Advanced CBT Intensive Training: CBT for Multiple Symptom Sets - Day 2

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CBT FOR MULTIPLE SYMPTOM SETS: DAY 2 AGENDA

- Bridge and Introduction to Day 2
- Wrapy Up Core Competencies and Basic Tenets
- Cognitive Model fo Depression
- Cognitive Model of Anger
- Cognitive Model fo Anxiety
- Cognitive Approaches to OCD
- PTSD, Trauma, and Addiction
- Relapse Prevention

BEHAVIOURAL INTERVENTIONS

COGNITIVE BEHAVIORAL THERAPY: BEHAVIORAL EXPERIMENTS

1) Identify Assumption w/ specific predicted Outcome
2) Collaboratively ID task that will test assumption
3) Experiment must have clear bearing on validity
4) Review Findings

COGNITIVE BEHAVIOR THERAPY (CBT): BEHAVIOURAL PATTERN - BREAKING

- Abandonment
- Vulnerability
- Subjugation

ADVANCED COGNITIVE BEHAVIOR THERAPY (CBT)

Events Thoughts eelings Ations Rults

TECHNOLOGY IN CBT???

TECHNOLOGY IN CBT

- Virtual Reality Therapies
- Smart phone cognitive cue cards
- Smart Phone Aps

TECHNOLOGY IN CBT: CASE EXAMPLE

- Trigger: Boyfriend brushes girlfriends hand off leg at the movie

ADVANCED CBT INTENSIVE

Application to Clinical Practice

THE THERAPEUTIC ALLIANCE

- Predictive of outcome
- Collaborative approach
- Non-Judgmental
- Neutral inquiry
- Ruptures

APPLICATION TO CLINICAL PRACTICE: STRUCTURE OF A SESSION

1. Intro
   - Mood Check
   - Bridge
   - Agenda
2. End
   - Topic
   - Homework
3. End
   - Summary/Feedback
   - Homework

APPLICATION TO CLINICAL PRACTICE

Phase I: (sessions 1-4)

- T.A.
- Assessment variables
- Socialization to Cognitive Model
- Development of Treatment Goals

APPLICATION TO CLINICAL PRACTICE

Phase II: Sessions 4 →

- Cognitive Conceptualization
- Cognitive Restructuring
- Ongoing Education/behavioral interventions
- Homework

APPLICATION TO CLINICAL PRACTICE

Phase III: Final 4-6 Sessions/Booster

- Relapse Prevention
- Cognitions related to ending/loss
- Booster Sessions

APPLICATION TO CLINICAL PRACTICE: BOOSTER SESSIONS (ADAPTED, J. BECK, 2011)

1. Schedule ahead of Time
2. Come regardless of Progress
3. What has gone well?
4. What problems have arisen? How did you think and cope? Differently?
5. Do you notice any themes in your thinking and coping? What CBT work will you commit to?
6. What could arise between now and the next booster? How can you prepare?

APPLICATION TO CLINICAL PRACTICE: SELF-THERAPY SESSIONS

1. Schedule ahead of time
2. Set an agenda
3. Mood check
4. Identify and event in which you were triggered
5. Identify and challenge distorted thoughts
6. Identify coping skills you could use if triggered similarly in the future and write on coping card
7. Identify strengths you will use this week
8. Assign homework for next session

THE COGNITIVE MODEL OF DEPRESSION

THE COGNITIVE MODEL OF DEPRESSION: BELIEF MODIFICATION PROTOCOL

- Identify Maladaptive Belief
- Identify Alternate Adaptive Belief
- Rate Believability
- Interventions
- Rate Believability at Regular Intervals

THE COGNITIVE MODEL OF DEPRESSION: NEGATIVE COGNITIVE TRIAD

- Self
- Others
- World/Future

THE COGNITIVE MODEL OF DEPRESSION

Depressed Mood

Loss of Energy

Cognitive Deficits

Appetite/Sleep Disturbance

Hopelessness

Suicidality

THE COGNITIVE MODEL OF DEPRESSION

- Common Schemas
  - Failure
  - Defective
  - Worthless
  - Helpless
  - Hopeless
  - Undeserving

THE COGNITIVE MODEL OF DEPRESSION

- Common Distortions
  - Selective Abstraction/Discounting the positive

BEHAVIORAL ACTIVATION

- Activity Monitoring
- Activity Scheduling

THE COGNITIVE MODEL OF DEPRESSION: SELF CARE

LIFE AREAS ASSOCIATED WITH DEPRESSION

1. Mastery
2. Pleasure
3. Meaning

THE COGNITIVE MODEL OF DEPRESSION: RELATIONSHIPS AND SUPPORT

Intimacy
=
"Into - Me - See"

0 %
25%
50%
75%
100%
ME
1
2
3
4
5

THE COGNITIVE MODEL OF DEPRESSION: GRATITUDE

THE COGNITIVE MODEL OF DEPRESSION: GRATITUDE

- Family
- Friends
- Housing
- Financial Provision
- Senses
- Teachers
- God
- Nature
- Sun & Moon
- Pets
- Entertainment
- Kind Strangers
- Shoes
- Time to be on earth
- Employment
- Good Food
- Laughter
- Physical Health

THE COGNITIVE MODEL OF DEPRESSION: OTHER COGNITIVE STRATEGIES

- Gratitude List
- Evaluating and Testing Negative Interpretations
- Positive Psychology
- Rainy Day Coping Narrative
- Schema Modification Work

THE COGNITIVE MODEL OF DEPRESSION: OTHER COGNITIVE STRATEGIES

Rainy Day Coping Narrative

"Just because I can't see it now
doesn't mean it isn't coming"

THE COGNITIVE MODEL OF DEPRESSION: ONGOING DATA LOGS

BIPOLAR DISORDER – CHARACTERISTICS OF MANIA

- Overly positive cognitions
- Elevated Mood
- Risk-Taking Behaviors

BIPOLAR DISORDER –MANIA COPING SKILLS

- Medication
- Mood Tracker
- Exercise, other "energy burning" tasks
- Self-Control Strategies
- Limit Setting
- *Inoculate against manic distorted thinking*

BIPOLAR DISORDER: MOOD TRACKER TOOL

COGNITIVE STRATEGIES FOR INSOMNIA

CBT STRATEGIES FOR INSOMNIA: PROBLEMS WITH SLEEP?

- Screen Time
- Napping/Sleeping In
- Caffeine Ingestion
- Sugar Intake
- Alcohol/Drugs
- Arousal Activities Close to Bedtime

CBT STRATEGIES FOR INSOMNIA: ASSESS

- Assess for arousal activities before bed
- Sleep Diary

CBT STRATEGIES FOR INSOMNIA: TYPES OF INSOMNIA?

- Difficulty falling asleep
- Difficulty staying asleep
- Poor sleep quality

CBT STRATEGIES FOR INSOMNIA: ENVIRONMENT

- Safe?
- Dark?
- Comfortable temperature?
- Quiet?

CBT STRATEGIES FOR INSOMNIA: BEDTIME ROUTINE

- Prescribed sleep/wake times
  - "Stay up" Activities
    - take a brisk walk around house or apartment
    - read something captivating
    - call someone to talk to
    - play loud or upbeat music
  - "Wind Down" activities
    - hot bath
    - reading
    - candles/incense
    - clothes for the next day
    - spend time with pets
    - brush, floss teeth, grooming
    - sew, knit
    - progressive muscle relaxation/ guided imagery

CBT STRATEGIES FOR INSOMNIA: MIDDLE OF THE NIGHT ACTIVITIES

- Make a grocery list
- Look at pictures
- Watch infomercials
- Draw/color/children's book

CBT STRATEGIES FOR INSOMNIA: GET OUT OF BED STRATEGIES

- Have a reason!
- Make coffee!
- Walk the dog
- Make breakfast
- Walk to the mailbox
- Make you bed

CBT STRATEGIES FOR INSOMNIA: COGNITIVE WORK

- "I have to sleep!"
- "I must have 8 hours"
- "If I don't sleep it will be horrible"
- "I can't sleep more than x hours"
- "I can't sleep without medicine"
- "Sleep is not that big of deal"

CBT WITH SUICIDAL CLIENTS

- Suicide Cannot be Prevented or Predicted, all we can do is assess risk
- Suicidality is not Static

CBT WITH SUICIDAL CLIENTS

- Warning Signs - behaviors that you observe that give rise for concern
- Risk Factors - factors in the clients life that increase risk of completing
- Protective Factors -factors that increase likelihood of staying alive

CBT WITH SUICIDAL CLIENTS: WARNING SIGNS

- Threatening to harm or kill self
- Decreased reason for living/sense of purpose
- Increased anxiety or agitation
- Increased substance use
- Feeling trapped or hopeless
- Giving away possessions, saying goodbye
- Writing a will
- Extreme change in mood

CBT WITH SUICIDAL CLIENTS: RISK FACTORS

- Suicidality
- Hopelessness
- Psychiatric Diagnosis
- Psychosocial Features
- Cognitive Features (perfectionistic, inability to tolerate intense feelings, etc)
- Demographic Features

CBT WITH SUICIDAL CLIENTS: MODIFIABLE RISK FACTORS

- Anxiety
- Agitation
- Hopelessness
- Insomnia
- Substance Abuse
- Access to Guns
- Many environmental stresses

CBT WITH SUICIDAL CLIENT: UNMODIFIABLE RISK FACTORS

- **Race**
- **Age**
- **History of suicide in family/Previous Attempts**
- **Chronic medical illness**

CBT WITH SUICIDAL CLIENTS

4 Ps of Risk Assessment

1. Is there a Plan?
2. Is there a history of Past Attempts?
3. What is the Probability? (likelihood of acting)
4. Protective Factors (What is preventing them from acting?)

CBT WITH SUICIDAL CLIENTS: PROTECTIVE FACTORS

3 Fs of Protective Factors

- Faith
- Family
- Fear of Failing

CBT WITH SUICIDAL CLIENTS: PROTECTIVE FACTORS

- Positive Therapeutic Relationship
- Children in Home
- Pregnancy
- Healthy Coping Skills
- General Life Satisfaction

CBT WITH SUICIDAL CLIENTS: REASONS FOR LIVING

CBT WITH SUICIDAL CLIENTS: SAFETY PLANNING

No Harm Contracts vs. Safety Planning

CBT WITH SUICIDAL CLIENTS

- Warning Signs - behaviors that you observe that give rise for concern
- Risk Factors - factors in the clients life that increase risk of completing
- Protective Factors -factors that increase likelihood of staying alive

The The Model of Anger

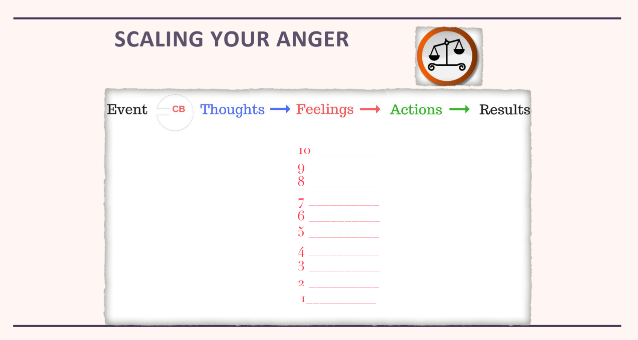
ANGER MANAGEMENT

THE COGNITIVE MODEL OF ANGER

trigger Should

- Identification of Triggers
- Identification of Target Behaviors
- Identify Bodily Sensations
- Identification of Emotions
- Challenging "Hot" Cognitions
- Coping Statements
- Role Plays
- Letter Writing
- Values Clarification
- Schema/Forgiveness Work
- Pros and Cons

SCALING YOUR ANGER



CBT FOR ANGER: BEHAVIORAL STRATEGIES

- Assertiveness Exercises
- Express anger in safe environment
- Letter writing
- Journal of triggers and responses
- Exercise
- Develop ability to empathize with person angry with
- Count to 10
- Walk away

CBT FOR ANGER: COGNITIVE STRATEGIES

- Rational Responding Techniques
- Reduce Personalization
- Challenge "Shoulds"
- Id and replace "Hot" Cognitions
- Forgiveness Work
- Pros and Cons

CBT FOR ANGER: SCHEMATIC CONSIDERATIONS

- Values-Based Work

CBT FOR ANGER: FORGIVENESS INTERFERING COGNITIONS

- Forgive and Forget
- Forgiveness = Trust
- *If I forgive I have to like/love and stay in relationship with them*
- *If I forgive him I am letting him off the hook*
- *If I forgive I am saying what she did is ok*
- *I will not give him the satisfaction of my forgiveness*

THE COGNITIVE MODEL OF ANXIETY

THE COGNITIVE MODEL OF ANXIETY

Anxiety = Risk/Resources

- Increased Awareness of Resources
- Increase Resources
- More Realistic Appraisal of the Risk

THE COGNITIVE MODEL OF ANXIETY: PRIMARY DISTORTIONS

- Mind-Reading
- Fortune-Telling
- Magnification

CHARACTERISTICS OF ANXIETY

- Triggers
- Cognitive Biases in Processing
- Physical Sx
- Compulsive or Safety Behaviors
- Cognitive and Behavioral Avoidance
- Environmental Factors

SCHEMAS ASSOCIATED WITH ANXIETY DISORDERS

- GAD – multiple schemas, pervasive, less compelling
- Social Anxiety – helpless, unlikable/unlovable
- OCD –Helpless, vulnerable, worthless, unlovable
- PTSD – Helpless, Vulnerability/Defective

CBT FOR GAD

- Verbal Cognitive Strategies
- Behavioral experiments
- Journaling
- Deep Breathing exercises
- Metacognitive Strategies

CBT FOR GAD: POSITIVE METACOGNITIVE BELIEFS

- Worrying helps me cope
- If I worry, Ill be more prepared
- Worrying helps me stay in control
- If I worry, I can anticipate problems

CBT FOR GAD: NEGATIVE METACOGNITIVE BELIEFS

- I have no control over my worry
- Worry has taken over my life
- I have lost control of my thoughts

CBT FOR GAD: NEGATIVE METACOGNITIVE BELIEFS

- "Worry will make me lose my mind"
- "Worry will make me have a breakdown"
- "Worry will cause a heart attack"

CBT FOR PHOBIAS

- In-Vivo
- Hierarchies
- Behavioral Experiments

CBT FOR PANIC DISORDER

- Trigger is anxiety vs environmental
- Restructure Misinterpretation of sx
- Interoceptive Strategies
  - Empirically supported protocol: Clark, Barlow

CBT FOR SOCIAL ANXIETY

- Trigger is always people
- Approval-Seeking Schema Work
- Challenging People Pleasing Cognitions
- Continuums

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  My Wife … Neighbor's Dog
- Polling Exercises

CBT for Anxiety Disorders: Thought Log

CBT for Anxiety Disorders: Cognitive Cue Card

OTHER ANXIETY STRATEGIES

- Distraction Techniques
- Facing Your Fears
- Schema-Based-Journaling

GENERAL STRATEGIES FOR DEALING WITH ANXIETY

- Exercise
- Yoga
- Limit Caffeine, Sugar
- Journaling

Cognitive Approaches to OCD

OBSESSIVE-COMPULSIVE DISORDER

- *Obsession – a recurrent thought, impulse, or image*
- *Compulsion – a repetitive behavior or mental act*

CBT FOR OCD

- Focus on belief vs automatic thoughts
- Mindfulness/Metacognitive Work
- Separate in groups

CBT - CHARACTERISTICS OF OCD

- Worry
- Rumination
- Intrusive Thoughts
- Compulsive behaviors
- Thought Suppression
- Overt and Covert Rituals
- Low memory confidence
- “Stop signs”

CBT - “TYPES” OF OCD

- “Relationship”
- “Sexual”
- “Magical Thinking”
- “Religious”
- “Violence”
- Symmetry and Orderliness
- “Contamination”

CBT FOR OCD – REASONS COPING RESPONSES BACKFIRE

- Strengthen thoughts/Images
- Prevent pt from experiencing info that leads to new beliefs

CBT FOR OCD

- 2 Metacognitive Beliefs
  - Thought-Event Fusion
  - Thought-Action-Fusion

- Prospective
- Retrospective

CBT FOR OCD - ERP

- Standard "Gold Star" treatment for OCD
- Goal is habituation
- Mechanisms of change

1) Neurological nervous system habituation

2) Social learning

- Importance of accepting risk of uncertainty/experience discomfort

CBT FOR OCD - ERP

- 2 Steps

1) Direct contact with trigger
2) Gradual elimination of safety behaviors

CBT FOR OCD - ERP

- Step 1: Hierarchy Development
- Step 2: SUDS Rating Scale
- Step 3:Assign SUDS and Order Hierarchy
- Step 4: Expose Gradually

ERP – STANDARD SUDS

0 = State of Complete Calm

10-30 – A Little Discomfort

40-60 – Moderate Discomfort

70-90 – Extreme Anxiety

90-100 – Worst Fear Ever Experienced

CBT FOR OCD - ERP

- Example SUDS: Checking Compulsions
  - Lock house door one time before going to bed – 60
  - Turn off faucet w/o checking if dripping – 70
  - Turn off stove – check knobs only 1 x – 80
  - Go to bed with hot ashes in fireplace - 90
  - Use iron, unplug, and leave house w/o checking - 100

CBT FOR OCD - ERP

- Case Example: Bryan
  - Sexual OCD
  - Vice Principal at middle school
  - Coaches boys and girls basketball
  - Daily Thoughts: "What if I molested that girl?"
  - Daily intrusive images of girls naked
  - Thoughts:
    - "I am disgusting"
    - "I am a pervert"
    - "What if I want them more than my wife?"

CBT FOR OCD - ERP

- SUDS
  - Watch E television at home with wife -60
  - Compliment girl at Bball practice - 70
  - Make eye contact with girl in class - 80
  - Supervise Lunch on playground – 90
  - Parent teacher conf with girls father - 100

CBT FOR OCD - ERP

- Cognitive Work
  - "Its just my OCD"
  - "Just bc I think it doesn't make it true"
  - If I really did, kids would not be ignoring me"
  - "If I really did I would not still be teaching"
  - "If I really were a pervert I wouldn't be disgusted"
  - "If I really did, her dad wouldn't praise me at the conference"

CBT FOR OCD - ERP: CUE CARD

- "Just because I have these thoughts and images doesn't make me a bad person. They are just symptoms of my condition. I don't believe Tachychardia makes Jimmy a bad person, so it is not fair to believe these make me a bad person. I can still be a loving husband, serve in church, and maybe even have kids of my own one day. My thoughts do not define me and my OCD will not conquer me"

ERP – FINAL TID-BITS

1) Work gradually up hierarchy list
2) When anxiety reduced 2-3 days, move on
3) It is not necessary to eliminate ALL discomfort before moving on…just reduction of anxiety
4) Work on need to do exposures perfectly
5) Anticipation anxiety is normal part of process
6) Anxiety is uncomfortable but NOT DANGEROUS

A Cognitive Approach to PTSD

COGNITIVE APPROACHES TO TRAUMA AND PTSD

- 60-80% Canadians/Americans experience 1 traumatic event
- 8% of lifetime ptsd
- Most trauma survivors never develop ptsd symptoms and majority who do recover
- Women 2x more likely than men
- Most recovery in 1st 3 months
- When persists for 1 yr almost never remits w/o tx

COGNITIVE APPROACHES TO TRAUMA AND PTSD

- Classification - Trauma and Stressor - Related Disorders

- PTSD dx requires having been exposed to traumatic or stressful event that involved actual or threatened death or serious injury

COGNITIVE APPROACHES TO TRAUMA AND PTSD

- Becomes pathological when

  1) Associations among stimuli do not accurately reflect the world
  2) Harmless stimulus erroneously associated with threat meaning
  3) Avoidance behaviours are evoked by harmless stimuli
  4) Excessive and easily triggered response elements interfere with daily function

COGNITIVE APPROACHES TO TRAUMA AND PTSD

- Traditionally characterized as a normal response to abnormal event
- Much current thinking is to view this differently

COGNITIVE APPROACHES TO TRAUMA AND PTSD: GOALS

- Decrease/Eliminate flashbacks and dissociation
- Move from flashback to intentional recall
- Change meaning associated with
- Acceptance
- Benefits/Growth/Resilience
- Improve overall functioning

COGNITIVE APPROACHES TO TRAUMA AND PTSD

- PTSD persists when information is processed in such a way that real past threat is perceived as current ("fear conditioning")

- Cognitive and Emotional processing is mechanism underlying successful reduction of symptoms
- Goal is to help pts face traumatic memories and situations associated with them
- Fear is represented in memory as cognitive structure that is program for escaping danger
- Structure includes 1) fear stimuli and 2) fear response

and 3) meaning associated with

COGNITIVE APPROACHES TO TRAUMA AND PTSD

- Conditions necessary for successful modification of fear structure:
  - Fear structure must be activated, otherwise it is not available for modifications
  - New information incompatible with fear structure must be incorporated
  - Confrontation with stimuli that are safe or low probability of harming

- Requires deliberate, systematic confrontation with stimuli that are safe or low probability of harming

COGNITIVE APPROACHES TO TRAUMA AND PTSD

1. **Pre-Exposure Stage**
2. **Exposure Stage**
3. **Post-Exposure Stage**

COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 1 - PSYCHOEDUCATION AND TEACHING OF TOOLS

- Psychoeducation re PTSD
- Psychoeducation re Neurobiology of Trauma
- Explain Rationale for Exposure based treatment & Obtain Consent
- Teach Basic De-escalation Skills

COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 1 - EDUCATION AND TOOLS

- **Soothing**
- **Distraction**
- **Grounding**

COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 2 - EXPOSURE

- 3 part summary of life

1. Post Trauma (Impact statement)
2. Pre trauma life (emphasis on positives)
3. Trauma Narrative

COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 2 - EXPOSURE

- Views of:
  - Self
  - World
  - Safety
  - Trust
  - Power
  - Competency
  - Intimacy

COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 2 - EXPOSURE

Guidelines for Trauma Narrative

- Hand written
- First person
- As much detail as possible

COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 3

- Residual Nightmare work
- Dealing with moral injury & cognitions related to guilt and shame
- Reclaim former self and other post-traumatic growth
- Silver Lining Technique
- Trauma taken tool and other resilience strategies
- Attaching shame, relational healing, & seeking connection
- Values - Based Recovery
- Managing triggers, anger management, skills training and other quality of life improving work

COGNITIVE APPROACHES TO TRAUMA AND PTSD: THE SILVER LINING TECHNIQUE

COGNITIVE APPROACHES TO TRAUMA AND PTSD: PREEMPTIVE NIGHTMARE & RESCRIPTING

COGNITIVE APPROACHES TO TRAUMA AND PTSD: MORAL INJURY

"- the damage done to one's conscience or moral compass when that person perpetuates, witnesses, or fails to prevent acts that transgress one's own moral beliefs, values, or ethical code of conduct"

COGNITIVE APPROACHES TO TRAUMA AND PTSD

- Trauma is an event that has an effect on one's ongoing sense of threat AND moral injury
- Not just violence happening TO people; but acts they did or did not do towards others
- Importance of ongoing creating a sense of safety as well as reassigning blame and redefining value and helping them see good things can come from difficult situations

COGNITIVE APPROACHES TO TRAUMA AND PTSD: MORAL INJURY

- Isolation
- Anger
- Guilt and Shame
- Powerlessness
- Suicide

COGNITIVE APPROACHES TO TRAUMA AND PTSD: MORAL INJURY

- Come out of hiding
- Restructure cognitions related to guilt and shame
- Spiritual healing
- Making meaningful connections
- Reassign meaning associated with suffering and promote resilience

COGNITIVE APPROACHES TO TRAUMA AND PTSD: POST-TRAUMATIC GROWTH

- Positive psychological changes resulting from the struggle with challenging circumstances around the crisis
- They say what does not kill you makes you stronger - not always the case - but with proper cognitive approach can be true
- May never be exactly the same afterwards, but can be healthy and happy

COGNITIVE APPROACHES TO TRAUMA AND PTSD: SHAME SILENCER TOOL

COGNITIVE APPROACHES TO TRAUMA AND PTSD: TRAUMA TAKEN TOOL

Cognitive Model of Addiction

CBT FOR ADDICTION: ADDICTION BIOLOGICAL RISK FACTORS

- Trait Impulsivity/Aggression
- Other Genetic factors (estimated 40-60%)
- Race
- Gender
- Stage of Development

CBT FOR ADDICTION: ENVIRONMENTAL RISK FACTORS

- Lack of Parental Supervision
- Peer and School Experiences
- Drug experimentation as children or adolescents
- How the drug is used
- Community Poverty

THE TRANSTHEORETICAL MODEL

MOTIVATIONAL ENHANCEMENT THERAPY:
THE "STAGES OF CHANGE" MODEL

Pre-Contemplation — Contemplation — Preparation — Action — Maintenance

INSTANT GRATIFICATION

GAINING INSIGHT

Expressions of Concern

CBT FOR ADDICTIONS - PROS AND CONS

PROS & CONS – IV HEROIN USE

CASE CONCEPTUALIZATION

CONCEPTUALIZATION – ESSENTIAL COMPONENTS

- Relevant Childhood Data
- Current Life Stressors
- Core beliefs
- Substance/Addiction Related Beliefs
- Thoughts
- Emotions
- Behaviors

CASE CONCEPTUALIZATION ALSO ADDRESSES

- Why did the pt start using?
- How did recreational use lead to problem usage?
- Why has pt not been able to stop on their own?
- How did key beliefs and coping skills develop?
- How did the pt function before substance problem?

CASE STUDY: “VONNIE”

GOAL SETTING AND TREATMENT PLANNING

1. Problem List
2. Goal List
3. Behavioral Targets
4. Identify Triggers for Behaviors
5. Identify Cognitions associated with target behaviors

CONCEPTUALISATION DRIVES TREATMENT PLANNING

COGNITIVE MODEL OF ADDICTION: SESSION ACUITY PROTOCOL

1. Usage or other Destructive Behaviors
2. Therapy Interfering Behaviours
3. Quality of Life Interfering Behaviours

COGNITIVE MODEL OF ADDICTION - TREATMENT

Interventions

- Restructure cognitions related to function of use
- ID drug related beliefs
- Pros & Cons
- Imagery
- Flashcards
- Addict Letters
- Cue Cards

CBT FOR TRAUMA AND ADDICTION: WHY PEOPLE USE SUBSTANCES

- To Feel Good
- To Not Feel at all (numb)
- To Forget
- To alleviate pain
- To regulate emotions
- To foster feelings of relaxed state or excitement

ADDICTIVE BEHAVIOUR
RELAPSE PREVENTION QUESTIONS

- Did you relapse this week?
- If yes, tell me what happened
- On a scale of 0-10 how close did you get?
- At what point during the week were you most tempted to use? What were you doing?
- On a scale of 0-10 how strong was the craving at that time.
- What was going through your mind at the time?

ADDICTIVE BEHAVIOUR
RELAPSE PREVENTION QUESTIONS

- What kept you from relapsing? Anything else?
- How many times to you think you were tempted to use this week but didn't?
- What skills did you use to resist the urges?
  - Behavioral Skills? (what did you do?)
  - Cognitive (what did you think?)
- What did you do right this week
- What changes do you need to implement this week?

COGNITIVE MODEL OF ADDICTION

CB Chain Analysis

COGNITIVE MODEL OF ADDICTION:
COGNITIVE CUE CARD

COGNITIVE MODEL OF ADDICTION
BEHAVIOURAL COPING CARD

COGNITIVE APPROACHES TO ADDICTION:
SCHEMA-BASED LETTER WRITING

SMART RECOVERY 4 POINT PROGRAM

- Building and Maintaining Motivation
- Coping with Urges
- Managing Thoughts, Feelings, and Behaviors
- Living a Balanced Life

WANT MORE ADDICTIONS TOOLS?

The Addictions Toolkit
$9.99

Email me at jeff@jeffriggenbach.com to join my list and get more free addiction tools!

DAY 2 QUESTIONS???

LET'S CONNECT!

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