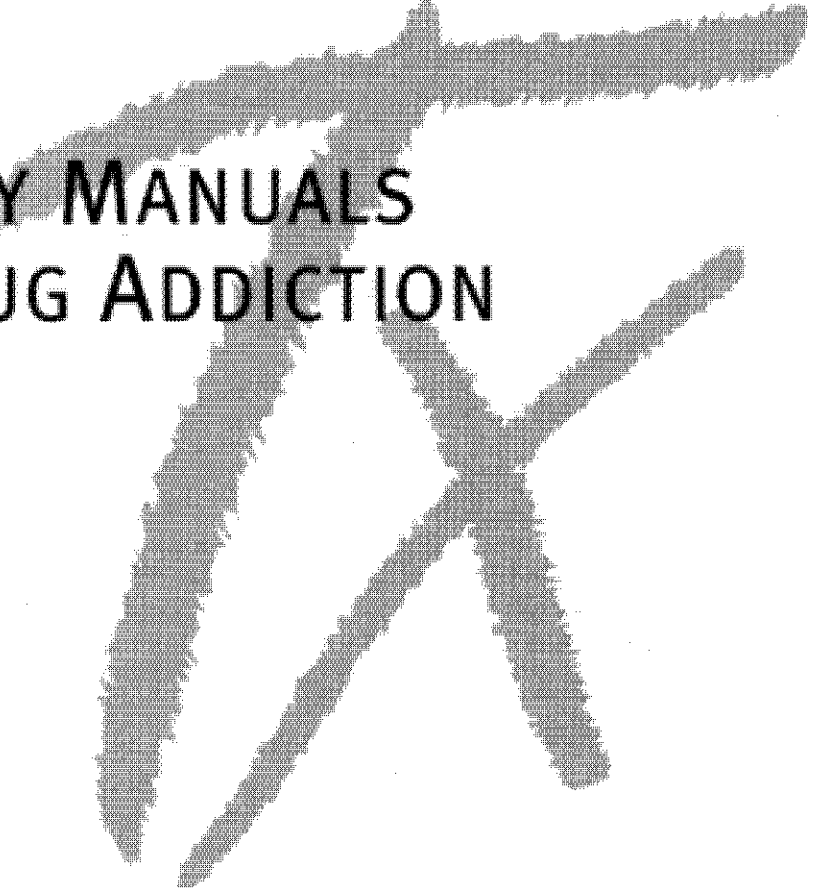


National Institute on Drug Abuse

THERAPY MANUALS FOR DRUG ADDICTION

Manual

A Cognitive- Behavioral Approach: Treating Cocaine Addiction



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A Cognitive- Behavioral Approach: Treating Cocaine Addiction

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Foreword

More than 20 years of research has shown that addiction is clearly treatable. Addiction treatment has been effective in reducing drug use and HIV infection, diminishing the health and social costs that result from addiction, and decreasing criminal behavior. The National Institute on Drug Abuse (NIDA), which supports more than 85 percent of the world's research on drug abuse and addiction, has found that the most effective treatment approaches include both biological and behavioral components.

To ensure that treatment providers apply the most current science-based approaches to their patients, NIDA has supported the development of the “Therapy Manuals for Drug Addiction” series. This series reflects NIDA's commitment to rapidly applying basic findings in real-life settings. The manuals are derived from those used efficaciously in NIDA-supported drug abuse treatment studies. They are intended for use by drug abuse treatment practitioners, mental health professionals, and all others concerned with the treatment of drug addiction.

The manuals present clear, helpful information to aid drug treatment practitioners in providing the best possible care that science has to offer. They describe scientifically supported therapies for addiction and give specific guidance on session content and how to implement these techniques. Of course, there is no substitute for training and supervision, and these manuals may not be applicable to all types of patients nor compatible with all clinical programs or treatment approaches. These manuals should be viewed as a supplement to, but not a replacement for, careful assessment of each patient, appropriate case formulation, ongoing monitoring of clinical status, and clinical judgment.

The therapies presented in this series exemplify the best of what we currently know about treating drug addiction. As our knowledge evolves, new and improved therapies are certain to emerge. We look forward to continuously bringing you the latest scientific findings through manuals and other science-based publications. We welcome your feedback about the usefulness of this manual series and any ideas you have on how it might be improved.

Alan I. Leshner
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Cognitive-Behavioral Therapy: An Overview

Cognitive-behavioral coping skills treatment (CBT) is a short-term, focused approach to helping cocaine-dependent individuals (In this manual, the term cocaine abuser or cocaine-dependent individual is used to refer to individuals who meet DSM-IV criteria for cocaine abuse or dependence.) become abstinent from cocaine and other substances. The underlying assumption is that learning processes play an important role in the development and continuation of cocaine abuse and dependence. These same learning processes can be used to help individuals reduce their drug use.

Very simply put, CBT attempts to help patients recognize, avoid, and cope. That is, RECOGNIZE the situations in which they are most likely to use cocaine, AVOID these situations when appropriate, and COPE more effectively with a range of problems and problematic behaviors associated with substance abuse.

Why CBT?

Several important features of CBT make it particularly promising as a treatment for cocaine abuse and dependence:

- CBT is a short-term, comparatively brief 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 as treatment for cocaine abuse. In particular, evidence points to the durability of CBT's effects as well as its effectiveness with subgroups of more severely dependent cocaine abusers (see appendix B).
- CBT is structured, goal-oriented, and focused on the immediate problems faced by cocaine abusers entering treatment who are struggling to control their cocaine use.
- CBT is a flexible, individualized approach that can be adapted to a wide range of patients as well as a variety of settings (inpatient, outpatient) and formats (group, individual).

- CBT is compatible with a range of other treatments the patient may receive, such as pharmacotherapy.
- CBT's broad approach encompasses several important common tasks of successful substance abuse treatment.

Components of CBT

CBT has two critical components:

- Functional analysis
- Skills training

Functional Analysis For each instance of cocaine use during treatment, the therapist and patient do a functional analysis, that is, they identify the patient's thoughts, feelings, and circumstances before and after the cocaine use. Early in treatment, the functional analysis plays a critical role in helping the patient and therapist assess the determinants, or high-risk situations, that are likely to lead to cocaine use and provides insights into some of the reasons the individual may be using cocaine (e.g., to cope with interpersonal difficulties, to experience risk or euphoria not otherwise available in the patient's life). Later in treatment, functional analyses of episodes of cocaine use may identify those situations or states in which the individual still has difficulty coping.

Skills Training CBT can be thought of as a highly individualized training program that helps cocaine abusers unlearn old habits associated with cocaine abuse and learn or relearn healthier skills and habits. By the time the level of substance use is severe enough to warrant treatment, patients are likely to be using cocaine as their single means of coping with a wide range of interpersonal and intrapersonal problems. This may occur for several reasons:

- The individual may have never learned effective strategies to cope with the challenges and problems of adult life, as when substance use begins during early adolescence.
- Although the individual may have acquired effective strategies at one time, these skills may have decayed through repeated reliance on substance use as a primary means of coping. These patients have essentially forgotten effective strategies because of chronic involvement in a drug-using lifestyle in which the bulk of their time is spent in acquiring, using, and then recovering from the effects of drugs.
- The individual's ability to use effective coping strategies may be

weakened by other problems, such as cocaine abuse with concurrent psychiatric disorders.

Because cocaine abusers are a heterogeneous group and typically come to treatment with a wide range of problems, skills training in CBT is made as broad as possible. The first few sessions focus on skills related to initial control of cocaine use (e.g., identification of high-risk situations, coping with thoughts about cocaine use). Once these basic skills are mastered, training is broadened to include a range of other problems with which the individual may have difficulty coping (e.g., social isolation, unemployment). In addition, to strengthen and broaden the individual's range of coping styles, skills training focuses on both intrapersonal (e.g., coping with craving) and interpersonal (e.g., refusing offers of cocaine) skills. Patients are taught these skills as both specific strategies (applicable in the here and now to control cocaine use) and general strategies that can be applied to a variety of other problems. Thus, CBT is not only geared to helping each patient reduce and eliminate substance use while in treatment, but also to imparting skills that can benefit the patient long after treatment.

Critical Tasks

CBT addresses several critical tasks that are essential to successful substance abuse treatment (Rounsaville and Carroll 1992).

- *Foster the motivation for abstinence.* An important technique used to enhance the patient's motivation to stop cocaine use is to do a decisional analysis which clarifies what the individual stands to lose or gain by continued cocaine use.
- *Teach coping skills.* This is the core of CBT - to help patients recognize the high-risk situations in which they are most likely to use substances and to develop other, more effective means of coping with them.
- *Change reinforcement contingencies.* By the time treatment is sought, many patients spend most of their time acquiring, using, and recovering from cocaine use to the exclusion of other experiences and rewards. In CBT, the focus is on identifying and reducing habits associated with a drug-using lifestyle by substituting more enduring, positive activities and rewards.
- *Foster management of painful affects.* Skills training also focuses on techniques to recognize and cope with urges to use cocaine; this is an excellent model for helping patients learn to tolerate other strong affects such as depression and anger.

- *Improve interpersonal functioning and enhance social supports.* CBT includes training in a number of important interpersonal skills and strategies to help patients expand their social support networks and build enduring, drug-free relationships.

Parameters of CBT

Format

An individual format is preferred for CBT because it allows for better tailoring of treatment to meet the needs of specific patients. Patients receive more attention and are generally more involved in treatment when they have the opportunity to work with and build a relationship with a single therapist over time. Individual treatment affords greater flexibility in scheduling sessions and eliminates the problem of either having to deliver treatment in a “rolling admissions” format or asking patients to wait several weeks until sufficient numbers of patients are recruited to form a group. Also, the comparatively high rates of retention in programs and studies may reflect, in part, particular advantages of individual treatment.

However, a number of researchers and clinicians have emphasized the unique benefits of delivering treatment to substance users in the group format (e.g., universality, peer pressure). It is relatively straightforward to adapt the treatment described in this manual for groups. This generally requires lengthening the sessions to 90 minutes to allow all group members to have an opportunity to comment on their personal experiences in trying out skills, give examples, and participate in role-playing. Treatment will also be more structured in a group format because of the need to present the key ideas and skills in a more didactic, less individualized format.

Length

CBT has been offered in 12 to 16 sessions, usually over 12 weeks. This comparatively brief, short-term treatment is intended to produce initial abstinence and stabilization. In many cases, this is sufficient to bring about sustained improvement for as long as a year after treatment ends. Preliminary data suggest that patients who are able to attain 3 or more weeks of continuous abstinence from cocaine during the 12-week treatment period are generally able to maintain good outcome during the 12 months after treatment ends.

For many patients, however, brief treatment is not sufficient to produce stabilization or lasting improvement. In these cases, CBT is seen as preparation for longer term treatment. Further treatment is recommended directly when the patient requests it or when the patient has not been able to achieve 3 or more weeks of continuous abstinence during the initial treatment.

We are currently evaluating whether additional booster sessions of CBT during the 6 months following the initial treatment phase improves outcome. The maintenance version of CBT focuses on the following:

- Identifying situations, affects, and cognitions that remain problematic for patients in their efforts to maintain abstinence or which emerge after cessation or reduction of cocaine use.
- Maintaining gains through solidifying the more effective coping skills and strategies the subject has implemented.
- Encouraging patient involvement in activities and relationships that are incompatible with drug use. Rather than introducing new material or skills, the maintenance version of CBT focuses on broadening and mastering the skills to which the patient was exposed during the initial phase of treatment.

Setting

Treatment is usually delivered on an outpatient basis for several reasons:

- CBT focuses on understanding the determinants of substance use, and this is best done in the context of the patient's day-to-day life. By understanding who the patients are, where they live, and how they spend their time, therapists can develop more elaborate functional analyses.
- Skills training is most effective when patients have an opportunity to practice new skills and approaches within the context of their daily routine, learn what does and does not work for them, and discuss new strategies with the therapist.

Patients

CBT has been evaluated with a broad range of cocaine abusers. The following are generally *not appropriate* for CBT delivered on an out-patient basis:

- Those who have psychotic or bipolar disorders and are not stabilized on medication
- Those who have no stable living arrangements
- ^a Those who are not medically stable (as assessed by a pretreatment physical examination)
- Those who have other concurrent substance dependence disorders, with the exception of alcohol or marijuana dependence (although we assess the need for alcohol detoxification in the former)

No significant differences have been found in outcome or retention for patients who seek treatment because of court or probation pressure

and those who have DSM-IV diagnoses of antisocial personality disorder or other Axis II disorders, nor has outcome varied by patient race/ethnicity or gender.

Compatibility With Adjunctive Treatments

CBT is highly compatible with a variety of other treatments designed to address a range of comorbid problems and severities of cocaine abuse:

- Pharmacotherapy for cocaine use and/or concurrent psychiatric disorders
- Self-help groups such as Cocaine Anonymous (CA) and Alcoholics Anonymous (AA)
- Family and couples therapy
- Vocational counseling, parenting skills, and so on

When CBT is provided as part of a larger treatment package, it is essential for the CBT therapist to maintain close and regular contact with other treatment providers.

Active Ingredients of CBT

All behavioral or psychosocial treatments include both common and unique factors or “active ingredients.” Common factors are those dimensions of treatment that are found in most psychotherapies - the provision of education, a convincing rationale for the treatment, enhancing expectations of improvement, provision of support and encouragement, and, in particular, the quality of the therapeutic relationship (Rozenzweig 1936; Castonguay 1993). Unique factors are those techniques and interventions that distinguish or characterize a particular psychotherapy.

CBT, like most therapies, consists of a complex combination of common and unique factors. For example, in CBT mere delivery of skills training without grounding in a positive therapeutic relationship leads to a dry, overly didactic approach that alienates or bores most patients and ultimately has the opposite effect of that intended. It is important to recognize that CBT is thought to exert its effects through this intricate interplay of common and unique factors.

A major task of the therapist is to achieve an appropriate balance between attending to the relationship and delivering skills training. For example, without a solid therapeutic alliance, it is unlikely that a patient will stay in treatment, be sufficiently engaged to learn new skills, or share successes and failures in trying new approaches to old problems. Conversely, empathic delivery of skills training as tools to help patients

manage their lives more effectively may form the basis of a strong working alliance.

Essential and Unique Interventions

The key active ingredients that distinguish CBT from other therapies and that must be delivered for adequate exposure to CBT include the following:

- Functional analyses of substance abuse
- Individualized training in recognizing and coping with craving, managing thoughts about substance use, problemsolving, planning for emergencies, recognizing seemingly irrelevant decisions, and refusal skills
- Examination of the patient's cognitive processes related to substance use
- Identification and debriefing of past and future high-risk situations
- Encouragement and review of extra-session implementation of skills
- Practice of skills within sessions

Recommended But Not Unique Interventions

Interventions or strategies that should be delivered, as appropriate, during the course of each patient's treatment but that are not necessarily unique to CBT include those listed below.

- Discussing, reviewing, and reformulating the patient's goals for treatment
- Monitoring cocaine abuse and craving
- Monitoring other substance abuse
- Monitoring general functioning
- Exploring positive and negative consequences of cocaine abuse
- Exploring the relationship between affect and substance abuse
- Providing feedback on urinalysis results
- Setting the agenda for the session
- Making process comments as indicated
- Discussing advantages of an abstinence goal
- Exploring the patient's ambivalence about abstinence
- Meeting resistance with exploration and a problemsolving approach
- Supporting patient efforts
- Assessing level of family support
- Explaining the distinction between a slip and a relapse

- Including family members or significant others in up to two sessions

Acceptable Interventions

Four interventions are not required or strongly recommended as part of CBT but are not incompatible with this approach:

- Exploring self-help involvement as a coping skill
- Identifying means of self-reinforcement for abstinence
- Exploring discrepancies between a patient's stated goals and actions
- Eliciting concerns about substance abuse and consequences

Interventions Not Part of CBT

Interventions that are distinctive of dissimilar approaches to treatment and less consistent with a cognitive-behavioral approach include those listed below.

- Extensive self-disclosure by the therapist
- Use of a confrontational style or a confrontation-of-denial approach
- Requiring the patient to attend self-help groups
- Extended discussion of 12-step recovery, higher power, "Big Book" philosophy
- Use of disease model language or slogans
- Extensive exploration of interpersonal aspects of substance abuse
- Extensive discussion or interpretation of underlying conflicts or motives
- Provision of direct reinforcement for abstinence (e.g., vouchers, tokens)
- Interventions associated with Gestalt therapy, structural interventions, rational-emotive therapy, or other prescriptive treatment techniques

CBT Compared to Other Treatments

It is often easier to understand a treatment in terms of what it is not. This section discusses CBT for cocaine abuse in terms of its similarities to and differences from other psychosocial treatments for substance abuse.

Similar Approaches

CBT is most similar to other cognitive and behavioral therapies, all of which understand substance abuse in terms of its antecedents and

consequences. These include Beck's Cognitive Therapy (Beck et al. 1991) and the Community Reinforcement Approach (CRA) (Azrin 1976; Meyers and Smith 1995), and particularly, Marlatt's Relapse Prevention (Marlatt and Gordon 1985), from which it was adapted.

***Cognitive
Therapy***

Cognitive therapy "is a system of psychotherapy that attempts to reduce excessive emotional reactions and self-defeating behavior by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions" (Beck et al. 1991, p. 10).

CBT is particularly similar to cognitive therapy in its emphasis on functional analysis of substance abuse and identifying cognitions associated with substance abuse. It differs from cognitive therapy primarily in terms of emphasis on identifying, understanding, and changing underlying beliefs about the self and the self in relationship to substance abuse as a primary focus of treatment. Rather, in the initial sessions of CBT, the focus is on learning and practicing a variety of coping skills, only some of which are cognitive.

In CBT, initial strategies stress behavioral aspects of coping (e.g., avoiding or leaving the situation, distraction, and so on) rather than "thinking" one's way out of a situation. In cognitive therapy, the therapist's approach to focusing on cognitions is Socratic and based on leading the patient through a series of questions; in CBT, the approach is somewhat more didactic. In cognitive therapy, the treatment is thought to reduce substance use by changing the way the patient thinks; in CBT, the treatment is thought to work by changing what the patient does and thinks.

***Community
Reinforcement
Approach***

The Community Reinforcement Approach (CRA) "is a broad-spectrum behavioral treatment approach for substance abuse problems...that utilizes social, recreational, familial, and vocational reinforcers to aid clients in the recovery process" (Meyers and Smith 1995, p. 1).

This approach uses a variety of reinforcers, often available in the community, to help substance users move into a drug-free lifestyle. Typical components of CRA treatment include (1) functional analysis of substance use, (2) social and recreational counseling, (3) employment counseling, (4) drug refusal training, (5) relaxation training, (6) behavioral skills training, and (7) reciprocal relationship counseling. In the very successful approach developed by Higgins and colleagues for cocaine-dependent individuals (Higgins et al. 1991, 1994), a contingency management component is added that provides vouchers for staying in treatment. The vouchers are redeemable for items consistent with a drug-free lifestyle and are contingent upon the patient's provision of drug-free urine toxicology specimens.

Thus, CRA and CBT share a number of common features, most importantly,

the functional analysis of substance abuse and behavioral skills training. CBT differs from CRA in not typically including the direct provision of either contingency management (vouchers) for abstinence or intervening with patients outside of treatment sessions or the treatment clinic, as do community-based interventions (job or social clubs).

***Motivational
Enhancement
Therapy***

CBT has some similarities to Motivational Enhancement Therapy (MET) (Miller and Rollnick 1992). MET “is based on principles of motivational psychology and is designed to produce rapid, internally motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client’s own change resources” (Miller et al. 1992, p. 1).

CBT and MET share an exploration, early in the treatment process, of what patients stand to gain or lose through continued substance use as a strategy to build patients’ motivation to change their substance abuse.

CBT and MET differ primarily in emphasis on skill training. In MET, responsibility for how patients are to go about changing their behavior is left to the patients; it is assumed that patients can use available resources to change behavior and training is not required. CBT theory maintains that learning and practice of specific substance-related coping skills foster abstinence. Thus, because they focus on different aspects of the change process (MET on why patients may go about changing their substance use, CBT on how patients might do so), these two approaches may be seen as complementary. For example, for a patient with low motivation and few resources, an initial focus on motivational strategies before turning to specific coping skills (MET before CBT) may be the most productive approach.

**Dissimilar
Approaches**

While it is important to recognize that all psychosocial treatments for drug abuse share a number of features and may overlap or closely resemble one another in several ways, some approaches differ significantly from CBT.

***Twelve-Step
Facilitation***

CBT is dissimilar to 12-step, or disease-model approaches, in a number of ways. Twelve-Step Facilitation (TSF) (Nowinski et al. 1994) “is grounded in the concept of alcoholism as a spiritual and medical disease. The content of this intervention is consistent with the 12 Steps of Alcoholics Anonymous (AA), with primary emphasis given to Steps 1 through 5. In addition to abstinence from all psychoactive substances, a major goal of the treatment is to foster the participant’s commitment to and participation in AA or Cocaine Anonymous (CA). Participants are actively encouraged to attend self-help meetings and to maintain journals of their AA/CA attendance and participation” (Project MATCH Research Group 1993).

While CBT and TSF share some concepts - for example, the similarity between the disease model's "people, places, and things" and CBT's "high-risk situations" - there are a number of important differences. The disease-model approaches are grounded in a concept of addiction as a disease that can be controlled but never cured. In CBT, substance abuse is a learned behavior that can be modified. The emphasis in disease model approaches is on patients' loss of control over substance abuse and other aspects of their lives; the emphasis in CBT is on self-control strategies, that is, what patients can do to recognize the processes and habits that underlie and maintain substance use and what can be done to change them.

Similarly, the major change agent in disease-model approaches is involvement with the fellowship of AA/CA and working the 12 Steps, that is, the way to cope with nearly all drug-related problems is by going to meetings or deepening involvement with fellowship activities. In CBT, coping strategies are much more individualized and based on the specific types of problems encountered by patients and their usual coping style.

While attending AA or CA meetings is not required or strongly encouraged in CBT, some patients find attending meetings very helpful in their efforts to become or remain abstinent. CBT therapists take a neutral stance to attending AA; they encourage patients to view going to meetings as a, not the coping strategy. The CBT therapist may explore with the patient the ways in which going to a meeting when faced with strong urges to use may be a very useful and important strategy to cope with craving; however, therapists will also encourage patients to think about and have ready a range of other strategies as well.

Interpersonal Psychotherapy

CBT is also different from interpersonal and short-term dynamic approaches such as Interpersonal Psychotherapy (IPT) (Rounsaville and Carroll 1993) or Supportive-Expressive Therapy (SE) (Luborsky 1984). IPT "is based on the concept that many psychiatric disorders, including cocaine dependence, are intimately related to disorders in interpersonal functioning which may be associated with the genesis or perpetuation of the disorder. IPT, as adapted for cocaine dependence, has four definitive characteristics: (1) adherence to a medical model of psychiatric disorders, (2) focus on patients' difficulties in current interpersonal functioning, (3) brevity and consistency of focus, and (4) use of an exploratory stance by the therapist that is similar to that of supportive and expressive therapies."

IPT differs from CBT in several ways: CBT has a structured approach, whereas IPT is more exploratory. Extensive efforts are made in CBT to teach and encourage patients to use skills to control their substance abuse, while in the more exploratory IPT approaches, substance abuse

is viewed as a symptom of other difficulties and conflicts and thus may deal less directly with the substance use.

Basic Principles of CBT

CBT is collaborative. The patient and therapist consider and decide together on the appropriate treatment goals, the type and timing of skills training, whether a significant other is brought into some of the sessions, the nature of outside practice tasks, and so on. Not only does this foster the development of a good working relationship and avoid an overly passive stance by the therapist, but it also assures that treatment will be most useful and relevant to the patient.

Learned Behavior

CBT is based on social learning theory. It is assumed that an important factor in how individuals begin to use and abuse substances is that they learn to do so. The several ways individuals may learn to use drugs include modeling, operant conditioning, and classical conditioning.

Modeling

People learn new skills by watching others and then trying it themselves. For example, children learn language by listening to and copying their parents. The same may be true for many substance abusers. By seeing their parents use alcohol, individuals may learn to cope with problems by drinking. Teenagers often begin smoking after watching their friends use cigarettes. So, too, may some cocaine abusers begin to use after watching their friends or family members use cocaine or other drugs.

Operant Conditioning

Laboratory animals will work to obtain the same substances that many humans abuse (cocaine, opiates, and alcohol) because they find exposure to the substance pleasurable, that is, reinforcing. Drug use can also be seen as behavior that is reinforced by its consequences. Cocaine may be used because it changes the way a person feels (e.g., powerful, energetic, euphoric, stimulated, less depressed), thinks (I can do anything, I can only get through this if I am high), or behaves (less inhibited, more confident).

The perceived positive (and negative) consequences of cocaine use vary widely from individual to individual. People with family histories of substance abuse, a high need for sensation seeking, or those with a concurrent psychiatric disorder may find cocaine particularly reinforcing.

It is important that clinicians understand that any given individual uses cocaine for *important* and *particular* reasons.

Classical Conditioning

Pavlov demonstrated that, over time, repeated pairings of one stimulus (e.g., a bell ringing) with another (e.g., the presentation of food) could elicit a reliable response (e.g., a dog salivating). Over time, cocaine abuse may become paired with money or cocaine paraphernalia, particular places (bars, places to buy drugs), particular people (drug-using associates, dealers), times of day or week (after work, weekends), feeling states (lonely, bored), and so on. Eventually, exposure to those cues alone is sufficient to elicit very intense cravings or urges that are often followed by cocaine abuse.

Functional Analysis

The first step in CBT is helping patients recognize why they are using cocaine and determining what they need to do to either avoid or cope with whatever triggers their use. This requires a careful analysis of the circumstances of each episode and the skills and resources available to patients. These issues can often be assessed in the first few sessions through an open-ended exploration of the patients' substance abuse history, their view of what brought them to treatment, and their goals for treatment.

Therapists should try to learn the answers to the following questions.

Deficiencies and Obstacles

- Have the patients been able to recognize the need to reduce availability of cocaine?
- Have they been able to recognize important cocaine cues?
- Have they been able to achieve even brief periods of abstinence?
- Have they recognized events that have led to relapse?
- Have the patients been able to tolerate periods of cocaine craving or emotional distress without resorting to drug use?
- Do they recognize the relationship of their other substance abuse (especially alcohol) in maintaining cocaine dependence?
- Do the patients have concurrent psychiatric disorders or other problems that might confound efforts to change behavior?

Skills and Strengths

- What skills or strengths have they demonstrated during any previous periods of abstinence?
- Have they been able to maintain a job or positive relationships while abusing drugs?

- Are there people in the patients' social network who do not use or supply drugs?
- Are there social supports and resources to bolster the patients' efforts to become abstinent?
- How do the patients spend time when not using drugs or recovering from their effects?
- What was their highest level of functioning before using drugs?
- What brought them to treatment now?
- How motivated are the patients?

***Determinants
of Cocaine Use***

- What is their individual pattern of use (weekends only, every day, binge use)?
- What triggers their cocaine use?
- Do they use cocaine alone or with other people?
- Where do they buy and use cocaine?
- Where and how do they acquire the money to buy drugs?
- What has happened to (or within) the patients before the most recent episodes of abuse?
- What circumstances were at play when cocaine abuse began or became problematic?
- How do they describe cocaine and its effects on them?
- What are the roles, both positive and negative, that cocaine plays in their lives?

Relevant Domains

In identifying patients' determinants of drug abuse, it may be helpful for clinicians to focus their inquiries to cover at least five general domains:

- *Social*: With whom do they spend most of their time? With whom do they use drugs? Do they have relationships with those individuals that do not involve substance abuse? Do they live with someone who is a substance abuser? How has their social network changed since drug abuse began or escalated?
- *Environmental*: What are the particular environmental cues for their drug abuse (e.g., money, alcohol use, particular times of the day, certain neighborhoods)? What is the level of their day-to-day exposure to these cues? Can some of these cues be easily avoided?

- *Emotional*: Research has shown that feeling states commonly precede substance abuse or craving. These include both negative (depression, anxiety, boredom, anger) and positive (excitement, joy) affect states. Because many patients initially have difficulty linking particular emotional states to their substance abuse (or do so, but only at a surface level), affective antecedents of substance abuse typically are more difficult to identify in the initial stages of treatment.
- *Cognitive*: Particular sets of thought or cognition frequently precede cocaine use (I need to escape, I can't deal with this unless I'm high, With what I am going through I deserve to get high). These thoughts are often charged and have a sense of urgency.
- *Physical*: Desire for relief from uncomfortable physical states such as withdrawal has been implicated as a frequent antecedent of drug abuse. While controversy surrounding the nature of physical withdrawal symptoms from cocaine dependence continues, anecdotally, cocaine abusers frequently report particular physical sensations as precursors to substance abuse (e.g., tingling in their stomachs, fatigue or difficulty concentrating, thinking they smell cocaine).

Assessment Tools

Standardized instruments may also be useful in rounding out the therapist's understanding of the patient and identifying treatment goals. The following assessment tools have been helpful.

- Substance abuse and related problems
 - The *Addiction Severity Index* (McLellan et al. 1992) assesses the frequency and severity of substance abuse as well as the type and severity of psychosocial problems that typically accompany substance abuse (e.g., medical, legal, family/ social, employment, psychiatric).
 - The *Change Assessment Scale* (DiClemente and Hughes 1990) assesses the patient's current position on readiness for change (e.g., precontemplation, contemplation, commitment), which may be an important predictor of response to substance abuse treatment (Prochaska et al. 1992).
 - A record of daily substance use can be used to collect information on cocaine and other substance use day by day over a significant period.
 - The *Treatment Attitudes and Expectation* form, a self-report instrument, has been adapted from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (Elkin et al. 1985) and modified for use with

cocaine abusers. Greater congruence between patients' expectations of treatment and beliefs about the causes of substance use and those of the treatment they receive may result in improved outcome, as compared to persons whose treatment expectations contrast with the treatment received (Hall et al. 1991).

- Psychiatric diagnosis and symptoms
 - The *Structured Clinical Interview for DSM-IV (SCID)* and *SCID-P* (First et al. 1995) provides DSM-IV diagnoses (for Axis I and II psychiatric diagnoses). It can also be used to assess severity of cocaine dependence by the total number of dependence syndrome elements endorsed (from the DSM-III-R substance abuse criteria).
 - The *California Psychological Inventory Socialization Scale (CPI-So)* has been found to be a valid continuous measure of sociopathy in alcoholics (Cooney et al. 1990) and an important variable for patient-treatment matching in alcoholics (Kadden et al. 1989).
 - The self-report *Beck Depression Inventory (BDI)* (Beck et al. 1961) and a clinician-rated instrument, the *Hamilton Depression Rating Scale* (Hamilton 1960), assess depression. The *Symptom Checklist (SCL-90)* (Derogatis et al. 1973) assesses a broader range of symptoms.
- Baseline level of coping skills and self-efficacy
 - The *Cocaine Use Situations Inventory* monitors changes in patients' self-efficacy and expectations of abstinence. This self-report form lists approximately 30 different types of high-risk situations and helps clinicians pinpoint specific situations that the patient does not cope with effectively. This instrument was derived from the self-efficacy instrument developed by Condiotte and Lichtenstein (1981) for use with alcoholics.

Skills Training

Learning serves as an important metaphor for the treatment process throughout CBT. Therapists tell patients that a goal of the treatment is to help them “unlearn” old, ineffective behaviors and “learn” new ones. Patients, particularly those who are demoralized by their failure to cease their cocaine abuse, or for whom the consequences of cocaine abuse have been highly negative, are frequently surprised to consider cocaine abuse as a type of skill, as something they have learned to do over time. After all, they are surprised when they think of themselves as having *learned* a complex set of skills that enabled them to acquire the money

needed to buy cocaine (which often led to another set of licit or illicit skills), acquire cocaine without being arrested, use cocaine and avoid detection, and so on. Patients who can reframe their self-appraisals in terms of being skilled in this way often see that they also have the capacity to learn a new set of skills that will help them remain abstinent.

Learning Strategies Aimed at Cessation of Cocaine Use

In CBT, it is assumed that individuals essentially learn to become cocaine abusers through complex interplays of modeling, classical conditioning, or operant conditioning. Each of these principles is used to help the patient stop abusing cocaine.

- *Modeling* is used to help the patient learn new behaviors by having the patient participate in role-plays with the therapist during treatment. The patient learns to respond in new, unfamiliar ways by first watching the therapist model those new strategies and then practicing those strategies within the supportive context of the therapy hour. New behaviors may include how to refuse an offer of drugs or how to break off or limit a relationship with a drug-using associate.
- *Operant conditioning* concepts are used several ways in CBT.
 - Through a detailed examination of the antecedents and consequences of substance abuse, therapists attempt to understand why patients may be more likely to use in a given situation and to understand the role that cocaine plays in their lives. This functional analysis of substance abuse is used to identify the high-risk situations in which they are likely to abuse drugs and, thus, to provide the basis for learning more effective coping behaviors in those situations.
 - Therapists attempt to help patients develop meaningful alternative reinforcers to drug abuse, that is, other activities and involvements (relationships, work, hobbies) that serve as viable alternatives to cocaine abuse and help them remain abstinent.
 - A detailed examination of the consequences, both long- and short-term, of cocaine and other substance abuse is employed as a strategy to build or reinforce the patient's resolve to reduce or cease substance abuse.
- *Classical conditioning* concepts also play an important role in CBT, particularly in interventions directed at reducing some forms of craving for cocaine. Just as Pavlov demonstrated that repeated pairings of a conditioned stimulus with an unconditioned stimulus could elicit a conditioned response, he also demonstrated that repeated exposure to the conditioned stimulus *without* the unconditioned stimulus would, over time, extinguish

the conditioned response. Thus, the therapist attempts to help patients understand and recognize conditioned craving, identify their own idiosyncratic array of conditioned cues for craving, avoid exposure to those cues, and cope effectively with craving when it does occur so that conditioned craving is reduced.

Generalizable Skills Since CBT treatment is brief, only a few specific skills can be introduced to most patients. Typically, these are skills designed to help the patient gain initial control over cocaine and other substance abuse, such as coping with craving and managing thoughts about drug abuse. However, the therapist should make it clear to the patient that any of these skills can be applied to a variety of problems, not just cocaine abuse.

The therapist should explain that CBT is an approach that seeks to teach skills and strategies that the patient can use long after treatment. For example, the skills involved in coping with craving (recognizing and avoiding cues, modifying behavior through urge-control techniques, and so on) can be used to deal with a variety of strong emotional states that may also be related to cocaine abuse. Similarly, the session on problemsolving skills can be applied to nearly any problem the patient faces, whether drug abuse-related or not.

Basic Skills First This manual describes a sequence of sessions to be delivered to patients; each focuses on a single or related set of skills (e.g., craving, coping with emergencies). The order of presentation of these skills has evolved with experience with the types of problems most often presented by cocaine-abusing patients coming into treatment.

Early sessions focus on the fundamental skills of addressing ambivalence and fostering motivation to stop cocaine abuse, helping the patient deal with issues of drug availability and craving, and other skills intended to help the patient achieve initial abstinence or control over use. Later sessions build on these basic skills to help the patient achieve stronger control over cocaine abuse by working on more complex topics and skills (problemsolving, addressing subtle emotional or cognitive states). For example, the skills patients learn in achieving control over craving (urge control) serve as a model for helping them manage and tolerate other emotional states that may lead to cocaine abuse.

Match Material to Patient Needs CBT is highly individualized. Rather than viewing treatment as cookbook psychoeducation, the therapist should carefully match the *content*, *timing*, and *nature of presentation* of the material to the patient. The therapist attempts to provide skills training at the moment the patient is most in need of the skill. The therapist does not belabor topics, such as breaking ties with cocaine suppliers, with a patient who is

highly motivated and has been abstinent for several weeks. Similarly, the therapist does not rush through material in an attempt to cover all of it in a few weeks; for some patients, it may take several weeks to truly master a basic skill. It is more effective to slow down and work at a pace that is comfortable and productive for a particular individual than to risk the therapeutic alliance by using a pace that is too aggressive.

Similarly, therapists should be careful to use language that is compatible with the patient's level of understanding and sophistication. For example, while some patients can readily understand concepts of conditioned craving in terms of Pavlov's experiments on classical conditioning, others require simpler, more concrete examples, using familiar language and terms.

Therapists should frequently check with patients to be sure they understand a concept and that the material feels relevant to them. The therapist should also be alert to signals from patients who think the material is not well suited to them. These signals include loss of eye contact and other forms of drifting away, overly brief responses, failure to come up with examples, failure to do homework, and so on.

An important strategy in matching material to patient needs (and providing treatment that is patient driven rather than manual driven) is to use, whenever possible, *specific examples* provided by the patients, either through their history or relating events of the week. For example, rather than focusing on an abstract recitation of "Seemingly Irrelevant Decisions," the therapist should emphasize a recent, specific example of a decision made by the patient that ended in an episode of cocaine use or craving. Similarly, to make sure the patient understands a concept, the therapist should ask the patient to think of a specific experience or example that occurred in the past week that illustrates the concept or idea.

"It sounds like you had a lot of difficulty this week and wound up in some risky situations without quite knowing how you got there. That's exactly what I'd like to talk about this week, how by not paying attention to the little decisions we make all the time, we can land in some rough spots. Now, you started out talking about how you had nothing to do on Saturday and decided to hang out in the park, and 2 hours later you were driving into the city to score with Teddy. If we look carefully at what happened Saturday, I bet we can come up with a whole chain of decisions you made that seemed pretty innocent at the time, but eventually led to you being in the city. For example, how did it happen that you felt you had nothing to do on Saturday?"

Use Repetition

Learning new skills and effective skill-building requires time and repetition. By the time they seek treatment, cocaine users' habits related to their drug abuse tend to be deeply ingrained. Any given patient's routine

h around acquiring, using, and recovering from cocaine use is well established and tends to feel comfortable to the patient, despite the negative consequences of cocaine abuse. It is important that therapists recognize how difficult, uncomfortable, and even threatening it is to change these established habits and try new behaviors. For most patients, mastering a new approach to old situations takes several attempts.

Moreover, many patients come to treatment only after long periods of chronic use, which may affect their attention, concentration, and memory and thus their ability to comprehend new material. Others seek treatment at a point of extreme crisis (e.g., learning they are HIV positive, after losing a job); these patients may be so preoccupied with their current problems that they find it difficult to focus on the therapist's thoughts and suggestions. Thus, in the early weeks of treatment, repetition is often necessary if a patient is to be able to understand or retain a concept or idea.

In fact, the basic concepts of this treatment are repeated throughout the CBT process. For example, the idea of a functional analysis of cocaine abuse occurs formally in the first session as part of the rationale for treatment, when the therapist describes understanding cocaine abuse in terms of antecedents and consequences. Next, patients are asked to practice conducting a functional analysis as part of the homework assignment for the first session. The concept of a functional analysis then recurs in each session; the therapist starts out by asking about any episodes of cocaine use or craving, what preceded the episodes, and how the patient coped.

The idea of cocaine use in the context of its antecedents and consequences is inherent in most treatment sessions. For example, craving and thoughts about cocaine are common antecedents of cocaine abuse and are the focus of two early sessions. These sessions encourage patients to identify their own obvious and more subtle determinants of cocaine abuse, with a slightly different focus each time. Similarly, each session ends with a review of the possible pitfalls and high-risk situations that may occur before the next session, to again stimulate patients to become aware of and change their habits related to cocaine abuse.

While key concepts are repeated throughout the manual, therapists should recognize that repetition of whole sessions, or parts of sessions, may be necessary for patients who do not readily grasp these concepts because of cognitive impairment or other problems. Therapists should feel free to repeat session material as many times and in as many different ways as needed with particular patients.

Practice Mastering Skills

We do not master complex new skills by merely reading about them or watching others do them. We learn by trying out new skills ourselves, making mistakes, identifying those mistakes, and trying again.

In CBT, practice of new skills is a central, essential component of treatment. The degree to which the treatment is skills *training* over merely skills *exposure* has to do with the amount of practice. It is critical that patients have the opportunity to try out new skills within the supportive context of treatment. Through firsthand experience, patients can learn what new approaches work or do not work for them, where they have difficulty or problems, and so on.

CBT offers many opportunities for practice, both within sessions and outside of them. Each session includes opportunities for patients to rehearse and review ideas, raise concerns, and get feedback from the therapist. Practice exercises are suggested for each session; these are basically homework assignments that provide a structured way of helping patients test unfamiliar behaviors or try familiar behaviors in new situations.

However, practice is only useful if the patient sees its value and actually tries the exercise. Compliance with extra-session assignments is a problem for many patients. Several strategies are helpful in encouraging patients to do homework.

***Give a Clear
Rationale***

Therapists should not expect a patient to practice a skill or do a homework assignment without understanding why it might be helpful. Thus, as part of the first session, therapists should stress the importance of extra-session practice.

“It will be important for us to talk about and work on new coping skills in our sessions, but it is even more important to put these skills into use in your daily life. You are really the expert on what works and doesn’t work for you, and the best way to find out what works for you is to try it out. It’s very important that you give yourself a chance to try out new skills outside our sessions so we can identify and discuss any problems you might have putting them into practice. We’ve found, too, that people who try to practice these things tend to do better in treatment. The practice exercises I’ll be giving you at the end of each session will help you try out these skills. We’ll go over how well they worked for you, what you thought of the exercises, and what you learned about yourself and your coping style at the beginning of each session.”

***Get a
Commitment***

We are all much more likely to do things we have told other people we would do. Rather than assume that patients will follow through on a task, CBT therapists should be direct and ask patients whether they are willing to practice skills outside of sessions and whether they think it will be helpful to do so. A clear “yes” conveys the message that the patient understands the importance of the task and its usefulness. Moreover, it sets up a discussion of discrepancy if the patient fails to follow through.

On the other hand, hesitation or refusal may be a critical signal of clinical issues that are important to explore with the patient. Patients may refuse to do homework because they do not see the value of the task, because they are ambivalent about treatment or renouncing cocaine abuse, because they do not understand the task, or for various other reasons.

***Anticipate
Obstacles***

It is essential to leave enough time at the end of each session to develop or go over the upcoming week's practice exercise in detail. Patients should be given ample opportunity to ask questions and raise concerns about the task. Therapists should ask patients to anticipate any difficulties they might have in carrying out the assignment and apply a problem-solving strategy to help work through these obstacles. Patients should be active participants in this process and have the opportunity to change or develop the task with the therapist, to plan how the skill will be put into practice, and so on.

Working through obstacles may include a different approach to the task (e.g., using a tape recorder for self-monitoring instead of writing), thinking through when the task will be done, whether someone else will be asked to help, and so on. The goal of this discussion should be the patient's expressed commitment to do the exercise.

Monitor Closely

Following up on assignments is critical to improving compliance and enhancing the effectiveness of these tasks. Checking on task completion underscores the importance of practicing coping skills outside of sessions. It also provides an opportunity to discuss the patient's experience with the tasks so that any problems can be addressed in treatment.

In general, patients who do homework tend to have therapists who value homework, spend a lot of time talking about homework, and expect their patients to actually do the homework. The early part of each session must include at least 5 *minutes* for reviewing the practice exercise in detail; it should not be limited to asking patients whether they did it. If patients expect the therapist to ask about the practice exercise, they are more likely to attempt it than are patients whose therapist does not follow through.

Similarly, if any other task is discussed during a session (e.g., implementation of a specific plan to avoid a potential high-risk situation), be sure to bring it up in the following session. For example, "Were you able to talk to your brother about not coming over after he gets high?"

Use the Data

The work patients do in implementing a practice exercise and their thoughts about the task convey a wealth of important information about the patients, their coping style and resources, and their strengths and

weaknesses. It should be valued by the therapist and put to use during the sessions.

A simple self-monitoring assignment, for example, can quickly reveal patients' understanding of the task or basic concepts of CBT, level of cognitive flexibility, insight into their own behavior, level of motivation, coping style, level of impulsivity, verbal skills, usual emotional state, and much more. Rather than simply checking homework, the CBT therapist should explore with the patients what they learned about themselves in carrying out the task. This, along with the therapist's own observations, will help guide the topic selection and pacing of future sessions.

***Explore
Resistance***

Some patients literally do the practice exercise in the waiting room before a session, while others do not even think about their practice exercises. Failure to implement coping skills outside of sessions may have a variety of meanings: patients feel hopeless and do not think it is worth trying to change behavior; they expect change to occur through willpower alone, without making specific changes in particular problem areas; the patients' life is chaotic and crisis ridden, and they are too disorganized to carry out the tasks; and so on. By exploring the specific nature of patients' difficulty, therapists can help them work through it.

***Praise
Approximations***

Just as most patients do not immediately become fully abstinent on treatment entry, many are not fully compliant with practice exercises. Therapists should try to shape the patients' behavior by praising even small attempts at working on assignments, highlighting anything they reveal was helpful or interesting in carrying out the assignment, reiterating the importance of practice, and developing a plan for completion of the next session's homework assignment.

The Structure and Format of Sessions

CBT is highly structured and is more didactic than many other treatments. Thus, CBT therapists assume a more directive and active stance than therapists conducting some other forms of substance abuse treatment.

A great deal of work is done during each session, including reviewing practice exercises, debriefing problems that may have occurred since the last session, skills training, feedback on skills training, in-session practice, and planning for the next week. This active stance must be balanced with adequate time for understanding and engaging with the patient.

20/20/20 Rule

To achieve a good integration of manual-driven and patient-driven material in each session, we have developed the “20/20/20 Rule” for the flow of a typical 60-minute CBT session (**exhibit 1**). During the first 20 minutes, therapists focus on getting a clear understanding of patients’ current concerns, level of general functioning, and substance use and craving during the past week, as well as their experiences with the practice exercise. This part of the session tends to be characterized by patients doing most of the talking, although therapists guide with questions and reflection as they get a sense of the patients’ current status.

The second 20 minutes is devoted to introduction and discussion of a particular skill. Therapists typically talk more than patients during this part of the session, although it is critical that therapists personalize the didactic material and check back with patients frequently for examples and understanding.

The final 20 minutes reverts to being more patient dominated, as patients and therapists agree on a practice exercise for the next week and anticipate and plan for any difficulties the patients might encounter before the next session.

Exhibit 1: Session Flow in CBT, The 20/20/20 Rule

First 20 minutes

- Assess substance abuse, craving, and high-risk situations since last session.
- *Listen* for/elicit patients' concerns
- Review and *discuss* the practice exercise

Second 20 minutes

- Introduce and discuss the session topic
- *Relate* the session topic to current concerns

Third 20 minutes

- *Explore* the patient's understanding of and reactions to the topic.
- *Assign* a practice exercise for the next week
- Review plans for the week and *anticipate* potential high-risk situations.

First Third of Session

Assess Patient Status Therapists greet the patients and typically start the session by asking them how they are doing. Most patients respond by spontaneously reporting whether they used cocaine or had cravings during the last week. If patients do not report substance use, therapists should ask about this directly. Particularly in the beginning of treatment, therapists should obtain detailed, day-by-day descriptions of how much cocaine was used.

For each episode of use, therapists should spend several minutes doing a functional analysis (what happened before the episode, when was the patient first aware of the desire or urge to use, what was the feeling, how and where did the patient acquire the cocaine, what was the high like, what happened afterward). If patients report no cocaine use, therapists should probe for any high-risk situations or cravings they may have experienced and debrief these as well. The therapists' goal is to get a detailed sense of the patients' current level of functioning, motivation, and cocaine use.

Urine Tests Objective feedback on patients' clinical status and progress through urine toxicology screens is an important part of this and any other drug treatment program. Urine specimens should be collected by therapists at every clinical contact (and at least weekly). The early part of the session is a good opportunity to review the results of the most recent urine toxicology report with patients. Ideally, the clinic would have

access to a dipstick method where urine can be tested on the spot, and drug abuse within the past 3 days can be detected.

While discussing urine test results is straightforward when patients report being drug-free and the laboratory results confirm this, it is somewhat more complicated when patients deny cocaine use but the urine screen is positive. While patients often present excuses or creative explanations for why the toxicology screen was in error, it is best to point out that laboratory errors are quite unusual, that patients have little to gain from not being honest about substance abuse, and in fact, have much to lose, since treatment will be less helpful if patients are not open about the kinds of problems they are having.

Confronting patients about discrepancies in self versus laboratory reports of substance use is very important; done well, this can advance the therapeutic relationship and the process of treatment significantly. However, pointing out these discrepancies should not be done in a confrontational style. Rather, therapists might point out discrepancies between the patients' stated treatment goals and the urine results ("You've said things are all going great, but the urine results make me wonder if it's all been as easy as you say. What do you make of this?"). Therapists might also point out some reasons why patients are often reluctant to admit to ongoing drug abuse (fear of being terminated from treatment, wanting to please the therapist, testing the therapist), explore these with the patients, and process these as appropriate.

"It sounds like you're afraid that treatment is not working for you as quickly as you, and especially your wife, would like, and admitting you used last week might mean you wouldn't continue in treatment. I want you to understand that as long as you keep coming, working hard, and trying to stop use, I'll keep working with you. The only way that would change is if your cocaine use increased to a level where it was clear that outpatient treatment just wasn't enough to help you stop. In that case, we'd talk about increasing the frequency of sessions or other options, like having you enter an inpatient unit. How does that sound?"

* * *

Therapist: "I know the cocaine level from last week's lab test wasn't high, but it does indicate some recent cocaine abuse. Is it possible you used even a small amount last week?"

Patient: "Well, I did use a dime, but I didn't think that counted."

Therapist: "One line in the last week is a lot less than you were using just a few weeks ago and that's really great. But before we get into how you were able to cut down your use that much, I was wondering why you think that one line 'doesn't count,' since there's probably a lot we can learn about even that small amount of use."

Problemsolving

It is not unusual for patients, particularly those who have not been in treatment before, to come late to appointments or miss appointments without calling. In such cases, therapists may apply a problemsolving strategy. This entails some inquiry about why the patient was late, brainstorming solutions to lateness, and working through how plans to attend sessions promptly might be implemented.

Listen for Current Concerns

In reporting on substance abuse and major life events since the last session, patients are likely to reveal a great deal about their general level of functioning and the types of issues and problems of most current concern. Therapists should listen carefully and assess patients in a number of domains.

- Has the patient made some progress in reducing drug abuse?
- What is the patient's current level of motivation?
- Is a reasonable level of support available in efforts to remain abstinent?
- What's bothering this person most right now?

Therapists should listen intently, clarify when necessary, and where appropriate, relate current concerns to substance abuse.

"It seems like you're really worried about the guys at work getting you in trouble with your boss. Are these the same guys you used with?"

or

"It sounds like you were really lonely and bored this weekend, and maybe you've been feeling this way for a long time. Is that something you'd like to work on in here?"

During this part of the session, while getting a clear sense of patients' current concerns, therapists should be planning for the rest of the session, particularly in terms of how the planned session topic relates specifically to a problem or issue the patient has experienced recently.

"Talking about how bored you felt over the weekend makes me wonder if you weren't having a lot of craving for cocaine as well. If you think that's true, I'd like to spend time in this session talking about understanding craving and learning to deal with it."

When done well, this approach builds strong working relationships and heightens the relevance of CBT tremendously, because patients get the sense that the therapist is responding to their struggles with useful, timely techniques and strategies.

Discuss the Practice Exercise

The early part of each session should also include detailed review of the patients' experience with and reactions to the practice exercise. The primary focus should be on what the patients *learned* about themselves in carrying out the exercise.

- Was it easier or harder than expected?
- What coping strategies worked best?
- What did not work as well?
- Did the patients come up with any new strategies?

If therapists spend considerable time engaged in a detailed review of the patients' experience with the implementation of extra-session tasks, not only will the therapists convey the importance of practice, but both therapists and patients will learn a great deal about the patient.

Therapists should not diminish the importance of practice by doing any of the following.

- Merely asking patients whether they completed the task or accepting a one word (yes/no) response without further probing.
- Collecting the patients' practice exercise as if it were a homework assignment. Instead, patients should be encouraged to keep a notebook or journal with their practice exercises, since they may find this a useful reference long after they leave treatment.
- Using an aggressive or confrontational style when patients do not attempt new skills or do so in a perfunctory way.

Again, therapists should move patients toward practicing skills outside of sessions by giving a clear rationale, getting a commitment from the patients, anticipating and working through obstacles, monitoring task completion closely, making good use of the data, exploring resistance, and praising approximations.

Second Third of Session

Introduce the Topic After getting a clear sense of the patients' general functioning, current concerns, and progress with task implementation, therapists should move toward a transition to the session topic for that week. This may be either introducing a new topic or finishing up or reviewing an old one. In any case, an agenda for the remainder of the sessions should be set or reviewed at this time.

“Since you had that problem with Jerry last week, I think it might be a good idea to talk more about how you can avoid or refuse offers of cocaine and to practice a few more times so you feel more confident the next time that comes up. Then we can spend some time figuring out how you can have another clean week. How does that sound?”

Relate Topic to Current Concerns

Therapists should explicitly point out the relevance of the session topic to the patients’ current cocaine-related concerns and introduce the topic by using concrete examples from the patients’ recent experience.

“I think this is a good time to talk about what to do when you find yourself in a really tough high-risk situation, like what happened at the park on Tuesday. You coped with it really well by getting out of there quickly, but maybe there are some other things we can come up with if you find yourself in that kind of situation again.”

Explore Reactions

Therapists should never assume that patients fully understand the session material or that it feels timely and useful to them. While going through the material, therapists should repeatedly check the patients’ understanding.

- **Ask for concrete examples from the patients.**

“Can you think of a time last week when this happened to you?”

- **Elicit the patients’ views on how they might use particular skills.**

“Now that we’ve talked about craving and talked about urge surfing, distraction, and talking it out, what do you think would work best for you? Which of these techniques have you used in the past? Is there any other way you’ve tried to cope with craving?”

- **Ask for direct feedback from patients.**

“Does this seem like it’s an important issue for us to be working on right now, or do you have something else in mind?”

- **Ask patients to describe the topic or skill in their own words.**

“We’ve talked a lot about building an emergency plan. Just to make sure you’re confident about what you want to do, can you tell me what you’re planning the next time you get into an emergency situation?”

- **Role-play or practice the skill within the session.**

“It sounds like you’re ready to practice this. Why don’t we try that situation you were telling me about when your father got angry when you asked for a ride over here?”

- Pay attention to the patients' verbal and nonverbal cues.

"I notice that you keep looking out the window and I was wondering what your thoughts are on what we're talking about today."

In many cases, patients feel that a particular topic is not really relevant. For example, patients may deny experiencing any craving for cocaine. While using their clinical judgment in determining the salience of particular material for particular patients, therapists might work through a particular topic by pointing out that some problems may come up in the future, and having a particular skill in the patients' repertoire may be quite useful.

"I know you're not feeling bothered by craving now and don't think you'll experience any in the near future, but it may come up in a few weeks or even after you leave treatment. In any case, it might be helpful to spend a little more time talking about it, so if it does come up, you'll be prepared. What do you think?"

Final Third of Session

The last third of the session is, like the first third, likely to be characterized by patients talking more, with therapists guiding the discussion by asking questions and obtaining clarification.

Assign a Practice Exercise

As part of the winddown of the session, therapists and patients should discuss the practice exercise for the next week. It is critical that patients understand clearly what is required. Early in treatment for most patients, and throughout treatment for others, therapists may find it useful to model the assignment during the session. Therapists should also ask for a commitment from patients to try out the skill and to work through obstacles to implementing the skill by planning when and where they will complete the task.

A suggested practice exercise accompanies each session. An advantage of using these sheets is that they also summarize key points about each topic and thus can be useful reminders to patients of the material discussed each week. However, the extra-session practice of skills is most useful to patients if it is individualized. Thus, rather than being bound by the suggested exercises, therapists and patients are encouraged to use these as starting points for discussing the best way to implement the skill and come up with variations or new assignments. Similarly, not all assignments must be written; a number of patients may have limited literacy, and they may tape their thoughts about the practice exercise.

Anticipate High-Risk Situations

The final part of each session should include a detailed discussion of the patients' plans for the upcoming week and anticipation of high-risk situations.

“Before we stop, why don't we spend some time thinking about what the next few days are going to be like for you. What are your plans after you leave here today? What's the hardest situation you think you'll have to deal with before we meet on Friday?”

Therapists should try to model the idea that patients can literally plan themselves out of using cocaine. For each anticipated high-risk situation, therapists and patients should identify appropriate and viable coping skills. Early in treatment, this may be as concrete as asking a trustworthy friend or significant other to handle a patient's money.

Anticipating and planning for high-risk situations may be difficult in the beginning of treatment, particularly for patients who are not used to planning or thinking through their activities, or whose lives are highly chaotic. This models an important skill that is the focus of the session on “Seemingly Irrelevant Decisions,” that is, learning to modify behavior by looking ahead.

For patients whose lives are chaotic, this may also help reduce their sense of lack of control. Similarly, patients who have been deeply involved with drug abuse for a long time will discover through this process that they have few activities to fill their time or serve as alternatives to drug abuse, especially if they have been unemployed or have few social supports unrelated to their substance abuse. This provides an opportunity to discuss strategies to rebuild a social network or begin to think about going back to work.

Topics

Eight skill topics are covered in CBT for cocaine dependence plus a termination session and elective sessions that involve significant others. The sequence in which the topics are presented should be based on the clinical judgment of therapists and the needs of the patients. They are given here in the sequence most often used with cocaine abusers. The most critical behavioral skills for patients just entering treatment are introduced first, followed by more general skills.

Since CBT is usually delivered in 12-16 sessions over 12 weeks, there are fewer skills-training topics than sessions. This provides some flexibility for therapists to allow for greater practice and mastery of a small but critical set of skills as well as repetition of session material as needed. It is intended to prevent patients from being overwhelmed with material.

Several skill guidelines are given for each session, many more than can be reasonably introduced. When delivered as a single session, therapists should carefully select skills to match the patients and not attempt to cover them all. A therapist might pick one or two coping skills the patient has used in the past and introduce one or two more that are consistent with the patient's coping style.

When delivered in more than one session, therapists should split up the guidelines, discussing and practicing the most basic and familiar skills in the first session and more challenging ones in the second. Moreover, the two-session format allows patients to be introduced to a skill in the first session, practice it in the interval before the next session, and discuss and work through any difficulties during the second session. Practice exercises should be given for both sessions, with the exercise for the second session being a variant of the first (e.g., trying out a skill not used the week before, increasing the difficulty or complexity of the task).

Some patients, particularly less severe users, may move through the skills very quickly. When this occurs, excellent elective session material can be found in *Treating Alcohol Dependence: A Coping Skills Training Guide in the Treatment of Alcoholism* (Monti et al. 1989). Since this material tends to focus on broad, interpersonal skills, such as coping with criticism or anger, it is comparatively straightforward to adapt for use with cocaine abusers.

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Integrating CBT and Medication

CBT is highly compatible with pharmacotherapy. When used in combination with medication, the range of CBT interventions expands to include a focus on enhancing medication compliance. Generally, medication response and compliance are monitored during the early part of each session (i.e., the first third of a 20/20/20 session). The following specific strategies (Adapted from Carroll and O'Malley 1996.) have been found useful:

- Inquire as to patients' previous experience with medication.

Therapists should ask patients about their prior history with pharmacotherapy for any psychiatric disorder or condition.

- Why was it prescribed?
- Was it helpful?
- Under what conditions was it terminated?
- Did they take the medication as prescribed?

Previous noncompliance should alert therapists to the need to establish the patients' view of why they did not comply previously and to attempt to address those issues proactively.

- Address patients' concerns about medication.

During all sessions, therapists should listen carefully for any concerns, misunderstandings, or prejudices about taking medication and address these rapidly and assertively. These may include misconceptions about expected medication effects, time needed to experience the effect, side effects, dosing, and interactions with cocaine and other substances. Therapists should provide clarification in clear, familiar terms and frequently check back with patients to be sure they understand.

When medication effects may not be immediately apparent, it is important to inform patients that it may take several weeks before therapeutic effects emerge; thus, patients should be encouraged to expect gradual

rather than all-or-nothing change. Explaining the gradual emergence of medication effects provides an opportunity for the therapist to emphasize that *patients should not expect to benefit from an entirely passive stance regarding CBT treatment* simply because they are taking medication. Mastery and implementation of coping skills remain an essential and important part of treatment; medication may be an additional, useful adjunct or tool.

- Assess medication compliance since last session.

Close, consistent, and careful monitoring is one of the most effective strategies for enhancing compliance with medications. Thus, a portion of each session should be devoted to evaluating medication compliance and working through any difficulties that might arise. In general, until the patients' compliance pattern is clearly established, therapists should, at each meeting, inquire about medication compliance, day by day, since the last session. This should include asking when patients take the medication, how they take the medication, and a thorough discussion of any deviation from the prescribed dose and schedule.

Fawcett et al. (1987) noted that compliance and retention are most difficult to achieve early and late in treatment - early if the patient is not receiving obvious benefit, and later if the patient, after obtaining a partial or full therapeutic response, does not appreciate the need to continue treatment. Thus, therapists should be particularly attentive to compliance and motivation issues during early and late sessions.

- Praise medication compliance.

Therapists should also convey confidence in the medication and inform patients of the likely benefits. Therapists should be strongly on the side of compliance and praise patients' compliance enthusiastically and genuinely.

"I see you have taken your medication every day since our last meeting. That's really great. I know you had your doubts about whether the medication would work for you, and I'm glad you were willing to give it a try. Have you noticed any positive changes you think might be related to the medication?"

- Relate patients' clinical improvement to compliance and lack of improvement to noncompliance.

A crucial role of the therapist is to establish and stress the connection between medication compliance, psychotherapy sessions, and improvement. Therapists should make explicit causal links between patients' compliance and improvement in cocaine abuse and other appropriate target symptoms. Conversely, therapists might tie poor compliance to failure to improve.

“Since you’ve been taking the medication, I can see a lot of positive changes in your life...you’ve cut way down on your cocaine use and you say you’ve been feeling a lot better. I think the changes indicate that the medication is helping you. What do you think?”

Or

“I know you’re discouraged about how you’ve been feeling, but since we’ve begun to work together, you’ve also told me you haven’t been taking the medication every day. As we’ve discussed, I don’t think you’ll notice a real change until you take the medication more consistently. How about giving it a try?”

- Use a problemsolving strategy for noncompliance.

When patients are not compliant with medication, therapists should take a practical, objective approach. They should try to help patients clarify reasons or obstacles to compliance and generate practical solutions. For example, patients may report difficulty remembering to take the medication. Practical strategies to cue the patient (e.g., notes on the bathroom mirror, taking the medication at a regular mealtime, enlisting family support and reminders) should be generated and followed up on in the next session. In all of these discussions, therapists should be nonjudgmental and nonconfrontational. Efforts should be made to help patients feel ownership of the plan. This can be done by having them take the primary role in developing the plan, rather than having therapists telling them what to do.

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Session 1: Introduction to Treatment and CBT

Tasks for Session 1

- Take history and establish relationship
- Enhance motivation
- Present the CBT model
- Introduce functional analysis
- Negotiate treatment goals and treatment contract
- Provide a rationale for extra-session tasks

Session Goals

The first session is the most important and often the most difficult because the therapist must address several areas.

- Begin to establish a relationship with the patient
- Assess the nature of the patient's substance use and other problems that may be important factors in treatment
- Provide a rationale for the treatment
- Establish the structure for the remaining sessions
- Initiate skills training

Because of the complexity of the tasks involved in the first session, the therapist should allow 90 minutes, rather than rely on the typical 1-hour session.

Key Interventions

History and Relationship Building

Therapists should spend a considerable amount of time during the first session getting to know the patients, obtaining histories of them and their substance use, getting a sense of their level of motivation, and determining what led them to seek treatment. This can occur through a series of open-ended questions that should cover at least the following areas.

Reasons for seeking treatment and treatment history

- What brought you here today?
- Have you ever been in treatment for cocaine abuse before?
- If yes, when was that? How long did you stay there? What was it like? What did you like or not like about the program? Why did you leave?
- Have you ever been in treatment for abuse of other substances, like heroin, alcohol, or benzodiazepines?

History and current pattern of cocaine abuse

- What is your cocaine use right now? How do you use it?
- How often do you use cocaine? How much do you use?
- What is your longest period of abstinence from cocaine? When did it start? Stop?
- What is the longest period of abstinence you've had in the last 3 months? How did that start and end?
- What have you tried to do to cut down on your cocaine use?
- How do you get cocaine?
- How much alcohol do you drink? How does drinking affect your cocaine use?
- How long have you been able to not drink?
- What other types of drugs are you using?
- How do you feel after using cocaine?
- How did your cocaine use get started?

Other problems and resources

- Where do you live? Does anyone you live with use cocaine?
- Who among the people you spend the most time with use drugs? Who doesn't use?
- Are you working now? How has your cocaine use affected your employment?
- Does your family know about your cocaine use?
- When was your last physical? Do you have any medical problems or worries?
- Do you have any legal problems? Is probation or parole involved with your decision to seek treatment?

- How do you feel most of the time? Have you been depressed or down? Have you ever thought about hurting yourself? Have you ever done so? Does that happen only when you use cocaine?
- Have you ever become paranoid or thought someone was after you while using? What was that like?

If patients have been through an extensive pretreatment assessment battery, therapists should attempt to be sensitive to further questions.

“I know you’ve already spent several hours answering questions, but now as we’re beginning treatment, I hope you can answer a few more questions that should help you and me plan where we go from here.”

Enhance Motivation

As patients respond to the above questions, the therapist should listen closely for and, where possible, elicit statements or comments from them concerning their reasons for seeking treatment or reducing cocaine use. Some of the general strategies recommended by Miller and colleagues (1992) for enhancing motivation and avoiding resistance are extremely useful. These are summarized below.

- Elicit self-motivational statements.

“It sounds like, from what you’ve told me, that your parents and your probation officer are worried about your cocaine use, but I was wondering how you feel about it?”

“Tell me how using cocaine has affected you.”

“What bothers you most about your cocaine use?”

- Listen with empathy.

“It sounds like you’re worried about taking all this on at once.”

“You feel like you want to stop, but you’re worried because you’ve tried treatment before and you’ve gone back to cocaine use each time.”

“On one hand, you feel not seeing Jerry as much would be an important step forward for you because you’ve always used with him, but on the other hand, you worry about cutting yourself off from a friend you’ve been close to for a long time.”

The therapist should avoid interrupting the patient, arguing with or challenging the patient, or changing the subject.

- Roll with resistance.

“You’re not sure you’re ready to spend a lot of time changing your lifestyle right now.”

“I think you’re jumping ahead a bit; we can take some time to talk about what’s the best goal for you and how to approach it.”

- Point out discrepancies.
“You’re not sure cocaine is that big a problem, but at the same time a lot of people who care about you think it is, and getting arrested for drug possession is causing some problems for you.”
- Clarify free choice.
“There’s nothing I or anyone else can do to make you stop using cocaine; what you do is really up to you.”
“You can decide to take this on now or wait until another time.”
- Review consequences of action and inaction.
“What do you see happening if you don’t stop using cocaine?”
“It sounds like you’ve got some concerns about slowing things down with Jerry; what do you think will happen if you don’t?”

Negotiate Treatment Goals

CBT for cocaine dependence is an abstinence-oriented treatment for many reasons. Cocaine use, even in small amounts, is associated with a variety of serious medical and psychiatric risks. Furthermore, unlike alcohol where some cognitive-behaviorally oriented treatments advocate a moderate drinking goal, cocaine is an illicit drug with considerable legal risks. Clinically, better outcomes are usually seen for patients who are abstinent.

However, relatively few patients come to treatment completely committed to abstinence. Many seek treatment because of some external persuasion or coercion; others want to cut down to a point where the negative consequences are eliminated, but cocaine use might go on. For highly ambivalent patients, clinicians must recognize that commitment to abstinence is a process that often takes several weeks to work through. Moreover, in most patients, abstinence takes several weeks to achieve and does not occur all at once.

Therapists should explicitly state that the goal of treatment is abstinence. However, for highly ambivalent patients, this should be done in a manner that acknowledges their uncertainty.

“I know you’re not sure about stopping cocaine use completely, and we’ll spend some time over the next few sessions talking about what you want to decide. However, there are some good reasons to consider abstinence from cocaine, as well as abstinence from other drugs and alcohol. For example, by trying to stop completely while you’re here, you’ll learn a lot about yourself and some of the factors that might be pushing you to continue using. You might also find it easier to understand the circumstances that make it more likely that you will use and some things you can do to stop using. You’ll also avoid substituting other substances for cocaine. After a period of abstinence, you can get a clear idea of how you will feel without

cocaine in the picture and can get a sense of whether that's what you really want to do. You can always change your mind later. What do you think?"

While this is a short-term treatment focused on cessation of cocaine use, patients often have a number of coexisting problems and concerns. Some are related to cocaine dependence, but some are not. While the primary focus of treatment should be stopping cocaine abuse, it is important to recognize and help patients sort through other problems and symptoms.

Therapists should also ask whether patients have other goals, as well as how stopping substance use might help them reach those goals (e.g., regain custody of their children, go back to work). In the case of problems that may be closely related to cocaine dependence (e.g., depressive symptoms, marital conflict, legal problems), it is critical for therapists to acknowledge these, work with patients to prioritize goals in relation to cocaine use, negotiate reasonable treatment goals and how the goals of treatment will be addressed, and monitor these other target symptoms and problems as treatment proceeds.

"I know you've been feeling down and want to try Prozac again, but you've been abusing cocaine for a long time, and it's going to be hard to sort out how much of how you're feeling is related to cocaine abuse and how much might be a depressive problem that's separate from your cocaine abuse. The best way to tell is after a period of abstinence from cocaine. Generally, we find that depressed feelings which last more than a month after the last use indicate the need to address drug abuse and depression separately, possibly with medication for the depression. What do you think about being abstinent for a month, and then considering a referral to a psychiatrist for a medication evaluation? In the meantime, it also sounds like we should spend some time talking about feeling down and how that might be related to your cocaine use."

* * *

"It sounds like there have been some problems with Billy for a long time, and he's asked you to leave, but you think things might get better if you stop using cocaine. One thing we can do in our work is to invite Billy to attend a session or two so he can ask questions and learn more about this treatment program, and the two of you can talk about where to go from here. After we complete this first 12 weeks, we might also think about a referral to family services. How does that sound?"

Present the CBT Model

Next, therapists should provide an explanation and rationale for the treatment. This should cover the following points.

- Cocaine use can be seen as learned behavior.

“One way of looking at cocaine use is that it’s something people learn to do over time. They learn from watching other people use it; they learn ways to get and use it; they learn that cocaine has certain effects that may make them feel more energetic or attractive or social. As you’ve been talking, it seems like you’ve been doing a lot of learning over the years, too.”

- Over time, cocaine use affects how people think, how they feel, and what they do.

“This learning process affects a lot of things about a person over time. People start developing certain beliefs about cocaine - like it’s hard for them to function without it. You’ve probably developed your own set of beliefs about cocaine abuse. By looking at these beliefs, we’ll be able to understand them better and that will help you learn ways to stop. Cocaine also affects how people feel. Some people find it makes them feel better for a short period of time, others talk about using cocaine to try to stop feeling so bad. Over time, those feelings become associated with cocaine, and it’s important to try to look at and understand these reactions. Finally, cocaine affects what people do. You’ve already talked about how cocaine is such a habit for you, that it’s something you do without even thinking.”

- By understanding this process, individuals find it easier to learn to stop using cocaine and other drugs.

“You’ve said there’s a lot about cocaine that’s pretty automatic for you, like how you don’t even remember going to New York last week. What we’ll do is spend a lot of time slowing that process down. We will look at what happens long before you use, what you’re thinking and feeling and where you are using. We will look at what use is like for you, and we’ll look at what happens after you use. By understanding what seems so automatic now, your cocaine abuse will be a lot easier to control.”

- New, more effective skills can replace old habits that lead to cocaine use.

“It’s not just understanding these automatic processes, it’s also doing something different that helps people stop using. You’ve talked about how just stopping the cocaine and not changing anything else doesn’t really work for you. Really stopping cocaine means learning to do things differently. That’s where coping skills come in. Instead of responding to old cues and problems with cocaine, we’ll be talking about, and practicing, new, more effective ways of coping. This isn’t always easy, because you’ve learned your cocaine coping style over a long period of time. What we’ll do is help you unlearn some old, less effective strategies and learn some new, more effective ones. It’ll take some time and a lot of practice to learn some new skills, but I bet if we look at the time you were abstinent for 4 months last year, we’ll find you used some pretty effective coping mechanisms.”

- Practice is essential.

“It takes practice trying out new ways of responding to old situations. One thing that might help is to remember that it took a lot of time for you to learn how to be such an effective cocaine abuser - how to get the money, buy cocaine, use it, and not get caught. That’s a highly developed skill for you. Since you’ve been doing it for so long, a lot of other kinds of skills that you might have aren’t being practiced and won’t be natural for you at first. That’s where practice of new skills comes in. We’ll practice during sessions, but each week we’ll also talk about how you can practice new skills outside our sessions. This kind of practice is really important. It won’t seem natural or easy at first. By sticking it out and practicing outside of our meetings though, you’ll learn a lot about yourself and what works and doesn’t work for you. You can always bring problems in and talk about new ways of coping. Can you see yourself doing some practice outside of sessions?”

Establish Treatment Ground Rules

In addition to treatment goals and tasks, it is important to establish clear expectations for the patient in terms of treatment, your obligations, and the patient’s responsibilities. The following areas should be reviewed and discussed.

- Scheduling of sessions and length of treatment
- Importance of regular attendance
- Calling in advance if the patient will miss the session or be late
- Collection of a urine specimen at each session
- The need to come to sessions free of cocaine, alcohol, or other drugs

Introduce Functional Analysis

Therapists should work through a recent episode of cocaine use with patients, conducting a full functional analysis.

“To get an idea of how all this works, let’s go through an example. Tell me all you can about the last time you used cocaine. Where were you and what were you doing? What happened before? How were you feeling? When was the first time you were aware of wanting to use? What was the high like at the beginning? What was it like later? Can you think of anything positive that happened as a result of using? What about negative consequences?”

Practice Exercise

The practice exercise (exhibit 2) asks patients to do a functional analysis of at least three recent episodes of cocaine use. It follows closely the format of the functional analysis conducted by the therapist within the session. Therapists may want to use the sheet as a within-session example.