment was manualised and was designed to work in such a way that session one to four consisted of motivational interviewing and session's five to ten, CBT.

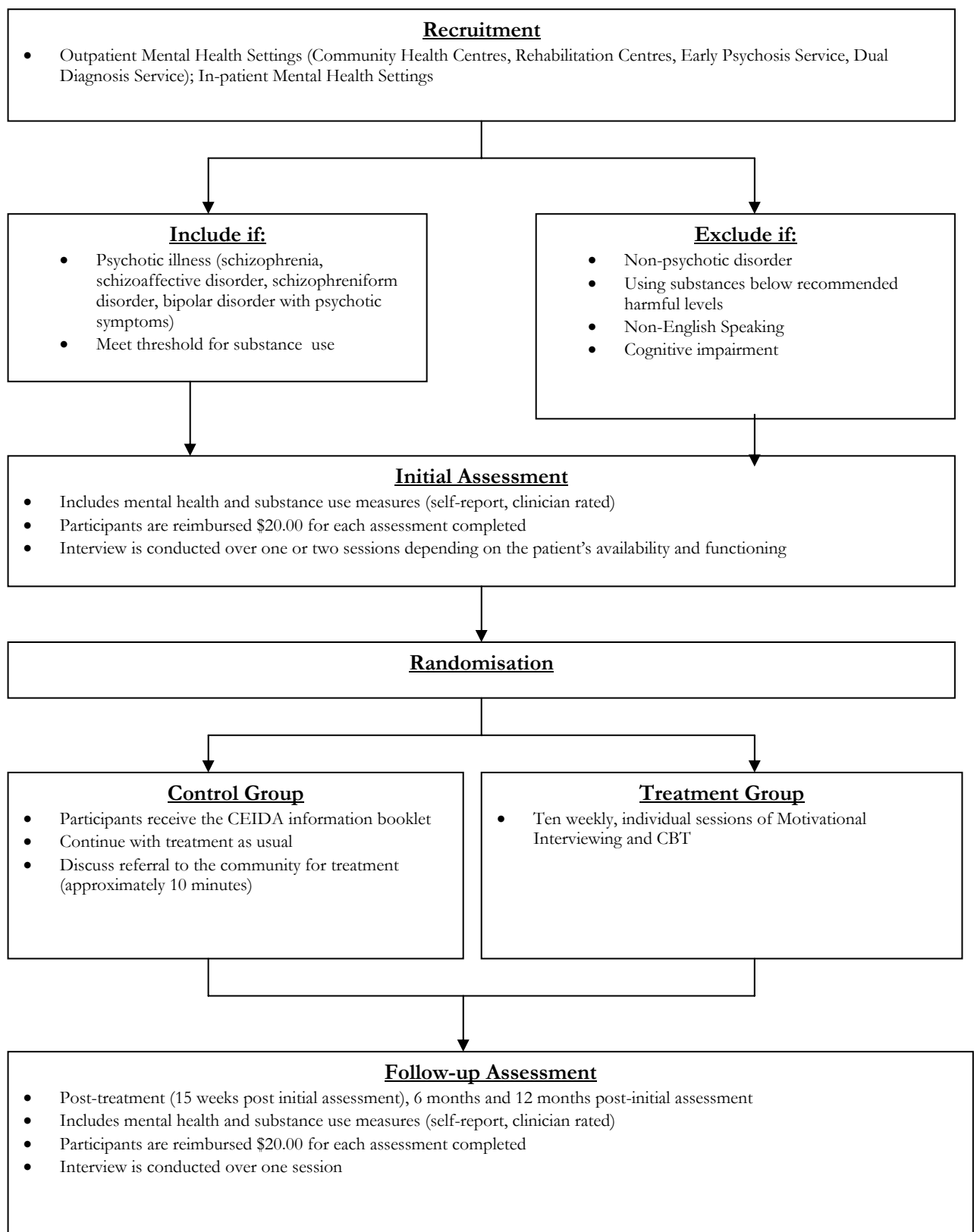


Figure 2.1 Study Protocol

2.5 Components of the Interventions

2.5.1 Motivational Interviewing

Motivational interviewing is a form of counseling that involves a partnership whereby the therapist respects the client's own expertise and perspectives in an atmosphere that is explorative and supportive. Motivational interviewing is directed towards the resolution of ambivalence and movement towards change, with the resources and motivation to change considered residing within the client. The therapist's task is to create a set of conditions that will enhance the client's own motivation and commitment for change by drawing on their personal perceptions, goals and values. An important assumption of motivational interviewing is that responsibility for change is left to the client. In this way, change will serve the person's own goals and values rather than the therapist's (Miller & Rollnick, 2002).

Whilst four sessions were allocated to motivational interviewing, if participants were not ready to move into the CBT component of the intervention, the therapist continued to use motivational interviewing until the client indicated that s/he was ready to contemplate change. Similarly, if participants were ready to move into the CBT component earlier than the fourth session, the CBT model was employed. Moreover, if participants became abstinent from their substance(s) of choice throughout the course of treatment, relapse prevention became the focus of the remaining treatment sessions.

2.5.2 Cognitive Behaviour Therapy (CBT)

CBT was manualised and delivered individually to participants by a trained therapist. The therapy commenced by providing individual, personalised feedback regarding the assessment results, including level of substance use and high risk situations for use, and continued with four sessions of motivational interviewing to encourage participants to attempt substance reduction/abstinence. In following sessions, education about the interaction between substance use and mental health, medication and cognition was provided. Beliefs regarding the relationship between substance use and mental health were identified and challenged, with alternatives to substance use identified. In later sessions, strategies such as coping with cravings, lifestyle issues and relapse prevention were discussed. Psychiatric symptoms and medication adherence were monitored by the therapist. Psychiatric management of each participant was provided by their own psychiatrist, community case manager or GP.

2.5.3 Therapists

Therapists were University Psychology Graduates registered with the relevant State Psychologists Registration Board. A week long training, led by Dr Baker, was held at the commencement of the research to train therapists in the manual. This covered research procedures and role plays of assessment instrument administration and intervention sessions. Session checklists were employed to guide weekly supervision provided by Dr Baker. In addition, monthly team meetings were held to monitor procedures and adherence to treatment.

2.5.4 Control condition

Participants allocated to the control condition received a self-help booklet published by CEIDA (2000) and continued with receiving treatment as usual. All participants allocated to this condition were followed-up at post-treatment, 6 month and 12 month time points.

2.6 Summary of Main Results

Characteristics of participants at the pre-treatment assessment

The sample consisted of 130 people with an ICD-10 psychotic illness and coexisting alcohol, cannabis and/or amphetamine problems (hazardous levels). The mean age was

28.83 years. The majority of the sample was male (78.2%), Australian born (90.8%) and receiving welfare support (88.2%). Primary diagnosis was schizophrenia (62.2%), and the majority of the sample met past 12 months and/or lifetime alcohol and cannabis abuse or dependence, whilst 17.0% of the sample reported past 12 months and/or lifetime abuse or dependence for amphetamine for the last month. Substance use intervention thresholds were met by the following proportions of the sample: 41.5% for alcohol, 63.1% for cannabis, and 42.0% for amphetamine. More than half the sample experienced a psychosocial stressor prior to the onset of their illness. Two thirds of participants had at least one hospital admission within the past 12 months.

Twelve percent (N=8) of those allocated to treatment did not attend any treatment sessions, 17.0% (N=11) attended some sessions and the remaining 71.0% (N=46) attended all ten treatment sessions.

Repeated measures analyses of variance were used to examine differences between groups in patterns of change over time, with $p < 0.01$ being chosen as the threshold for statistical significance. Owing to the different patterns of assessment completion, the major outcome analyses were conducted in two blocks: (a) Participants who completed the initial, post-treatment and 6 month follow-up phases (N=119), and (b) Participants who completed all four assessment phases (N=97). In the analyses which follow, planned comparisons between the first three assessment occasions are based on the first block (N=119), while comparisons between the final phase and each of the earlier phases are based on the second block (N=97).

Changes in substance use over assessment occasions

There were significant time effects for alcohol, polydrug use and the aggregate hazardous use index, but no group main effects or group x time interactions. Alcohol revealed significant main effects for time, but no significant group main effect or interaction contrasts. Alcohol consumption fell significantly for the sample as a whole from baseline to 3, 6 and 12 month follow-ups. The overall reduction in alcohol consumption between baseline and 12 months was equivalent to an overall effect size change of 0.80 units. This difference tended to be more marked for the control group (0.97) than the treated group (0.54).

There were no significant effects for both cannabis and amphetamine. For cannabis, the treatment group had higher consumption compared with the control condition initially (8.18 vs 4.80), and whilst not statistically significant, there was a trend for a differential cannabis reduction between the initial and post-treatment phases for the treatment group compared with controls ($F_{(1,71)} = 6.25, p = 0.02$). Mean daily cannabis consumption fell 0.36 standardised units for the treatment group and -0.02 standardised units for the control condition. This represents a differential change of over a third of a standard deviation, a moderate effect size.

For amphetamine, there was a trend (non-significant) for a differential (Baseline vs 6 months) reduction in amphetamine use in the treatment condition compared with the controls ($F_{(1,18)} = 4.70, p = 0.04$). Mean daily occasions of amphetamine use fell 1.33 standardised units for the treatment condition, and -0.40 standardised units for controls. Expressed in effect size units, this represents a differential change of over 1.5 standard deviations, a strong effect size. This differential was less marked (0.95) for the 12 month follow-up, but still strong.

Reflecting the significant reduction in alcohol use among the whole sample and the change in amphetamine use, there was a significant overall reduction in poly drug use

scores over time, with significant differences between baseline and each of the follow-up assessments. For the aggregate hazardous use index, a similar pattern emerged.

Changes in symptomatology over assessment occasions

There were significant differences between baseline and each of the follow-up occasions for BPRS negative cluster scores and BDI-II depression scores. For both of these variables, the standardised change between baseline and 12 month follow-up was just under half a standard deviation.

In regards to the BPRS depression cluster, there were significant interaction effects, with a significantly marked reduction in BPRS depression scores for the treatment condition compared with controls from baseline to 6 months, but a change in the opposite direction from 6 to 12 months. For BDI-II, there was a reduction between baseline and 6 months among the intervention group compared with the control group.

The study showed significantly superior GAF scores at the 12 month follow-up phase among the treatment group compared to the routine care group, with the treatment group improving over time whilst the controls declined. Thus, CBT for substance use problems among people with psychosis is associated with improvement in general functioning which is sustained over time.

Overall, there were moderate reductions in substance use and symptoms across the course of the study, particularly for alcohol, polydrug use, negative symptoms and depression. These effects tended to be more marked in the first three months following recruitment and, in most instances, were consistent across the treatment groups. As evidenced by treatment completion patterns and overall retention rates, there was a high level of engagement with this project. Other non-specific factors (e.g. intensity of assessments and associated feedback, recruitment through existing services and overall motivation to participate) may have also contributed to the improvement shown by the control group.

Nevertheless, at the end of the study period, a reasonable percentage of those who were initially above threshold would have still met the study's entry criteria (25.5% for alcohol, 60.0% for cannabis and 16.7% for amphetamines). Collectively, these findings suggest that there may be a variety of treatment needs—those who would benefit from a brief intervention, those requiring a more intensive intervention, such as that used in the current study, and those who need longer more sustained interventions. In short, a stepped care approach with adequate monitoring.

3. THE INTERVENTION

3.1 Rationale and principles of treatment

This treatment adopts the assumption of the motivation enhancement therapy (MET) approach that the responsibility for change lays within the client (Miller, Zweben, DiClemente & Rychtarik, 1995). The task of the therapist is to create a set of conditions that will enhance the client's own motivation and commitment for change. The therapist does this by following the five basic motivational interviewing principles discussed in Phase 1" Building Motivation to Change.

3.2 Goals of treatment

The main goal of treatment is prevention of relapse to an acute episode of psychosis. If the client had a concurrent AOD problem then there were two further goals of treatment: (a) enhance the client's understanding of possible interactions between their use of AODs and their mental illness (symptomatology and medication compliance), and (b) reduce the harm (e.g. mental/physical health, financial, social, occupational) associated with problem AOD use and psychiatric symptomatology. Some participants with concurrent mental health and AOD problems are motivated to reduce their use. However, others do not wish to address their AOD problems directly. Therefore, the manual can be used flexibly to work on relapse prevention either directly addressing AOD use as a risk factor for relapse, or by focussing on other factors associated with relapse.

3.3 Monitoring Symptomatology

The therapist should monitor symptomatology throughout the treatment program, and be aware that changing substance use may be a stressor that could potentially contribute to symptom exacerbation.

3.3.1 Suicide Risk Assessment

If you identify throughout your assessment or at any stage during treatment sessions that the client is at risk of suicide, use the questions in Figure 3.1 as a guide for assessing the level of risk. If you feel that the client fits in a "high-risk" suicide category, follow the suicide policy in place at your workplace.

If a decision is made to manage a high-risk suicidal client, the client should be given written information about how to seek 24-hour assistance if required, including who to contact for information in your area. Participants at risk of suicide should be monitored closely throughout the intervention.

1. Have you been feeling depressed for several days at a time?
2. When you feel this way, have you ever had thoughts of killing yourself?
3. When did these thoughts occur?
4. What did you think you might do to yourself?
5. Did you act on these thoughts in any way?
6. How often do these thoughts occur?
7. When was the last time you had these thoughts?
8. Have your thoughts ever included harming someone else as well as yourself?
9. Recently, what specifically have you thought of doing to yourself?
10. Have you taken any steps toward doing this? (e.g. getting pills/buying a gun?)
11. Have you thought about when and where you would do this?
12. Have you made any plans for your possessions or left any instructions for people for after your death such as a note or a will?
13. Have you thought about the effect your death would have on your family or friends?
14. What has stopped you from acting on your thoughts so far?
15. What are your thoughts about staying alive?
16. What help could make it easier to cope with your problems at the moment?
17. How does talking about all this make you feel?

Reproduced with permission from Treatment Protocol Project (2000) *Management of Mental Disorders pp. 22-23*, Third Edition, Sydney: World Health Organisation Collaborating Centre for Mental Health and Substance Abuse.

Figure 3.1 Questions for assessing suicidal ideation

3.4 Therapist checklist

This treatment manual has been designed for people with substance use problems and a co-existing psychotic illness. It is essential the core components in this manual are discussed with the participant. In the randomised controlled trial described in this manual, therapists were required to complete a *Therapist Checklist* (adapted from NIDA, 1989) at the end of each session to monitor their sessions. This checklist supplemented clinical notes kept on each participant allocated to the treatment condition by their treating therapist. The *Therapist Checklist* has been included in this manual, and appears in the session handouts for each session described in this manual.

3.5 Format of therapy

Guidelines for the delivery of the treatment are given for each of the ten sessions in this manual. These guidelines are general, around which a therapist will be able to add his or her own style and experience.

3.5.1 Timing and length of intervention

The treatment is designed to be conducted individually over a total of ten therapy sessions. Each session should last around 45 minutes to an hour in length.

One or two assessment sessions are undertaken in the week prior to therapy commencing in which key data are obtained from the client, and an outline of the nature and content of the therapy is given. Questionnaire data may be scored in the week prior to the first session to allow relevant comprehensive feedback to be provided to the client.

A letter is sent to the participant's GP, psychiatrist and case manager identified in the initial assessment informing them of the person's involvement in the program and with contact details of the researchers for any questions.

Ideally, the timing and physical location of the therapy sessions should be as consistent as possible. That is, appointments for the same time and day should be made for each subsequent week, and the place should be held constant. This may help optimise the establishment of a working rapport with the therapist and assist the client in becoming comfortable with the therapeutic arrangements.

Although weekly sessions are preferable, there will be occasions when clients cannot attend, or forget, their appointment. In this case, an attempt should be made to reschedule for the same week. If this is not possible, the session should be carried over to the regular time the following week. Missed sessions of more than three weeks in a row are a serious compromise to the effective running of the program, and clients in this position should be encouraged to consider seriously their reasons for being involved in the program.

Missed appointments

The following protocol was implemented in the randomised controlled trial of the intervention described in this manual, when participants missed more than three consecutive appointments. This strategy may be useful to therapists outside the research setting to foster completion of therapy:

- telephone the client and clarify the reasons for the missed appointment;
- affirm the client - reinforce him/her for having come to earlier sessions;
- express your eagerness to see the client again;
- briefly mention serious concerns that emerged and your appreciation (as appropriate) that the client is exploring these;
- express your optimism about the prospects for change; and
- reschedule the appointment.

If a reasonable explanation for the missed appointment is not offered, explore this with the client and determine whether the missed appointment is reflective of any of the following:

- uncertainty about whether or not treatment is necessary;
- ambivalence about making a change;
- frustration/anger for participating in treatment.

These issues should be handled in a manner consistent with the MET approach. If you cannot reach the person by phone, write a letter in your own handwriting, offering another appointment and affirming the client. This should be done within two days of the missed appointment to maximise the likelihood of the client's return.

Letter: Following session 1

Dear _____

This is just a note to say that I'm glad you were able to spend time talking with me this week. I appreciated how openly you discussed your lifestyle and health concerns. I look forward to seeing you again on [day, date, time].

Regards _____

3.5.2 Phases of treatment

Graham (2000) outlines four treatment phases:

- Engagement and building motivation for change
- Negotiating behaviour change

- Early relapse prevention
- Relapse prevention/management

As clients will move between the different stages of change (Prochaska & DiClemente, 1992, described in Miller & Rollnick, 1991) within and between sessions, the therapist will need to adapt strategies according to the client's stage of change.

3.5.3 Conducting the therapy

At the beginning of each session description, a *Therapist Summary Sheet* is included which briefly lists all the techniques, strategies and information to be discussed during the session, and includes a list of all the handouts/homework sheets that supplement the session agenda. Therapists can take these summary sheets into each session and refer to them throughout treatment.

Abstinence versus Harm Reduction Approaches

A harm reduction approach was generally taken with the intervention described in this manual. Participants were provided with the opportunity to set and work towards their own goals for reduction or abstinence. Although, having said this, therapists encouraged a goal of abstinence when it was suggested by the client.

3.6 Getting Started

3.6.1 The case formulation (Persons, 1989)

In preparation for the first session, it is useful for the therapist to develop a case formulation for their client. The case formulation model conceptualises psychological problems as occurring at two levels, **overt** (cognitions, behaviour, mood) and **underlying mechanisms**. Underlying mechanisms include irrational beliefs and difficulties with problem solving. One important area of consideration is the link between beliefs about mental illness and AOD use. Environmental factors play a role in eliciting and triggering underlying beliefs and overt difficulties. Your formulation about the underlying mechanism will play a central role in guiding your choice of intervention strategies. It provides the basis for the treatment plan, which follows directly from the hypothesis about the nature of the underlying issues of the patient's problem. It is important to individually construct a case formulation specific to the participant to gain a better understanding of their presenting problems and to anticipate potential barriers to treatment. Use the assessment information to generate working hypotheses about the underlying mechanisms of the overt presentation.

The case formulation has six parts:

1. The problem list
2. The proposed underlying mechanism
3. An account of the way in which the proposed mechanism produces the problems on the problem list
4. Precipitants of current problems
5. Origins of the mechanism in the patient's early life
6. Predicted obstacles to treatment based on the formulation

Below are some questions to consider when developing your case formulation (Graham, 2000, p20-21). Information collected from the assessment will additionally be useful here, and can inform the case formulation.

What are the factors that maintain current problems?

- What factors (e.g. situations, mood, psychotic symptoms) trigger using?

- What factors maintain their using/symptoms (i.e. reasons for using; effects/problems associated with using)?
- What beliefs are held about using/psychosis?
- What are the positive/negative influences in the social network towards using?

How did these problems develop?

- What key early experiences might have shaped the clients view of themselves/world/other people?
- What core beliefs does the client hold about him/herself?

What is the relationship between the various problems this client has?

- What is the relationship between using AODs and psychosis?
- What are the links in client's beliefs about their using and psychosis?

Figure 3.2 displays the case formulation summary sheet used in the randomised controlled trial. It is important to revise your problem list and case formulation when necessary throughout treatment.

Identifying Information

Main Concern

Problem List
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
How did these problems develop?

How are these problems related to the client's main concerns?

Treatment Plan

Figure 3.2 The Case Formulation

SESSIONS 1 - 4 – MOTIVATIONAL INTERVIEWING

Therapist Summary Sheet

Aims:

- Engagement, building motivation and strengthening commitment for change in mental health and substance use problems
- Prepare to address, cut down/quit substance use

Materials needed for Sessions 1-4

- *Handout:* Pros and cons balance sheet
- *Handout:* Personal feedback report
- *Handout:* Change plan worksheet
- *Handout:* Treatment contract
- *Handout:* Self monitoring form
- *Handout:* AOD monitoring form
- Therapist Checklist

Main areas to be covered:

- Motivational Interviewing: Background and Rationale
- Phase 1: Building Motivation for Change
 - Goals of Motivational Interviewing
 - Stage of Change
 - General Principles of Motivational Interviewing
 - Presenting the Rationale for Treatment
 - Mental Health Problems
 - Exercise: Pros and Cons Balance Sheet
 - Personal Feedback from Assessment
 - Exercise: Personal Feedback Report
 - Exploring Importance and Confidence
 - Signs of Behaviour Change
- Phase 2: Strengthening Commitment
 - Introduction
 - Explanation of Techniques used to Strengthen Commitment to Change
 - Exercise: Change Plan Worksheet
 - Exercise: Rationale and Treatment Contract
- Rationale for Cognitive Behaviour Therapy (CBT)
- Homework
 - Symptom Monitoring Form
 - Alcohol and Other Drug (AOD) Monitoring Form
- Therapist Checklist

Sessions 1 – 4: MOTIVATIONAL INTERVIEWING

Motivational Interviewing

Build Rapport

The first few sessions of treatment will focus on building rapport. It is important that you allow plenty of time for the subject of AOD use to emerge. Focussing too soon on substance use will most likely elicit resistance from the client and interfere with rapport building. Remember that critical conditions for promoting change are: accurate empathy; non-possessive warmth and genuineness. Motivational interviewing in these sessions starts very broadly, allowing the client to identify lifestyle issues that are of concern to him/her. In keeping with this initial broad approach, you will need to be open to helping the client maximise his/her potential to be receptive to considering whether substance use is cause for concern.

Graham et al. (2000) lists a number of strategies that are helpful in building a working alliance with people who have severe mental health problems and co-existing AOD use problems. These include offering:

- (i) Practical assistance with everyday tasks as part of an assertive outreach
- (ii) Framework (e.g., identifying hobbies, leisure time activities)
- (iii) Crisis intervention for mental, physical or financial crises quickly and practically if appropriate and empathising with their situation
- (iv) Assistance with medication adherence (dosage packs, discussing difficulties with side effects and arranging medication review, education about the medication, medication compliance therapy)
- (v) Enhancement of psychological coping strategies for psychotic symptoms

Motivational Enhancement Training (MET; Miller et al, 1995)

Familiarise yourself with the MET manual. MET can be used flexibly, allowing for the therapist to stay with their own personal style whilst experimenting with different strategies.

Clients will be at various stages of change for their AOD use and psychosis. Ideally, the therapist will address each class of substance the client is using, at some point, although it is important you gauge how quickly you can move to discussing AOD directly with each client. In this way you will get an idea about the areas of behaviour change which may be approached earlier with the client and those that may require later or more sophisticated strategies.

The aim over the next few sessions is to elicit self-motivational statements from the client about the arguments for change. When motivational interviewing is performed correctly, it is the client, rather than the therapist, that voices concern for change (Miller & Rollnick, 2002).

PHASE 1: BUILDING MOTIVATION TO CHANGE

Goals of Motivational Interviewing

The goals of motivational interviewing are to:

- (i) Maintain rapport
- (ii) Accept small shifts in attitude as a worthy beginning
- (iii) Promote some concern about risk (e.g. for relapse)
- (iv) Avoid increasing resistance
- (v) Promote self-efficacy and responsibility
- (vi) View lifestyle holistically (each aspect usually effects the other)

Stage of Change (Prochaska & DiClemente, 1984)

Prochaska and DiClemente (1984) suggest that successful change of substance use involves progressing from pre-contemplation through to maintenance. According to this approach, if a client is in the *pre-contemplation* stage, s/he is not aware, for example, that their cannabis use could be causing them harm. As the client becomes aware that their cannabis use could be problematic, then s/he enters the *contemplation* stage. This is where the client acknowledges that their use is problematic at a certain level and begins to think about making changes. Clients may stay in this stage for weeks, months or even years before changing current behaviour. The *action* stage is considered to be much shorter and involves a commitment to change behaviour. As the client continues to enforce changes s/he enters the *maintenance* stage where commitment and behaviour change is strengthened. It can be helpful to keep these stages in mind when working with your client.

General Principles of Motivational Interviewing

There are four basic motivational principles used to enhance a client's motivation and commitment for change. These principles were originally outlined by Miller and Rollnick (2002; pg. 36) and include:

1. Express empathy
2. Develop discrepancy
3. Roll with resistance
4. Support self-efficacy

Following the development of the client's commitment to change, the therapist assists the client in learning skills that will help him/her achieve change (Miller et al, 1995). The four general principles are detailed below.

1. Express Empathy

The underlying attitude of expressing empathy is *acceptance*. By using reflective listening, the therapist seeks to understand the client's feelings and perspectives without judging, criticising or blaming, along with a genuine desire to understand the client's perspective as understandable and valid. Ambivalence is accepted as a normal part of human experience rather than evidence of pathology. Acceptance does not mean agreeing, endorsing or approving of the client's behaviour. It is still possible to accept and appreciate a person's perspective without necessarily endorsing it (Miller & Rollnick, 2002).

2. Develop Discrepancy

Identifying and clarifying the client's personal goals and values and highlighting the conflict with their current behaviour is an important first step before working through this phase. This can be created through the client becoming aware of his/her discontent with the costs of present behaviour and the perceived advantages of changing behaviour. When current behaviour is seen to conflict with important personal goals, then change is more likely to occur. This is developing discrepancy, and the question here is how to best present an unpleasant reality so that the client can confront and change their problematic behaviour. This technique focuses on client's moving from a place where they are stuck, past ambivalence and towards positive behaviour change. Discrepancy is created by presenting to the client their current behaviour along with their broader goals and values (Miller & Rollnick, 2002).

3. Roll with Resistance

If you don't argue for change, then what do you do? In motivational interviewing, the therapist does not oppose resistance, rather rolls with it. It is important you work with a

client's possible resistance and reframe it to create new momentum toward change, rather than arguing for change and the client becoming defensive. Having the therapist reframe the client's behaviour (cannabis use) so that a new meaning is given to their use can be helpful (e.g. using cannabis as a protective function/adaptive function). By reframing current problems in a more positive light, the therapist hopes to communicate that the problem is changeable. Use the client's own words, views and perceptions.

In motivational interviewing, a question or problem voiced by the client is placed back onto them so that both client and therapist work collaboratively through concerns. This way, the client discovers the potential problems in their ideas. Resistance, then, is a sign for the therapist to shift approach. It is considered an interpersonal phenomenon rather than a client being obstructive. How the therapist responds to the client influences whether resistance amplifies or abates (Miller & Rollnick, 2002). An example of rolling with resistance follows:

I know that life is tough for you right now. Perhaps I have underestimated exactly how difficult it is for you to make changes. The important thing is that you make a start.

Miller and Rollnick (2002; pg. 48) identify four categories of resistance behaviour in clients:

- *Arguing*: Client contests the accuracy, expertise or integrity of the therapist (challenging, discounting, hostility);
- *Interrupting*: Client interrupts the therapist by either talking over him/her or cutting him/her off;
- *Negotiating*: Client is unwilling to recognise problems, take responsibility or co-operate (blaming, disagreeing with therapist suggestions, excusing own behaviour, minimising, pessimism);
- *Ignoring*: Client ignores the therapist (inattention, non-answer, no response, sidetracking by changing the direction of the conversation).

The following techniques can be used to overcome such resistance:

- *Reflection*: reflect what the client is saying;
- *Reflection with amplification*: reflect but exaggerate what the client is saying to the point where the client is likely to disavow it;
- *Double-sided reflection*: reflect a resistant statement back with the other side (based on previous statements made in the session);
- *Shift focus*: shift attention away from the problematic issue;
- *Paradoxical statements*: this will often bring the client back to a balanced perspective.

4. Support Self Efficacy

This reflects a client's belief in his/her ability to complete a specific task. If the client recognises that s/he has a problem, however does not believe in their internal capacity for change, then behaviour changes won't be made. It is important to help enhance your client's confidence in their ability to cope with and manage obstacles in the process of change. The client's belief in the possibility for change is an important motivating factor. The message you do not want your client to receive is that "I (therapist) will change you", rather the message is "If you wish, I can help you change". Clients may be encouraged by the success of others or by their own past success in changing behaviour (Miller & Rollnick, 2002).

Presenting the rationale for treatment

The MET manual (1995, p50) gives the following example of what you might say to your client:

Before we begin, let me just explain a little about how we will be working together. You have already spent time completing the assessment that we need, and we appreciate the effort you put into that process. We'll make good use of that information today. This is the first of ten sessions that we will be spending together, during which we'll take a close look together at your situation. I hope that you'll find these ten sessions interesting and helpful.

I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing, you will be the one who does it. I'll be giving you a lot of information about yourself and maybe some advice, but what you do with all of that after our sessions together is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is you. How does that sound?

Ask about mental health problems

It is important to better understand better how the client sees their situation, before giving any feedback from assessment. Proceed with strategies for eliciting self-motivational statements, approach health and lifestyle issues first and gently fit questions about using into this perspective. The following is an example of what you might say:

The information we have talked about in previous weeks has given me a bit of an idea about what is going on in your life at the moment. But, I really don't know a lot about you and the kind of life you lead. Perhaps we can spend a few minutes with you telling me about a typical day in your life, so that I can understand in more detail what happens? Tell me a bit more about the things you struggled with and how you felt at the time. Can you think of a typical recent day from beginning to end... You got up...

Allow the person to continue with as little interruption as possible. If necessary prompt with open-ended questions: *What happened then?* Review and summarise. If necessary, ask: *Is there anything else at all about this picture you have painted that you would like to tell me?*

If the person does not volunteer information about using, ask the following: *Can you tell me where using fits in?*

You could ask the following to explore the person's beliefs about their using: *How does using affect your symptoms, or your mood?*

Look for motivational statements elicited by the client in response to this summary. Continue to listen reflectively as they provide more detail about their using related beliefs. You may be able to continue with: *While there are good things you are able to see in using, you are also finding that in some cases it doesn't live up to your expectations.*

Pros and cons balance sheet (adapted from Miller & Rollnick, 2002)

Continue with the discussion above until you feel it is appropriate to commence a more formal assessment of the pros and cons of the client's using habits.

Exercise: Exploring the Pros and Cons of using Cannabis.

- Use the sheet displayed in Figure 3.3
- Elicit from the client all the positives they associate with using AODs and write them down in the relevant quadrant. Consider with the client how important these positive aspects are.
- Repeat this exercise with the negatives of using AODs and assess how important these are to the client.
- Ask the client to list the positives and negatives associated with reducing/quitting AOD use and record in the relevant quadrant. For each issue raised, discuss the importance to the client.

Keep in mind that many clients will be ambivalent to address/change their substance use, particularly if their peers use drugs. Despite this, your client may be aware that there are down sides to using. Whilst ambivalence is a normal experience, it becomes problematic when people become stuck, after which problems usually persist and intensify. A useful tool for identifying ambivalence is working through the pros and cons balance sheet. This sheet can be used to specify the benefits and costs associated with using.

For example, you and your client are weighing up whether s/he should continue smoking pot or cut down/quit. The benefits of continuing to smoke may be to relax and spend time with friends, whilst the costs associated include family conflict, damage to health and spending money. Similarly, the benefits of quitting could include less family conflict, improved health and saving money, whereas the costs may be loss of enjoyment smoking and loss of friends. Explore these issues with your client.

Pros and Cons Balance Sheet

Good things about using	Importance (0-10)	Less good things about using	Importance (0-10)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Less good things about changing my use	Importance (0-10)	Good things about changing my use	Importance (0-10)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Figure 3.3 Pros and Cons Balance Sheet

Working with the Pros and Cons Balance Sheet (Baker, Kay-Lambkin, Lee, & Claire, 2003)

Elicit from the client all the positives they associate with using their substance of choice and write them down in the relevant quadrant. Use the following questions as a guide:

*Tell me about your cannabis use. What do you like about it?
What is positive about using for you?*

Consider with the client how important these positive aspects are, and ask the client to write their importance rating next to the relevant aspect. Use the following questions as a guide:

How important is this to you personally? If '0' was 'not important' and '10' was 'very important' what number would you give this aspect of your substance use?

Repeat this exercise with the less good things associated with substance use and assess how important these are to the client. Ask the client to write these issues down in the relevant quadrant on this sheet. Use the following as a starting point:

And what's the other side? What are your concerns about your substance use?

Finally, continue with a discussion of the good/less good things the client associates with changing substance use. Record the issues raised in the relevant quadrant. For each issue raised, discuss the importance to the client.

Weighing up the pros and cons of using AODs is not just a simple matter of number of items for and against continuing to use. Miller and Rollnick (2002) suggest that the importance the client places on these items is far more powerful, so that if a client has ten reasons for changing their substance use, but one powerful reason for continuing to use, tipping the balance in favour of cutting down/quitting will not necessarily result.

Once the client raises a motivational topic, it can be useful to ask him/her to elaborate (Miller & Rollnick, 2002). This will reinforce the power of the statement and can often lead to further motivational statements about change. One useful method is to ask for specific examples and/or for the client to clarify why this particular issue is a concern.

Raise the issue of using AODs (e.g. Cannabis)

I wonder how you feel about smoking cannabis.

How does using cannabis affect your mental health?

Some people find that cutting down their use of cannabis can improve their symptoms. What do you think?

I've been wondering what the most important thing is that we should concentrate on to improve your health and lifestyle at the moment. What do you think the priority should be?

Tell me about your smoking cannabis...And what's the other side? Tell me what you've noticed about your using? How has it changed over time? What things have you noticed that concern you?

Explore concerns:

What concerns you about cannabis?

What other concerns do you have about cannabis?

What can you imagine happening to you?

How much does that concern you?

Explore **health risks** (in addition to the interaction between using, psychosis and medication levels):

Can you tell me some reasons why using may be a health risk?

Would you be interested in knowing more about the effects of using? How important are these issues to you?

Explore **financial costs of using**: The client may raise the cost of using as a factor in their decision to quit. Ask the client:

Do you have any idea just how much money you think you would save if you didn't drink or use at these levels? How important are these issues to you?

Explore the client's **history** and how they picture things in the **future**:

What were things like before you started using?

How would you like things to be different in future?

What's stopping you from doing what you like?

How does using affect your life at the moment?

If you decide to change, what are your hopes for the future?

Explore the client's perceptions of **Self versus User**:

What would your best friend/mum say were your best qualities?

Tell me, how would you describe the things you like about yourself?

And how would you describe you, the pot smoker?

How do these two things fit together?

Looking back:

What were things like before you started using?

Looking forward:

How would you like things to be different in future?

What's stopping you from doing what you like?

How does using affect your life at the moment?

If you decide to change, what are your hopes for the future?

Summarise

So far you've told me that you are concerned you may be damaging your health by using. What else concerns you?

Add any additional reasons for using on the pros and cons balance sheet, including ratings of importance for each new reason. Continue working with this sheet until you are able to tip the balance in favour of the positives of changing and the negatives of using. Importantly, try to tip the balance of *importance* in favour of changing.

Changing Roles

If you find that the above techniques are not useful, you may wish to consider switching roles so that the therapist becomes the client and the client plays the role of the therapist. This can be very powerful in shifting the client's ambivalence as s/he has a chance to view the situation objectively. You may wish to introduce this role play technique via a paradoxical discussion in the following way (Miller & Rollnick, 2002):

One thing I find helpful is to clarify the real reasons for a change. We have started to do this a little bit already, but I've heard from you some reasons why you are reluctant to think about changing your cannabis use. So, now I have a suggestion. I want to have a little debate with you. I will take the side that you don't really have a problem and don't need to change, and I want you to do your best to convince me otherwise. I'm going to be you, and you have to persuade me as best you can that there really is a problem here that I need to examine and do something about.

Personal feedback from assessment

- Presenting the client with feedback from assessment is important, however doing so before this point in the first session could elicit resistance and hinder engagement in the treatment program. To minimise this, therapists are advised to wait until they have a reasonably clear picture of how the client's using fits into their typical day, and their current concerns about their AOD use. Ask the client's permission to provide feedback from your assessment in the following way:

In getting a feel for what's going on in your everyday life at the moment, you've mentioned several things that are concerning you (summarise these problem areas briefly, using those issues raised by the client in the "typical day" discussion, e.g. quality of life, health, mood, speed use). Would it be OK if I gave you some feedback from the assessment we completed together, because I think it fits into some of these issues?

- Discuss the client's level of dependence and other salient results from the initial assessment. Talk about the diagnosis of dependence, and the implications of this, including physical and psychological dependence. Check whether the client feels this is an accurate reflection. Ask the following questions: *How do you feel about this? Does it surprise you?*

Personal feedback report

When the client appears ready to receive more formal feedback regarding the information they provided during the initial assessment, give him/her the personal feedback report (Figure 3.4). The personalised feedback sheet contains considerable information about your client's substance use. For some people, a formal report can be a shock, especially if they haven't sat down and consciously thought about their use before. Allow the client time to look at their report before taking him/her through it step by step. Observe and monitor the client, allow time for him/her to respond verbally. Reframe resistance statements. (e.g. *So, this is confusing for you. It seems like you smoke about the same amount of cannabis as your friends, yet here are the results. This isn't what you expected to hear*).

Discuss any diagnosis of dependence and implications of this including physical and psychological dependence. Check whether client feels this is an accurate reflection:

How do you feel about this?

Does it surprise you?

Diagnosis: _____

Memory Score: _____(_____)

Visual Score: _____(_____)

Language Score: _____(_____)

Attention Score: _____(_____)

Delayed Memory Score: _____(_____)



Personal Feedback Report

Name: _____

Figure 3.4 Personal Feedback Report

Drug and Alcohol Assessment

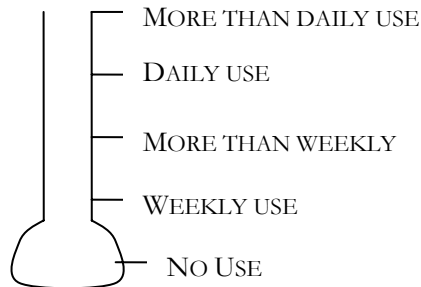
Alcohol Use

National Guidelines for Safe Use		My Score
Men	Women	
20 standard drinks per week	10 standard drinks per week	

Cannabis Use

This pattern of use causes damage to health:

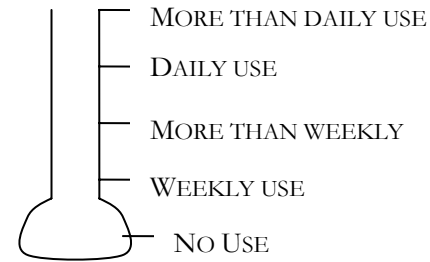
- Really wanting to use pot
- Using more pot than intended
- Withdrawal symptoms when not using
- Need more pot to get same effect
- Lots of time spent getting/using/recovering
- Still smoke pot even though I'm having problems



Speed Use

This pattern of use causes damage to health:

- Really wanting to use speed
- Using more speed than intended
- Withdrawal symptoms when not using
- Need more speed to get same effect
- Lots of time spent getting/using/recovering
- Still use speed even though I'm having problems



My reasons for using

Alcohol: _____

Cannabis: _____

Speed: _____

Exploring Importance and Confidence

It is important to build a person's intrinsic motivation for change, with the overall purpose to resolve ambivalence. The amount of time spent in this stage will depend on the client's starting point in relation to the stage of change model. Find out how important it is for your client to alter their using patterns and to assess their confidence in changing their use. This can be assessed by asking your client to rate their importance and confidence on a scale.

How important would you say it is for you to alter your cannabis use? On a scale from 0 to 10, where '0' is 'not at all important' and '10' is 'extremely important', where would you say you are?

0	1	2	3	4	5	6	7	8	9	10
Not at										Extremely
important										
all important										

And how confident would you say you are that if you decided to change your cannabis use, you could do it? On the same scale from 0 to 10, where would you say you are?

Examples of Importance and Confidence Questions (Rollnick et al. 1999)

Importance

- What would have to happen for it to become much more important for you to change?*
- What would have to happen before you seriously considered changing?*
- What made you give yourself such a high score on importance?*
- What would need to happen for your importance score to move up from 4 to 10?*
- What stops you moving up from 4 to 10?*
- What are some of the good things about smoking pot? What are some of the less good things?*
- What concerns do you have about smoking pot?*
- If you were to change, what would it be like?*
- Where does this leave you now?*

Confidence

- What would make you more confident about making these changes?*
- What made you give yourself such a high score on confidence?*
- How could you move up higher, so that your score goes from 4 to 10?*
- How can I help you move forward?*
- Is there anything you found helpful in any previous attempts to change?*
- What have you learned from the way things went wrong last time you tried?*
- Are there any ways you know about that have worked for other people you know?*
- What are some of the practical things you would need to do to achieve this goal?*
- Is there anything you can think of that would help you feel more confident?*

A more detailed example includes:

You mentioned that going to TAFE is important to you and smoking pot stops you from going sometimes, but you are not confident you can change. What ideas have you got for helping yourself in this situation? OK, as you say you could not smoke in the morning. How confident are you that you could give up the first smoke in the morning?

Signs of Behaviour Change

Signs of behaviour change which signify movement from Phase 1 Phase 2 include:

- Decreased resistance
- Decreased questions about the problem
- Resolve (may seem more peaceful or settled, a resolution has been reached)
- Self-motivational statements
- Increased questions about change
- Envisioning (client talks about what life might be like after a change)
- Experimenting (client may have begun experimenting with possible change approaches)

After discussing the content of previous sessions, examine the client's use of language in talking about their cannabis use. Notice if they have started to express "intention to change" statements, or "optimism for change" statements. Upon this assessment, you must decide with the client whether to move forward into Phase 2 motivational interviewing, or whether consolidation is necessary (Miller & Rollnick, 2002).

PHASE 2: STRENGTHENING COMMITMENT

The next motivational interviewing phase is to consolidate the issues raised by the client and build on their motivation to change. This works best when the person has moved to the late contemplation or early action stage of change. The aim here is to strengthen commitment to a change plan. Be aware that ambivalence will still be present, and you may need to continue drawing on techniques outlined in Phase 1.

The key components of Phase 2 include:

1. Recapitulation
2. Key questions
3. Information and advice
4. Negotiating a plan.

These components are detailed in Miller and Rollnick (2002). Keep in mind that this phase may also elicit resistance from the client. If this occurs, remember to use the techniques described in Phase 1 for management.

1. *Recapitulation*

It is useful to begin this phase by offering a broad summary of the client's current situation that reflects your sessions to date. This may include: summarising the client's own concerns (using their self motivational statements), summarising the client's remaining ambivalence (including what remains positive about continuing to use), a review of any objective evidence regarding risks/problems of continued use (perceived consequences of changing/not changing), summary of the client's own self motivational statements about their optimism for change, as well as your own assessment of the client's situation. It is important to bring together as many reasons for change as possible, while still acknowledging ambivalence.

2. *Key Questions*

In addition to the techniques outlined in Miller and Rollnick (2002), the MET manual includes another form of questioning to help the client shift from reasons for change to actually negotiating a plan for change. The therapist's goal is to elicit from the client a plan for what to do about using:

What do you make of all this?
Where does this leave you in terms of your using?
I wonder what you're thinking about your using at this point?
Now that you're this far, I wonder what you might do about these concerns with smoking pot?

3. *Giving information and advice (Miller & Rollnick, 2002)*

There are two situations in motivational interviewing where giving information and advice is both useful and important: when a client requests it, and when the client gives you permission. Some approaches include:

I'll be happy to give you some ideas, but I don't want to get in the way of your own creative thinking. You are the expert on you.

I don't know if this would work for you or not, but I can give you an idea of what some other people have done in your situation.

This may or may not make sense for you, but it is one possibility. You will have to decide whether it applies to you.

I wonder would it be useful to spend a few minutes looking at the question of how cannabis affects mental illness? Some people say that.....

I can give you ideas and strategies, but I want to stress that you'll have to try them out to see if they work for you. It's up to you what you do about this.

4. *Negotiating a Change Plan (Miller & Rollnick, 2002)*

Once it is apparent that the client is prepared to take some action in changing their cannabis use, it is important to set some clear goals for this change. Miller and Rollnick (2002) explain that motivation is driven by an inconsistency between a person's goals and their current state. Ideally, the client will see that both their symptoms and substance use can be worked on simultaneously, with goals established for each.

Communicate free choice (Miller et al., 1995)

Although abstinence is the desired goal, controlled usage may be preferred by some. Certainly the client has the ultimate responsibility and freedom of choice to change. Work with the client to decide what their goal for treatment will be.

Consider the degree of dependence, recent patterns of using, and previous attempts to control using, and discuss these issues with the client. Keep in mind the experience from cannabis intervention trials, which suggest that restricting smoking to weekends or social occasions leads to a slow but steady increase in smoking over time. Clients who decide to reduce their use, rather than quit completely, must have a firm, personal rule for recreational smoking (e.g. only once or week, or to never buy AODs).

The client has the ultimate responsibility and freedom of choice.

It's up to you what you do about this.

No-one can decide this for you.

No-one can change your using for you. Only you can do it.

You can decide to go on drinking just as you were or to change.

Consequences of **action** and **inaction** (Miller et al., 1995)

Anticipate the result if the client stops using, along with the likely consequences. Ask the client:

What would be likely consequences if you cut down on using?

What might be the possible negative consequences of not changing?

What might be the benefits of making a change?

Address **fears**:

What might be the negative consequences of reducing use of AODs?

What are the advantages of continuing to use as before?

Setting **Goals** (Miller & Rollnick, 2002)

Talk through the characteristics of good, realistic goals with the client. Make sure you cover the following points:

- Goals the client reaches can be celebrated/rewarded, but others that aren't achieved can be used as learning experiences
- Goals need to be concrete, specific and realistically achievable. For example, the goal of *quitting cannabis* is not as specific or concrete as, *I will no longer buy AODs*.

The client needs to choose his/her own goal(s). The therapist does not impose their standards on the change process. While abstinence may be the therapist's desired goal, this prospect may be overwhelming for a client to contemplate. It is far more important to maintain rapport and a good working alliance, and to start with goals that s/he is motivated to achieve (Miller & Rollnick, 2002). If a client identifies multiple goals, it is important to prioritise them through a shared decision making process that addresses the most important and attainable goals at the stage. If abstinence is the desired goal you might say:

Successful abstinence is a safe choice. If you don't use you can be sure that you won't have mental health problems because of the cannabis. There are good reasons to at least try a period of abstinence (e.g. to find out what it's like to live without cannabis, and how you feel, to learn how you have become dependent on it, to break your old habits, to experience a change and build some confidence, to please your family)

Similarly, clients unwilling to discuss immediate and long-term abstinence might be more responsive to a short-term (trial) abstinence period ("a break from cannabis") or tapering off their use toward abstinence. Miller and Rollnick (2002) describe the following alternatives to immediate abstinence:

1. Negotiate a period of trial abstinence;
2. Commence a process of gradual tapering down toward abstinence;
3. Commence a period of trial moderation. Moderation may be an appropriate goal to start with, even though abstinence may be the longer-term outcome.

If, however, the client is at risk for developing psychosis, you may wish to voice your concerns for tapering substance use.

It's your choice of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned.

If you think this will seriously jeopardise the therapeutic alliance, work with the clients identified goal. The view taken in motivational interviewing is that it is better to maintain a strong therapeutic alliance and work with the goals the client is most willing to address.

Dealing with resistance (MET; Miller et al, 1995)

Met with reflection, reframing or gentle paradoxical statements e.g.,

Maybe you'll decide that it's worth it to you to keep on drinking the way you have been, even though it's costing you.

Juxtaposing two important and inconsistent values:

I wonder if it's really possible for you to keep drinking and still have your marriage too.

Considering **Change Options**

Once a goal has been identified, it is important therapist and client collaboratively discuss ways of achieving this goal. Brainstorm possible change strategies considering a range of options (including far-fetched ones), evaluate each suggestion and consider how realistic and acceptable options might be so that the client chooses rather than refutes ideas, then choose the most appropriate option.

Arriving at a **Plan**

This is when together you work towards a clear plan of change. This can be achieved by asking the following questions:

What is it specifically that you plan to do?

What do you think is the first step?

How will you go about it?

A more detailed example is outlined below (adapted from Miller & Rollnick, 2002):

Let me see if I can accurately summarise where you are then. You wanted me to know about different ways that people can cut down/quit using pot, and we've talked about a number of possibilities. You're thinking that you may need to quite completely in the long run, but you're really not ready to do that first without trying to cut down. You considered different options and decided that you'd like to work on your own with the self control materials that we've talked about. We should be able to tell in 6-8 weeks whether that is going to work for you. Even if you decide then that what you need to do is quit, cutting down is a positive step along the way. So, what you are going to do is read the self-help pamphlets I've given you, begin keeping daily records of your use of cannabis and come back over the next couple of sessions and we can talk about how you are going.

Following this process, ask the client to complete the Change Plan Worksheet (Miller & Rollnick, 2002; Figure 3.5).

Change Plan Worksheet

- The most important reasons for making this change are:

- My main goals for myself in making this change are:

- I plan to do these things in order to accomplish my goals:

<u>Specific action</u>	<u>When?</u>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

- Other people could help me with change in these ways:

<u>Person</u>	<u>Possible ways to help</u>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

- There are some possible obstacles to change, and how I could handle them:

<u>Possible obstacles to change</u>	<u>How to respond</u>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

- I will know that my plan is working when I see results in:

Figure 3.5 Change Plan Worksheet

Summarise and make a contract for treatment (Miller et al, 1995)

It is important to obtain a concrete plan from the client in relation to change their use of AODs, and how they plan to bring about that change. Reinforce the perceived benefits of change and the consequences of action.

Stress to the client that the therapist is capable of helping facilitate change in the client, but ultimately it requires the commitment from the client. This requires certain ground rules (Graham, 2000, p24):

- Attendance – the client should be able to explain the reasons for missing a session
- Promptness – the client should be on time for sessions or contact the therapist if s/he cannot be on time
- Completion of Homework – treatment relies on the therapist/client making a decision about the appropriate skills to learn and how best to learn them

These agreements are set out in the form of a contract (Figure 3.6) that the client reads and signs. The treatment contract should be signed once you have established with your client that s/he is ready to commit to treatment. Note that you do not have to deliver the designed four motivational interviewing sessions if the client is ready to address their mental health/drug and alcohol issues.

Treatment Contract			
1. I understand that this treatment will last for 10 sessions, and I agree to participate for that length of time. If I decide to withdraw from the treatment program, I agree to discuss this decision with my therapist.			
2. I realise I will be receiving weekly homework and agree to complete this work for the following session. I agree to bring in the exercise sheet(s) each week to discuss with my therapist and practice some of the skills discussed in treatment.			
3. If I know I will be late for a session, I agree to phone my therapist in advance to advise him/her of the delay or reschedule my appointment.			
4. I agree to attend each session drug free, and understand that a session will not continue if I am in a substance-induced state.			
5. I agree to not miss more than 3 consecutive sessions.			
◆ My expectations of therapy are as follows:			

I have reviewed the above statements with my therapist, and we both agree to abide by them.			

<i>Signed (Participant)</i>	<i>Date</i>	<i>Signed (Therapist)</i>	<i>Date</i>

Figure 3.6 Treatment Contract

Session Termination and Assigning Homework

Briefly discuss the format for therapy over the treatment period.

Outline the rationale of CBT

Graham (2000) suggests that the overall objective of CBT is to identify and challenge unrealistic beliefs that maintain problematic patterns of thought and behaviour, and replace them with more adaptive beliefs that will lead to and strengthen behavioural change; to facilitate an understanding of the relationship between using/mental health problems; teach specific skills for controlling and managing using/mental health problems and developing social support for an alternative lifestyle. Use the following explanation:

Using (drug) is viewed as harmful behaviour. Once people start using regularly, they sometimes learn that it changes the way they feel. For example, some people use to help them deal with stressful situations. Others think it will make them more confident and others will use to keep from thinking about things. After a while, things in the environment, sometimes without the person realising, can trigger using. Environmental triggers may include seeing other people use, being in the presence of people who are using or being in stressful situations. You may even find you have developed your own views about using. For example, "Smoking pot helps me relax and unwind". Using can even change the way a person thinks, feels and acts, which can make it a habit that is very easy to start and very difficult to stop. The purpose of our treatment is to help you cope better with those situations in which you tend to use, and to help you find behaviours that you can do instead.

Outline the specific elements of the treatment program

These include:

- Exploration of reasons and motives for using
- Coping with cravings; identification of triggers for using
- Learning techniques for managing automatic thoughts that accompany using
- General coping skills
- Relapse prevention strategies

Identify areas that particularly seem relevant to the client or evoke interest, for emphasis in upcoming sessions.

Introduction to behavioural self-monitoring

The first step in learning to manage daily life without using AODs is to first identify those situations in which the client is most likely to use. Explain that monitoring AOD use over time has an important influence in helping to slow down the 'automatic' nature of an addictive behaviour.

Homework

- Throughout session 2, 3 and 4, set homework appropriate to the level of the client's motivation and participation in sessions. Over the next few weeks, ask the client to keep a symptom monitoring (Figure 4.1)/AOD diary (Figure 4.2) (this will foreshadow the use of the thought monitoring activities to come). Explain that at the end of each day fill out the diary so you and the client can get a snapshot of his/her daily symptom level/AOD usage. The client is to bring this with them to each session.
- If you do not cover the information set out for each session, set the remaining tasks for homework (if this is appropriate) and discuss at the beginning of the following session.
- Complete the Therapist Checklist at the completion of each session.

Symptom Monitoring Form

	Triggers Where were you? Who were you with?	Thoughts/Feelings What were you thinking/feeling at the time?	Symptom Rating How would you rate your symptoms 1=Worst symptoms 5=No symptoms
Monday			1 2 3 4 5
Tuesday			1 2 3 4 5
Wednesday			1 2 3 4 5
Thursday			1 2 3 4 5
Friday			1 2 3 4 5
Saturday			1 2 3 4 5
Sunday			1 2 3 4 5

Figure 4.1 Symptom Monitoring Form

AOD Monitoring Form

	Triggers Where were you? Who were you with?	How much AOD did you use? Record number	Thoughts/feelings What were you thinking/feeling at the time?
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Figure 4.2 AOD Monitoring Form

Therapist Checklist Adapted from NIDA (1989)

Client ID _____

Date of Session: _____

Site: _____

Therapist: _____

Session Number: _____

Please complete the following based on this session:

1. What topic was covered this week?

- | | |
|--|--|
| <input type="checkbox"/> Motivational Interviewing | <input type="checkbox"/> Problem Solving |
| <input type="checkbox"/> Motivational Enhancement | <input type="checkbox"/> Managing Unhelpful Thoughts |
| <input type="checkbox"/> Decisional Balance | <input type="checkbox"/> Coping with Cravings |
| <input type="checkbox"/> Mood Monitoring | <input type="checkbox"/> Drink/Drug Refusal Skills |
| <input type="checkbox"/> Thought Monitoring | <input type="checkbox"/> Planning for Emergencies |
| <input type="checkbox"/> Activity Scheduling | <input type="checkbox"/> Coping with a Lapse |
| <input type="checkbox"/> Introduction to CBT | <input type="checkbox"/> Relapse Prevention |
| <input type="checkbox"/> High Risk Situations | |

2. Did your client complete the homework set from last session?

- No attempt made
- Some attempt made
- Practice exercise completed adequately
- Not applicable; not assigned

3. How much time did you spend on each of the aims of this session?

(Record in approximate minutes)

- **Review the Previous Week** _____ minutes
- **Setting the Agenda** _____ minutes
- **Reviewing Homework Tasks** *(tick the relevant homework set for last session):*
 - Symptom Monitoring: ___ minutes
 - AOD Monitoring: ___ minutes
 - Modifying AOD Use: ___ minutes

4. Record any deviations from the manual for this session and/or additional comments:

Figure 4.3 Therapist Checklist – Sessions 1-4

SESSION 5 – CONCEPTUALISING TREATMENT: INTRODUCTION TO CBT

Therapist Summary Sheet

Aims:

- Outline the rationale of CBT and specific elements of the CBT intervention
- Outline specific skills/techniques to assist client in becoming more effective when making/maintaining desired changes
- Form a collaborative relationship
- Discuss change strategies client may have identified as particularly useful
- Determine high-risk situations

Materials needed for Session 5

- *Handout:* Self monitoring record
- *Handout:* Challenging unhelpful thinking

Main areas to be covered:

- Review of week and homework. Set agenda
- Rationale for CBT
- Link Between Thoughts, Feelings and Behaviours (A-B-C)
- Exercise: Demonstrating the Link Between Thoughts, Feelings and Behaviour
- Thought Monitoring
- Exercise: Monitoring Thoughts about Triggers
- Exercise: Self Monitoring Record
- Assessing and Avoiding High Risk Situations
- Homework
 - Observing the link between thoughts, feelings and behaviours
 - Practice challenging automatic negative thoughts
 - Self Monitoring: psychotic symptoms/AOD use
- Therapist Checklist

SESSION 5: Introduction to CBT for psychotic symptoms, and AOD use

Review of the week and homework exercise

Start with an informal discussion about general activities, and also determine whether there are any important issues that have arisen, any questions so far.

Review the homework activity with the client and discuss triggers for using the client has identified throughout the week. If the client has not completed the homework task, ask them to do so now.

Review the client's AOD using pattern for the week. Did the client meet the planned goals for reducing/quitting? Reinforce positive changes and address minor problems if convenient.

Set the agenda for the session by explaining to the client the issues that will be covered.

Brief explanation of CBT rationale and the process of treatment

Therapist Rationale (Graham et al., 2000)

The overall objective of CBT is to identify and challenge unrealistic beliefs that maintain problematic patterns of thought and behaviour, and replace them with more adaptive beliefs that will lead to and strengthen behavioural change; facilitate an understanding of the relationship between problem substance use/mental health problems; teach specific skills for controlling and managing substance use/mental health problems and developing social support for an alternative lifestyle.

Having established rapport with the client, the therapist may present the rationale for CBT. The explanation may be given to those with a comorbidity as follows:

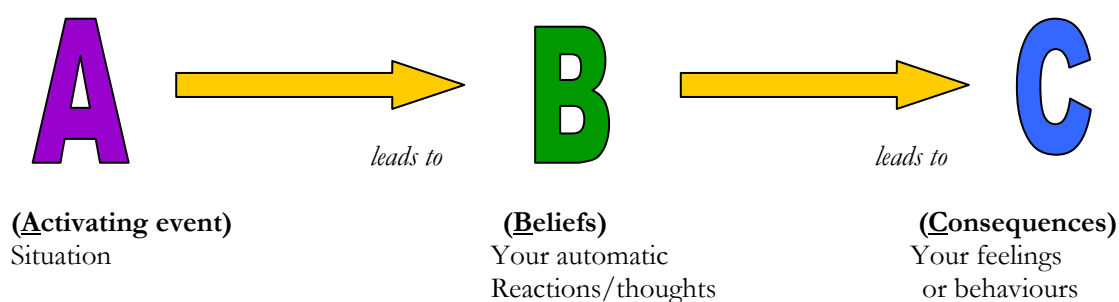
In thinking about your substance use, using AODs excessively is viewed as harmful behaviour. Once people start drinking a lot of alcohol/using other drugs they sometimes learn that it changes the way they feel. For example, some people use AODs to help them deal with stressful situations or psychotic symptoms. Some people think it will make them more confident, and others will use them to keep from thinking about things. After a while, things in the environment, sometimes without the person realising it, can trigger using AODs. Environment triggers may include seeing other people drink/use, being in the presence of people who are drinking/using or being in stressful situations. You may find you have developed your own views about AODs. For example, "Drinking is not a problem for me. I can stop whenever I want".

Using alcohol/other drugs can change the way a person thinks, feels and acts. This can make substance use very easy to start and very difficult to stop. The purpose of our treatment is to help you cope better with those situations in which you tend to drink/use, and to help you find behaviours that you can do instead of drinking.

Link between thoughts, feelings and behaviours

Over the past few weeks, the client has learned how to monitor their thoughts and feelings in response to activating events. It is important that the therapist now demonstrates the link between thoughts, feelings as well as behaviours using the cognitive model illustrated below (Ellis, 1975). Hopefully the client will have started to observe patterns in their thoughts/feelings/behaviours, and possibly how their AOD use fits with these patterns. Next in this process is to help clients learn how to examine their cognitions and emotions more closely, and break down the steps occurring between a situation or trigger for psychotic AOD use/symptoms. The ABC cognitive model is a simple and useful framework for this process, and can assist the client in regaining some control over their environment (Ellis, 1975; Graham et al., 2000; Beck et al., 1979). The following rationale can be used to orientate your client to the CBT model:

All people who are trying to reduce their AOD use will have thoughts about using, and will increasingly experience urges to seek out and use AODs. Similarly, those trying to manage their psychosis may have learned to think and respond in a particular way to themselves and their environment.



Explaining the ABC model

Use the following dialogue to explain the ABC model to your client:

*Events or situations don't usually **cause** our feelings or behaviour; rather it is our interpretation (or thoughts) about those events that will directly relate to our feelings and actions. So, rather than feeling hopeless about trying to control situations that pop up (which is virtually impossible) a more useful approach is to learn how to change or control our response to those events and to feel more positive about our situation. The ABC model shows that when particular situations happen (A's=activating events), they trigger certain thoughts (Bs = beliefs), and these Bs cause our feelings, or control our behaviour (Cs = our consequences). "As" (or activating situations) don't have much to do with our feelings at all, rather it is our interpretations/our response to those situations that controls how we feel. Often, the negative or unhelpful thoughts happen so quickly in response to events that you do not even realise what is happening. That is why these thoughts are often referred to as "automatic." Usually, what happens to people is that they suddenly realise they are feeling bad, or are having a craving/urge to use AODs. These feelings are often a signal that someone has had an automatic thought about the present situation that has resulted in a craving or activation of psychotic symptoms.*

Exercise: Demonstrating the link between thoughts, feelings and behaviour

(Jarvis, Tebbutt & Mattick, 1995)

- Ask the client to imagine a scenario from the past week where they experienced strong urges/cravings to use AODs or when they have felt particularly symptomatic.
- Ask the client to interpret this event: *What is the first thought that came into your mind?* Write this down on a piece of paper.
- Ask the client to identify how they would feel or what they might do in this situation.
- Help the client identify the A's, B's and C's surrounding the situation: A=scenario, B=Interpretation, C=how they felt or what they might do.
- Summarise by saying: *This process happens for every situation we encounter. Quite often, this whole process happens so quickly we don't even realise that it has happened like this – it is almost automatic. Usually, we just suddenly realise we are feeling bad, or having disturbed thoughts or craving to use AODs.*
- Over the next week, ask the client to refer to this example over the next week and think of other examples where this might happen.

The aim of the following few sessions will be to help the client identify the pattern of thinking they have in association with their craving/use of AODs. You will then help the client to learn ways to challenge these unhelpful thoughts and replace them with more helpful ones. In this way the client will learn how to manage thoughts about stressors and also cope with the cravings they may experience.

Explain to the client:

In working out how to manage our symptoms or AOD use, it is helpful to know which situations are most likely to lead you to use or to have unhelpful thoughts. What we want to learn is what kinds of things are triggering or maintaining your thoughts and feelings. Then, we can try to develop other ways you can deal with these “high-risk” situations without using substances. This involves learning specific skills and strategies. What we’ll discuss over the next few sessions will relate to: identification of triggers; learning techniques for managing automatic thoughts; general coping skills for symptoms and relapse prevention strategies. We can also talk about any areas that you are having particular difficulty in.

Give the client the handout at the end of this session to help them practice thought monitoring (Figure 5.1).

Practice thought monitoring

Working with the ABC model can take a bit of practice. Over the next week, ask the client to practice identifying the A, B, Cs of situations, re-iterating the rationale if necessary. Below is an exercise to assign the client for homework. Show the client the “Self Monitoring Record” and demonstrate its use with the example used in the exercise above.

Exercise: Monitoring thoughts about triggers (Jarvis, Tebbutt & Mattick, 1995)

- Use the sheet titled “Self Monitoring Record”. Explain to the client that *this exercise is an important first step in taking control of your thoughts and feelings. It involves a “real world” experiment. Over the next week, please complete the self-monitoring record on each day.*
- Be sure to communicate the importance and relevance of the homework activity to the client.
- Explain how to use the sheet: *Over the next week, pay close attention to those times and situations when you find yourself with symptoms of psychosis and/or with the urge to use AODs. While you are still getting used to this activity, you might find that you don’t realise such a situation has occurred where you have experienced symptoms or used AODs. So, over the next week when this happens, say to yourself **STOP, SLOW-DOWN**, and fill in this sheet.*
- Ask the client to write down the situation that led to the feelings in the “Trigger” column. Then, write down the automatic thoughts they have about that situation in the “Thoughts” column, writing down their words as if they were speaking them out loud. In the “Feelings” column, ask them to describe the feelings or symptoms they are experiencing (including whether they experienced a craving). Finally, ask the client to indicate in the “Behaviours” column what they did (e.g. whether they used, tried to switch off, etc.).
- Ask the client to bring in the completed form next session.

Self Monitoring Record

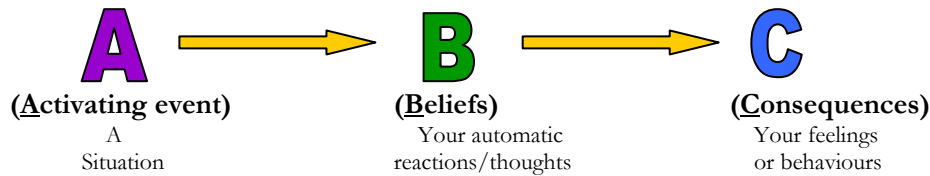
	A - Trigger Where were you? Who were you with?	B - Thoughts What was I thinking?	C - Feelings What was I feeling?	C - Behaviours What did I do?
	At home, bored, haven't got anything to do	<i>I've got nothing to do, nobody to do anything with, life sucks</i>	Sad, Angry, Useless, Worthless	Had a couple of drinks Watched TV on the lounge
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Figure 5.1 Self Monitoring Record

CHANGING UNHELPFUL THINKING

Adapted from Jarvis, Tebbutt and Mattick (1995)

Step 1: Identify the link between thoughts, feelings and behaviours



Step 2: Don't act on the unhelpful thoughts

STOP, SLOW DOWN and THINK

Do not act upon the thought for a short period of time.

It is likely that the thought will pass soon without any harmful consequences

Step 3: Challenge the unhelpful thoughts

"What is the evidence to support this thought? Is this 100% true?"

It is common for people to mistake their feelings for evidence/fact, when in reality feelings are not facts.

"What are the advantages/disadvantages of thinking in this way?"

Weigh up the positives and negatives of this automatic thought. Remember, automatic thoughts will have some advantages for you, particularly when they help you avoid a difficult situation, or something you don't really want. Are there more negatives than positives about this automatic thought?

Are you falling into the habit of an "unhelpful thought pattern"? For example, are you taking things personally, blowing things out of proportion, jumping to negative conclusions, using all/nothing thinking or should/ought statements? If so, this is a sign that you are putting yourself at risk for using.

"What alternative ways of thinking about the situation are there?"

There will always be more than one way to think about any trigger situation. Often these other thoughts will be more helpful than the initial, automatic thought. Take a minute to try to think of some different ways of thinking/reacting to the stressful/trigger situations.

Figure 5.2 Changing Unhelpful Thinking

Assessing and Avoiding High-Risk Situations

Once you have offered the client a rationale for treatment, begin an informal assessment of high-risk situations. Questions that may be useful include:

In what kinds of situations do you drink/ experiencing symptoms?

What are your triggers for drinking / experiencing symptoms?

Can you give a specific example (e.g. a relapse or situational story)?

Can you remember your thoughts and feelings at the time?

What were the positive/negative consequences of drinking/feeling unwell?"

If the client cannot identify potentially high-risk situations, use the following classification table as a prompt to help the client:

Adapted from Marlatt and Gordon, 1985

1. Intrapersonal-Environmental Determinants

- This applies whenever relapse relates to a response to intrapersonal forces (psychological or physical), or to a precipitating event that does not involve others.

(a) Coping with Negative Emotional States

- Relapse often occurs when one is emotionally upset, therefore participants need to be aware of ways to cope with negative thoughts / feelings;
- **(i) Coping with frustration and/or anger:** Involves an experience of frustration and/or anger in terms of the self or some non-personal environmental event. Includes all references to guilt, response to environmental demands or from within the self that are likely to produce feelings of anger.
- **(ii) Coping with other negative emotional states:** Involves coping with aversive emotional states other than frustration/anger including feelings of fear, anxiety, tension, depression, loneliness, sadness, boredom, worry, apprehension, grief, loss. Also includes reactions to evaluation stress (exams, public speaking, etc.), employment and financial difficulties, personal fortune or accident.

(b) Coping with Negative Physical States

- Assess craving to alleviate unpleasant symptoms associated with withdrawal
- **(i) Coping with physical states associated with prior substance use:** Includes states that are specifically associated prior use of substances, such as “withdrawal agony” or “physical craving” associated with withdrawal.
- **(ii) Coping with other negative physical states:** Coping with pain, illness, injury, fatigue, etc. that are not associated with prior substance use.

(c) Enhancement of positive emotional states

- Use of substances to increase feelings of pleasure, joy, freedom, celebration, etc. includes use of substance for primary positive effect.

(d) Testing Personal Control

- *e.g.* willpower, internal fortitude. Use of substance to test one’s ability to engage in controlled moderate use; to “just try it once” to see what happens, or in cases of testing the treatment

(e) Giving into temptations/urges

- Substance use in response to internal urges, temptations. Includes references to craving or intense subjective desire in the absence of interpersonal factors.
- **(i) In the presence of substance cues:** Use occurs in the presence of cues associated with substance use (i.e. passing by a bar).
- **(ii) In the absence of substance cues:** The urge/temptation comes “out of the blue” and is followed by the persons attempt to procure the substance.

2. Interpersonal Determinants

- This applies whenever relapse involves the significant influence of others (e.g. argument with partner).

- (a) Coping with interpersonal conflict**
- Coping with a current conflict associated with any interpersonal relationship (e.g. marriage, etc.)
 - **(i) Coping with frustration and/or anger:** Involves frustration and/or anger stemming from an interpersonal source. Emphasis is on any situation in which the person feels frustrated/angry with someone (**e.g.** arguments, disagreements, fights, jealousy, discord, hassles, guilt, etc.).
 - **(ii) Coping with other interpersonal conflict:** Involves coping with conflicts other than frustration/anger stemming from an interpersonal source. (**e.g.** feelings such as anxiety, fear, tension, worry, concern, apprehension, etc. which are associated with interpersonal conflict).
- (b) Social Pressure**
- Involves responding to the influence of another individual/group who exert pressure (direct or indirect) on the individual to use the substance.
 - **(i) Direct social pressure:** Direct contact with another person/group who puts pressure on the user or who applies the substance to the user (**e.g.** being offered a drug by somebody). Distinguish from situations in which the substance is obtained from someone else at the request of the user.
 - **(ii) Indirect social pressure:** Responding to the observations of another person/group that is using the substance or serves as a model of substance use for the user.
- (c) Enhancement of positive emotional states**
- Use of substance in primary interpersonal situation to increase feelings of pleasure, celebration, sexual excitement, freedom, etc. Distinguish from situations in which the other person(s) is using the substance prior to the individual's first use.

Homework

- For each session following, set homework appropriate to the level of the client's motivation and participation in sessions. Depending on the stage of change the client is at and the material covered this session, ask the client to complete the homework outlined in this section.
- Ask the client to continue working with the Exercise: Demonstrating the link between thoughts, feelings and behaviour. The client is to refer to the exercise throughout the next week and think of examples. Ask the client to document these and bring them to the next session.
- Complete the self monitoring record for symptoms. When the client completes the record, ask him/her to refer to the handout: Changing unhelpful thinking and begin to practice challenging these unhelpful ways of thinking (Figure 5.2).
- If you do not cover the information set out for this session, set the tasks for homework (if this is appropriate) and discuss at the beginning of the following session.
- Complete the Therapist Checklist (Figure 5.3).

Therapist Checklist Adapted from NIDA (1989)

Client ID: _____

Date of Session: _____

Site: _____

Therapist: _____

Session Number: _____

Please complete the following based on this session:

1. What topic was covered this week?

- | | |
|--|--|
| <input type="checkbox"/> Motivational Interviewing | <input type="checkbox"/> Problem Solving |
| <input type="checkbox"/> Motivational Enhancement | <input type="checkbox"/> Managing Unhelpful Thoughts |
| <input type="checkbox"/> Decisional Balance | <input type="checkbox"/> Coping with Cravings |
| <input type="checkbox"/> Mood Monitoring | <input type="checkbox"/> Drink/Drug Refusal Skills |
| <input type="checkbox"/> Thought Monitoring | <input type="checkbox"/> Planning for Emergencies |
| <input type="checkbox"/> Activity Scheduling | <input type="checkbox"/> Coping with a Lapse |
| <input type="checkbox"/> Introduction to CBT | <input type="checkbox"/> Relapse Prevention |
| <input type="checkbox"/> High Risk Situations | |

2. Did your client complete the homework set from last session?

- No attempt made
- Some attempt made
- Practice exercise completed adequately
- Not applicable; not assigned

3. How much time did you spend on each of the aims of this session?

(Record in approximate minutes)

- **Review the Previous Week** _____minutes
- **Setting the Agenda** _____minutes
- **Reviewing Homework Tasks** *(tick the relevant homework set for last session):*
 - Demonstrating ABC: _____minutes
 - Self Monitoring Record for Symptom _____minutes
 - Changing Unhelpful Thinking _____minutes

4. Record any deviations from the manual for this session and/or additional comments:

Figure 5.3 Therapist Checklist – Session 5

SESSION 6 – CBT

SEEMINGLY IRRELEVANT DECISIONS; PROBLEM SOLVING; MANAGING UNHELPFUL THOUGHTS

Therapist Summary Sheet

Aims:

- Awareness of seemingly irrelevant decisions
- Learn and practice problem solving skills
- Identify the “unhelpful automatic thoughts” that can lead to urges to use AODs or to an exacerbation in symptoms
- Learn to challenge “unhelpful automatic thoughts”

Materials needed for Session 6

- *Handout:* Seemingly irrelevant decisions
- *Handout:* Problem solving
- *Handout:* Unhelpful automatic thought patterns
- *Handout:* Steps in managing unhelpful automatic thoughts

Main areas to be covered:

- Review of the week and homework. Set agenda
- Seemingly Irrelevant Decisions: Background
- Exercise: Seemingly Irrelevant Decisions
- Problem Solving Skills
- Exercise: Problem Solving Skills
- Identifying Unhelpful Thought Patterns
- Exercise and Handout: Negative Automatic Thought Patterns
- Exercise and Handout: Managing Negative Automatic Thought Patterns
- Homework
 - Identify a seemingly irrelevant decision
 - Implement action plan from problem-solving exercise
 - Problem-solve an additional problem
 - Identifying automatic negative thoughts
- Therapist Checklist

SESSION 6: CBT

Seemingly irrelevant decisions, Problem solving, Managing unhelpful thoughts

Review of the week and homework exercise

Start with an informal discussion about general activities, and also determine whether there are any important issues that have arisen, any questions so far.

Review the homework activity with the client. If s/he has not completed the homework, ask them to fill in the self monitoring sheet for their most recent craving/symptom within the session. Discuss/address any difficulties and affirm efforts.

Review the client's AOD using pattern for the week. Did the client meet the planned goals for reducing/quitting? Reinforce positive changes and address minor problems if convenient.

Set the agenda for the session by explaining to the client the issues that will be covered.

Seemingly Irrelevant Decisions (SIDS; Monti, Abrams, Kadden & Cooney, 1989)

Previous exercises have helped the client to identify situations in which they are most likely to use AODs. Explain to the client that one useful way of avoiding these situations, and hence the trigger for a craving, is to become aware of the "seemingly irrelevant" decisions they make that can lead to them being in a situation of high-risk for using. Present the following rationale to the client:

Many daily choices on the surface seem to have nothing to do with using. Although decisions may not directly involve choosing whether to use AODs, they may slowly move you closer to such behaviour. It is often through seemingly irrelevant decisions that you gradually work your way closer to entering high-risk situations that may lead to using.

People often fall victim to their situations (e.g. "I always end up using at parties and can't help it"). Although it is difficult to recognise choices made when in the decision-making process, each small decision you make over a period of time can gradually lead you closer to your predicament. The best way to combat this is to think about each choice you make, no matter how seemingly irrelevant it is to using, so you anticipate potential dangers ahead.

Always choose the lowest-risk option when faced with a decision, to avoid putting yourself in a risky situation. When you become aware of seemingly irrelevant decisions, you will be better able to avoid high-risk situations. It is easier to simply avoid the high risk situation before you are actually in the situation.

Exercise: Seemingly irrelevant decisions (Monti, Abrams, Kadden & Cooney, 1989)

- Ask the client to think about their last relapse to using and to describe the situation/events that preceded the relapse. What decisions led up to the relapse?
- Take the client through the reminder sheet (Figure 6.1)

✂

SEEMINGLY IRRELEVANT DECISIONS (Monti et al., 1989)

When making any decision, whether large or small, do the following:

- ◆ Consider what options you may have
- ◆ Think ahead to the possible outcomes of each option. What positive/negative consequences you can anticipate, and what is the risk of relapse to using?
- ◆ Select one of the options: Choose one that will minimise your risk of relapse. If you decide to choose a high-risk option, plan how to protect yourself while in the high-risk situation
- ◆ *Practice Exercise:* Think about a decision you have made recently or are about to make. The decision could involve any aspect of your life (*eg.* friends, family). Identify low-risk options and choices that decrease your risk of relapse

Decision to be made: _____

Low-risk option: _____

High-risk option: _____

✂

Figure 6.1 Seemingly Irrelevant Decisions

Problem solving skills

The aim of problem solving is to enable the client to resolve real life problems that impinge upon his/her ability to maintain a drug free/limited lifestyle.

Problems are a recurring part of everyday life, and our ability to deal with difficult issues makes a big difference in how we generally feel. Sometimes avoiding certain things places us under more pressure later on. While everyone is different in their ability to solve problems, it can be learned and improved just like any other skill. This has a big impact in helping people to lead easier lives, and reduces the pressure which often leads to using substances.

Problem-solving is an important general skill that clients will be able to easily learn and use in a variety of situations that occur in their everyday lives. These situations include those that may pose a threat to a client remaining committed to their goals (reducing AOD use). They can be substance specific (*eg.* being in a group where THC is freely available), can arise from thoughts or feelings (*e.g.* intrusive thoughts), in interactions with others (*e.g.* arguments) or they can be more general (*e.g.* work concerns).

Explain to the client that it is important to work through problems that occur in day-to-day life, rather than to ignore them or deal impulsively with them. Pressure from an unresolved problem could easily lead to a relapse. It is important for the client to recognise situations as problems, and take time to work out and think through the most appropriate solutions.

In general, problem-solving is broken down into six steps (Jarvis, Tebbutt & Mattick, 1995):

1. Defining exactly what the problem is
2. Brainstorming the options to deal with the problem
3. Choosing the best option/s
4. Generating a detailed action plan
5. Putting the plan into action
6. Evaluating the results

Step 1: Define exactly what the problem is:

- The first step in problem solving is often the most difficult. It is important to assist the client to define their problem in very concrete terms (concrete behaviours that your client can modify).
- For example, simply saying *I don't like my life*, defines a person's problem in very vague terms – it is almost impossible to solve this problem. Alternatively, breaking the problem down into *I feel lonely because I don't have many friends* and re-defining this as an achievable goal *I'd like to work on making some friends* more concretely identifies those aspects of the person's life with which they are unhappy about, thereby making them more easily targeted.
- Well-defined problems have the following characteristics:
 - Specific and concrete
 - Realistic – the client needs to be able to change the behaviour/problem
 - Adequate – the definition needs to be comprehensive, incorporating all aspects of the problem. Re-define the problem as an achievable goal
 - Owned by the client – the client needs to feel that the definition is truly representative of what they feel the problem is. Allow the client time to work this out for him/herself

Exercise: Defining the problem (Jarvis, Tebbutt & Mattick, 1995)

- Use Figure 6.2 to work through this exercise.
- Have the client select a problem situation. If the client has difficulty finding a problem, try to identify a potentially high-risk situation where they may be tempted to use.
- Help the client to frame the problem clearly in concrete, specific, realistic, and adequate terms as an achievable goal. If necessary, get them to break a larger problem down into “sub-problems” which will be more manageable.
- Write the problem down in the space provided at Step 1 in Figure 6.2.

Step 2: Brainstorm possible options to deal with the problem

- Brainstorming is an effective way of helping clients to generate alternatives to a situation, or different ideas about that situation or their future. The quality and efficacy of their action plans will be better if the clients are able to choose the strategies from a large and exhaustive list of options. Use the following rules for brainstorming as a guide.
- No criticism allowed. Leave evaluation of the options generated until Step 3.
- Encourage wild and adventurous ideas. Remember any idea is acceptable at this stage. Also, the less impeded the client is, the more chance there is of coming up with a good, novel idea.
- Quantity of ideas is important.
- Think about solutions that have worked before. An old solution may be a good starting point, even if it needs to be altered.

- Always make sure the client goes first. It is important that even if you come up with a suggestion for the list, it is the client who decides whether it will be added.

Exercise: Brainstorming options (Jarvis, Tebbutt & Mattick, 1995)

- Have the client generate as many alternatives/options for dealing with the problem situation they identified in the last activity, using the guidelines mentioned above.
- Write these ideas down in the space provided at Step 2 in Figure 6.2.

Step 3: Choose the best option (pros and cons of each solution)

- Every behaviour/thought will have both pros and cons associated with it. It is therefore important to encourage the client to think through both the positives and negatives associated with each option they generate. This will prevent rash decision making about a course of action to take when confronted with a problem (*e.g.* using to cope with anxiety, or assuming that your partner hates you because of an argument you just had). This process will also help the client to sort out and discard any obviously impractical options.

Exercise: Choosing the best option (Jarvis, Tebbutt & Mattick, 1995)

- Have your client carefully consider each of the options they generated during the brainstorming session, and identify the pros and cons of putting that option into practice.
- Write these down at Step 3 in Figure 6.2.
- After the list is exhausted, work with the client to identify his/her most preferred option/s.
- Record the most preferred option.

PROBLEM-SOLVING (*Jarvis, Tebbutt & Mattick, 1995*)

Step 1: My problem is:

Step 2: What are the possible solutions?

Step 3: What are the positives and negatives of each solution?

Possible Solutions	Positives	Negatives
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Circle the best solution

Step 4: What are the steps in putting the best solution into practice?

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Step 5: Putting the plan into practice

When you go home today, take this problem-solving sheet with you and take some time to go through your action plan in your head. Then, tomorrow, try it out.

Step 6: Evaluate the plan

How did your plan succeed? Do you need to go back to step 3 and try again?

Figure 6.2 Problem-Solving

Step 4: Generate a detailed action plan (what's my plan?)

- The next step in successful problem solving is to break down the preferred option into smaller, more concrete and achievable steps.
- For example, if the client decided they wanted to “*exercise more*” and thereby feel better about themselves, the action plan would need to specify which type of exercise, when/how often it would occur, how to get there, when to start, with whom, etc.
- It is important to make the first step in any action plan something simple so that the client can easily achieve it and experience immediate success. This will increase their motivation to continue working through the plan.

Exercise: Develop an action plan (Jarvis, Tebbutt & Mattick, 1995)

- Help the client to break their preferred option down into manageable, concrete and achievable steps.
- Develop a detailed action plan to help guide the client in putting their preferred solution into practice.
- Record the plan at Step 4 in Figure 6.2.

Step 5: Put the plan into practice

- It is important for the client to mentally think through or rehearse their plan, and you may even like to conduct a role-play around their problem to help them practice putting the plan into action.

Exercise: Putting the plan into action (Jarvis, Tebbutt & Mattick, 1995)

- If appropriate, carry out a role play with the client that involves their problem situation. Have them practice carrying out their action plan (and even voice/rehearse what they will say to themselves when confronted with that situation).
- Set some homework for the following week – carry out the action plan.

Step 6: Evaluate the results

- Talk with the client in session about how the action plan succeeded and/or failed when it was put into practice in the role-play. How does the client predict the plan will translate into practice?

Identifying “unhelpful automatic thoughts”

One of the strategies clients may find useful in brainstorming alternative options to their problem situations is to challenge the “unhelpful automatic thoughts” they may have in response to these situations.

When attempting to cut down or quit using AODs, it is important for people to become aware of the way they view their drug use, particularly in terms of how it fits into the situations that occur during each day. For example, is the drug use related to escape/avoidance of unpleasant situations, wanting to unwind/relax, to be social, to cope during a crisis/times of stress.

Help the client discover how their view of everyday situations perpetuates their symptoms. The self-monitoring sheet the client has been using will provide some guide as to how they perceive their drug use/psychosis, and the client may be able to elaborate on this within the session.

It is important for the client to identify “unhelpful, automatic” thoughts s/he has developed. These thoughts may be based on the use of drugs as a solution to other

problems, or biases in thinking that confirms a pessimistic view of the world. Unhelpful thinking can lead to quite negative emotions (as the client has most likely already identified via the homework activity), which can then lead to using AODs as a coping strategy or escape.

Exercise: Negative Automatic Thought Patterns (Beck et al., 1979; Persons et al., 2001; Segal et al., 2002)

- Use the handout titled “Unhelpful Automatic Thought Patterns” (Figure 6.3).
- Explain: *People with psychosis often jump to negative conclusions about what others are thinking of them, or indeed what they think of themselves. I would like us to look at this sheet together, and see whether you identify with any of these ways of thinking.* Take the client through the 5 types of thinking patterns listed on the form, explaining each one.

Once you have helped the client identify these unhelpful ways of thinking, take him/her through the next exercise.

Exercise: Managing Negative Automatic Thought Patterns (Segal et al., 2002; Persons et al., 2001; Beck et al., 1979)

- Use the sheet titled: “Managing Unhelpful Thoughts”
- Explain to the client that this new process of monitoring and managing their thoughts will take practice and some time to get used to. So, to start with, it is important to formalise the process and write down each of these steps as they happen. Be sure to communicate the importance of this task.
- Take the client through the sheet, and explain how to complete each column.
- Ask the client to complete that sheet for homework, for each situation that triggers a negative automatic thought.
- Ask the client to use this sheet in conjunction with the sheet titled “Steps in Managing Unhelpful Automatic Thoughts” (Figure 6.4).

Homework

- Ask the client to identify a SID and work through the SIDs handout as applicable.
- In regards to the problem solving exercise, ask the client to work through problems that arise throughout the week and put the action plan discussed during this session into practice. Evaluate the results of this implementation in your next session.
- Ask the client to complete the sheet titled “Managing Unhelpful Thoughts” (Figure 6.5). Encourage the client to write down their thoughts as if they were speaking them out aloud without evaluating them. Then go through the “steps in managing unhelpful automatic thoughts” handout to challenge and evaluate these thoughts.
- If you do not cover the information set out for this session, set the tasks for homework (if this is appropriate) and discuss at the beginning of the following session.
- Complete the Therapist Checklist (Figure 6.6).

Unhelpful Automatic Thought Patterns

Do you have any of the following unhelpful automatic thought patterns?

Are you a **Black and White Thinker**?

- ◇ Are things are either all good or all bad – with nothing in between, no balance.
- ◇ Because something has gone wrong once, it will always go wrong.
- ◇ Do you have strict rules about yourself and your life? For example, do you think that in order to be good at something, you must do it perfectly or not at all?
- ◇ If things don't work out perfectly do you feel hopeless, like you have failed completely? For example: *If I fail partly, it is as bad as being a complete failure*, or *If a person is not a complete success, then life is meaningless* or *I never get what I want so it's foolish to want anything*.
- ◇ Have you ever thought: *even if I use once this week, I'm a failure, so why bother* or *I can't change, so it's pointless trying at all*.
- ◇ Black and white thinkers may also believe that in order to be a good person, everybody must like them all the time. They may think that *People will probably think less of me if I make a mistake*, or *If a person I love does not love me, it means I am unlovable*.

Do you **Jump to Negative Conclusions**?

- ◇ Do you automatically draw a negative conclusion about something more times than not?
- ◇ People who “jump to negative conclusions” sometimes act like “mind readers”. They think they can tell what another person is **really** thinking, often without really checking it out or testing it.
- ◇ Other times, people who “jump to negative conclusions” may do a bit of “fortune telling”. They believe that things will turn out badly, and are certain that this will always be the case. For example, they think things like *Things just won't work out the way I want them to*, or *I never get what I want so it's stupid to want anything*, or *There's no use in really trying to get something I want because I probably won't get it*.
- ◇ In relation to their alcohol/other drug use, people with this pattern of thinking may believe *I'll never be able to change my drinking/drug using, it'll never be any different*.

Do you **Catastrophise**?

- ◇ Sometimes people give too much meaning to situations.
 - ◇ They convince themselves that if something goes wrong, it will be totally unbearable and intolerable. For example, *If I get a craving, it will be unbearable and I will be unable to resist it*.
 - ◇ If “catastrophisers” have a disagreement with someone, they may think that *the person hates me, doesn't trust me, and things will never change*. Or, *if I don't have a drink, I'll never be able to cope with this*.



Are you a **Personaliser**?

- ◇ “Personalisers” will blame themselves for anything unpleasant that happens.
- ◇ They take a lot of responsibility for other people's feelings and behaviour, and often confuse facts with feelings. For example, *My brother has come home in a bad mood, it must be something that I have done* or *I feel stupid, so I am stupid*.
- ◇ People with this pattern of thinking often put themselves down, and think too little of themselves, particularly in response to making a mistake. They may think things like *I'm weak, stupid, ugly* or *I'm an idiot*.

Are you a **Should/Ought** Person?

- ◇ People with this pattern of thinking use 'should' 'ought' and 'must' when they think about lots of situations. This often results in them feeling guilty.
- ◇ Shoulds and Oughts quite often set a person up to be disappointed, particularly if these thoughts are unreasonable. For example, *I must not get angry*, *He should always be on time*.
- ◇ 'Should' statements can cause a person to experience anger and frustration when that person directs these statements at others.

Figure 6.3 Unhelpful Automatic Thought Patterns

Steps in Managing Unhelpful Automatic Thoughts

(Segal et al., 2002; Persons et al., 2001; Beck et al., 1979)

- 1 Spot your unhelpful automatic thought.
Negative feelings
Cravings for alcohol/other drugs
- 2 Ask yourself: *Have I just had an automatic thought?* The answer is most likely 'yes'.
- 3 Try and distance yourself from the thought, and see it for what it is.
When you recognise an automatic thought, **STOP, and step out of automatic pilot**...remind yourself: ***thoughts are just thoughts, they are not facts and I am not my thoughts.***
- 4 Next look at the thought itself. Ask yourself: *Which unhelpful automatic thought has happened here?*
And label your thoughts as catastrophising, personalising, jumping to negative conclusions, black/white thinking or shoulds/oughts.
- 5 Then, ask: *What are the facts here – do these thoughts fit with the facts?*
- 6 Ask: *Which other way can I interpret this situation? Is this explanation just as likely to be true? Does this explanation make me feel better?* Usually, the answer will be 'yes'.

Figure 6.4 Steps in Managing Unhelpful Automatic Thoughts

Managing Unhelpful Thoughts (Segal et al., 2002; Beck et al., 1979)

Situation	Thoughts	Feelings		Which automatic thought is this?*	What is a more helpful way of looking at this?	Feelings now
Sitting at home, bored, nothing to do	I should be out doing something, but I've got nothing to do, nobody to do it with	Sad, Angry, Useless, Worthless	This is just a thought Thoughts are not facts (even the ones that tell me they are) I am not my thoughts	Jumping to negative conclusions Shoulds/oughts	My psychosis is telling me I don't have anything to do.	A bit more motivated and worthwhile

Figure 6.5 Managing Unhelpful Thoughts

Therapist Checklist

Adapted from NIDA (1989)

Client ID: _____

Date of Session: _____

Site: _____

Therapist: _____

Session Number: _____

Please complete the following based on this session:

1. What topic was covered this week?

- | | |
|--|--|
| <input type="checkbox"/> Motivational Interviewing | <input type="checkbox"/> Problem Solving |
| <input type="checkbox"/> Motivational Enhancement | <input type="checkbox"/> Managing Unhelpful Thoughts |
| <input type="checkbox"/> Decisional Balance | <input type="checkbox"/> Coping with Cravings |
| <input type="checkbox"/> Mood Monitoring | <input type="checkbox"/> Drink/Drug Refusal Skills |
| <input type="checkbox"/> Thought Monitoring | <input type="checkbox"/> Planning for Emergencies |
| <input type="checkbox"/> Activity Scheduling | <input type="checkbox"/> Coping with a Lapse |
| <input type="checkbox"/> Introduction to CBT | <input type="checkbox"/> Relapse Prevention |
| <input type="checkbox"/> High Risk Situations | |

2. Did your client complete the homework set from last session?

- No attempt made
- Some attempt made
- Practice exercise completed adequately
- Not applicable; not assigned

3. How much time did you spend on each of the aims of this session?

(Record in approximate minutes)

- **Review the Previous Week** _____minutes
- **Setting the Agenda** _____minutes
- **Reviewing Homework Tasks** *(tick the relevant homework set for last session):*
 - SIDs: _____minutes
 - Problem Solving: _____minutes
 - Managing Unhelpful Thoughts _____minutes

4. Record any deviations from the manual for this session and/or additional comments:

Figure 6.6 Therapist Checklist – Session 6

SESSION 7 – CBT

COPING WITH CRAVINGS/URGES TO USE AODs, THE “BREAKING THE RULE” EFFECT, ACTIVITY SCHEDULLING

Therapist Summary Sheet

Aims:

- Learn ways to manage the triggers for use.
- Learn ways to cope with urges/cravings for AODs.
- Learn about the importance of participating in positive activities.
- Learn how to actively schedule positive activities into a weekly timetable.

Materials needed for Session 7

- *Handout:* All Purpose Coping Plan
- *Handout:* Facts About Cravings
- *Handout:* Coping with Cravings
- *Handout:* Activities List
- *Handout:* The Activity Record

Main areas to be covered:

- Review of the week and Homework. Set agenda
- Introduction to Coping with urges to use AODs
- Exercise: Describing a Craving
- Practical Behavioural and Cognitive Strategies to Cope with Urges/Cravings
- Relaxation and imagery
- Exercise and handout: Coping with Cravings
- Exercise: Devising a Craving plan
- Dealing with a Lapse
- Background and Exercise: Activity Scheduling of Pleasurable and Achievement Tasks
- The Activity Record
- Exercise: Activity Record
- Homework:
 - All Purpose Coping Plan
 - Activities List
 - The Activity Record
- Therapist Checklist

SESSION 7: CBT

Coping with cravings/urges to use AODs, Coping with the abstinence/violation effect, Activity Scheduling

Review of the week and homework exercise

Start with an informal discussion about general activities, and also determine whether there are any important issues that have arisen or any questions so far.

Review the homework activity with the client. If s/he has not completed the homework, ask them to complete their homework in session. Discuss/address any difficulties and affirm efforts. If necessary, review exercises from last week.

Review the client's AOD using pattern for the week. Did the client meet the planned goals for reducing? Reinforce positive changes and address minor problems if convenient.

Set the agenda for the session by explaining to the client the issues that will be covered.

Introduction to coping with urges to use AODs

AOD cravings are the sense of wishing to have a substance, or an impulse to seek out and use AODs. Cravings will generally increase during withdrawal and/or in the absence of AOD use. Therefore if your client is trying to abstain from or modify their use, s/he will experience more intense cravings. Complete the following exercise with the client.

Describing cravings (Adapted from Monti, Abram, Kadden & Cooney, 1989)

The first step in coping with cravings is to become aware of all the different sensations, behaviours and thoughts that together form the craving experience. With this awareness comes an ability to sense a craving in the early stages, and to intervene early in the process.

Exercise: Describing a craving

- Ask the person to describe their experience of a craving. Then ask, *Tell me a bit more about your cravings – what are they like?*
- Write down each of the feelings, thoughts, physical responses the person uses to describe their craving, grouping together those that are behavioural (e.g. fidgety), thoughts (e.g. *I must have a drink*), and physical (e.g. heart races, feeling sick) in nature.
- Explain that it is possible to fit the person's experience of cravings into a model:
BEHAVIOURS + PHYSICAL REACTIONS + THOUGHTS = CRAVING
- In coping with a craving, it is important to address each of these parts.

Use the sheet titled "Facts about Cravings" (Figure 7.1) and read through its content. This will provide the client with some additional information about cravings.

Practical behavioural and cognitive strategies to cope with urges/cravings

(Graham et al., 2000)

Explain to the client that sometimes cravings have many components and cannot be avoided, and so it is necessary to find ways to cope with them. Strategies that have been found to be helpful in coping with cravings are listed below. These correspond to the behavioural, physical and cognitive (thought) aspects of cravings described above. Help the client to identify the strategies s/he has used and found helpful in the past. The

following exercise is a useful way to begin thinking about how the client will cope with their craving.

Behavioural

- Discuss the “4Ds” of coping with cravings (deep breathing, drinking fluids, doing something else, delaying when you feel like using). Use the following information to discuss the “4Ds” in more detail.

Delaying – avoid situational triggers, particularly during the early phase; delay the decision to use for an hour to try and break the habit of immediately reaching for a beer, some pot, or a ‘shot’.

Distraction – once the decision to use is delayed, distract yourself from your thoughts about using.

Doing something else- Brainstorm some alternative options to use as a distraction technique such as going for a walk, calling a support person, relaxation, listening to music, *etc.* Once the person is interested in doing something else, s/he will find the urge will go away.

Drink water and/or chew gum.

Cognitive

- Positive talk – by reminding themselves about the short-term nature of cravings (e.g. *this feeling will pass*) the client’s urges will be easier to deal with. It is important to “decatastrophise” the experience of cravings – acknowledge that they are uncomfortable/unpleasant but also that they will pass.

Relaxation and Imagery

- Relaxation/deep breathing – if cravings develop in response to stressful situations, relaxation techniques and deep breathing exercises can be useful.
- The urges that some client’s experience can often be in the form of images. Some strategies found to be helpful in managing/transforming this image are listed below. Each of these strategies can be rehearsed and practiced within the session:

Mastery- For example, get the client to conjure up an image of themselves walking past their dealers house instead of going in and buying pot, amphetamines. Ask him/her to imagine how good they would feel about their achievement.

Alternative- (i.e. replace the image with an alternative adaptive/“healthy” image). For example, ask the client to conjure up an image of him/herself walking along the beach on a holiday they have taken when s/he was abstinent. This may be difficult with some clients, so be creative with this alternative view.

Fast forward- (i.e. unfreeze the image and move it on in time, a few minutes, hours, days *etc.* to enable the client to see that s/he is looking at only a part of the picture which may in fact be a distortion of the whole picture). For example, ask the client to conjure up an image of their dealers house and then unfreeze it and fast forward (almost as if pressing a fast forward button on a video) and envisage the usual consequences that follow purchasing drugs from this house. Ask the client to describe the immediate, short and long-term consequences in detail.

Surfing the Urge- transform the image from one that feels overwhelming (e.g. a wave crashing over you) to an image of successfully overcoming the urge/craving by riding/surfing the urge in the way in which a surfer would surf a wave.

Exercise: Coping with Cravings

- Provide the client with the information sheet titled “Coping with Cravings” (Figure 7.2).
- Give the following rationale: *Sometimes, cravings cannot be avoided, and so it is necessary to find ways to cope with them. On this sheet are listed a number of strategies that seem helpful in managing cravings/urges to use AODs. These correspond to the behavioural, physical and cognitive (thought) aspects of cravings you have just described.*
- Read through the list of techniques with the client.
- Ask the client to tick those strategies they feel most able to implement – those strategies the client has used successfully in the past, and those new techniques they are willing to try.
- Practice some techniques in session if the need arises.

Devising a Craving Plan

Following discussion of the above issues, it is time to develop a plan for the client to use to assist in coping with the cravings s/he may experience.

Exercise: Devising a craving plan (Kadden et al., 1995)

- Identify the client’s high-risk situations for using generated by the client during the session.
- Ask the client to circle the triggers s/he feels they can simply avoid or reduce their exposure to (e.g. not having pot in the house, not buying it), thereby reducing the likelihood of experiencing a craving.
- Of the remaining triggers that cannot be avoided, go through the coping strategies described above with your client and jointly identify those that s/he can put in place when experiencing a craving/urge.
- If the client has not tried any of the coping strategies before (eg. urge surfing, relaxation, nominating a support person to call on) encourage them to practice the technique in session.
- Complete the “All-purpose Craving Plan” (Figure 7.3) in session.
- Ask the client to refer to the plan throughout the week when a craving develops.

Conclusion

It is crucial at this time to offer supportive, encouraging statements as in the last session. Encourage any progress the client has made and commend them for considering their current habits. Thank him/her for completing the homework tasks from last session, and encourage them to complete the tasks set for the coming week. Affirming the client can be helpful through strengthening the work relationship; enhancing the attitude of self-responsibility and empowerment; reinforcing effort and self-motivational statements, and supporting client self-esteem.

Facts about cravings

(Marlatt & Gordon, 1985)

Cravings are a natural part of changing drug use. This means that you won't have any more difficulty changing your drug use than anybody else does. Understanding cravings helps people to overcome them, so let's go through some simple facts.

Cravings are the result of long-term alcohol/other drug use and can continue long after your use has stopped. So, people with a heavier history of use will experience stronger urges.

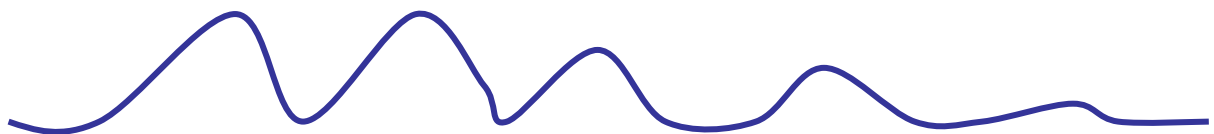
Cravings can be triggered by: people, places, things, feelings, situations or anything else that has been associated with alcohol/other drug use in the past.

A craving is just like a wave at the beach. Every wave in a set starts off small, and builds up to its highest point, and then it breaks and flows away to shore. Each individual wave never lasts more than a few minutes. A craving is just the same. It starts off small, and then builds up – with physical parts, behaviours and thoughts. But, it reaches peak, just like a wave, and it will eventually break, and disappear. This whole process usually doesn't last more than about 10 minutes.



Cravings will only lose their power if you don't add force to them by drinking/using. Even if you use only once in a while, you will still keep those cravings alive. Cravings are like a stray cat – if you keep feeding them, they will keep coming back.

Like the picture below, each time a person does something other than drink or take drugs when they are craving, the craving will lose its power. The peak of the craving wave will become smaller, and the waves will be further apart.



Quitting alcohol/drugs totally, is the quickest way to get rid of the cravings.

Cravings are strongest in the early parts of quitting/cutting down, but people may continue to experience cravings for the first few months and sometimes even years after the drug use has ceased.

Each craving will not always be less intense than the previous one. Be aware that sometimes, particularly in response to stress and certain triggers, the peak will return to the maximum.

Figure 7.1 Facts About Cravings

Coping with Cravings

Sometimes, cravings can't be avoided, and so you need to find ways to cope with them. Below are some things for you to try out, to cope with the physical, behavioural and psychological effects of cravings. Put a tick (✓) in the box next to those things you think you could do.

- Eat regularly, even when you don't feel like it
- Drink plenty of water – especially when you get the craving
- Instead of drinking alcohol or using, drink water or chew gum
- Use “**Delaying**” and “**Distraction**” when your craving is set off. When you experience a craving, put off the decision to drink or use for a while. Go and do something else during that time like go for a walk, listen to music, etc. This breaks the habit of you immediately reaching for alcohol, pot or speed when you get a craving. You will find that once you are interested in something else, the craving will go away.
- Use **relaxation and deep breathing** techniques to cope with a craving once it is set off. If a craving develops in response to stressful situations, relaxation techniques and deep breathing exercises are really useful – you can't be stressed if you are relaxed! Get yourself in a comfortable position – maybe sitting on the lounge. Close your eyes and take 3 big, deep, slow breaths. Concentrate on your breathing. Breathe deeply in, and as you breathe out, say the word “relax”. Wait a few seconds between each breath. Once you are relaxed, form a picture in your mind of a wave at the beach. This is a craving wave, and remember that the craving wave will build up to its highest point, and then fall away as it rolls into shore. Picture the craving wave building up, getting ready to break, see it break, see the foam form, and see the wave fade away as it rolls into shore. Now, picture yourself riding the wave, surfing the craving wave into shore. You don't fall off, you don't get dumped and churned around, just picture yourself calmly surfing the craving wave into shore. Remind yourself that this little craving wave, is only a small part in your day. You can surf the craving wave at any time, and wait for it to fade away.
- Use **positive talk** when a craving is set off. Tell yourself that cravings only last about 10 minutes. Tell yourself *this feeling will pass*. You will find that the urges and cravings themselves will be easier to deal with. Say to yourself, *yes, this feels pretty bad, but I know it will be over soon*.
- Use your **self-monitoring form** to write down your thoughts and feelings about the situation that triggered your craving. Check whether you are falling into an unhelpful pattern of thinking, and see if you can think of other ways to look at the situation.
- Other ideas:**

- Other ideas:**



Figure 7.2 Coping with Cravings

All Purpose Coping Plan (NIDA, 1989)

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

If I run into a high risk situation:

1. I will leave or change the situation

Safe place I can go:

2. I will put off the decision to use for 15 minutes. I'll remember that my craving usually goes away in ___ minutes and I have dealt with craving successfully in the past

3. I'll distract myself with something to do

Good distracters:

4. I'll call my list of emergency numbers

Name: _____

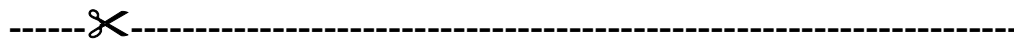
Name: _____

Name: _____

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

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

Figure 7.3 All Purpose Coping Plan



Dealing with a lapse (“Breaking the Rule” effect)

It is important to talk with the client about something called the “Abstinence/Rule Violation” effect, although it may be more helpful to use the term the “Breaking the Rule” effect. Often people who have been trying to change their substance use will feel very bad about themselves if they have a lapse – they will probably see it as the end of the world or a finish to their attempts at quitting. Slips and lapses are common in the recovery process, so it is important to discuss them with the client early on in therapy. While slips are disappointing, they do not mean failure or indicate an inability to change. The client’s challenge is to find ways to overcome slips and maintain goals as best as possible. A slip is treated as a learning experience.

Give the following explanation to your client:

The “Breaking the Rule” effect could happen if you have a slip-up and “break your rules”. These rules could be staying off alcohol, pot or speed completely, or cutting down. The “Breaking the Rule” effect happens when you have slip-up and then think something like “stuff it, I’ve had a drink (or hit) – broken my rule, might as well keep going”. In this case, the “Breaking the Rule” effect would be that you thinking something like “here I go again – I knew this therapy wouldn’t work, I’m not good enough to change so I’m just not going to try anymore”.

In both of these cases, there are other ways of looking at the situation. Slip-ups will happen – everybody makes mistakes, and it doesn’t mean that you have failed completely. You can stop at one drink, one cone or one hit, and go from there - you can start with a clean slate. But, if you have a slip-up, it is more likely to turn into a relapse if you give into the “Breaking the Rule” effect.

The main thing to help you cope with the “Breaking the Rule” effect is to change those unhelpful automatic thinking patterns that cause the effect. Just like in your monitoring record, you need to realise that you are falling into that pattern of unhelpful thinking. In particular, the “Breaking the Rule” effect is an example of black and white thinking, catastrophising and jumping to negative conclusions. So, all you need to do is to develop other ways of thinking about your slip-ups – because everybody makes mistakes, everybody will have a slip-up. It is not the end of the world, and it doesn’t mean that you have failed.

The main strategy to help your client cope with the abstinence/rule violation effect is to re-evaluate and modify the thinking errors that contribute to the effect. The aim is for the client to firstly identify the distortions in thinking that occur in relation to using (e.g. minimisation, all or nothing, overgeneralisation). Secondly, you can help the client generate a more helpful, less catastrophic and more realistic way of viewing the situation (e.g. a slip/mistake rather than a complete failure).

For example,

Unhelpful thought: *I’ve blown it*

Helpful thought: *I’ve just had a slip and I can get back on track*

Unhelpful thought: *I knew I wouldn’t be able to stop*

Helpful thought: *I have been able to make a change...this is only a slip and I will keep on trying*

Unhelpful thought: *I’ve messed up already so I might as well keep going*

Helpful Thought: *I’ve just made a mistake and I can learn from it and get back on course.*

Activity Scheduling

When people are going through difficult times, it is rare for them to remember doing anything meaningful or fun throughout their day. Activity scheduling is a key behavioural component of CBT. It is important to focus on behavioural interventions, with a view to restoring a person's functioning to higher levels. Their unhelpful thoughts mean they are more likely to focus on the things they have not done, or missed out on doing. In these cases, identifying pleasurable activities (that they may have forgotten as a result of their illness/using) can be a useful and helpful process to take your client through.

Encourage the client to increase their activity level (if appropriate) and increase their involvement in activities they find pleasant or that provide them with a sense of achievement. Firstly, identify the time of day or week that seems to be the most problematic for the person – those “danger” times when people are most at-risk of falling victim to their symptoms or drinking/using – and plan pleasant or achievement activities for the person to carry out at these times. By planning “pleasurable” activities into the day, people will realise that they can enjoy themselves, and also, by completing achievement tasks can gain a sense of control or mastery over the things in their life that they need to do.

Exercise: Identifying enjoyment and achievement tasks

- Take out the “Activities List” (Figure 7.4).
- Process the list of activities the client has already written under the “Pleasant Activities” column. Are there any additional activities they like and enjoy doing, aside from taking AODs. For example, going for a walk, time to themselves, visiting friends, *etc.* Make sure these activities are broken down into concrete things. For example, *time to myself* needs to be broken down into the actual activities that constitute time to oneself. These could include listening to the radio, practice relaxation *etc.*
- Add these tasks to the “Pleasant Activities” column.
- Next, ask the client to list the things s/he needs to do. This could include attending treatment sessions, keeping appointments, therapy homework, looking after kids, *etc.* Break these activities down into discrete, concrete tasks. For example, *Looking after the kids* should also be broken down into concrete tasks (*e.g.* bathing, walking to/from school), and may also include doing fun things with them.
- List these tasks under the “Achievement Activities” column.

The Activity Record

For people trying to cut down or stop using AODs, it is common for them to have narrowed their behaviours to those associated with drinking/using. As such, they tend to over-emphasise the importance of using or drinking in their day, and it is difficult for them to imagine how else they could fill in their time. An activity schedule is a useful way of broadening the selection of activities in which they can be involved. In the longer term, if they decide to cut down or stop using AODs, planning into their day specific tasks, means they may be able to distract themselves from thinking about using.

The first step in activity scheduling is to collect concrete information about what the person is currently spending their time doing (Persons et al., 2001). This may also provide useful information about the “danger” times when people are most at-risk of falling victim to their symptoms and/or using. People are often surprised when they compare their beliefs about their activities with their activity record (Persons et al., 2001).

The next step is to plan time for each of these activities to occur. Explain to the client that it is important that each day has at least one enjoyable activity and at least one achievement activity scheduled in. Work through the following exercise within this session to teach the client how to plan their week in advance.

Exercise: Activity Record (Persons et al., 2001)

- Use the sheet titled “The Activity Record” (Figure 7.5)
- Explain the importance of including both pleasant and achievement activities into the client’s day. This will increase their satisfaction with the way they spend their time. In addition the Activity Record can be used to break large, complex tasks down into more concrete, manageable steps, which are less overwhelming.
- Either during the day or at the end of each day, ask the person to complete the activity record, and detail their activities at the times listed throughout the day. Using the list of pleasant and achievement activities you have already developed, complete with the client a schedule for the following day. Ask the client to select at least one pleasant activity and one achievement activity for that day. Mark each activity as pleasant or achievement.
- You may also like to focus on any “high-risk” times that the client identifies and plan in session what they will do in these times to reduce the risk of elevation in symptoms or using AODs.
- Encourage the client to complete the activity record each day over the next week and bring it to next weeks’ session. Whilst in the session, schedule in your next appointment with the client, and enter this spot on the Activity Record. If the client is aware of any appointments they must meet through the week, add those into the Activity Record during the session.

Complete the activity record for the following day with the client’s help. It is important to acknowledge that it is impossible to plan every moment of every day in advance. Indeed there will be times when unpredictable things happen and the client will not be able to carry out the pleasurable and achievement tasks set down for that day. Discuss this with the client, and explain that the activity record is not a rigid plan, and they should not feel guilty or bad if they cannot stick exactly to the plan. In addition, they are able to substitute alternative activities into the record if something prevents them from doing what they planned. For example, on the day a client plans to go for a walk it may be raining. So, explain to the client that in these cases, they are free to substitute an alternative pleasurable task into that timeslot.

Homework

- Encourage the client to practice the techniques discussed in session when s/he experiences a craving/urge to use AODs. Ask the client to refer to the Ask Purpose Coping Plan throughout the week when a craving develops and to continue to use the Coping with Cravings handout for management strategies associated with cravings. If the client lapses at any time throughout treatment, encourage him/her to consider their use of AODs as a slip or learning experience rather than catastrophising.
- Ask the client to allocate time for one pleasurable activity (taken from the Activities List) and incorporate this into their daily activity. When the client completes this, ask him/her to document it on the Activity Record and bring it with them to the next session.
- If you do not cover the information set out for this session, set the tasks for homework (if this is appropriate) and discuss at the beginning of the following session.
- Complete the Therapist Checklist.

Activities List

Pleasant Activities <i>(Things I enjoy)</i>	Achievement Activities <i>(Things I have to do)</i>

Figure 7.4 Activities List

The Activity Record

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	<i>Pleasant activity?</i>	<i>Pleasant activity?</i>	<i>Pleasant activity?</i>	<i>Pleasant activity?</i>	<i>Pleasant activity?</i>	<i>Pleasant activity?</i>	<i>Pleasant activity?</i>
7-8 a.m.							
8-9 a.m.							
9-10 a.m.							
10-11 a.m.							
11-12am.							
12-1 p.m.							
1-2 p.m.							
2-3 p.m.							
3-4 p.m.							
4-5 p.m.							
5-6 p.m.							
6-7 p.m.							
Evening							

Figure 7.5 The Activity Record

Therapist Checklist Adapted from NIDA (1989)

Client ID: _____

Date of Session: _____

Site: _____

Therapist: _____

Session Number: _____

Please complete the following based on this session:

1. What topic was covered this week?

- | | |
|--|--|
| <input type="checkbox"/> Motivational Interviewing | <input type="checkbox"/> Problem Solving |
| <input type="checkbox"/> Motivational Enhancement | <input type="checkbox"/> Managing Unhelpful Thoughts |
| <input type="checkbox"/> Decisional Balance | <input type="checkbox"/> Coping with Cravings |
| <input type="checkbox"/> Mood Monitoring | <input type="checkbox"/> Drink/Drug Refusal Skills |
| <input type="checkbox"/> Thought Monitoring | <input type="checkbox"/> Planning for Emergencies |
| <input type="checkbox"/> Activity Scheduling | <input type="checkbox"/> Coping with a Lapse |
| <input type="checkbox"/> Introduction to CBT | <input type="checkbox"/> Relapse Prevention |
| <input type="checkbox"/> High Risk Situations | |

2. Did your client complete the homework set from last session?

- No attempt made
- Some attempt made
- Practice exercise completed adequately
- Not applicable; not assigned

3. How much time did you spend on each of the aims of this session?

(Record in approximate minutes)

- **Review the Previous Week** _____ minutes
- **Setting the Agenda** _____ minutes
- **Reviewing Homework Tasks** *(tick the relevant homework set for last session):*
 - Craving Plan for AODs _____ minutes
 - “Breaking the Rule” effect: _____ minutes
 - Pleasurable activities: _____ minutes
 - The activity record: _____ minutes

4. Record any deviations from the manual for this session and/or additional comments:

Figure 7.6 Therapist Checklist – Session 7

SESSION 8 – CBT

DRINK/DRUG REFUSAL, LIFESTYLE ISSUES

Therapist Summary Sheet

Aims:

- Learn and practice refusal skills
- Discuss lifestyle changes (e.g. weight control and exercise)

Materials needed for Session 8

- *Handout:* refusal Skills
- *Handout:* Dealing with Worries about Weight Gain

Main areas to be covered:

- Review of the week and homework. Set agenda
- Background and Exercise: Learn and Practice Drug Refusal Skills
- Lifestyle Issues
- Handout: Dealing with Worries about Weight Gain
- Foreshadow Treatment Termination
- Homework
 - Refusal Skills
- Therapist Checklist

SESSION 8: CBT

Drink/Drug refusal, Lifestyle issues

Review of the week and homework exercise

Start with an informal discussion about general activities, and also determine whether there are any important issues that have arisen or any questions so far.

Review the homework activity with the client. If s/he has not completed the homework, ask them to complete their homework in session. Discuss any difficulties and affirm efforts. If necessary, re-visit the problem-solving exercise from last week.

Review the client's AOD using pattern for the week. Did the client meet the planned goals for reducing? Reinforce positive changes and address minor problems if convenient.

Set the agenda for the session by explaining to the client the issues that will be covered.

Learn and Practice Drug Refusal Skills

Whilst in the early stages of modifying use of AODs it is important to consider avoiding these high-risk situations completely, it is acknowledged that avoidance is not a long-term solution, nor is it always a practical one. There are a number of strategies that can make saying NO easier:

Non-verbal Measures for Refusing Alcohol/Other drugs (Monti et al., 1989)

1. Use a clear, firm, confident and unhesitating tone of voice
2. Make direct eye contact with the other person to increase the effectiveness of your message. Stand/sit straight to create a confident air
3. Do not feel guilty about the refusal and remember, you will not hurt anyone by not drinking/using

Verbal Measures for Refusing Alcohol/Other drugs (Monti et al., 1989)

1. "NO" should be the first word out of your mouth. A direct statement is more effective when refusing the offer
2. Suggest an alternative (*e.g.* something else to do/eat/drink).
3. Request a behaviour change so that the other person stops asking (*e.g.* ask the person not to offer AODs anymore)
4. Change the subject to something else to avoid getting involved in a drawn out debate about using/drinking
5. Avoid using excuses and avoid vague answers, which will imply that at a later date you may accept an offer to use/drink

Exercise: Rehearsing Alcohol/Other Drug Refusal (Monti et al., 1989; NIDA, 1998)

- Use the sheet titled “Refusal Skills” (Figure 8.1).
- Explain the rationale for learning and practicing refusal skills to the client. Use the following information: *It is often difficult to refuse someone who is offering you AODs. This is particularly the case if you don't want to offend the other person. It can be tough to say “no”, particularly when you have said “yes” before. But, equally important are your feelings and your goals, so it is a good idea to practice what you might say in these situations before they happen. There are some key ways to get your message across, in a way that you feel comfortable, and that won't offend the other person. To help you say “NO” comfortably, take some time to prepare some responses you might make to different people who might offer you AODs.*
- Read through the essential elements of an effective refusal with the client.
- Next, ask the person to fill in the table on the sheet and nominate some responses they may use when confronted by “a friend they used to use with”, “a co-worker”, “a party”, or other potentially “high-risk” situation. Write down the exact words the client feels they can use in each of these situations, using the key principles. This sheet can then be taken with the client.
- Note – if appropriate, the client may want to practice saying these responses aloud during the session, or you may like to conduct a role-play around one of the nominated scenarios.

Refusal Skills

(NIDA, 1989)

Tips for responding to offers of alcohol/other drugs:

- Say no first.
- Make direct eye contact.
- Ask the person to stop offering drugs.
- Don't leave the door open to future offers.
- Remember there is a difference between being assertive and being aggressive. Assertiveness means being direct but not bossy, being honest but not bigheaded, and being responsible for your own choices without forcing your opinions on everybody else.

People who might offer me drugs	What I'll say to them
<i>A friend I used to drink or use with.</i>	
<i>A coworker.</i>	
<i>At a party:</i>	
<i>Other:</i>	

Figure 8.1 Refusal Skills

Lifestyle Issues


Adjusting to a life without AODs can involve learning new things to do in place of taking drugs. This is also the case for people who are adjusting to living with a psychotic illness; several lifestyle changes may become necessary in order to remain well and to prevent relapse.

Managing weight gain

One important lifestyle change is that of managing weight, ensuring a healthy diet and regular exercise. The benefits of these are widespread, and include the following:

- You will be able to breathe more easily
- Your mind will be clearer
- You will sleep better
- You will have more energy
- You will reduced stress and tension
- Your bones will get stronger
- Fat weight will change to muscle weight
- You will increase your muscle strength
- **YOU WILL FEEL BETTER!**

Many clients will be concerned about gaining weight as a result of giving up using or taking anti-psychotic medication. Use Figure 8.2 below as a guide for discussing the concerns about gaining weight.



DEALING WITH WORRIES ABOUT WEIGHT GAIN

When you give up smoking, you are going to have more energy, breathe easier, have an improved sense of taste and smell, and feel more alert. On the other hand, you may be worried about gaining weight. Remember, smoking is more harmful to you than being a little overweight for a little while.

In most cases, it is easy to avoid weight gain by planning ahead, by adding physical exercise (eg. walking) into your day, or by focussing on adding low calorie foods to your diet. It is also important to drink loads of water. Understanding why and how you might gain weight when you stop smoking will help you in planning ahead. Answer the following questions to help you through this process.

1. Do you feel a need to put something in your mouth to replace cigarettes?
 Yes No
2. Do you deliberately treat yourself by eating extra foods or sweets as a reward for stopping smoking?
 Yes No
3. Has your sense of taste improved since stopping smoking, and has your desire to eat increased?
 Yes No
4. Do you have a better appetite now you have stopped smoking, because your health has improved?
 Yes No
5. Have you used smoking in the past as a substitute for food, or to maintain a lower than normal weight?
 Yes No
6. Have you used smokes as a “pick-me-up” whenever you had a break? For example, do you now reach for a sweet biscuit every time you have coffee or tea?
 Yes No
7. Have you used smoking or food in the past to deal with symptoms?
 Yes No

If you answered YES to any of these questions, use the following tips to help reduce your risk of weight gain when you stop smoking...

- Cut your food into smaller pieces
- Drink plenty of water
- Eat slowly, avoid going for seconds
- Have set times for meals, avoid the kitchen at other times
- Keep your mind focused & hands busy
- Leave the table as soon as you finish
- Brush your teeth as soon as you finish
- Eat your dinner later if snacks are a problem
- Stay away from coffee shops & snack bars when shopping
- Spend more time outdoors, exercising
- Only go shopping when you are feeling OK and not hungry
- Choose a non-food reward for not smoking
- Eat small, healthy meals
- Plan a range of healthy snacks to make dieting easier
- Have 3 meals a day
- Always eat breakfast
- Eat fresh fruit and veggies to give your taste buds a lift
- Try chewing gum or cinnamon sticks instead of lollies or biscuit

Figure 8.2 Dealing with worries about weight gain

Foreshadow treatment termination (Adapted from Monti, Abrams, Kadden & Cooney, 1989).

The therapist should at this point foreshadow the cessation of sessions following the next 2 weeks. Notice the client's reaction at this point, e.g. discouragement, pessimism, greater reports of problems, etc. Terminating the therapist/client relationship may result in a certain level of emotional distress to the client and may in turn find expression through generalised negative feelings. Therefore, help the client understand the process of termination to help them cope more effectively.

Homework

- If the client is offered substances throughout the week, encourage him/her to use the refusal skills discussed this session. The client may want to practice role playing these skills with a support person (if appropriate).
- If the client has concerns about weight, encourage him/her to work through the weight gain handout.
- If you do not cover the information set out for this session, set the tasks for homework (if this is appropriate) and discuss at the beginning of the following session.
- Complete the Therapist Checklist.

Therapist Checklist Adapted from NIDA (1989)

Client ID: _____

Date of Session: _____

Site: _____

Therapist: _____

Session Number: _____

Please complete the following based on this session:

1. What topic was covered this week?

- | | |
|--|--|
| <input type="checkbox"/> Motivational Interviewing | <input type="checkbox"/> Problem Solving |
| <input type="checkbox"/> Motivational Enhancement | <input type="checkbox"/> Managing Unhelpful Thoughts |
| <input type="checkbox"/> Decisional Balance | <input type="checkbox"/> Coping with Cravings |
| <input type="checkbox"/> Mood Monitoring | <input type="checkbox"/> Drink/Drug Refusal Skills |
| <input type="checkbox"/> Thought Monitoring | <input type="checkbox"/> Planning for Emergencies |
| <input type="checkbox"/> Activity Scheduling | <input type="checkbox"/> Coping with a Lapse |
| <input type="checkbox"/> Introduction to CBT | <input type="checkbox"/> Relapse Prevention |
| <input type="checkbox"/> High Risk Situations | |

2. Did your client complete the homework set from last session?

3. How much time did you spend on each of the aims of this session?

(Record in approximate minutes)

- **Review the Previous Week** _____minutes
- **Setting the Agenda** _____minutes
- **Reviewing Homework Tasks** *(tick the relevant homework set for last session):*
 - Refusal Skills: _____minutes
 - Lifestyle Issues: _____minutes

4. Record any deviations from the manual for this session and/or additional comments:

Figure 8.3 Therapist Checklist – Session 8

SESSION 9 – RELAPSE PREVENTION

Therapist Summary Sheet

Aims:

1. Develop client's awareness of the notion of relapse prevention that incorporates psychosis, medication and substance use
2. Discuss the role of relapse prevention
3. Identify a relapse signature

Materials needed for Session 9

- *Handout:* The Relapse Management Plan

Main areas to be covered:

- Review of the week and homework. Set agenda
- Relapse Prevention
- Steps in Developing a Relapse Prevention plan
- Exercise: The Relapse Prevention Plan
- Homework
 - Complete Relapse Prevention Plan
- Therapist Checklist

SESSION 9: RELAPSE PREVENTION

Review of the week and homework exercise

Start with an informal discussion about general activities, and also determine whether there are any important issues that have arisen or any questions so far.

Review the homework activity with the client. Review patterns of AOD use and symptoms throughout the week.

Set the agenda for the session by explaining to the client the issues that will be covered.

Relapse Prevention

Once clients have learned the skills and behaviours to help alleviate their symptoms and their use of AODs, they are ready to begin preparing for life after therapy where they must manage on their own. Relapse Prevention is concerned with anticipating situations in the future that pose risks to the client in terms of relapsing into psychosis and AOD use. This session can be a way of increasing the client's self-efficacy about how they will cope in high-risk situations, perhaps circumventing a relapse in the process (Wilson, 1992).

At this stage, both you and the client have the benefit of hindsight to assist you in collaboratively preparing for future high-risk situations. That is, you know how the client has responded to the different skills/techniques taught in previous sessions, as well as how they relate events, thoughts and behaviours. In addition, the client has hopefully incorporated some of the skills/techniques into their coping strategies, and will have a greater understanding of their problem (Wilson, 1992).

You will have already discussed, in general terms, the course of events that led a client to relapse in the past. It is now time to work out an individualised relapse prevention plan with the client that deals with situations in the future that are associated with relapse. Once you have identified the chain of events that contribute to the client's acute episode or problematic pattern of AOD use, you will find that this chain of events then forms the basis for the development of a relapse prevention plan.

Relapse prevention is a plan of action that enables the client to self-manage his/her psychotic symptoms, or substance use by replacing his/her beliefs with more realistic beliefs, and by learning new coping skills and making lifestyle changes. A relapse prevention plan should address the cognitive, behavioural and social factors that have maintained your clients' problem.

Steps in developing a relapse management plan

There are some key elements that make up a relapse prevention plan, which include (adapted from Kay-Lambkin, Hazell & Waring, 2000):

1. *Anticipating difficult situations* – Often the client may not be able to think about potentially threatening situations. Recognising these situations as early warning signs may raise the client's awareness that s/he is thinking or behaving in unhelpful ways. Useful questions include: *What situations do you consider to be high-risk for relapse? How will you know when a lapse occurs? Who can help you maintain the skills you have learnt?*
2. *Regulating thoughts and feelings* – It is important to explain to the client that it is normal for him/her to lapse and that it is common when attempting to reduce substance use/change unhelpful thoughts. Reassure the client that these thoughts/feelings are temporary responses to situations that s/he can modify and learn from. Useful questions include: *What might be an unreasonable thought or feeling in response to a lapse? What can I do to deal more effectively in this situation?*
3. *Diagnosing necessary support skills* – Emphasise that the client takes stock of everything they discussed and practiced in therapy. This is a good opportunity for you to ask the client whether there are any additional skills they think they may need. When discussing relapse prevention, it is important that the client considers involving a support person. This will ensure two things: that the client has shared his/her decision to make a positive change (this will provide an additional incentive to maintain the changes achieved) and that the client can receive support from someone who s/he knows well and will find supportive to prevent/better manage relapses. An important goal when others are involved is to promote a shared understanding of the relapse process with all those involved. This will allow you to discuss possible strategies that will help avoid relapse with a particular emphasis on social support and positive support for change.
4. *Regulating Consequences* – Point out to the client that s/he needs to create their own reward. It is unlikely that the client will receive any accolades for maintaining high levels of functioning from anyone other than from himself or herself. Useful questions include: *How will you know that you are successful in maintaining your behaviour/thoughts? How can you reward yourself for a job well done?*

Once these concepts are clear you will have conveyed the message that lapses and relapses can be prevented. Foster a positive orientation towards the person with the problem and minimise attitudes that may foster a feeling of failure or criticism if the client does indeed lapse/relapse.

The Relapse Management Plan

Developing a relapse management plan in anticipation of problematic situations and feelings in the future is an important part of teaching your client to look after him or herself. In addition, the following steps will be useful when you are identifying the client's own situational/internal triggers:

1. If not previously known from the treatment sessions, introduce the client to examples of early warning signs of relapse
2. Ask the client to review the most recent episode when s/he experienced a relapse or was admitted to hospital

3. Identify any noticeable changes in perceptions, thoughts, feelings and behaviours, using the examples of early warning signs of relapse as a prompt
4. Identify any particular stressful events or factors that may have triggered these changes. Prompt the client by using open-ended questions, about any stressful or unusual events, worries or concerns s/he may have had around that time
5. Identify from your discussion the chain of external events and internal events (i.e. relapse signature) that preceded the relapse
6. Find out if this is the general chain of events leading up to him/her becoming unwell. You can do this by asking about another recent occasion and the first time s/he became unwell. Repeat steps 2, 3 and 4 for these two episodes to pick up if there is usually a similar pattern/chain of events
7. Explore the role of AOD use within the client's relapse signature, by identifying the points along the chain of events at which s/he used AODs. You can do this by asking the client directly whether s/he used during this episode and at which points s/he used
8. Identify the client's pattern of use by asking what s/he used, amount: how much s/he used, frequency: how often s/he used, where did s/he use and who s/he used with
9. It is also important to identify the reasons why the client used AODs at each point and what were his/her beliefs about using the substance (e.g. was it to increase pleasure, to socialise, to cope?)
10. Explore the role of medication adherence within the relapse signature, by identifying the points along the chain of events at which the client was taking his/her medication as prescribed or not. You can do this by asking the client directly whether s/he was taking his/her medication during this episode and at which points s/he was not
11. Identify the client's pattern of medication adherence at each point along the chain by asking; what medication s/he taking, Dosage: how much was s/he taking, Frequency: how often was s/he taking it
12. It is also important to identify the beliefs the client holds about his/her medication, and the reasons why s/he did or did not take his/her medication at each point in the relapse signature

Exercise: The Relapse Management Plan (Segal et al., 2002; Graham, 2000)

- Take out the “Relapse Management Plan” (Figure 9.1) and complete each section within the session. These sections include: identifying support people (including contact details), high-risk situations for lapses, warning signs and plans of action, and rewards.
- Ask the client to keep this plan close to hand so that it can be easily referred to in the future.

Homework

- Review the *Handout*: Relapse Management Plan completed in session

I will reward myself for acting on these early warning signs by:

My high risk situations for a relapse are:

Coping strategies I can use include:

I will reward myself by:

Psychologist: _____

Case Manager: _____

General Practitioner: _____

Mental Health Team: _____

Support Person: _____

Figure 9.1 Relapse Management Plan



Centre for Mental Health Studies

The Health Sketch Project



RELAPSE AN

Name: _____

If I notice these early warning signs I will (Segal et al., 2002)

1. Switch off my automatic pilot and ask myself *“How is my mood and my thoughts affecting my body?”*
2. Remind myself that the feelings and thoughts I am experiencing now just events of the mind. They are no more, they are not facts and do not mean I am back to square one.
3. Take some action:
 - Look for the Unhelpful automatic thoughts I am using
 - Manage unhelpful automatic thoughts
 - Think about Seemingly Irrelevant Decisions
 - Do some problem solving
 - Look at my Emergency Plan and Coping with Cravings strategies
 - Choose some enjoyment and achievement activities from my list and schedule them into each day using my activity record
 - Refusal skills
 - Use my support person:
 - _____
 - _____
 - _____
 - _____

My early warning signs of relapse are:

(e.g. medication, thinking, activity level, alcohol/drugs, etc..)

Action: _____

Plan: _____

My late warning signs of lapse are

(e.g. medication, thinking, activity level, drug/alcohol, etc....)

Action: _____

Plan: _____

Therapist Checklist Adapted from NIDA (1989)

Client ID: _____

Date of Session: _____

Site: _____

Therapist: _____

Session Number: _____

Please complete the following based on this session:

1. What topic was covered this week?

- | | |
|--|--|
| <input type="checkbox"/> Motivational Interviewing | <input type="checkbox"/> Problem Solving |
| <input type="checkbox"/> Motivational Enhancement | <input type="checkbox"/> Managing Unhelpful Thoughts |
| <input type="checkbox"/> Decisional Balance | <input type="checkbox"/> Coping with Cravings |
| <input type="checkbox"/> Mood Monitoring | <input type="checkbox"/> Drink/Drug Refusal Skills |
| <input type="checkbox"/> Thought Monitoring | <input type="checkbox"/> Planning for Emergencies |
| <input type="checkbox"/> Activity Scheduling | <input type="checkbox"/> Coping with a Lapse |
| <input type="checkbox"/> Introduction to CBT | <input type="checkbox"/> Relapse Prevention |
| <input type="checkbox"/> High Risk Situations | |

2. Did your client complete the homework set from last session?

- No attempt made
- Some attempt made
- Practice exercise completed adequately
- Not applicable; not assigned

3. How much time did you spend on each of the aims of this session?

(Record in approximate minutes)

- **Review the Previous Week** _____minutes
- **Setting the Agenda** _____minutes
- **Reviewing Homework Tasks** *(tick the relevant homework set for last session):*
 - Relapse Management Plan: _____minutes

4. Record any deviations from the manual for this session and/or additional comments:

Figure 9.2 Therapist Checklist – Session 9

SESSION 10 – RELAPSE PREVENTION

Therapist Summary Sheet

Aims:

1. Develop client's awareness of the notion of relapse prevention that incorporates psychosis, medication and substance use
2. Discuss the role of relapse prevention
3. Identify a relapse signature
4. Termination of treatment

Materials needed for Session 10

- *Handout:* Relapse Preparation Sheet

Main areas to be covered:

- Review of the week and homework, particularly the rationale for Relapse Prevention. Set agenda
- Identification of High Risk Situations: Exercise
- Preparation for High Risk Situations: Exercise
- Regulate the Consequences: Exercise
- Using the Relapse Prevention plan
- Termination
- Appointment for Follow-Up
- Therapist Checklist

SESSION 10: RELAPSE PREVENTION

Review of the week and homework exercise

Start with an informal discussion about general activities, and also determine whether there are any important issues that have arisen, any questions so far.

Review the homework activity with the client in session 9. Re-cap that rationale for Relapse Prevention as in session 9.

Set the agenda for the session by explaining to the client the issues that will be covered.

Identification of High-Risk Situations

It is inevitable that negative events will occur in the client's life that poses threats to not using or remaining symptom free. A vital first step in preventing relapse is to identify those high risk situations in advance and allow the client time to prepare how they will deal with them when they occur. Take time in the session to revisit the self-monitoring record the client completed previously as a guide to the types of situations that have posed problems for them in the past. In addition, probe for life events the client can anticipate posing difficulties for them, for example, loss events (social, financial, failure, loss of status).

Exercise: Identify/anticipate high risk situations (Wilson, 1992)

- Ask the client to brainstorm high-risk situations or changes that they can anticipate in the future (e.g. adjustment to new situations, financial changes, and social separation).
- Use the following questions to assist the client generate the list: *What kinds of people/places/things will make it difficult for you to stay on top of things/feel good about yourself? What situations do you consider to be high risk for relapsing? How will you know when a slip occurs?*
- Write these situations down on paper and give it to the client once completed.

Preparation for high-risk situations

In preparing for the high-risk situations that will inevitably occur, it is useful for the client to take stock of everything s/he has learned during the therapy. This will also help the client to generalise the lessons learned in therapy to real life situations. Up until now, the relapse prevention sessions will have focused on recognition skills (Wilson, 1992) that is, learning to identify which situations are high risk for the person. The next step is to reinforce how best to respond to that event by selecting an appropriate strategy in order to cope.

Documenting which strategies are most useful in dealing with specific high-risk situations can also be useful, and can serve as a reference for the client at a later stage.

At this point it is also important to ask the client: *Who can help you to maintain these skills you have learned? Are there any additional skills you think you need so you can maintain your current level of use and level of coping?*

There will be some situations that cannot be predicted. Therefore, generate some general strategies for dealing with adverse events.

Exercise: Preparing for High Risk Situations (Wilson, 1992)

- Look at the list made in the previous activity that will detail the client’s anticipated high-risk situations.
- Ask the client to reflect on all the different skills s/he have learned during the therapy sessions, and nominate which ones are appropriate to use in each of the high-risk situations. Examples may include: drink/drug refusal, problem solving, coping with cravings, challenging unhelpful thoughts, increasing pleasant/achievement activities, medication adherence, etc. write these high-risk situations and coping strategies on the “Relapse Preparation Sheet” Sheet (Figure 10.1).
- Explain to the client that not all situations can be anticipated in advance. Therefore it is useful to think about some generic coping strategies that the client can employ regardless of the situation.
- Also ask the client whether there are any additional skills they think they may need to assist them in future situations. Discuss options for referral with the client to ensure s/he receives the necessary intervention.

Regulate the consequences

Finally, discuss how the client intends to reward him/herself for staying well. It is important for clients to create their own rewards as reinforcement for their behaviour, as this may not always come from other sources (e.g. family, friends).

It is useful to refer back to the list of pleasurable activities the client created during session 7 and revisit what it is that the client enjoys doing. By planning time for these activities the client can learn to regulate the consequences of their behaviour/thoughts for themselves.

Exercise: Regulate consequences (Wilson, 1992).

- Refer back to your previous discussions in High Risk Situations.
- Ask the client the following questions: *How will you know that you are successfully maintaining your behaviours? How can you reward yourself for a job well done?* In addition, refer back to the client’s Activity List created during session 7 for ideas as to what the client enjoys doing.
- Write these “rewards” down on the “Relapse Preparation Sheet” (Figure 10.1) handout and discuss more central coping strategies the client could use as well as any additional skills s/he requires.

Using the relapse prevention plan

Now that you have collaboratively worked out a relapse prevention plan for high-risk situations with the client, you need to ensure the client uses his/her plan effectively. To do this, Graham et al. (2000) suggests you talk with the client about the following things:

- *When to use his/her plan*
- *Regularly monitoring their early warning signs*
- *Refining and updating the plan as necessary (i.e. coping strategies, forms of intervention and supports) and as circumstances change*

If necessary, document this information on the “Relapse Management Plan” handout provided in session 9.

Termination

Formal termination should be acknowledged and discussed at the end of session 10. Recapitulate the client's progress and situation through the sessions and include:

- Reconfirmation of the most important factors motivating the client
- Summarise the commitments and changes made so far
- Affirm and reinforce changes already made
- Explore additional areas of change
- Elicit self-motivational statements for maintenance of change and further change
- Support self-efficacy
- Deal with any special problems
- Remind the client about continuing follow-up sessions

Appointment for Follow-Up

At the completion of session 10, make an appointment time for the post-treatment assessment. This should in fact be 1-2 weeks following the completion of this last session. Further follow-up sessions should then be scheduled.

Relapse Preparation Sheet

Anticipated High-Risk Situation	Coping Strategies	Reward

General Coping Strategies for any situation:

Additional Skills Required:

Figure 10.1 Relapse Preparation Sheet

Therapist Checklist Adapted from NIDA (1989)

Client ID: _____

Date of Session: _____

Site: _____

Therapist: _____

Session Number: _____

Please complete the following based on this session:

1. What topic was covered this week?

- | | |
|--|--|
| <input type="checkbox"/> Motivational Interviewing | <input type="checkbox"/> Problem Solving |
| <input type="checkbox"/> Motivational Enhancement | <input type="checkbox"/> Managing Unhelpful Thoughts |
| <input type="checkbox"/> Decisional Balance | <input type="checkbox"/> Coping with Cravings |
| <input type="checkbox"/> Mood Monitoring | <input type="checkbox"/> Drink/Drug Refusal Skills |
| <input type="checkbox"/> Thought Monitoring | <input type="checkbox"/> Planning for Emergencies |
| <input type="checkbox"/> Activity Scheduling | <input type="checkbox"/> Coping with a Lapse |
| <input type="checkbox"/> Introduction to CBT | <input type="checkbox"/> Relapse Prevention |
| <input type="checkbox"/> High Risk Situations | |

2. Did your client complete the homework set from last session?

- No attempt made
- Some attempt made
- Practice exercise completed adequately
- Not applicable; not assigned

3. How much time did you spend on each of the aims of this session?

(Record in approximate minutes)

- Review the Previous Week: _____minutes
- Setting the Agenda: _____minutes
- Reviewing Homework Tasks (*tick the relevant homework set for last session*):
 - Relapse Prevention: _____minutes
 - Relapse Management Plan: _____minutes

4. Record any deviations from the manual for this session and/or additional comments:

Figure 10.2 Therapist Checklist – Session 10

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