# Cognitive-Behavioral Therapy and Relapse Prevention Strategies

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## Learning Objectives

1. Increase knowledge of key learning, conditioning, and modeling principles
2. Improve understanding of how these principles form the foundation of cognitive behavioral treatment (CBT) and relapse prevention (RP)
3. Enhance ability to recognize the skills used in cognitive-behavioral approaches to address problematic substance use and mental illness
4. Develop clinical ability to recognize patterns of relapse/high risk behavior and identify emotional/behavioral/cognitive states associated, as well as identify distorted automatic thoughts

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## What is CBT?

- Has anyone practiced CBT before?
- Opinions about its effectiveness?

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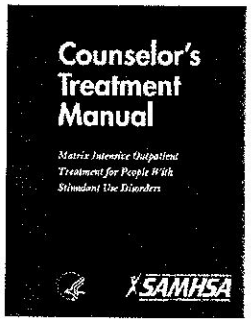
## SAMHSA Counselor's Manual

- Available in PDF form on the SAMHSA online store

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## What is CBT and how is it used to treat substance use disorders?

- CBT is a form of "talk therapy" that is used to teach, encourage, and support individuals about how to reduce / stop their harmful drug use.
- CBT provides skills that are valuable in assisting people in gaining initial abstinence from drugs (or in reducing their drug use).
- CBT also provides skills to help people sustain abstinence (relapse prevention)

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## Foundation of CBT

Cognitive behavioral therapy (CBT)

- Provides critical concepts of substance use disorders and how to not use drugs
- Functional Analysis to assess the factors that lead to drug use
- Emphasises the development of new skills
- Involves the mastery of skills through practice

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## CBT for MH vs. SUD

- Utilizing CBT for both mental health and Substance Use Disorders can improve symptoms
  - In mental health disorders, behavioral and cognitive strategies are often used simultaneously
  - With SUD it helps to start with behavioral strategies and add cognitive strategies later, particularly if there is significant cognitive impairment

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## Why is CBT useful?

- CBT is a counseling-teaching approach well-suited to the resource capabilities of most clinical programs
- CBT has been extensively evaluated in rigorous clinical trials and has solid empirical support
- CBT is collaborative, structured, goal-oriented, and focused on the immediate problems faced by substance users entering treatment who are struggling to control their use

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## Why is CBT useful?

- CBT is a flexible, individualized approach that can be adapted to a wide range of patients/clients as well as a variety of settings (inpatient, outpatient) and formats (group, individual)
- CBT is compatible with a range of other treatments the patient/client may receive, such as pharmacotherapy

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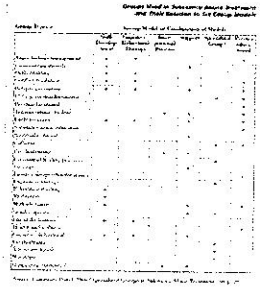
## CBT vs Other Groups (TIP 41)



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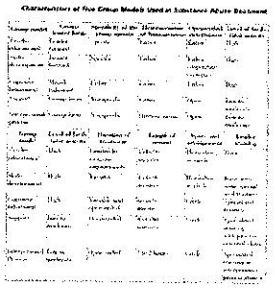
## CBT vs Other Groups (TIP 41)



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## Shopping Norms

- What are a few of the norms when standing in the check-out line?
- What do you do and what don't you do?
- How did you learn these rules?

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## Conceptualizing Behavior

- Social learning theory
- Classical conditioning
- Operant conditioning
  - Positive Reinforcement
  - Negative Reinforcement
  - Punishment

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## Activity 1: Why do people use?

- Each group will be assigned one of the types of behavioral conditioning
- Identify the role this type of conditioning plays in developing a SUD
- Give an example of how this would present itself in a session
- Give some examples of how you might address it in a group or individual session

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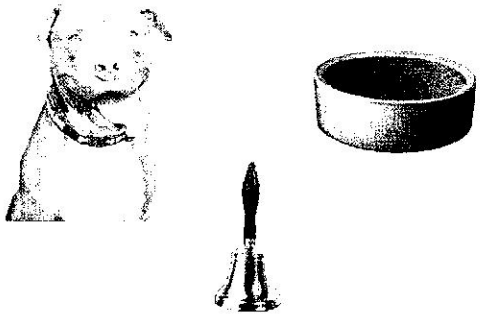
## Classical Conditioning



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## Important concepts in CBT
### Classical Conditioning

- Vital to help patient/client understand that classical conditioning takes place at an *unconscious* level
- Therefore, they have no control over whether or not it takes place
- Once established, it requires careful, specific strategies to extinguish the conditioned response

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## Important concepts in CBT
### Classical Conditioning

In the early stages of CBT treatment, strategies emphasize behavioral change.

Strategies include:

- planning time to engage in non-drug related behavior
- avoiding or leaving a drug-use situation.

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## Important concepts in CBT
### Operant Conditioning

Drug use is reinforced by the positive reinforcement that occurs from the pharmacological properties of the drug, i.e. the "high"

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## Important concepts in CBT
### Operant Conditioning

- Drug use is reinforced by the negative reinforcement of removing or avoiding painful withdrawal symptoms.

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## Important concepts in CBT
### Operant Conditioning

Punishment: negative consequences that *reduce* the occurrence of a particular behavior (theoretically)
(e.g., If you sell drugs, you will go to jail. If you take too large a dose of drugs, you may overdose.)

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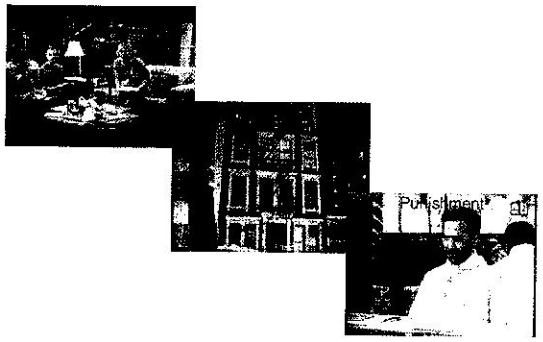
## Reinforcement



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## Important concepts in CBT
### Social Learning Theory

- Behavior is not fully explained by principles of conditioning – learning occurs in a social context
- "Dynamic and reciprocal interaction of the person, environment, and behavior"
- It is one thing to *initiate* new behavior; it is another to *maintain* it
- Ex. Return to old behavior immediately after release from custody – why?

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## Important concepts in CBT
### Social Learning Theory

- In order for Social Learning to occur there must be …
  - Attention: Pay Attention to the Model
  - Retention: Remember the Model's action
  - Motor Reproduction: Copy the Model's action
  - Motivation: Want to demonstrate what they have learned

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## Important concepts in CBT

In the early stages of CBT treatment, strategies emphasize behavioral change.

Strategies include:

- planning time to engage in non-drug related behavior
- avoiding or leaving a drug-use situation.

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## Important concepts in CBT

CBT attempts to help patients/clients:

- Follow a planned schedule of low-risk activities
- Recognize drug use (high-risk) situations and avoid these situations
- Cope more effectively with a range of problems and problematic behaviors associated with using

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## Important concepts in CBT

As CBT treatment continues into later phases of recovery, more emphasis is given to the "cognitive" part of CBT. This includes:

- Teaching patients knowledge about substance use
- Teaching patients about conditioning, triggers, and craving
- Teaching patients cognitive skills ("thought stopping" and "riding out the urge")
- Focusing on relapse prevention

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## Role of the Clinician in CBT

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## The Role of the CBT Clinician

What are the traits of an empathetic clinician?

What does an effective teacher do?

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## The Role of the CBT Clinician

CBT is very *active*. The CBT Clinician must strike a balance between being a good listener and understanding and teaching new information and skills

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## The role of the clinician in CBT

- CBT is a very active form of counseling.
- A good CBT clinician is a teacher, a coach, a "guide" to recovery, a source of reinforcement and support, and a source of corrective information.
- Effective CBT requires an empathetic clinician who can truly understand the difficult challenges of addiction recovery.

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## The role of the clinician in CBT

The CBT clinician has to strike a balance between:

- Being a good listener and asking good questions in order to understand the patient
- Teaching new information and skills
- Providing direction and creating expectations
- Reinforcing small steps of progress and providing support and hope in cases of relapse
- The clinician has to be flexible to discuss crises as they arise, but not allow every session to be a "crisis management session."

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## The role of the clinician in CBT

- The clinician is one of the most important sources of positive reinforcement for the patient during treatment.
- It is essential for the clinician to maintain a non-judgemental and non-critical stance.
- Motivational interviewing skills are extremely valuable in the delivery of CBT.

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## OARS (from MI)

- Open Ended Questions
- Affirmations
- Reflective Listening
- Summary Reflections

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## Key Concepts of CBT in MH and SUD Settings

- Recognize and modify thought patterns to alter moods and behaviors
- All or nothing thinking
- Abstinence Violation
- Negating the positive
- Minimizing
- Personalizing
- Focusing on the negative-self doubt
- Negative Core beliefs
- Monitor and modify distorted thoughts
- Practicing accurate-positive self-talk
- Self evaluation
- Thought (behavioral) Records
- Behavioral Activation
- Affirming incremental positive steps
- Functional Analysis
- Catastrophizing

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## Structuring an individual session

The sessions last 45-60 minutes.

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## Structuring a grouop session

The sessions last 60-90 minutes.

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## The 20/20/20 Rule (or 30/30/30)

Check-In and Review

New Skill and Practice

Reinforce and Homework

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## How to organize a clinical session with CBT: The 20 / 20 / 20 rule

- CBT clinical sessions are highly structured, with the clinician assuming an active stance.
- 90-minute sessions divided into three 30-minute sub-sessions (or 60 divided into 20)
- Empathy and acceptance of patient needs must be balanced with the responsibility to teach and coach.
  - Avoid being non-directive and passive
  - Avoid being rigid and machine-like

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## First 30 minutes

- Set agenda for session
- Focus on understanding group's (client's) current concerns (emotional, social, environmental, cognitive, physical)
- Focus on getting an understanding of group's (patient's) level of general functioning
- Assess substance use, craving, and high-risk situations since last session.
- Review and assess their experience with the practice exercise.
- (Individual only) Obtain detailed, day-by-day description of substance use since last session.

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## Second 30 minutes

- Introduce and discuss session topic
- Relate session topic to current concerns
- Make sure you are at the same level as patient and that the material and concepts are understood
- Practice skills

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## Final 30 minutes

- Explore patient's understanding of and reaction to the topic
- Assign practice exercise for next week
- Review plans for the period ahead and anticipate potential high-risk situations
- Use scheduling to create practice plan for next time period

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## Challenges for the clinician

- Difficulty staying focused if patient wants to move clinician to other issues
- 20 / 20 / 20 rule, especially if homework has not been done. The clinician may have to problem-solve why homework has not been done
- Refraining from conducting psychotherapy
- Managing the sessions in a flexible manner, so the style does not become mechanistic

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## Challenges

What are some of the difficulties that you have experienced in working with substance users in group or individual sessions?

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## CBT-Individual Session Introduction

- Review your patient's schedule.
- If no schedule, troubleshoot the schedule and have them re-create what they did-"reverse scheduling."
- Introduce the session topic to the patient, and review the material.

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## Structuring the session

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## Rules for an individual session

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## Group Clinician

What is important?

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## Rules for a group session

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## Qualities of a Group clinician

- Must work to develop a consistent, positive relationship with the patient
- Show concern, acceptance, genuineness and empathy
- Be an active listener
- Observant (recognize non-verbal cues)
- Be clear about the nature of the group rules
  - Yalom, 2005

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## Qualities of a Group clinician

- Have a firm sense of own identity
- Be aware of their own capacities and tendencies
- Be in control of their own emotional reactions
- Must be confident
- Creative and Flexible
- Be familiar with their institutions policies and regulations
- Show trust
- Have a sense of Humor
- Be able to project empathy

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## Clinician's Responsibility

- Creating and convening the group (set time and location)
- Choosing group members
- Facilitator/clinician is the unifying force
- Recognize and deter any threats to group cohesiveness (tardiness, absences, sub-grouping, extra group socialization, etc.)
  - Yalom, 2005

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## Group Therapy

- What does a group look like and how is it different from an individual session?
- What is a CBT group and how is it different than a process group.
- How do you as the clinician, prepare for a group session?

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## The Group Format

- Location and time should be consistent
- Important to begin and end on time
- Is it an Open or Closed group?
  - Will you need to introduce, or have new members introduce themselves?
- Length of group (60-90 minutes) depending on type of group and number of members
- Number of group members (ideally 8-10)

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## Aspects of a Healthy Group

- Assumes responsibility for its own functioning
- Can determine when it is working effectively or wasting time
- Promotes safe self-disclosure of intimate parts of themselves
- Is considered to be important by the group members
- Allows for continuity from one meeting to another
- Engages all group members

SOURCE: Yalom, 2005

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## Addressing Problems

Behavior: Occupying too much session time with an issue that has been addressed.
Intervention: Politely suggest that it is time to allow others to discuss their issues and move on.

Behavior: Arguing in favor of behavior that is counter to recovery (e.g., using, dropping out of group, using self-control instead of avoiding triggers) after receiving repeated feedback.
Intervention: Point out the futility of these sorts of approaches in light of the realities of addiction and the experience of others. If the client continues along the same lines, ask him or her to listen for the remainder of the group. Address individually.

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## Addressing Problems

Behavior: Making threatening, insulting, or personally directed remarks; behaving in a manner obviously indicative of intoxication.

Intervention: Take the client out of the group, and let the recovering co-leader lead the group. Have a brief individual session with the difficult client, or have another counselor intervene. Be sure that the client has calmed down before leaving him or her. Arrange for transportation home, if the client cannot drive or get home safely.

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## Addressing Problems

Behavior: Having a general lack of commitment to treatment, as evidenced by poor attendance, resistance to treatment intervention, disruptive behavior, or repeated relapses.

Intervention: Reassess and adjust the treatment plan in an individual or conjoint session with the uncommitted client. If the client agrees not to show up intoxicated or engage in inappropriate behavior, he or she can be allowed to attend the meeting but should be asked to listen and not to speak. The client should be given some discussion time at the end of this session, contingent on appropriate behavior.

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## Group Clinician Skills

- Need to understand skills development
- Familiar with group process issues
- Monitor patients for signs of potential relapse
- Nonjudgmental, supportive, & non-punitive
- Manage abstinence violation effect and minimize the impact of a single lapse
- Understand the impact of a potential relapse

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## Group Clinician Skills

- Focuses on changing cognition (beliefs, judgments and perceptions)
- Fosters development of problem-solving skills
- Knowledgeable in cognitive-behavioral therapy theory
- Can be active/directive to relatively non-directive
- Be non-confrontational

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## Group Clinician Skills

Knowledge of:

- Basic group therapy
- Understanding the way groups grow and evolve
- How people relate to one another

Experience with:

- Fostering interaction
- Managing conflict
- Demonstrating the skill set participants are attempting to develop

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## Break

break

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## CBT Technique: Functional Analysis

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## Functional Analysis

".. an open-ended exploration of the patients' substance use history, their view of what brought them to treatment and their goals for treatment." Carroll, 1998

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## Functional Analysis

Initially used in treatment to identify thoughts, feelings and circumstances surrounding drug use:

- Assess the determinants (high risk situations) leading to use;
- Provides insights into the reasons for use.

Utilized later in treatment to identify situations which continue to be difficult for the individual.

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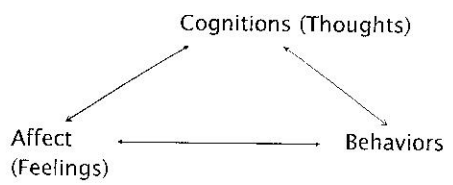
## Cognitive Triad (The ABCs)

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## What do we need to know?

- Does the patient recognize the need to reduce the availability of drugs and alcohol?
- Have they been able to recognize cues or triggers to their use?
- Have there been any periods of abstinence?
- What events have led to relapse?
- How has the patient managed periods of craving and distress without using?
- Is there a concurrent psychiatric disorder which may make behavior change more difficult?

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## Patient's skills and strengths?

- What have they demonstrated during previous periods of abstinence?
- Have they made, or maintained any educational or vocational progress during their use?
- What positive relationships do they have?
- Do they have non-drug using friends or relationships?
- What social support do they have to support abstinence?
- How does the patient spend time when not using or recovering from drug use?
- What was their highest level of functioning prior to initiating their drug/alcohol use?
- Why are they coming to treatment now?
- How motivated are they? What is their motivation?

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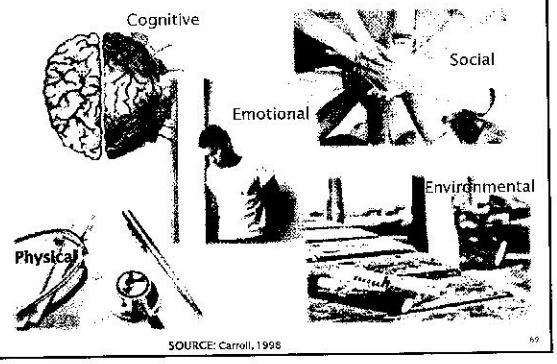
## What are the Relevant Domains?




SOURCE: Carroll, 1998

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## Social

- With whom to they spend the majority of their time?
- Who do they use drugs with?
- Who are the people they don't use drugs with?
- Do they live with a substance user(s)?
- What does their social network look like now that they are using, versus when they weren't using?

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## Environmental

- What are the environmental cues, (people, places, situations)?
- What is their day-to-day exposure to these cues?
- Which of these cues can they avoid?

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## Emotional

- "Feeling" states commonly precede substance use or craving.
- Early in treatment, patients have difficulty linking specific emotional states to their substance use.
  - Negative states including depression, anxiety, boredom, and anger, as well as;
  - Positive states including excitement, joy, and wanting to celebrate
  - Mania?

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## Cognitive

- Thoughts or cognition can precede substance use and or craving.
- The relative intensity of these thoughts and their impact can increase or diminish over the course of treatment.
- These thoughts often have a sense of urgency and are often very powerful.

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## Physical

- Relief from the discomfort of withdrawal has been identified as an antecedent of drug use (negative reinforcement)
- A set of physical symptoms or sensations associated with specific categories of drugs (what does withdrawal from alcohol look like? Opioids? Stimulants?)

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## The 5 Ws (functional analysis)

The 5 Ws of a person's drug use (also called a functional analysis)

- When?
- Where?
- Why?
- With / from whom?
- What happened?

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## The 5 Ws

- People who become dependent on drugs do not use them at random. It is important to know:
- The time periods **when** the patient uses drugs
- The places **where** the patient uses and buys drugs
- The external cues and internal emotional states that can trigger drug craving (**why**)
- The people with **whom** the patient uses drugs or the people from **whom** she or he buys drugs
- The effects the patient receives from the drugs — the psychological and physical benefits (**what happened**)

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## Questions clinicians can use to learn the 5 Ws

- What was going on before you used?
- How were you feeling before you used?
- How / where did you obtain and use drugs?
- With whom did you use drugs?
- What happened after you used?
- Where were you when you began to think about using?

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**Functional Analysis or High-Risk Situations Record**

| Antecedent Situation | Thoughts | Feelings and Sensations | Behavior | Consequences Positive/Negative |
|---|---|---|---|---|
| Where was I? | What was I thinking? | How was I feeling? | What did I do? | What happened after? |
| | | | What did I use? | |
| Who was with me? | | What signals did I get from my body? | How much did I use? | How did I feel right after? |
| | | | What paraphernalia did I use? | How did other people react to my behavior? |
| What was I doing? | | | | |
| When did I first become aware of wanting to use? | | | What did other people around me do at the time? | Any other consequences? |

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## First 20 minutes

- Set agenda for session
- Focus on understanding patient's current concerns (emotional, social, environmental, cognitive, physical)
- Focus on getting an understanding of patient's level of general functioning
- Obtain detailed, day-by-day description of substance use since last session.
- Assess substance use, craving, and high-risk situations since last session.
- Review and assess their experience with the practice exercise.
- ****Patients should do most of the talking during this part of the session with the clinician guiding with questions and reflections.**

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## Activity 2: Role-play of a functional analysis

Conduct a role-play of a functional analysis:

1. Identify high-risk situations
2. Review 5 W's with group
3. (debrief only)Provide analysis of how this information will guide treatment planning

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## Review/Discussion of Group Session Role-Play

- How was that for you?
- What worked well?
- Were you able to relate to the topic?
  - As the patient?
  - As the clinician?
- What would you have done differently?
- How is this the same as what you routinely do?
- How is this different than what you routinely do?

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Lunch

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## CBT Techniques for Substance Use Disorders: Triggers and Craving

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## Group Curriculum

- Where do we find the skills to teach?
- Use of manuals to plan the skills taught and the order of presentation.
- Several manuals available in public domain:
  - National Institutes of Health (NIH)
    - https://pubs.niaaa.nih.gov/publications/projectmatch/match03.pdf
  - National Institutes (NIDA)
    - https://archives.drugabuse.gov/sites/default/files/cbt.pdf
- Other curricula available for purchase

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## Cognitive-Behavioral/Relapse Prevention (CBT/RP) Groups

- Well accepted in substance use disorder treatment
- Promotes cognitive restructuring
- Presents dependency as a learned behavior
- Changes behavior by altering thinking patterns, beliefs and perceptions
- Facilitates the development of social networks to support abstinence

SAMHSA-Substance Abuse Treatment: Group Therapy TIP 41

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## CBT/RP Characteristics

- Provides structure
- Promotes an examination of emotions, thoughts, and beliefs that lead to maladaptive behavior
- Goal-oriented
- Often manual-driven
- Focuses on immediate problems rather than the historical roots of those problems

SAMHSA-Substance Abuse Treatment: Group Therapy TIP 41

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## RP Group Characteristics

- Focus on activities, problem solving and skills building
- Often derived from principals of cognitive therapy
- A form of skills development
- Work to increase a sense of self-control
- Effective in group or individual format

SAMHSA-Substance Abuse Treatment: Group Therapy TIP 41

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## Relapse Prevention

- Relapse is not a random event
- The process of relapse follows predictable patterns
- Signs of impending relapse can be identified by staff members and clients

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## Relapse Prevention Plan: Key Components

- Events or situations that triggered relapse in the past
- Early warning signs experienced in the past
- Things that help when experiencing an early warning sign
- People who help me
- What I would like them to do
- People I would like to contact in an emergency

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## Relapse Prevention group

Goals of Relapse Prevention Group:

- Allow clients to interact with other people in recovery
- Alert clients to the pitfalls of recovery and precursors of relapse
- Give clients the strategies and tools to use in sustaining their recovery
- Allow the counselor to witness the personal interactions of clients
- Allow clients to benefit from participating in a long-term group experience

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## "Triggers" (conditioned cues)

- One of the most important purposes of the 5 Ws exercise is to learn about the people, places, things, times, and emotional states that have become associated with drug use for your patient.
- These are referred to as "**triggers**" (conditioned cues).

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## "Triggers" for drug use

- A "trigger" is a "thing" or an event or a time period that has been associated with drug use in the past
- Triggers can include people, places, things, time periods, emotional states
- Triggers can stimulate thoughts of drug use and craving for the drug high

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## External triggers

- People: drug dealers, drug-using friends;
- Places: bars, parties, drug user's house, parts of town where drugs are used;
- Things: drugs, drug paraphernalia, money, alcohol, movies with drug use;
- Time periods: paydays, holidays, periods of idle time, after work, periods of stress.

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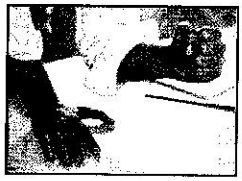
## Internal triggers

- Anxiety
- Anger
- Frustration
- Sexual arousal
- Excitement
- Boredom
- Fatigue
- Happiness



These are just examples; there are many more.

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## Trigger Process for Drug Use and Other Problematic Behaviors

**Trigger** → **Thought** → **Craving** → **Use**

**Trigger** → **Thought** → **Emotion** → (Impulsive) Problematic Behavior

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## CBT Techniques for Addiction Treatment: High-Risk & Low-Risk Situations

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## High- and low-risk situations (1)

- Situations that involve triggers and have been highly associated with drug use are referred to as high-risk situations.
- Other places, people, and situations that have never been associated with drug use are referred to as low-risk situations.

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## High- and low-risk situations (2)

An important CBT concept is to teach patients to decrease their time in high-risk situations and increase their time in low-risk situations.

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## Understanding Craving

- Craving (definition)
  - To have an intense desire for
  - To need urgently; require
- Similar to a hunger for food or thirst for water, but feels even more urgent
- Combination of thoughts and feelings
- Powerful physiological component that makes it a very difficult to resist

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## Craving: Different for everyone

- Cravings or urges are experienced in a variety of ways by different clients.
- For some, the experience is primarily somatic. For example, "I just get a feeling in my stomach," or "My heart races," or "I start smelling it."
- For others, craving is experienced more cognitively.
  - "I need it now" or "I can't get it out of my head" or "it calls me."

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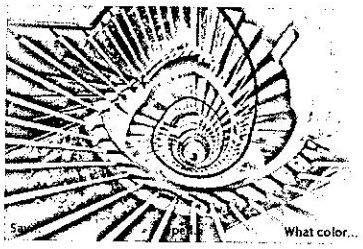
## Conditioning – Activity




Follow the trainer's instructions

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## Understanding Craving: Thoughts

Automatic thoughts

- Immediate, quick, reflexive thoughts that we have in response to a situation
- Often they are rooted in mistaken beliefs or attributions, or misperception of a situation
- Problematic automatic thoughts lead to negative emotions and inappropriate reactions
- Sometimes we don't even notice them consciously, and they are almost never examined or questioned
- Learning to monitor these automatic thoughts is an essential first step in making use of CBT

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## Understanding Craving: Thoughts

Examples of automatic thoughts

- "She thinks I'm weird"
- "I failed the test; I'll never get a driver's license"
- "I'll never get a job"
- "He's disrespecting me!"
- "OMG she's staring at me, what's wrong with me?"
- "My boss said most of my work is good but there are some things I could do better – I'm gonna get fired"

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## Understanding Craving: Thoughts

Types of automatic thoughts: Expectations

- Expectations – thoughts that certain behavior will bring about certain outcomes, defined in broad terms as pleasure or pain
- Self-efficacy – expectation of being able to accomplish a particular task, or particular reaction to a specific type of situation
- The higher the self-efficacy, the greater the chance that they will accomplish it
- Succeeding reinforces the expectation of succeeding the next time
- Failing reinforces the expectation that they will "never" be able to do it

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## Coping with craving

- Many individuals believe that once they begin to crave drugs, it is inevitable that they will use
- In their experience, they always "give in" to the craving as soon as it begins
- In CBT, it is vital to provide tools to resist craving

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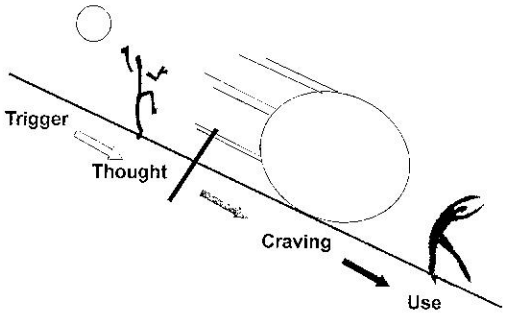
## Triggers and Cravings

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## Strategies to cope with craving

Coping with Craving:

1. Engage in non-drug-related activity
2. Talk about craving
3. "Surf" the craving
4. Thought stopping
5. Contact a drug-free friend or counselor
6. Prayer/meditation/mindfulness/ grounding

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## Second 30 minutes

- Introduce and discuss session topic
- Relate session topic to current concerns
- Make sure you are at the same level as patient and that the material and concepts are understood
- Practice skills

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## Role Play

- Section 2:
  Lead discussion re: Triggers
  Introduce the topic
  Identify automatic thoughts
  Link thought/feeling/behavior

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## Review/Discussion of Group Session Role-Play

- How was that for you?
- What worked well?
- Were you able to relate to the topic?
  - As the patient?
  - As the clinician?
- What would you have done differently?
- How is this the same as what you routinely do?
- How is this different than what you routinely do?

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## Break

break

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## Part 3: Generalization
## Creating a Daily Recovery Plan

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## Develop a plan (1)

Establish a plan for completion of the next session's homework assignment.

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## Develop a plan (2)

- Many drug users do not plan out their day. They simply do what they "feel like doing." This lack of a structured plan for their day makes them very vulnerable to encountering high-risk situations and being triggered to use drugs.
- To counteract this problem, it can be useful for patients to create an hour-to-hour schedule for their time.

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## Develop a plan (3)

- Planning out a day in advance with a patient allows the CBT clinician to work with the patient cooperatively to maximise their time in low-risk, non-trigger situations and decrease their time in high-risk situations.
- If the patient follows the schedule, they typically will not use drugs. If they fail to follow the schedule, they typically will use drugs.

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## Develop a plan (4)

A specific daily schedule:
- Enhances your patient's self-efficacy
- Provides an opportunity to consider potential obstacles
- Helps in considering the likely outcomes of each change strategy

Nothing is more motivating than being **well prepared**!

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## Stay on schedule, stay sober

- Encourage the patient to stay on the schedule as the road map for staying drug-free.
  - Staying on schedule = Staying sober
  - Ignoring the schedule = Using drugs

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## Develop a plan: Dealing with resistance to scheduling

- Patients might resist scheduling ("I'm not a scheduled person" or "In our culture, we don't plan our time").
- Use modelling to teach the skill.
- Reinforce attempts to follow a schedule, recognizing perfection is not the goal.
- Over time, let the patient take over responsibility for the schedule.

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## Activity 4: Exercise

Break out into groups; create your own 24-hour behavioral plan using the Daily / Hourly Schedule form provided. Role play as a clinician or patient then reverse the roles, planning out your day from the time you leave here until you return tomorrow.

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## Final 30 minutes

- Explore patient's understanding of and reaction to the topic
- Assign practice exercise for next week
- Review plans for the period ahead and anticipate potential high-risk situations
- Use scheduling to create practice plan for next time period

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## Scheduling/Practice Review

- How was it to follow a schedule?
- Was it easier or harder than expected?
- What were you able to do?
- What did not work so well?
- If you had it to do over, how would you have scheduled your time differently?

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## CBT Group Session–Activity

- Introduce the topic (provide a rationale as to why this is important to cover)
- Determine who will begin to read the material. Thank the reader and ask what they thought about what they read.
- Request that someone else read and repeat the process until the material is covered.
- Review each segment with the group.
- Ask for input/feedback on how the patient might see this as being relevant to their own life. You might need to provide examples here.
- Allow the group time to respond in writing to the questions on the form and review their responses.

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## Review/Discussion of Group Session Role-Play

- How was that for you?
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  - As the clinician?
- What would you have done differently?
- How is this the same as what you routinely do?
- How is this different than what you routinely do?

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## Thank You!

For additional information on this
or other training topics, please visit:

**www.psattc.org**
**www.uclaisap.org**

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