>> Three, two, one.
This presentation is entitled "Cognitive Behavioral Therapy & Motivational Interviewing."
I will now pass it off to Dr. Carla Marienfeld to begin the next session.
>> Hi, there. Welcome.
My name's Carla Marienfeld.
I'm a clinical professor of psychiatry and the University of California in San Diego.
And this is a presentation that I've adapted from several folks, so some of my own slides, but also, thank you to Drs. Finch, Earley, and Lasswell for some of the contribution of their slides.
And the lecture today is titled "Cognitive Behavioral Therapy & Motivational Interviewing."
And I'll go more in depth in the two of those, but we also talk about other psychosocial interventions that we use a lot in addictions during this talk.
I have no financial disclosures that are relevant for ACCME interests.
The objectives today -- we're gonna describe some of the terminology and approach that we use with Motivational Interviewing.
We're gonna understand the core concepts of Cognitive Behavioral Therapy for substance-use disorders.
And we'll review concepts and the approach of several evidence-based therapies that we use for substance-use disorders.
So, there's number of different models of how we think about addiction, and how we think about addiction influences what we might do to treat it.
In the past, we might think about of addiction being a moral failing, someone conceptualized the person as being weak or bad, or alternatively, and prohibition, the drug itself was considered to be evil. If you eliminate the drug, all the evils would be gone with it.
We have evolved a little bit and now we think often more about psychological or sociological contributions to addiction, we have had various conceptions over time, something called the addictive personality, whether that influences addiction or not, we have thought about learned behaviors, addiction is a learned behavior and it provides certain rewards to the brain despite some of the negative consequences. We think about family and cultural norms and how those things impact addiction, then there is also conceptions of addiction around me brain disease. This was certainly not a new idea but gained a lot of momentum in the 80s and 90s, once our technology cut up with our ability to understand addiction
and we consider among some of the genetic greatest division, chemical changes or structural changes or adaptations that occur with addiction, so there is all kinds of different models

of how we think about it. And again, how we understand some of these different
things does influence the targets for some of
our therapies. Many therapies are provided in group-based settings,
and this is often the modal, the most common format
for substance use disorder therapy because
it is cost-effective, right,
we can see more people at once, it helps to
increase access because you can see more people,
I think one thing that is often underappreciated his peers are a powerful agent
of change and having a good. Cohort is one of the things we
associate with likelihood for success. Certainly,
that is true in some of the mutual health models,
but also another group-based therapies.
Also, we see with groups a better
fidelity to therapeutic modality then we see
in individual therapy which can digressed with chitchat and things like that.
There are several advantages, we see peers trying to model behavior
and show a variety of different coping skills. We
see public affirmations of character traits or behavioral choices,
confessing and sharing your experiences in getting support in the development
of these networks
of support. Individual therapy also has its benefits, it is certainly
more private, there is flexibility to address
issues as they arise, so you don't have to
affect stick to the modality if something big has recently come
up, you can focus on unique individually relevant
issues. It's more practical for some providers, if your air provider, you may
not have a group room or space, and it's appealing
to a lot of patients but particularly certain
avoidant patients, patients with schizophrenia, who have been
traumatized, anxious, etc.,
can struggle more with the idea of groups although in
my opinion, I think that they can do well if they find a supportive
and appropriate . Cohort. So, we will go through
a few of these evidence-based treatments, I will focus on motivational
interviewing and cognitive behavioral therapy, we
will talk about mutual help groups, and eight,
AA, Smart recovery, women for sobriety, etc. pick
many of these, we talk about the community reinforcement
approach and the offshoot of back, community support, craft continuance
management, behavioral couples treatment, acceptance and commitment
therapy, and supportive therapies and some of the last ones will just be
a brief but I want to make sure the names
are at least familiar and you have some
idea of the therapeutic approach.
We will start with the question before we
actually get into the details of the teaching, which of the following terms
is used to describe the spirit of motivational

interviewing. It is it a? Palliation, B, acceptance. C, comparison. Or D, evolution. You have about 15 seconds to answer in the box on the platform and I will read it again. Which of the following terms is used to describe the spirit of motivational interviewing. Palliation, acceptance, comparison, or evolution? Okay, the answer is B, acceptance. Let's talk about motivational interviewing, it is about arranging conversation so people talk themselves into the change based on their own values and interests.

We are the facilitator or arranger of the conversation and we can think about different styles or approaches.

We can think about on one end, a direct classic medical model approach to talking to patients where I teach you something, ISS, I prescribe the treatment, I am the leader. It is very directive pick on the other side, we can think of a following style, listen to what is being said and I understand what is going on and I go along with whatever the patient wants and it's a very following style.

And motivational interviewing style, we advocate for a guiding style, which is where the person acts as a guide, a guide has a direction, they know where they want to get you, they want to get you to the top of the mountain. But they help you to succeed in getting there goodbye driving you out, encouraging you, motivating you, hoping you find the right path, etc. pick much of what underlies motivational interviewing is your general stance towards the patient, or the spirit in which you interact with the patient and there is an emphasis on how you approach rather than on specific techniques although we talk about techniques. There is a pace for the spirit that includes partnership, so we are in this together. We are a partner in trying to help you succeed, radical acceptance of where the patient is at, so they are not trying to make them someplace out they are not. Wanting to be better and wanting them to make positive choices and even location.

To get from the patient, their values and interests, what they think will help them be successful.

We also think of MI as a wrestling approach, the patient wants to make bad choices and I'm trying to push back with all the right choices they should make about their substances tomorrow have a dancing approach, where there is a leader who helps to guide what is going on and the other person goes along together and you come alongside each other.

So, next question, which of the following four processes are a part of motivational interviewing? Again, the answer, you are 15 seconds to answer, is it A, engaging the patient in the process.

That are being, fantasizing about a better future for yourself. C, eliciting
change talk from the patient.
G perseverating on the change the patient wishes
to make for themselves. Okay, take a few moments.
Okay.
We will talk about the four processes in just a
moment. But the first step is engagement, right, so the answer
there is A.
Iraq, so here is our four foundational processes, engagement
, focusing, evoking, and planning.
All right, so we have these four stairs, they seem like stairs,
they are not necessarily steps, they are processes.
It's a way of orienting yourself, where am I, am
I talking to the patient to engage them, am I focusing on what we want
to talk about? What are the patient's values?
What do they think is going to help?
Here are some ideas, here's a summary of what
has happened, let's figure out what we
are going to do. A lot of the core skills use ors. Regardless of the
process,
whether it's engagement or even location, we are asking open ended
questions,
we are affirming character traits or
positive choices, we reflect, when in doubt,
and motivational interviewing, we reflect. This is the bread and butter,
reflections are by definition, statements.
We reflect what we are hearing as a way to keep the patient talking.
We offer a lot of summarizing which is a
mega reflection, and we gave advice in MI, it's not that we
don't provide information or advice but we do so in
a way that makes it more likely for the person to hear.
Right now, drinking doesn't help me feel
better the way it used to. In fact, I feel worse.
So, you can echo back as a way of reflection,
drinking makes you feel worse now, that's
a statement, and the patient said, it used to be fun and look at
what is happened, etc. You could rephrase that,
so you find that drinking is no longer the helping you to feel better,
the way
it used to. You could use a double-sided reflection, where we and
online change. In the past, drinking helped you to
feel better, now it makes matters worse.
All of these things get the patient talking more.
You can do a continuation, a little more
advanced. You want to find some way to feel better instead of drinking.
It's not exactly what the patient is saying
but it was getting there. Motivational interviewing, we talk
about facilitating change, we listen for change talk. More change talk
we hear, the more we need to keep what we are
doing. They argue on behalf of one position, here
she becomes more committed to it. We talked to
ourselves into or out of things all the time. Sustained

talk, the more of that, the more likely the person will keep doing what they are
already doing. So, how do we identify change talk? There's a pneumonic called
the darn cat. And stands for ability, desire,
reason, need and the cat is more commitment language back the more
we hear from the person, the more likely they are to make the
change back I will do this, I intend
to do this, I'm going to do this, we hear activation statements, I'm ready to come I'm willing to,
or taking steps, specific actions toward change. We
are listening for words like I want this, I
could do that, I need to do it for this reason or that reason. So,
those are the things we listen for.
Motivational enhancement therapy is the really
them annualized motivational interviewing.
Hopefully, you got some of the basic vocabulary and I encourage you, a Sam has seminars
and things like that that are wonderful for helping
develop skills. Enhancement therapy was created to test MI.
At the systematic approach very evoking change , it is based on the principles of
motivational interviewing and its designed to produce
rapid, interline motivated change.
Does not intend to guide
and train the client, step-by-step, through recovery,
but instead employs motivational strategies to mobilize the clients own change
resources. Typically, it is four sessions, it has a four session protocol , more group based therapy. It's used
as a tailored approach, it can come in
three phases, there are different manuals for. This is something we want to morning manual driven approach you could do.
I read, next question. Which of the following are part of Marlatt and Gordons 1985 model of relapse prevention utilizing cognitive
behavioral therapy adapted for treatment of substance use disorders? You have
your 15 seconds to put your answer in the box. Is it
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 the 1995 model of relapse prevention came out of CBT that was adapted from
typically treatment for depression and anxiety
into treatment for substance use disorders.
Letter a, eliciting change talk, that is not part of
relapse prevention, earning vouchers for negative urine drug screens, that is
more contingently management. C, targeting cognitive,
affective, and situational or behavioral triggers
for substance use. The answer is C.
We will talk a little bit about cognitive behavioral therapy.

Those are among the most extensively evaluated interventions for substance
use disorders. I would say this is the basis for the
bread and butter of most programs , whether in
all different types of settings, that are used for substance use disorders.
And the relapse prevention model came
out of Marlatt and Gordons am not cognitive, affective and situational
triggers for substance use, and it provides skills training
specific to coping alternatives. If you see any questions
that say anything about coping skills, it's
usually relapse prevention or CBT, that's where a lot
of this came to. And CBT, substance use is reinforcing
, this interacts with psychological or behavioral
coping deficits, to produce an increase in substance use.
The solution is more effective coping.
We think about various stages of treatment,
additionally building rapport,
alliance, and prepare for change and do strategies which
is the coping skills stuff. And try to
, the basic idea and CBT is we can control our thoughts and the thoughts
affects how we feel in the choices we do in the behaviors
we make. Hard to control our feelings, we have impact on how we think
about things.
We anticipate certain situation, the kind of stuff you hear about in
AA, you think about that and CBT too. Wakeup,
we find alternative ways to manage
affect, dealing with
stress and dysphoria. Group based therapies, finding
support, socializing, finding fun, meaning, purpose,
these are some of the core elements.
Basic treatment components, identification of high risk
situations, development of coping skills, development
of new lifestyle behaviors.
You want to find new ways of being that are part of your routine,
part of your every day, day-to-day stuff, that decreases the need or role
of substance use. And you want to develop
a sense of self-efficacy. Built on small successes you are capable of doing,
motivating the fact you can succeed in this. Other
basic components, communication skills, refusal skills, asking
for help, preparation for lapses, so what we
learn when we have a lapse, how do we prevent a lapse from
becoming a relapse. Identifying and managing patterns of thinking that
we can identify, manage early on that are going to increase
our risk and the them in the butt
before they do. If we do have a relapse, how do
we do with it? It's not a catastrophe, we can focus on minimizing
the consequences and getting back on track pick
Iraq, another type of therapy is 12 step facilitation. This is
really the adaptation of the 12 step programs into more
addiction treatment settings, more or less. From the founders, they
say that therapy is grounded in the concept

of alcoholism as a spiritual and medical disease. The content of this intervention is
consistent with the 12 steps of AA with primary
emphasis given to steps one through five. In addition to abstinence from alcohol, major goal of the treatment is
to foster the patient's commitment you participate in AA. A big part of the facilitation is to help connect patients in treatment for substance
use with free community-based supports that have a pretty
good track record of helping many individuals.
It emphasizes concepts
like acceptance, surrendering to it, they do a moral inventory.
Sorry, I forgot, on D there, the moral inventory is related
to twelve-step facilitation and AA.
So, cover strategies like halt, identifying when you're hungry, angry, lonely
, or tired. These are pretty common stressors and triggers for people.
Include sessions for family members that cover how family members should not
be enabling you, detaching, etc. This is a common
thing that occurs in addiction treatment settings to help increase the likely benefit of somebody in the program like AA
or NA.
Then we have CRA, community reinforcement approach
and we have the community reinforcement approach
in family therapy.
Both are evidence supported behavioral treatments. Community reinforcement approach
is intended for the person pick up than
individual therapy for the person struggling with a substance
use disorder and its based on the leaf that
it triggers community , including family, their social,
friends, etc. Their colleagues at their job.
Play a critical role in supporting my
discouraging drug use.
So, it is not just you are choosing to do
this on your own, but the role these people play has a big impact on what you choose to do.
Consequently, the environment needs to be restructured such
that the sober lifestyle is more rewarding than a using lifestyle. So, craft
is an outgrowth of this but it's more geared
towards the family as one of the primary members
of the community. It's a method for working with concerned family members in order to get a treatment
refusing person to enter treatment or participate in treatment. It helps you
at a family member engage the person in treatment.
I'm going to misquote it, one of my favorite book titles
ever is alternatives to knocking, begging
and pleading, I think it's about 20 years old but
I think it's a great title.
Community enforcement approach, they think

of the substance use is a learned behavior, like any learned behavior, you
can go through and have an extinction of that.
There are naturalistic approaches
contingencies already operating in the individual's
natural environment.
To support change and abstinence.
Something that is a contingency that exists already that you
can choose to do to help modify the behavior.
It uses a functional analysis of behaviors,
functional analysis of both healthy and substance use behaviors
in terms of ability to reward or be aversive.
You want to think about all these different
behaviors and whether they reward or promote abstinence
of not using the substance or if they are aversive, causing the
person not to use the substance. You can think about
how to utilize those things in a person's life to reward good choices and
behaviors are to have consequences or aversive consequences
to negative choices.
There is a refining of problem-solving and goalsetting
efforts for the individual and/or the family.
They help they make contracts where you agree for various
behaviors and he set the natural contingencies or
etc.
At the scientifically based intervention
to concerned significant others to engage treatment
refusing users , it's a positive approach,
there was an old school confrontational approach
where you had to confront the person and tell them all the terrible
things that were happening, most of which they were already aware of but
when you put somebody , this is more MI, when
you put someone in a confrontational stance, their
natural instinct is to defend against flat. They end up arguing on
the side of keeping the behaviors they are
trying to change. And MI, we switch that around
and have you come alongside the person rather than confronting.
Craft is a similar idea, the positive approach and confrontation rarely
helps, it is culturally sensitive,
you can use it based on the person's own cultural mores
and beliefs to help develop a treatment plan.
The idea is you are basically teaching the family and
significant others to use positive reinforcers for rewards.
When a person does something that is dead, then the behavior is
reinforced.
And to suffer the natural consequences of using behavior, if somebody
passes
out at the bottom of the stairs, you don't pick them up and put them in
bed.
Just let them sit there.
It includes functional analysis, sobriety sampling, treatment plans,
behavioral
skills training, job skills, social and recreational counseling,
relief prevention and relationship counseling. None of these are just
one things, they all of different stuff and then. That is the basic idea.

Moving on to contingency management, probably the single most studied ineffective
of approach for use disorders and particular
, and the idea is we have therapeutically applied
incentives, summarily to CRA, it is
based on operant conditioning. And we use these incentives and other resources to increase one or more target behaviors. All kinds of reinforcement schedules, every time, can be random, there's lots of contingency
types and variations on this, the standard treatment,
manual has 12 weeks of contingency management and you can
use this as an adjunct to other therapies.
Other behaviors, etc.
You can be implemented across the
spectrum, you don't need therapy training or eight
years of higher education to do it.
And clinical trials that can increase attendance and addiction programming,
it can be used for abstinence,
and in particular, two populations of people that are difficult to include in treatment, patients with stimulant
use disorders, no medication options and adolescents who are
often last motivated who haven't suffered as
many negative consequences of their substance use, so it
can work well in both of those populations.
It's based on operant conditioning, with the idea that substance use is a learned behavior. If you can learn the behavior, you can change that learning and associate it with other things or
extinguish it.
You use contingencies set in place explicitly
and exclusively for therapeutic purposes.
Examples include entertaining vouchers for retail products or Starbucks or whatever that are contingent on negative
toxicology results or earning methadone take-home privileges
for negative urine drug screens, etc.
Those are examples of contingency management. Behavioral comparables therapy
, I don't think it is
as widely but it's an evidence-based intervention, you have to focus on the impact of substance use disorders across
interpersonal relationships and behavior of old
couples therapy tries to increase behaviors that support abstinence and long-term recovery. It can be used as a standalone or part of other treatments, sometimes he might have a couples therapy group and a cognitive behavioral therapy group . The
manual based version is two sessions, include recovery, relationship enhancement,
so it's one of the ones that really does focus
on these communication skills and interpersonal communication skills with significant others, as a recovery session,
and also skill building so it includes establishing shared goals, catching
partners doing something nice, this is a little bit of the
operant reward and conditioning stuff. Sharing

rewarding activities together as a couple,
employing problem-solving, generating an action plan
moving forward ,
acceptance and commitment therapy, a little bit like the new kid on
the block, substance use disorders, not as
widely as other modalities we've talked about, and has six core
processes. They include acceptance of the person where they are at,
cognitive diffusion,
being present, self as context, values and committed action. This
one has the sort of model of how these things work and the
interrelatedness because it contributes to the psychological flexibility.
There is some thought being towards
the side of commitment and behavior change
processes and more mindfulness and acceptance sort of processes and how
the things relate to each other. It is useful in helping
patients consider how their substance use disconnects them
from their values. They think about something like your sober values like
you have when you are not using, versus the
values you might unconsciously be employing when you
are using substances. And it helps to reconnect you to
your values.
DBT, like CBT, was not initially developed for treatment
of substance use disorders but has been adapted to be an effective
treatment.
For substance use disorders.
And that's a manual driven the behavioral treatment that uses validation
and motivational
enhancement techniques . It often has a combination of both
group and individual elements and just like DBT
that is not for substance use disorders, there
are four basic capabilities that focuses on.
Interpersonal effectiveness, how can you more effectively advocate
for yourself and be a contributor and participate
in relationships. Emotional and self-regulation capacities, improving
your
ability to tolerate uncomfortable affects rather than using substances,
ability to tolerate distress and mindfulness. So, those
are the four basic capabilities.
When DBT is successful, the patient learns to
envision, articulate, pursue and sustain goals that are independent of
their history of out-of-control behavior, including substance use, and it
is
better able to grapple with life's ordinary problems.
The core processes for this are change and acceptance. Sounds like
a CT. There is an emphasis on abstinence, so the idea
for change is that you are pushing for a media and
permanent cessation of the drug use.
The acceptance is you have a relapse,
should it occur, doesn't mean that the therapy
cannot achieve the desired results.
Some of the key skills, cope ahead, failing
well, if you fail, how do you feel well, you can use that and keep going.
Cope ahead,
I like that idea, planning ahead for coping skills you

can use.
And regular DBT, they talk about the wised mind, here you move from an attic
mind towards a clean mind, in stead of moving into the wise mind but it's a similar analogy.
Psychotherapy in everyday practice.
So, the basic elements of psychotherapy include
some sense of an expectation of receiving help,
the establishment and promotional development of the
therapeutic relationship, obtaining external perspectives and supports and encouraging positive
choices. And it gives you a little bit of a frame of understanding. All of these approaches are frames of thinking
about the person sitting in front of you,
they give you some steps or processes of things
to do, so you can understand and move forward. All of
these things are available in a medical
encounter. We don't necessarily have to have a lot
of advanced type of therapy training to provide some of the basic elements
of the supportive psychotherapy session.
Approved psychotherapy explicitly uses direct measures to ameliorate symptoms to retain, restore or improve self-esteem functions and adaptive skills. That's a lot of words. But basically, core psychotherapy, you are trying to support positive character traits, choices, behaviors, coping skills, sort of classically we think about
defense mechanisms, the positive defense mechanisms like humor or algorithms.
You focus on developing Lee's adaptive
capacity is in the person's life.
And you take into account the patient's limitations, so we think about the character defense mechanisms, life circumstances,
we consider all of these different things and helping
you use to help ameliorate specific symptoms.
Just like medications, we want to monitor what the effectiveness and outcome, we want to not just think in terms of sobriety and abstinence, we pay attention and reductions in substance use, assistance
with my opinion, the consequences of the negatives
impact on someone's life.
Also functional improvement, we want to think
about the emotional improvement that my be occurring,
interpersonal improvement, medical improvement, occupational improvement, legal
improvement, etc.
So, is the person functionally getting better,
and if so, then what you are doing is reliable. You
want to help out as their progress toward the patient's
self identified gold, as the active participation in treatment?
All of these are outcomes to determine to be monitoring
to determine whether you are doing is
helpful. Case management is another thing we often think about
combining when we think about therapies.
It's not therapy, per se, but it is an important component of helping connect people to things that

will increase their success in their likelihood of abstinence.
So, we adapt some treatments based on an ongoing assessment
of outcome, so case management, thinking about whether
or not they need a higher level of care for treatment. Is
outpatient sufficient ? Partial hospital, residential, etc.
Case management can improve
the recovery environment. Of housing is a huge stressor or being around
people who are using is a huge stressor, joblessness a huge stressor, all
of those
things, case management can connect people with resources and
certainly improve their likelihood of success in their outcomes. Case
management can help connect people to assess
for the need for and access treatment for psychiatric problems, it can
increase
skills for tolerating native affects. Case managers can
also help to sort of referred patients when
they think there might be an indication for medication treatment
to doctors, etc. There is a big role for case management in
terms of an assessment, somewhat of a therapeutic and connection to
resources.
For the treatment of co-occurring psychiatric disorders, so, you know,
many studies
showing that subsequent treatment is less effective
than concurrent treatment.
You know, you might need to stabilize somebody first if there
is an immediate medical
need. If someone is an alcohol withdrawal, seizures right now, you know,
you
need to stabilize that person first pick
in general, concurrent treatment for substance use disorder and
psychiatric
disorder provides the best outcome.
If you ignore either one of those, your outcomes for the other are not
as good. We see a lot of co-occurring PTSD, anxiety
depression as well. Said so treatment that includes things like
MDR, prolonged exposure, some of these treatments
can be effective for PTSD, in addition to treatment for
substance use disorder can be very, very helpful. In
conclusion, there are many very effective evidence-based psychotherapy
technique
interventions that can be done in many different settings
by different providers depending on the level
of training and expertise, and really, as much as certain
medications can have a huge impact on patients, particularly for
substance use and alcohol use disorder, these are the core of
treatment for many addictions and it is important
to have a sense for understanding them and recommending them and
potentially
providing them.
So, thank you very much for your time and attention.