Questions Asked During Live Webinar Broadcast on date here

Cognitive Behavior Therapy for Substance Use Disorder
Presenter: Frederick Dombrowski

Which other therapies have you used with your clients?
A: I have used DBT, Motivational Interviewing, Reality Therapy, and Gestalt Therapy. All of these types are easily integrated with CBT. I like Gestalt because being genuine can help a client become aware of their core beliefs which then allows us to challenge the beliefs. I like Reality Therapy and Choice Theory as this is helpful to list new behaviors that can help the client manage symptoms and prevent relapse.

Do you have any tips for using CBT in an opioid treatment program- where patients are harder to engage in counseling and therefore less likely to do homework, and there is often no specific termination date?
A: That’s a great question. We can use CBT for smaller problems such as relationship problems or anxiety related to life demands. We can use CBT on smaller immediate goals. This helps the client to open up to the idea of using CBT regularly. For some instances with ambivalent clients, I may focus on Motivational Interviewing before using CBT.

By time limited, what would you recommend such as numbers and frequency of session plus duration?
A: In many cases, CBT can be used for mild problems over the course of 8 individual psychotherapy sessions over 8 weeks at 45 minute sessions. For moderate problems CBT can be expanded up to a year using weekly individual sessions and weekly group sessions. If an individual has experienced severe trauma, they would benefit from Trauma Focused CBT which can take several months. This will include weekly individual sessions and group sessions. However, the individual may then need more individual sessions after treatment for trauma as they take steps to further improve their lives. CBT can be modified to go slower based on the clients needs. I have found that clients that use the worksheets will eventually get to a point where CBT becomes second nature.

What would be your recommendation for the client who is withdrawn and non-cooperative?
A: In cases such as this, anything to build a rapport with the client would be good. Chatting about the client’s interests, even just listening to them voice frustrations. Or even respecting their silence. In any instance where a client would speak, I would validate their statements as well as reiterate my commitment to the client. This will take several sessions and its OK that it take a while.

What are your recommendation for the client with multiple serious and chronic addiction with terminal illnesses?
A: For terminal illnesses, a client can have a thought such as “I am going to die”. In this situation, the thought is not a distortion and the thought can also cause the individual to feel very sad. I would also work with the client to identify what they would say to others that are in the same situation. There have been some instances where I wanted to use CBT (such as a client enduring the death of a loved one). The client was understandably upset. They did not show any distortions. When that happened, I switched my approach to Person Centered counseling to validate the client and to be with them during their problem. For a client with multiple addictions and chronic relapse, I would validate all of their contributing factors for relapse. I would find out what relapse means to them. When doing so, they would discuss their automatic thoughts. We can then work to identify distortions. I would work to understand the process of relapse and craving and then use CBT to challenge the thoughts that contribute to ongoing use.

When clients identify their feeling first, when asked for a thought, it is not that the client is mixing up their feelings and thoughts, they are just sharing their experience as it happens, based on other models (EFT/AEDP, etc) and neuroscience. Emotions/feelings are what the brain produces before a related thought occurs so I don't correct client, especially since client is the expert, not clinician. I wouldn't want that to trip up the process with the client. Comments?
A: What you are saying completely makes sense and I agree with your statements. There are many times that I ask clients to tell me their thoughts about a problem and they would say words such as “I’m angry” or “I’m sad”. Using the CBT worksheets with the client, I would ask the client what they think for the portion that says “automatic thoughts”. If they described a feeling instead, I would have them write their feeling on the portion of the worksheet that asks the clients to list their feelings as opposed to writing the feeling in the thought portion. I would then ask the client to put words to their feeling. So, if I asked them “What is your thought?” and they said “I’m angry” I would respond with “Tell me the words that your anger would say. Put words to your anger. What does your anger say about the situation?”

**What is the difference between inaccurate thoughts and cognitive distortions?**

A: The way I used the words “inaccurate” and “distorted” during the seminar; the words were interchangeable and synonymous. When I used them, they meant the same thing. However I would say in general, inaccurate thoughts are times when we objectively take in the information and we make a mistake such as doing math in our heads. A distortion is when our core beliefs taint that information. For example, if we paid 5$ for a hamburger but we inaccurately thought the burger was 4$, we can have a core belief that “People can’t be trusted” and therefore assume that someone is stealing money from us. The distortion is created by the core belief.

**In what ways, if any, do you see CBT being used in conjunction with EMDR?**

A: EMDR is a wonderful technique helping people to process and make sense of their trauma and experiences. I see EMDR as being the primary tool to help the client. However, people can have concerns about the process or may wonder what it means to them about themselves that they have suffered. The client can have distorted assumptions about the process of EMDR or what the process of treatment means to them. We can use CBT to challenge these distortions while also using EMDR as the main treatment.

**How do you address clients who "forgot" to do their homework between sessions?**

A: This is entirely normal and happens all the time. There are few answers to this.

#1. The clinician has to be totally sold on using CBT. We have to believe that CBT helps and that CBT works.

#2. During the informed consent phase of the initial session, we explain the purpose of treatment is to help the client become their own clinician so they won’t need us forever. As a result of this, we expect the client to do their part to take their recovery seriously. When I have started treatment like this from the very first sessions, I would say about 98% of the patients did the homework.

#3. If the client still doesn’t do the homework, we will do the homework with the client in the sessions (and I recommend we actually do the worksheets with the client in the session before we give them to the client for homework). Even when this doesn’t happen, I ask the client to at least carry the “Common Unhealthy Thought Patterns” worksheet and at least look at it when they find that they are getting frustrated.

#4, if this still doesn’t work, I just do it with the patient in the session completely.

#5, Lastly, if I do it with the client in the session and it’s still not connecting with the client, I will switch from CBT to other theoretical perspectives which may be a better fit for the client. I want to not push them away.

**Is there anything you can say about Computer Based Therapy for CBT with addiction?**

A: A friend of mine is using virtual reality in conjunction with CBT for clients that have phobias. This provides amazing in vivo experiences for the client. We then use CBT to help the client manage their thoughts and feelings while exposing them to their stressors. I believe that good clinical work can be done with addiction with counselors that are working with the client remotely. The Center for Credentialing and Education has a national certificate as a clinician “Board Certified- Tele Mental Health”. This is a wonderful credential as you are trained to use telemental health to help clients. You can use power point to help the client list their thoughts, feelings, and actions related to substance use.

**What are some techniques/exercises to use for criminal justice clients in a group setting?**

A: For many of my clients in criminal justice, they are mandated and don’t want to attend treatment. I would use CBT to help the client challenge their negative thoughts about being involved with treatment. Also, I would work small to help the client to use CBT on basic life problems such as interpersonal triggers.

**Are resources available where I can I see CBT applied, or shall I say, being put into action in a classroom/group setting?**
A: The Beck Institute has several amazing videos both explaining CBT and showing CBT sessions. However, these often cost money. I have used Youtube to show examples of CBT to my students. I particularly like this video although it is a little dated: https://www.youtube.com/watch?v=pfoKBNPbSPY

Can you give us the web address to access the New Responses Worksheet?
A: You can obtain all of the CBT worksheets reviewed in the seminar as well as many more at: http://www.specialtybehavioralhealth.com/pdfs-cognitive-behavioral-therapy/

Can you recommend a study guidebook one can use to prepare for license as LADAC?
A: Each state is different so be sure to contact your state licensing board to see if they have any recommendations regarding study guides. Many states may use the exam linked with the IC&RC. I have used the following website to obtain guidebooks for preparing for licensure or certification exams: https://www.internationalcredentialing.org/examprep