CBT & MI - Marienfeld

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This presentation is entitled Patient Interventions: Cognitive Behavioral Therapy and Motivational Interviewing. I will now pass it over to Dr. Carla Marienfeld to begin our presentation

00:13

Hi, my name is Carla Marienfeld. I am an addiction psychiatrist and Clinical Professor of Psychiatry at the University of California, San Diego. I'm going to be talking today about various behavioral interventions that we can use in addiction treatment, including cognitive behavioral therapy and motivational interviewing. I have a financial disclosure, I'm a consultant and I have stock options with CARI Therapeutics.

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Today, we're gonna go through some of the basic principles of common behavioral health interventions, and talk a little bit about their applications to addiction treatment.

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We'll begin with a polling question. So please use your polling feature to answer the following question. Which of the following terms best describes the spirit of motivational interviewing? A- palliation, B- acceptance, C- comparison, D- evolution? And please answer using your polling feature to the question. Which of the following terms is used to describe the spirit of motivational interviewing? A- palliation? B- acceptance, C- comparison, or D evolution?

01:25

Okay. So the correct answer is B- acceptance. And we'll talk a little bit about what we mean by the spirit of motivational interviewing, and the mnemonic we can use to remember it, and what the key components are in just a moment.

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So what is motivational interviewing about? Motivational interviewing, which we sometimes refer to as MI, not myocardial infarction, motivational interviewing is not really an interview. That's kind of an older term, harking back to this idea of the medical interview. But motivational interviewing is an approach that we have for arranging conversations, so that people talk themselves into change based on their values and interests. So we serve in the role of arranging the conversation, facilitating the conversation, such that it makes sense for the person to share their values and interests, and try to make decisions and plans based on what's important for them.

02:23

There's a range of different styles that we can have when we talk to patients. So we can think of the classic medical model style that's very directive or a directing style, you know, "I teach you what you need to know, I assess the situation, make the diagnosis, I prescribe the treatment, I lead the way" right? So that's that sort of classic directive, medical model style. Another style of approaching interactions with patients is a very empathic style. We call it more of a following style. "I listen to what you're saying, I understand, I communicate that..." it can be a really helpful, useful thing in many ways. But fundamentally, you're going along with what the person is saying, you aren't contributing much. In motivational interviewing, we advocate for more of what's called a guiding style. And if you think about a good guide, their job is to really draw you out. They're not there to like push you up that mountain, right? Or pull you up the mountain. They're there to help you figure out how you can get to the top of that mountain. They encourage you, they motivate you, they help you be successful. And so that's a way of thinking about how we approach patients when we're approaching it through a motivational interviewing lens.

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I mentioned in the question earlier, the spirit of motivational interviewing, and this is really what we want to communicate. This fundamentally underlies all of what we do when we're doing motivational interviewing. And we want to have an emphasis on this spirit as opposed to any one particular technique or skill in motivational interviewing. There's a pneumonic called PACE, which stands for Partnership, Acceptance, Compassion, and Evocation. In motivational interviewing, we're partners, we're in this together, we want you to be successful. We accept where the person is at, we communicate that non-judgmental stance, meeting them where they're at. It comes from a place of compassion, fundamentally and wanting the person to be better, do better.

04:17

There's some ethical considerations in that compassion as well. And then evocation, it really should come from the patient. Our job, again, is to facilitate that conversation and not put words in the patient's mouth, but help them come up with their own words for what they want and where they want to go.

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When we think about communicating the spirit of MI, we can think about it as changing from a more adversarial sort of wrestling relationship where you're kind of pushing back and forth, not gaining much ground, to one more of like a dancing style, where if you think about dancing, the partner, the leader in the dance, sort of creates the space and the other person naturally moves into that space. And the other idea behind dancing in this analogy is that you're moving together towards a common goal.

05:09

Our second review question: Which of the following four processes are part of motivational interviewing? Which of the following four processes are part of motivational interviewing? Please use- use your polling feature to answer: A- engaging patients in the process, B- fantasizing about a better future for yourself, C- eliciting change talk from the patient, or D- perseverating on the change the patient wishes to make for themselves. So again, which of the following is a one of the four processes that we talk about when we talk about the processes of motivational interviewing: A- engaging, B- fantasizing, C- eliciting or D- perserverating?

05:54

So actually, we have the four processes, which involves engagement, which is foundational, so answer A. So the four processes are: engaging the patient, focusing, evoking and planning. So it's a little bit of a trick question there. Because eliciting and evoking are very similar. But technically speaking, these are the the four processes. So if you use the idea of taking a walk together as an analogy, I think of the four processes as a way of helping me figure out what am I doing right now? So if we think about going for a walk, well, first, we have to engage the person, right? Shall we walk together? Are they even gonna walk with you? We have to focus. Where are we going? Are we going to walk around in circles? Are we going to walk down to the pond?

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Evoking: Why are we going on this walk? You know, are we going there because it's a nice day out? So we can have a nice conversation? To get some exercise? And then planning: How will we get there? You know, are we going to go on the sidewalk? Are we going to walk across the field? So it's a little bit of a way of thinking about what am I doing in the moment to accomplish this goal together.

07:11

In addition to the four processes, there's some core skills that we talk about motivational interviewing, and these are foundational to not just motivational interviewing, but all types of counseling and therapy really use a lot of these things. We use open questions, questions that can't be answered by a single word, that invite the person to reflect. We use affirmations, which are a little different than praise. Affirmations are where you identify a character trait or a behavior choice of somebody that we want to affirm, point out, support.

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We use a lot of reflections. So when in doubt in motivational interviewing, reflect. Reflections come in a couple of different flavors, they can be simple or complex. Reflections are, by definition, a statement, not a question. And the goal is to keep the conversation going forward. We selectively reflect the things that we want to highlight or reinforce, or continue the conversation in that direction. And so that's really where the skill is, in motivational interviewing, is learning how to selectively reflect things.

08:16

We provide summaries, which are like sort of mega reflections, kind of picking all of the good things we heard that we want to affirm and reinforce and reflect back in one sort of summary. And then we are able to inform people of things, right. So we have a lot of medical knowledge, that may be important. And maybe the person already knows it. And so we want to know that. But maybe there's some gaps that would be helpful for them to know. So we can provide information, and we can advise people. But in motivational interviewing, we want to do so in a way that makes it most likely that they're able to hear it and receive it and use it. And so we do so with permission. There's various techniques like elicit-provide-elicit or ask-tell-ask. So we have some ways of providing information again, that makes it more likely that the person will be able to hear it.

09:07

An example of reflective listening. So for example, if the patient says to you "Right now, drinking doesn't help me feel better the way it used to. In fact, I feel worse now." You could do a simple reflection- just echoing it back. "Drinking makes you feel worse now." They might say, "Yeah, you know, it used to be fun..." the goal of the reflection is to highlight again, the change and keep the conversation going. Just like we would have a normal conversation where we make statements back and forth.

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You could rephrase it and say "So you find that drinking is no longer helping you feel better the way it used to." You could do what we call a double sided reflection: "In the past, drinking helps you feel better. Now it makes matters worse." Or a continuation. If they say "Right now drinking doesn't help me feel better the way it used to. In fact, I feel worse now." "And you want to find some way to feel better. Instead of drinking, right?" So that's a more complex reflection. It's not exactly contained in the person what the person is saying that it sort of gets you there eventually.

10:11

In motivational interviewing, we talk about something called change talk, and we listen for change talk. And part of facilitating change is to elicit as much change talk as possible. Change talk is when a person starts arguing on behalf of that change. The more they start arguing on behalf of it, the more they become committed to doing it. We talk ourselves into or out of things all the time.

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Sustained talk on the other hand, in contrast, is sort of the opposite of that. It's reasons to not change or to stay the same. And the more of that, that you're hearing in the conversation, the more likely it is that the person is going to just keep doing what they are already doing.

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When we listen for a change talk, it comes in some different types of ways that we might listen for it. So there's a pneumonic called the DARN CAT, where we listen for Desire: "I want to. I'd like to. I wish I could stop this."

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Ability: "I can. I could. I'm able to make this change."

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Reasons: "You know, is there a reason I need to do it?"

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Needs: sometimes needs and reasons are similar, "Need to. Have. Must." So we listen for this kind of language and these kinds of phrases. And when we hear them, we want to reflect them back. So just like reflections come in two flavors, change talk can as well. We talk about the DARN or preparatory change, talk somebody who's preparing to make a change.

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And then we talk about mobilizing change talk, which is the CAT part of the DARN CAT. So that includes language around commitment, activation and taking steps.

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So somebody is willing to do it, intending to, going to... Activation: Ready to... Taking steps: actually has already started preparing to or even made the first few steps. When you hear this mobilizing change talk, somebody who's actually sort of going through with this, it's much more likely that they're going to follow through on it.

12:08

There's a form of motivational interviewing called motivational enhancement therapy, that really was a manualized version that was developed to be studied a little bit more easily than than just sort of

the generic general approach of motivational interviewing. So this is more of a systematic intervention. Originally, it was appropriate for sort of problem drinkers based on the principles of motivational psychology. And the manual for this is available. It's a four session protocol, which is great for sort of shorter term therapeutic relationships, but where you have the ability to meet a couple of times, as you can get that manual there.

12:53

Alright, so switching gears from talking about motivational interviewing, we're gonna transition with a question. Please use your polling feature. Which of the following are part of Marlatt and Gordon's 1985 model of Relapse Prevention, using Cognitive Behavioral Therapy adapted for the treatment of substance use disorders? Okay, so we're talking about Relapse Prevention, which is a modified form of CBT- Cognitive Behavioral Therapy.

13:20

Is the answer A- eliciting change talk from the patient? B- earning vouchers for negative urine drug screens?, C- targeting cognitive, affective and situational triggers for substance use? Or D- conducting a moral inventory? So go ahead and put your answer in using your polling feature. And the answer is C, targeting cognitive, affective and situational triggers for substance use.

13:49

Eliciting change talk is more of a motivational interviewing concept that we just mentioned. Earning vouchers or contingencies, is, or earning rewards, is part of contingency management. And so that might might be seeing that there. Conducting a moral inventory, not really related to cognitive behavioral therapy, although there's some overlap and ways of combining like mutual help groups and other things like that as therapies together.

14:24

So switching gears, we'll talk a little bit about cognitive behavioral therapy and some models sort of derived from that. These are among the most extensively studied evaluations for substance use disorders. There's a number of different variations based on substance type and different types of approaches. One thing that was sort of revolutionary in adapting cognitive behavioral therapy, from its origins, really focusing more on depression, and then anxiety was this model of relapse prevention. And the idea is that you target the cognitive, right? So it's the cognitive behavioral part, cognitive part of the thinking, the affective- of how you feel- and situational triggers, right? So we have cognitive triggers, we have affective triggers- how we're feeling... We have situations, right? So... all of these different triggers. And then we provide skills training specific to coping alternatives. So when you hear about coping skills, that's a red flag that we're talking probably about something founded in CBT.

15:22

So CBT says substance use is reinforcing. This interacts with our psychological or behavioral coping deficits, right, we don't have necessarily the greatest coping skills, and that this leads to an increase in substance use. It sort of maladaptively reinforces it. Substance use develops when a pattern is repeated, and the solution is changing what we do. So we can change our thoughts. How we change our thoughts affects how we feel. When we feel differently, our behaviors change, right?

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And so it's looking at how do we identify this relationship and intervene where we can intervene. It also deals with what they call expectancies or cognitions. Typically, in a CBT treatment, there's a couple of stages, including building rapport and alliance, preparing for the change. There's various CBT-specific strategies that were discussed and taught. And then there's a phase of our stage of treatment, maintaining the change, and then terminating the treatment.

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So some of the core elements when we talk about in CBT, for substance use disorders include recognition, right, so we recognize triggers and cues. And these can be internal and external. We anticipate and avoid things particularly high risk situations. These are the people places and things kinds of things. We cope when we can't avoid these things. That includes skills for relaxing, dealing with stress, tolerating dysphoria. And we connect- there are options for support socializing, fun, development of meaning, right, so these are some of the core elements that are addressed.

17:06

So some of the basic treatment components, including the identification of high risk situations that I mentioned, development of coping skills, development of new lifestyles, behaviors. Right? So this is an intentional thing to find new behaviors, settings, situations, routines, and habits that are non substance using and decrease the need for and the role of substance use. And over time, the idea is to develop a better sense of self efficacy, that you have some ability to impact how you think and what you do, and that you can develop skills to do that. So you build on small successes and coping and positive choices, that over time you learn that you can be proactive and empowered and making your own choices. And so developing that sense of self efficacy.

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Some other basic treatment components include communication skills, so practicing drug refusal, or alcohol refusal skills, asking for help, which is sometimes a big challenge for a lot of folks. We also prepare for lapses in CBT. So recognizing that that's sometimes the natural history of having a substance use disorder, and changing from viewing this as a failure to viewing this as an opportunity to learn. So we can learn some different things from lapses, we can prevent the lapse from becoming a full on sort of relapse, where you return to sort of that full pattern of problems that you had before. Identify and manage patterns of thinking that can increase your risk for lapse, dealing with a relapse or a lapse, that it can't be cato- That doesn't have to be catastrophic, again, reframing it as a learning opportunity. And then if it does happen, try to minimize the negative consequences. So again, minimizing it from becoming that full relapse.

19:03

So switching gears, we'll talk a little bit about CRA and CRAFT. CRA stands for the Community Reinforcement Approach. This is really intended for the person specifically struggling with a substance use disorder. In the context of alcohol, there's this belief that the person who's using the substance, they have a community in which they live, their family, their social interactions, their colleagues and coworkers, and that community can play a critical role in supporting or discouraging use. So consequently, the environment needs to be restructured such that a sober lifestyle is more rewarding or reinforcing than a using lifestyle. Right. And so we use our community to help intentionally create these rewarding aspects, reinforcing aspects to make a sober lifestyle more rewarding.

20:01

The community reinforcement and family therapy approach is really an outgrowth of this that's designed to help the family members, or the community or significant others, they sometimes designate them as, having skills, and how do you create this more rewarding lifestyle. And so it's a method of working with con- concerned family members in order to get into treatment, or helping the person get into treatment or helping them create things in their environment.

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The idea behind this is based on operant conditioning, this idea of substance use as a learned behavior, and trying again, to make natural contingencies already operating the individual's natural environment to help support change in absence, right, so getting praise or withholding praise for negative behaviors giving praise for positive behaviors. So they talk a lot about natural consequences here, and letting the natural consequences or sometimes negative consequences influence things, and then trying to reward some of the positive choices.

21:08

You look through this and do a functional analysis of both healthy and substance use behaviors, in terms of their ability to be rewarding or aversive. We do more of a refined problem solving and goal setting efforts for both the individual and or the family in the case of CRAFT. So this can be positive communication skills, contracting skills. So there's some skill building and goal setting types of activities with this as well.

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We think about CRAFT. This is from the founder. It's a scientifically based intervention designed to help concerned significant others or CSOs to engage treatment-refusing people with substance use disorders into treatment. And the goal is for treatment engagement, it's more of a positive approach, in contrast to some previous approaches that were more confrontational, it's culturally sensitive, it's

been shown to be helpful and adaptable in various different cultural situations with various mores and beliefs. Really, the idea is to again, teach the concerned significant others to use positive rewards and reinforcers strategically and to suffer natural consequences of the using behavior.

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Acceptance and Commitment Therapy, this is, has also been sort of adapted and has increasing prominence in the treatment of substance use disorder after initially being implemented in other situations and other processes. And so we're seeing more and more evidence of its approach in substance use disorders. Acceptance and Commitment Therapy has a little bit more of an extensive theoretical underpinning, there's something called the Six Core Processes. These include acceptance, cognitive diffusion, being present, self as context, values, and committed action. So if you look at these, there's sort of a diagram of how these things interrelate, and how all of these things come together.

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So you kind of go through this manualized process of looking at these six core processes, and use them in helping patients consider how their substance use disconnects them from their values, right? And this is not totally dissimilar from motivational interviewing, right, where we're trying to figure out what their values are, and use that to determine what are the behaviors that help them get towards that. So an example of ACT, of ACT would be comparing your "sober values" things that are important to you based on not using to "using values", what becomes important to you in that context, and trying to reconnect base to your underlying values.

23:57

Another approach is Dialectical Behavioral Therapy that has been adapted to really focus on substance use disorders, after initially really being developed more around personality disorders and other things. Dialectical Behavior Therapy is also manual driven. It also uses validation and motivational enhancement techniques. Often this is a little bit more extensive and combining sort of group and individual elements. And there are sort of four basic capabilities when we talk about Dialectical Behavioral Therapy. And these are the things we want to support, build skills around and improve, for people to be able to use these things better. It includes interpersonal effectiveness, right? So if you're going to put your energy towards something, doing so in an effective way. Emotional and self-regulation capacities, so this can include things like distress tolerance, and other things that you can do to improve your capacity to manage your self regulation and emotions. Ability to tolerate distress, and mindfulness.

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So we have these four basic capabilities from the founders of DBT. The idea is that when a patient learns to envision, articulate, pursue and sustain goals that are independent of his or her out-of-control behavior, including substance use, and better able to grapple with life's ordinary problems, right, so the idea is this therapy helps you manage yourself in a lot of different ways. It also talks about processes, the core processes of DBT include change and acceptance. There is an emphasis on

abstinence as the goal of- of treatment, as opposed to some other harm reduction approaches that might have a slightly different approach. There's change. So the idea is for both an immediate and permanent cessation of drug use or alcohol use. There is an acceptance part of it that relapses can and likely will occur and should they occur, it doesn't mean that the person or the therapist can't achieve the desired result. There are some key skills that they practice and work on including things like coping ahead, that's kind of like planning ahead to cope. Failing well, right? So this idea that I might fail- are there ways that I can fail to minimize risk? There's sort of this concept in DBT of the "wise mind." And so it's been adapted, for example, in substance use disorder to change from an addict mind, an addicted mind to more of a clean mind, which is akin to the wise mind in DBT.

26:48

So briefly, just mentioning treatment of co-occurring psychiatric disorders, with behavioral interventions. So in general, it's just as a reminder, concurrent treatment is often best, you might need to stabilize the person from any sort of acute medical risks of withdrawal or intoxication from their substance use. But in general, whether using medication or behavioral approaches, concurrent treatment of psychiatric disorders is best. When we're looking specifically at that PTSD, which is most commonly treated with with therapies as opposed to medications, we can see that there are a number of treatment options that can be employed that can help address substance use as well, including cognitive processing therapy, EMDR, prolonged exposure therapy. And there are some studies looking at concurrent treatment of PTSD and substance use, co-occurring substance use disorders, using for example, prolonged exposure therapy as an option. And so there's some evidence not only from the medication side, but also the behavioral therapy side that we can treat both.

28:00

So in summary, there are many effective evidence based psychotherapy techniques, we can use these in a lot of different settings. So some of them can be very manualized and driven. Others can be just a general approach or talking about patients and can be helpful to have little pointers and tips along the way. Motivational interviewing, for example, as a- more of a way of having a conversation- can really be used in any setting at any point in any timeframe. And these treatments really are the core of treatment for addictions. We have excellent medications for opioid use disorder, some medications that can be helpful for alcohol use disorder. However, a lot of the approach to treating substance use disorders is really based still on a lot of these behavioral interventions. And it's important to be familiar with them, and have a sense of comfort in either talking about them and potentially learning some skills around using them.

29:00

Alright, and in closing, here's some information. Thanks for ASAM. I thank you all very much for your attention. And I look forward to continuing to engage the conversation. Thank you.