SUPPORT ACT 101: 12 INDIVIDUAL THERAPY SKILLS

Paul Brasler, M.A., M.S.W.
Licensed Clinical Social Worker

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Disclaimer

- The information contained in this material can change as we learn more about the brain and the ways it is impacted by the environment, trauma, medications, substances of misuse, and other things
- The material in this webinar is intended for use by licensed clinicians, or licensed-eligible clinicians receiving clinical supervision
- Always follow the guidelines of your agency, ethical and legal standards of your certifying Board, evidence-based practice methods; local, state and Federal laws as well as your judgement and commonsense when working with clients

Questions?

If you have any questions, please do not hesitate to contact the author at

paul.brasler@dmas.Virginia.gov

SUPPORT Act Courses

1: ~~Tele-Behavioral Health in the Time of COVID-19~~ (No longer available—Incorporated into all courses!)

2: Client Engagement

3: Suicide

4: Crisis & De-Escalation

5: Withdrawal Syndromes & Withdrawal Management

6: Trauma-Informed Care

7: Overview of SUD

8: Opioids & Stimulants

9: SUD Treatment Basics

10: Screening & Assessment

11: Co-Occurring Disorders

12: Individual Therapy Skills

13: Group Therapy Skills

Recommendation

I highly recommend you review the following courses prior to this one:

2: Client engagement (which includes Motivational Interviewing)

6: Trauma-Informed Care

9: SUD Treatment Basics

Program Content

I. Psychodynamic Approaches

II. Cognitive-Behavioral Approaches

III. Tele-Behavioral Health Basics

PSYCHODYNAMIC APPROACHES

Psychodynamic Therapy

- Based on **Ego Psychology** and **Object Relations Theory**
- Typically conducted as individual therapy, and can be used alongside traditional group-based substance-abuse treatment or in place of group treatment
- The basic goal of Psychodynamic Therapy is to try and determine why the person uses drugs and what can be changed to limit or eliminate the person's continued use of drugs
- Also posits that substances are used to replace something missing in the person's life, or as a reaction to the damaged ego or a missing (or negative) "object"

Psycho-dynamic Therapy: A Word of Caution

- Cabaj (2000) cautions that traditional psychotherapy with active substance users is usually contraindicated because insight does not necessarily lead to recovery and can, in fact, lead to rationalizations for continued substance abuse (as cited in Anderson, 2009)
- Therefore psychodynamic therapies should be reserved for clients who are not ambivalent about changing and who are motivated for treatment
- In the absence of this, I recommend Motivational Interviewing to engage the client

Ego Psychology: Major Concepts

(Hauser & Safyer, 1995, as cited in Walsh, 2009)

- People are born with an innate capacity to adapt to their environments, and this capacity further develops through learning and psychosocial maturation
- Social influences on psychological functioning are significant, and many of these are transmitted through the family unit
- The innate drives of ***mastery*** and ***competence*** are important motivators of human behavior
- Problems in social functioning can occur at any stage of development, due to person-in-environment, as well as internal, conflicts

Defense Mechanisms

- We use defense mechanisms (often unconsciously) when faced with strong feelings of anxiety, doubt, shame or guilt
- These mechanisms often spiral out-of-control in our clients who misuse substances
- Some of the more common defense mechanisms:
  - *Denial (refusal to accept reality)*
  - *Repression (forcing unpleasant thoughts into unconsciousness)*
  - *Projection (placing our feelings onto others)*
  - *Displacement (redirection of behaviors onto a substitute)*
  - *Sublimation (replacing unacceptable behaviors with socially-acceptable one)*
  - *Regression (retreating to an earlier stage of development)*
  - *Rationalization (making up 'logical solutions' for why things happen)*

Object Relations Theory

- Derived from Ego Psychology
- “Objects” are people or parts of an individual’s personality
- Focuses on our internalized attitudes toward others and the self
- **Ego Psychology focuses on drives, but Object Relations looks at relationships**
- Attachment: All people have a biological need to form attachments with others to meet their emotional needs

Object Relations Theory

Self-object: How we view ourselves

True self vs. false self

Object constancy

"Good-enough mothering" (D. Winnicott): Mother has a primary preoccupation with the baby's welfare above all else; good moms will do these temporarily, and then return to other demands

Psychodynamic Therapy: Concepts of Practice with People with SUD

- **Narcissistic Crisis:** Drugs are used because the collapse of a "grandiose self" or idealized object that creates a reason to use in order to deal with the narcissistic injury (shame, guilt, rage, and frustration)
- Hidden (unconscious) pain as the source of stress that leads to substance use
- The need for control (and substances as a means to assert control)
- Displacement of anger toward an object or narcissistic injury to the use of drugs
- Identifying and confronting defense mechanisms
- Transference and counter-transference

Psychodynamic Therapy: Concepts of Practice with People with SUD

- Confrontation is used, typically regarding recovery, but is only done once a therapeutic relationship is established
- Relapse, or feelings of wanting to relapse, are seen as opportunities to learn more about the factors that lead to the client's use
- Understanding one's family of origin is also important, especially the roles that the person played in their family
- The therapist must remain aware that the patient can become dependent on them (the therapist) in place of a drug or another object; if this causes an intractable problem, a new counselor may be needed

Case Study: Cassandra (Part 1)

- "Cass" is 30 years old
- This is her sixth week of individual counseling to address an addiction to prescription opioids and benzodiazepines
  - *She has been sober for two months*
  - *She also attends AA meetings three times a week*
- She was in an abusive marriage for 10 years; her opioid use began after she was treated for a broken back after being thrown down a flight of stairs
  - *Soon-to-be ex-husband is in prison for malicious wounding*
- Cass has two children, ages six and eight
  - *The kids are doing well at this time, all things considered*

Case Study: Cassandra (Part 2)

- Cas is now living with her parents as she seeks to regain financial independence—she plans on moving out ASAP
- Cass's father is supportive, but is often emotionally distant
- Her mother is very critical of her, and always has been
- Cass just started a new romantic relationship that she is happy about but is taking things very slow
- She also struggles with anxiety and depression and is very worried about relapse

1. Conceptualize this case using a psychodynamic approach
2. What would your next steps be?

COGNITIVE-BEHAVIORAL INTERVENTIONS

A-B-C Model

The A-B-C Model

A = Activating Event: Something happens

B = Belief: The Activating Event causes the client to have a belief, which can be rational or irrational

C = Consequence: Rational beliefs lead to healthier consequences; irrational beliefs lead to unhealthier consequences

- The ABC model holds that events do not cause our emotions, but our **beliefs/interpretations** of the events do
- CBT challenges clients to examine, interpret and re-evaluate their beliefs, therefore changing their behaviors

Cognitive Therapy: Foundations of Practice

- Collaboration
- Case Conceptualization
- Structure
- Patient Education
- Application of cognitive-behavioral techniques

Cognitive Therapy: Foundations of Practice

Substance use is seen as a learned behavior and can be modified by changing the cognitive process by:

- *Management of cravings*
- *Avoidance of high-risk situations*
- *Case management*
- *Mood regulation*
- *Lifestyle change*

Principles of Cognitive Treatment

1. Cognitive therapy is based on a unique cognitive conceptualization of each patient
2. A strong therapeutic alliance is essential
3. Cognitive therapy is goal-directed
4. The initial focus of therapy is on the present
5. Cognitive therapy is time-sensitive
6. Therapy sessions are structured, with active participation expected from the client
7. Patients are taught to identify and respond to dysfunctional thoughts
8. Cognitive therapy emphasizes psychoeducation and relapse prevention

1. Cognitive Therapy is Based on a Unique Cognitive Conceptualization of Each Patient

- Analysis of the current problems, thoughts and reactions
- The counselor and client look for the client's automatic thoughts to identify their basic, core, dysfunctional beliefs: "I am useless"
- Also identify coping patterns (both positive and negative)
- Then the thoughts are connected to the actions
- Next, the client's developmental history is examined to try and determine how the client came to these beliefs
- Exploration of how these beliefs may not be true today, and were probably not true in the first place
- The cyclical problem of substance use is examined, with highlights on the points where intervention can occur

Case Conceptualization: Essential Components

- Relevant childhood data
- Current life problems
- Core beliefs or schemas (“I am unlovable”)
- Conditional assumptions/beliefs/rules
- Compensatory strategies
- Vulnerable situations
- Automatic thoughts and beliefs (especially drug-related)
- Emotions
- Behaviors
- Integration of the above data

2. A Strong Therapeutic Alliance is Essential

The client as expert and the counselor as shared-collaborator

Counselors explain what they are doing to the client and allow the client to test their own doubts

Counselors try to avoid activating their clients' core, negative beliefs, therefore they must pay close attention to their body language

3. Cognitive Therapy is Goal-Directed

Goals are set in the first session, and revisited regularly

Specific objectives and smaller goals help the client reach their main goals

Therapists provide honest feedback, and question how much the client really wants to meet their goals

Use of the pros and cons of changing, which we at looked when we discussed Motivational Interviewing, can be used here

4. The Initial Focus of Therapy is on the Present

- Address both mental health and substance abuse issues
- Role-play current problems and situations
- Anticipate all possible outcomes in a given situation and prepare for as many of them as possible
- The focus on the past is different from the Psychodynamic approach of examining the past
  - *The past, particularly family relationships, can be examined later*

5. Cognitive Therapy is Time-Sensitive

- Begin with the end in mind: “How will things look in your life once you have accomplished your goals?”
- Weekly (or more) sessions are recommended in the beginning phases of treatment
- Sessions are decreased as the client successfully begins using the tools (coping strategies, mood stabilization) they learn in treatment
- An open-door policy is usually instituted at the end of treatment so the client can return to counseling if they choose to

6. Therapy Sessions Are Structured, With Active Participation Expected From the Client (Part 1)

- *Mood check: "How are you feeling today?"*
- *Discuss any recent substance use (amount, type, frequency)*
- *Explore the client's progress, including how they felt about coming to treatment today*
- *Client and therapist set an agenda on what they are going to discuss today (looking at recent events and upcoming ones)*
- *Counselor then bridges to the previous session by asking the client to recall what was discussed (clients are encouraged to take notes and review them during the week)*

6. Therapy Sessions Are Structured, With Active Participation Expected From the Client (Part 2)

- *Review of homework from previous session*
- *Address specific items of concern to the client and problem-solve as needed*
- *Homework*
- *Constant summarizing to ensure the client understands*
- *The counselor asks for feedback at the end of the session*

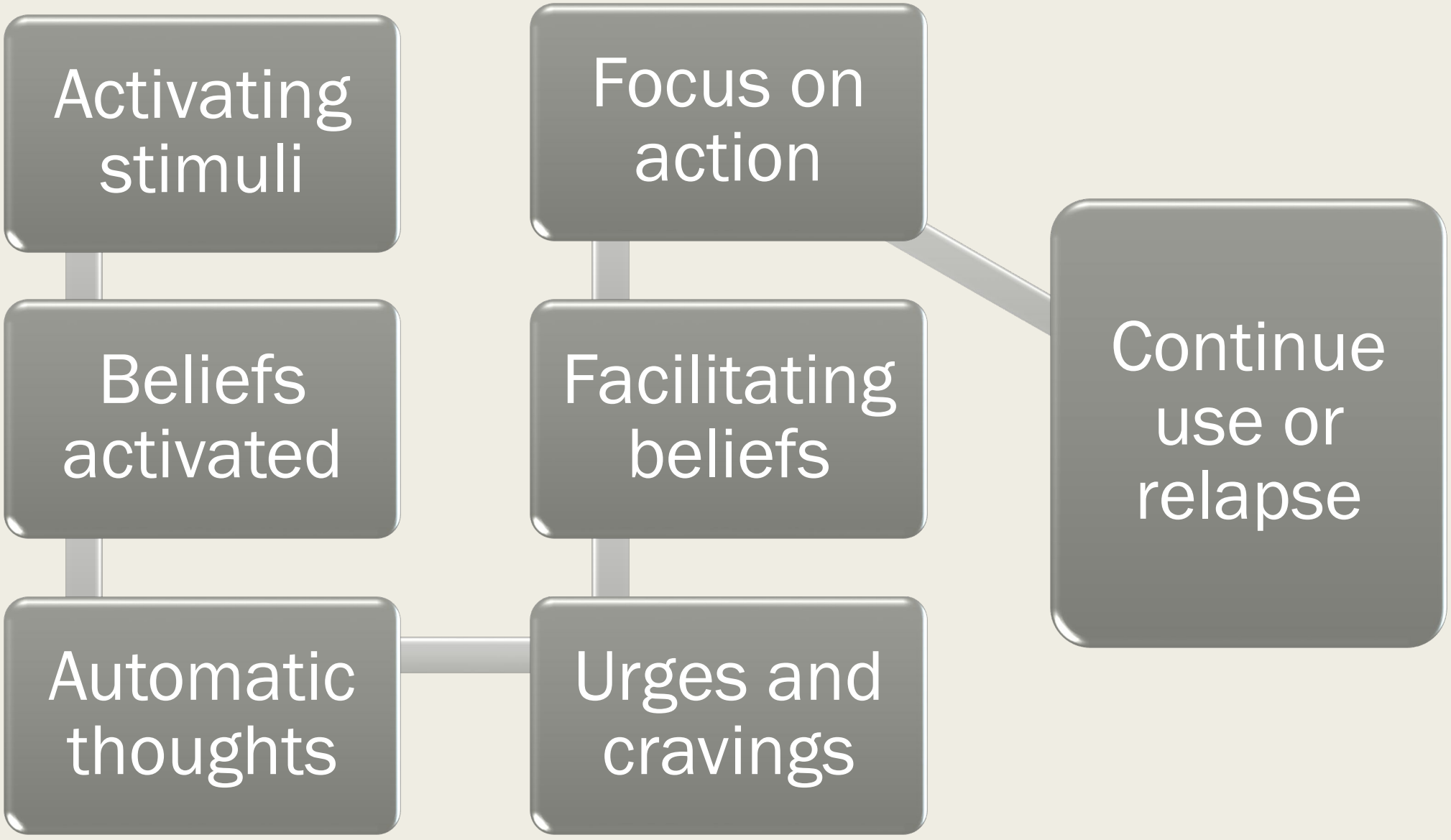
7. Patients Are Taught to Identify and Respond to Dysfunctional Thoughts

- The therapist emphasizes the cognitive model in each session: Our thoughts influence how we think, feel and behave
- Client and counselor discuss and investigate whether a given automatic thought is distorted
- When evaluating thoughts, the counselor usually asks questions of the client

8. Cognitive Therapy Emphasizes Psychoeducation and Relapse Prevention

- The counselor's goal is to maximize the client's learning
- Both counselor and client take notes as needed
- The therapist as a teacher
- The counselor wants to make the client their own best "cognitive therapist"
- Relapse prevention, including the use of role-plays, is emphasized

Cognitive Model of Substance Abuse



An Example of the Cognitive Model

Steps in Cognitive Therapy

- Help your client identify their automatic thoughts
  - *"What am I thinking right now?"*
- Help them recognize that these automatic thoughts are not completely valid
  - *"Is what I am thinking true?"*
- This helps the client to move toward seeing themselves more realistically
  - *This allows them to see situations differently*
- Use some of the tools used in counseling
  - *Reminder cards: "When I feel _____, I will ____ instead of _____."*
- When this happens, they will hopefully have less need to use substances
- Therapy will also focus on developing new habits to replace the older ones (substance use)
  - *"What could you do differently?"*

Breaking Down the Example

- The fight (Activating Stimuli)
  - *Self-awareness/self-talk: "I am vulnerable when I am angry"*
- Thoughts of drinking (Beliefs)
  - *Use a decisional balance: Drink/no drinking*
- Find ways to recognize and challenge automatic thoughts
  - *Use card prompts*
- See cravings and urges as temporary
  - *Wait five minutes before doing anything else*
- Challenge facilitating beliefs
  - *What are some ways to distract yourself or do something different?*
- Carry out the plan to do something different
  - *Listen to music, call your sponsor*

TELE-BEHAVIORAL HEALTH BASICS

Tele-Behavioral Health

We first need to admit that most of us do not enjoy “connecting” with clients this way; “I didn’t go to school for this!”

We also need to acknowledge that not all clients have access to technology to participate in tele-behavioral health and so we have to improvise

Therefore practitioners and clients are using phones, Skype and FaceTime to conduct sessions; and getting creative in other ways

Clinicians do not have to use HIPAA-compliant video conferencing technology during the current National Emergency; Health & Human Services will waive any penalties for HIPAA violations related to the platform used during this emergency

Tele-Behavioral Health: Clinician

- Have a space set up where you can connect with your client without being disturbed
- Your work-space should provide some privacy for your client
- Internet connectivity and/or phone signal strength should be tested prior to engaging in tele-behavioral health
- If conducting a group therapy session, educate clients on muting themselves unless they are speaking
- I recommend against using your personal phone, but sometimes this cannot be avoided
  - *If using a personal device, I would set firm boundaries with clients regarding when they can and cannot contact you*

Tele-Behavioral Health: Clinician

You'll likely notice that the flow of clinical sessions will be slower than in-person

Be aware that you will likely need to speak slower than in person

Try to express empathy with your voice, especially when not connecting via video

Tele-Behavioral Health: Client

- Try to have a private space where you can connect with your counselor that is also free from interruptions and distractions
- Test out your communications system (connectivity) prior to meeting with your counselor
- Most of us (counselors especially) don't like meeting this way, so remember this is temporary and we (like you) look forward to meeting face-to-face again

Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

- A statement explaining what tele-behavioral health will look like for you and the client (methods to be utilized: FaceTime, phone, etc.)
- A statement discussing the risks of tele-behavioral health (technology limitations and failures; possible/unintentional breaches of confidentiality)
- A statement agreeing that the sessions will not be recorded by either party
- A statement emphasizing that the content of the session is confidential and that a written release is required from the client to release information
- A statement noting the limits of confidentiality, including having to report suspected child abuse, vulnerable adult abuse, danger to self or others

Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

- A statement explaining what steps must be taken should the clinician believe that the client is a danger to themselves, a danger to others or is unable to care for themselves
  - *This could include a statement that participation in tele-behavioral health may not be appropriate and a higher level of care could be required*
- A statement describing how you will handle technical problems should they arise
- A statement explaining that the client must disclose their physical location during the session and an individual the clinician can contact in case of an emergency
- A statement that you are continuing to maintain treatment records during this time

Documentation

- If you don’t write it down, it never happened
- Record, in detail, all aspects of client interactions, including any known precipitating events, interventions, outcomes, staff members involved and all contacts with outside agencies
- Record where the client says they are contacting you from
- Do this as quickly as possible following the session
- **Stick to the facts**; do not presuppose or assume anything
- See documentation as a necessary means to protect yourself, the people you serve, and your organization

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