

Queensland Health  
**dual diagnosis**  
initiative

*co-occurring mental health and alcohol and other drug problems*

# CBT FOR DUAL DIAGNOSIS

BY KIM WOOD MSc (hons) (NZ); PG Dip CT (Oxford);  
MAPS, Member BABCP  
DUAL DIAGNOSIS COORDINATOR  
GOLD COAST DRUG COUNCIL

Tomorrow's Queensland:  
strong, green, smart, healthy and fair



# Aims of the Session

- Introduction to me!
- Introduction to CBT
- Introduction to CBT understanding of the problem
- Specific Interventions
- MI and CBT
- Changing Worker Behaviour

# Introduction to me!

- Clinical Psychologist/ Accredited CBT therapist
- 2000 - 2010 in UK (DTTO, FMHP, PCT, CMHT, IAPT). Before that GCSHC.
- At GCDC since March 2011!

# Dual Diagnosis Coordinator

- Lead the co-ordination of Dual Diagnosis Services across LLW
- Run the Youth (12 - 25) Dual Diagnosis Support Program at GCDC
- Develop proposals for service development and change
- Network with partner agencies
- Enhance the ability of community services to respond and support dually diagnosed young people:
  - acting as a clinical advisor
  - Providing/ facilitating training

# What is CBT?

# Origins of CBT

People are disturbed not by things,  
but by the views which they take of  
them.

EPICTETUS  
1<sup>st</sup> Century AD

**There's nothing either good or bad but  
thinking makes it so.**

**SHAKESPEARE**  
*IN HAMLET*

# What is CBT?

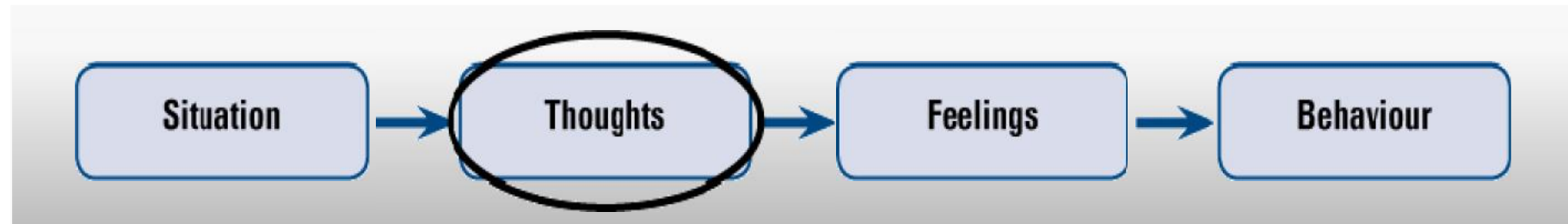
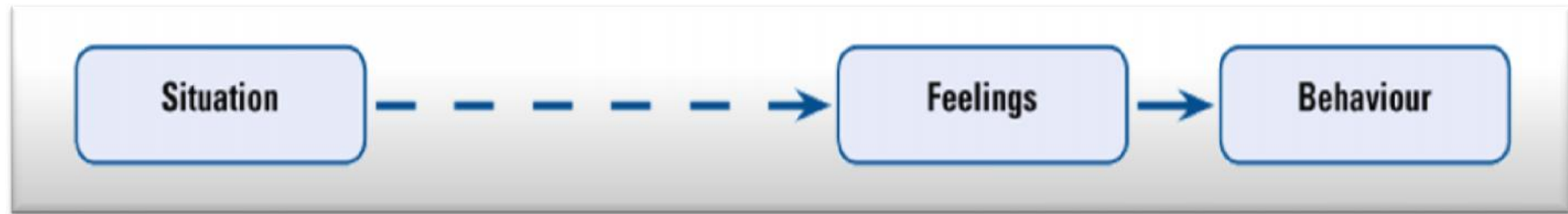
- Umbrella term for therapies with a cognitive and/or behavioural focus
- Cognitive = thinking, memory, attention, making sense of the world
- Behaviour = actions we do



# The CBT Model

- Assumes a link between thinking, affect/ mood, behaviour and physiology
- Assumes that often people get into a “vicious circle” in terms of thought, emotion and behaviour
- Mainly has a ‘here and now’ focus
- Will generate a problem list with associated goals
- Actively gets a person to experiment with their thinking/ behaviour to assess change
- Assumes the person CAN do something about their situation

# Simplified CBT Model



# Cognitions affect behaviour

Cognitions/thoughts	Behaviours
I must do things perfectly	Procrastinate
If I want something I must have it immediately	Engage in addictive behaviours
Making mistakes is an opportunity to learn	Willing to try again to reach goals

# CBT strategies

**Cognitive strategies** involve learning to recognise the thoughts, beliefs and attitudes that make us feel bad, and reframing them into more realistic psychologically healthy ways of thinking

**Behavioural strategies** involve undertaking certain behaviours that help us to change the way we think and feel. Includes experimenting with new behaviours eg: confronting situations, abandoning perfectionist behaviours, using assertive communication, practicing relaxation, problem solving, goal setting and activity scheduling

Cognitive therapy aims to help  
people change their thoughts

or their relationship to their thoughts

## CBT is:

- A joint venture between client and therapist (by building a trusting therapeutic relationship)
- Aims to achieve the clients goals (tailored to individuals)
- Uses guided discovery to ask questions to allow the client to come to their own answers
- Works in the here and now, uses concrete examples

## In Summary:

- The content of sessions – to provide a coherent model of treatment which is formulation driven
- The style focuses on the therapeutic relationship (empathy, warmth, genuineness); collaboration (equality, teamwork); and structure (focus, goal orientation)
- The method is to take a scientific stance – the client is the scientist/ practitioner; constant measurement and evaluation of progress; collaborative empiricism; behavioural experiments

# Evidenced Based Practice

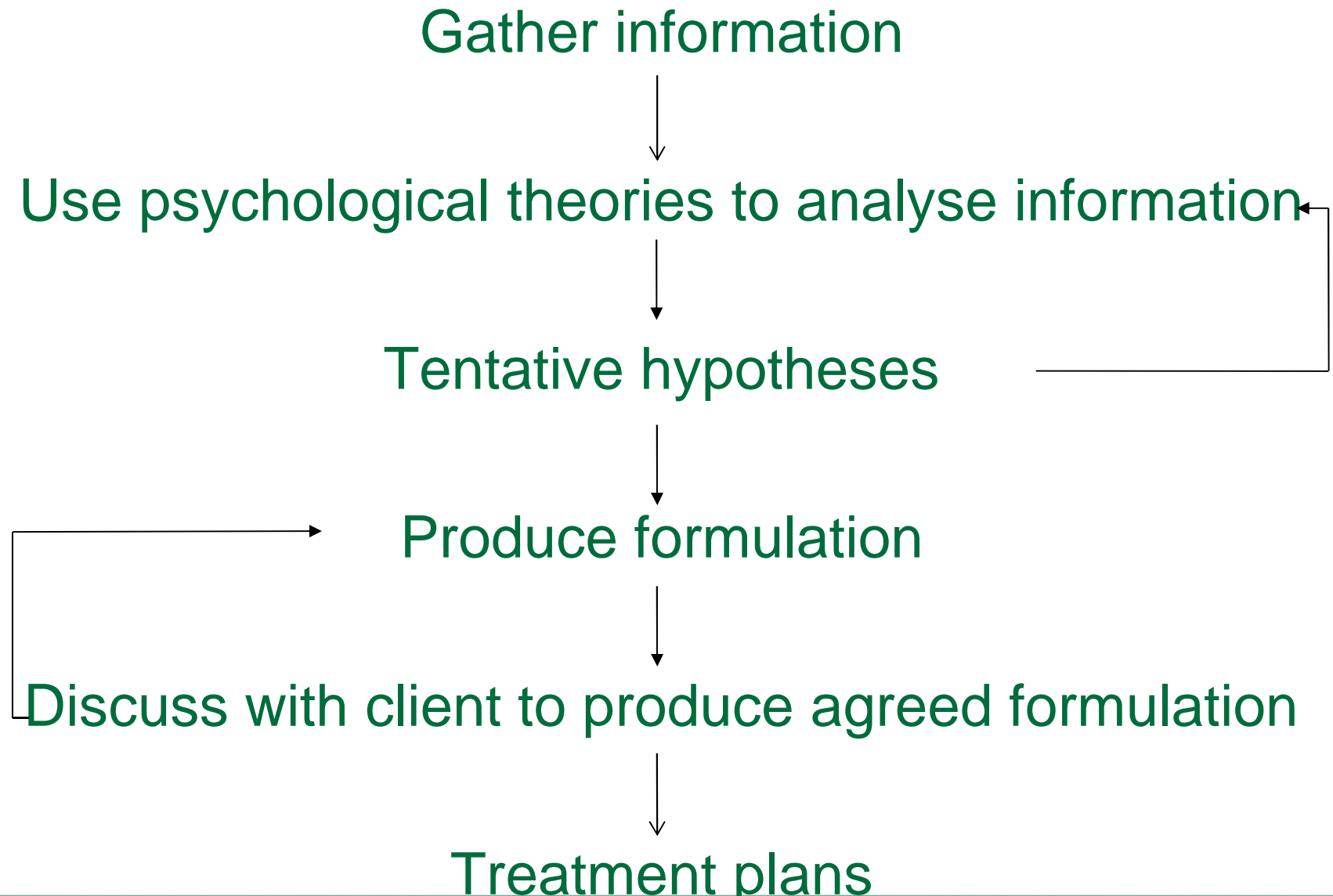
- Best evidence for CBT compared to other types of therapies
  - Most high level research (RCTs) and most positive research
  - Effective for a wide range of mental health problems including AOD, anxiety, psychosis, depression BUT
- Whatever framework you use, you can create your own evidence through measuring individual outcomes – CBT emphasises this



# WHAT WE DO.....

# Initial Interview

- Map the territory (data gathering; shared understanding)
  - Assess current status (standardised and idiosyncratic measures)
  - Problem list and associated goals
  - Onset, maintenance and methods of dealing with the problem (formulation)



# Problem list and associated goals

## PROBLEM LIST AND GOALS SETTING

Please list below the main 3 difficulties you are currently experiencing: (e.g. Queensland Health  
sleeping difficulties, low mood, uncontrollable worry, panic attacks)

dual diagnosis  
initiative

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please find space below to list 3 goals you would like to set yourself to perhaps overcome the problems you have listed above:

1. *Short-term goal:* \_\_\_\_\_

Where am I right now?

0% \_\_\_\_\_ 100%

Some steps towards reaching that goal:

- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_

2. *Medium-term goal:* \_\_\_\_\_

Where am I right now?

0% \_\_\_\_\_ 100%

Some steps towards reaching that goal:

- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_

3. *Long-term goal:* \_\_\_\_\_

Where am I right now?

0% \_\_\_\_\_ 100%

Some steps towards reaching that goal:

- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_

**PROBLEM LIST AND GOALS SETTING**

Please list below the main 3 difficulties you are currently experiencing: (e.g. Queensland Health sleeping difficulties, low mood, uncontrollable worry, panic attacks)



- 1. relationships
- 2. Self worth
- 3. \_\_\_\_\_

Please find space below to list 3 goals you would like to set yourself to perhaps overcome the problems you have listed above:

- 1. *Short-term goal:* Have self worth and build relationships (think more positively about self and abilities)

Where am I right now?

0% \_\_\_\_\_ X \_\_\_\_\_ 100%

Some steps towards reaching that goal:

- A. Notice good things about self
- B. Open up to people more
- C. Be more trusting (increase emotional honesty with others)

- 2. *Medium-term goal:* Complete program/ see daughter

Where am I right now?

0% \_\_\_\_\_ X \_\_\_\_\_ 100%

Some steps towards reaching that goal:

- A. Participate in all groups
- B. Go thru the legal process to see daughter
- C. Seek good support

- 3. *Long-term goal:* Gain employment/ save money

Where am I right now?

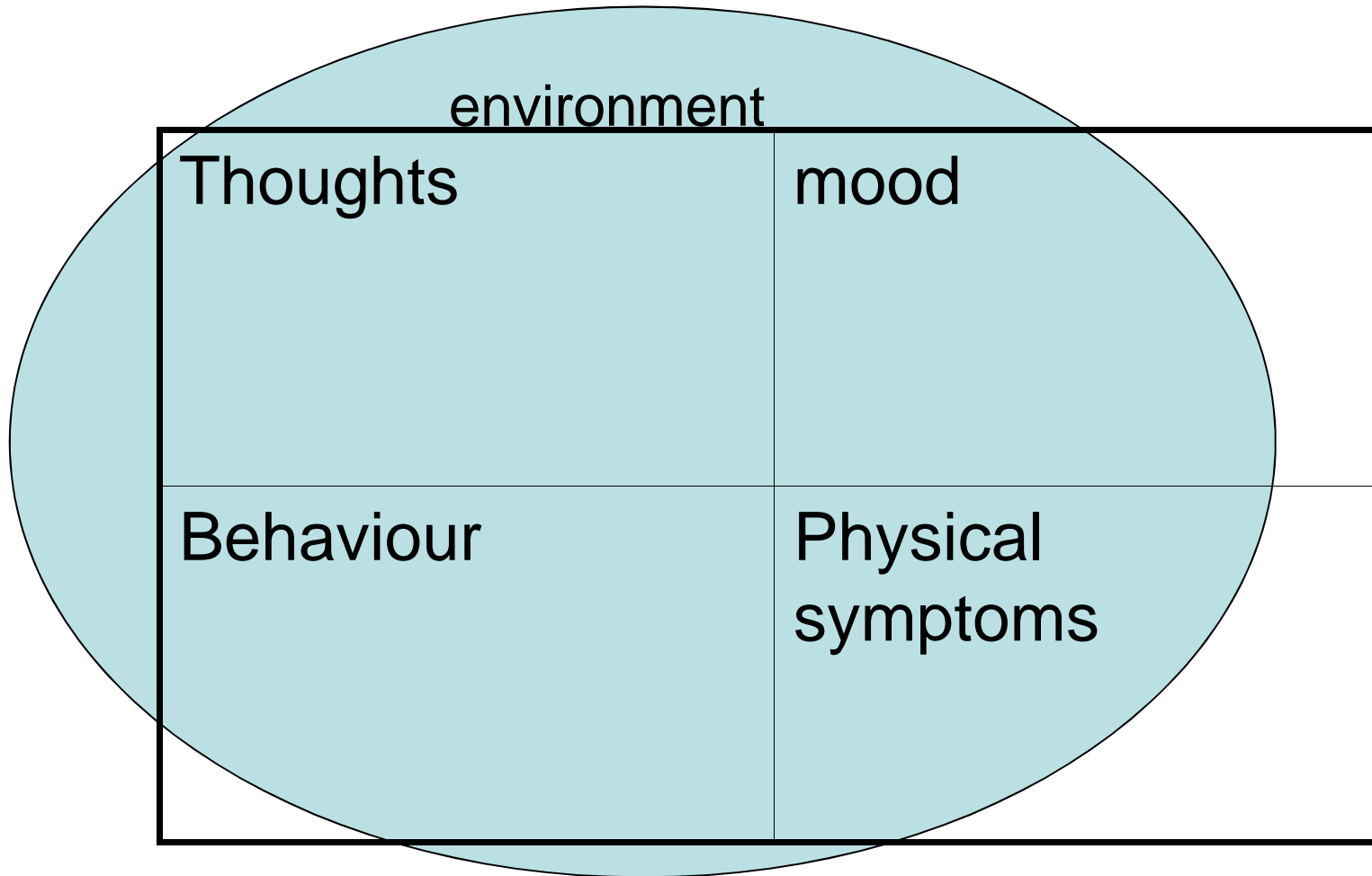
0% \_\_\_\_\_ X \_\_\_\_\_ 100%

Some steps towards reaching that goal:

- A. Stability in housing
- B. Maintain recovery – be honest with self
- C. Keep seeking support – Dad/ AA sponsor/ Mum

# UNDERSTANDING THE PROBLEM

# Padesky's 'Hot Cross Bun'





# Case Example

- J = 25 year old male. In relationship of two years. Currently unemployed. Currently on probation for DUI. Upcoming court for breach of probation. Recent A&E presentation for self harm. Uses alcohol, ice, weed, though has had periods of abstinence. Reports anger problems, anxiety, sadness, self harm, suicidal ideation, not sleeping, not eating regularly. Girlfriend has just started abusing oxycontin. He is upset about this and doesn't want her using as he is trying abstinence currently.
- History of extensive childhood sexual abuse by mothers partners. Mother AOD user, done long periods of jail time. Dad previous AOD user, current cannabis user, now very physically unwell, resists hospitalisation.
- J is main carer of father. J maintains a relationship with mum "because noone else will".
- J has six half sisters and brothers, all of whom have been in the care system. He has three younger siblings under ten, all mum's children, all currently in foster care. He tries to visit them and maintain relationship ("why should they suffer when they haven't done anything?")
- J wants to "not feel like this anymore", get back to employment and have positive relationships with others.

# Padesky's 'Hot Cross Bun'

Environment – arguments with girlfriend, not working, financial problems, family problems

## Thoughts

“I’m useless, I can’t do anything right, why won’t she believe me/ listen to me?”

## Mood

Sad, angry, scared, worried

## Behaviour

Verbal fights, hit things, break things, hurt self, use

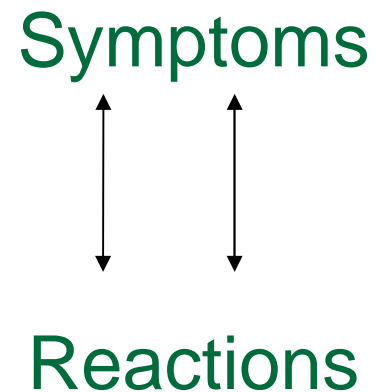
## Physical symptoms

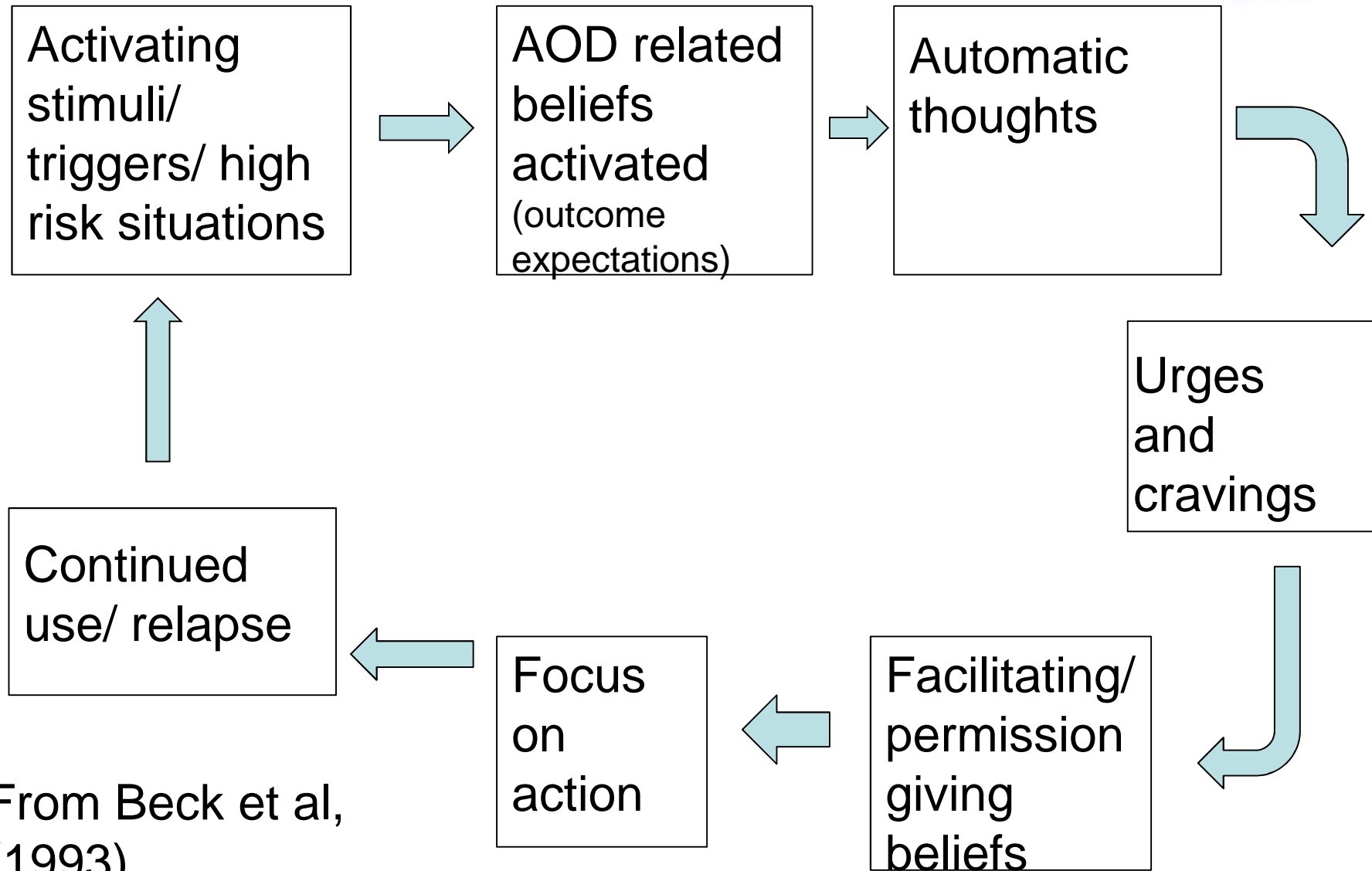
Nausea, tight chest, sweaty palms, fast breathing, shaking/ tremors

# SELF PRACTICE

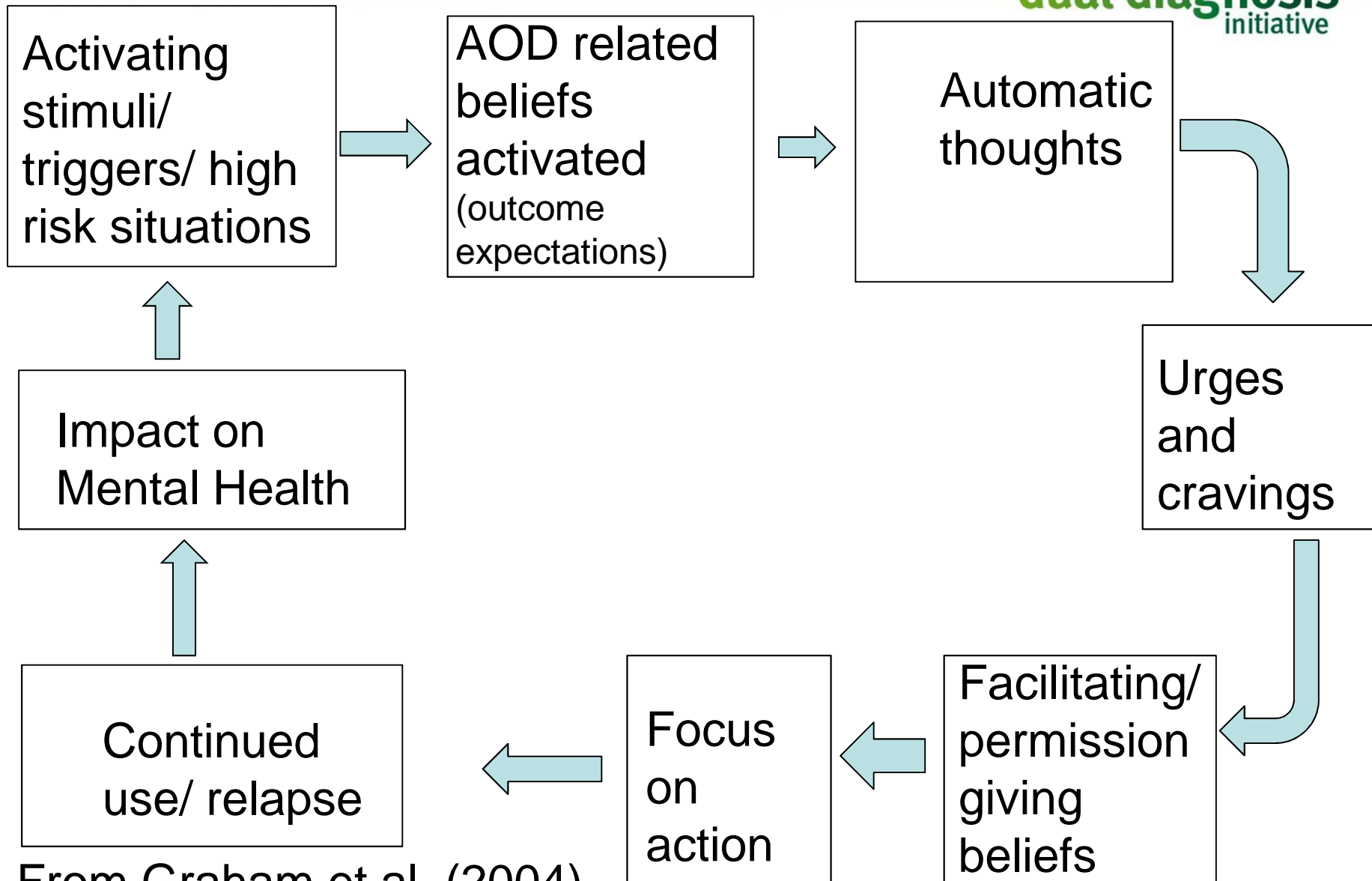
Create your own 'hot cross bun' for how you are  
right now

Cross sectional – triggers and maintenance  
cycles  
(processes that maintain the problem)



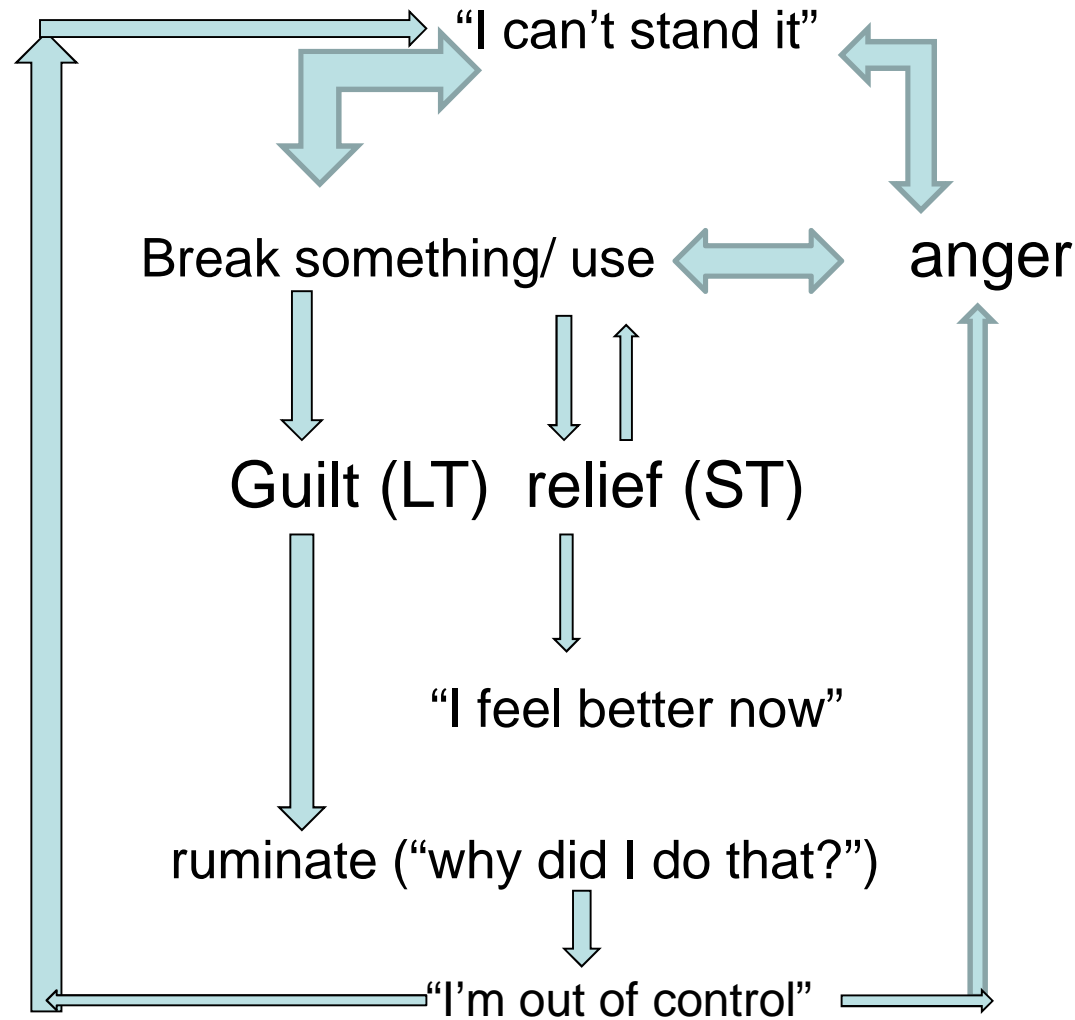


From Beck et al,  
(1993)



From Graham et al, (2004)

Trigger (arguments – not being believed)

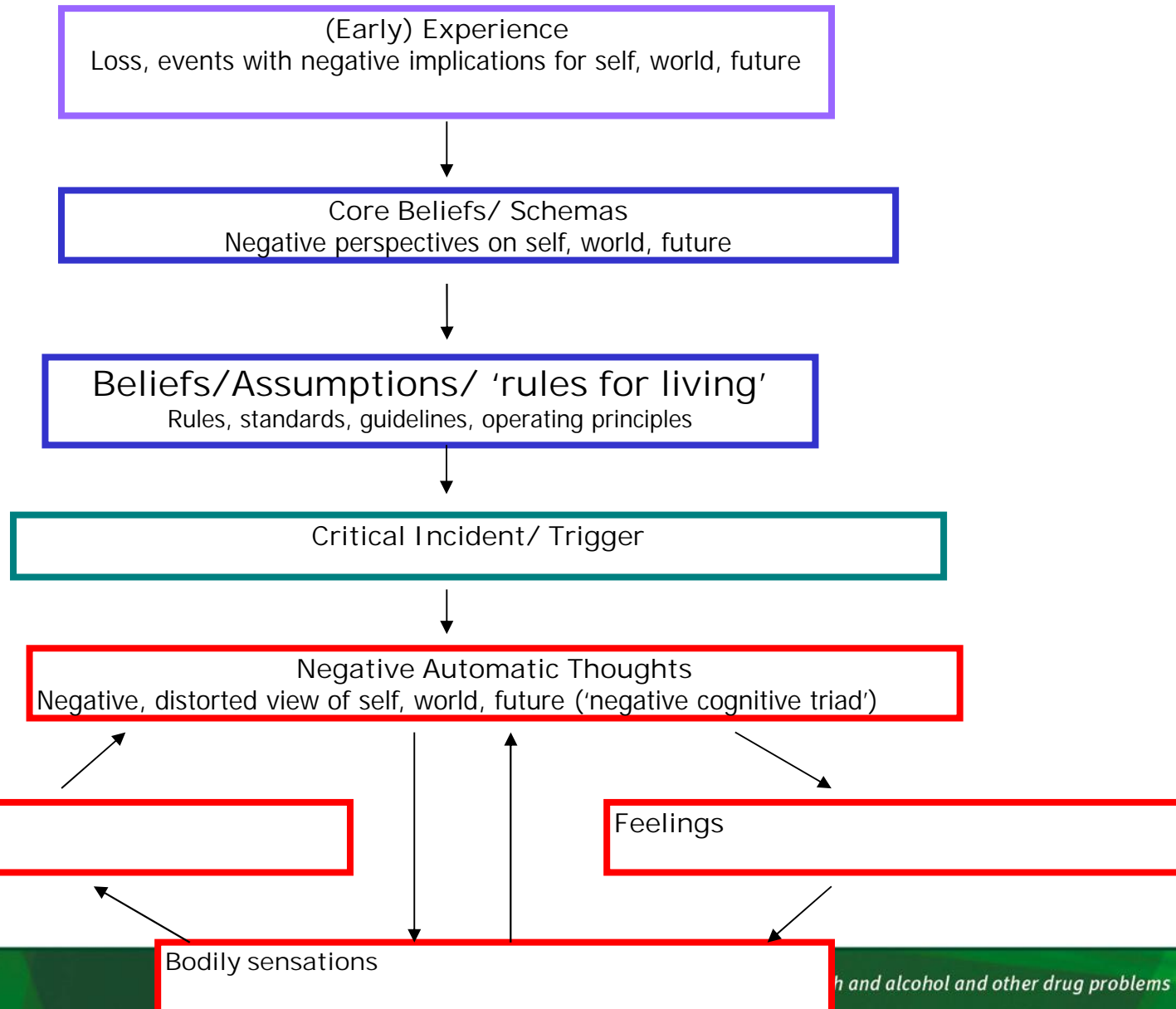


# SELF PRACTICE

Create a maintenance model for a client you  
are working with right now

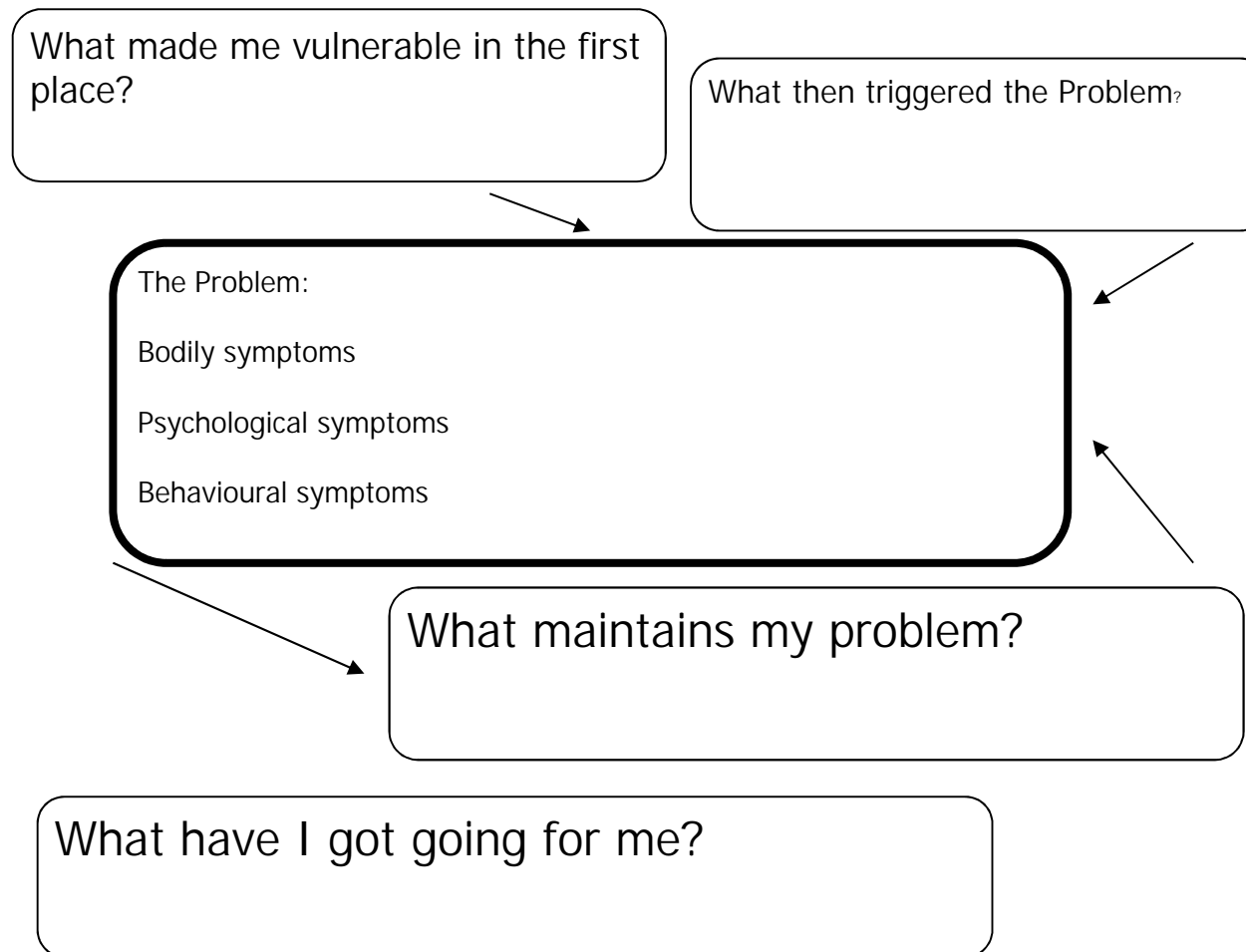


# BECK'S LONGITUDINAL MODEL

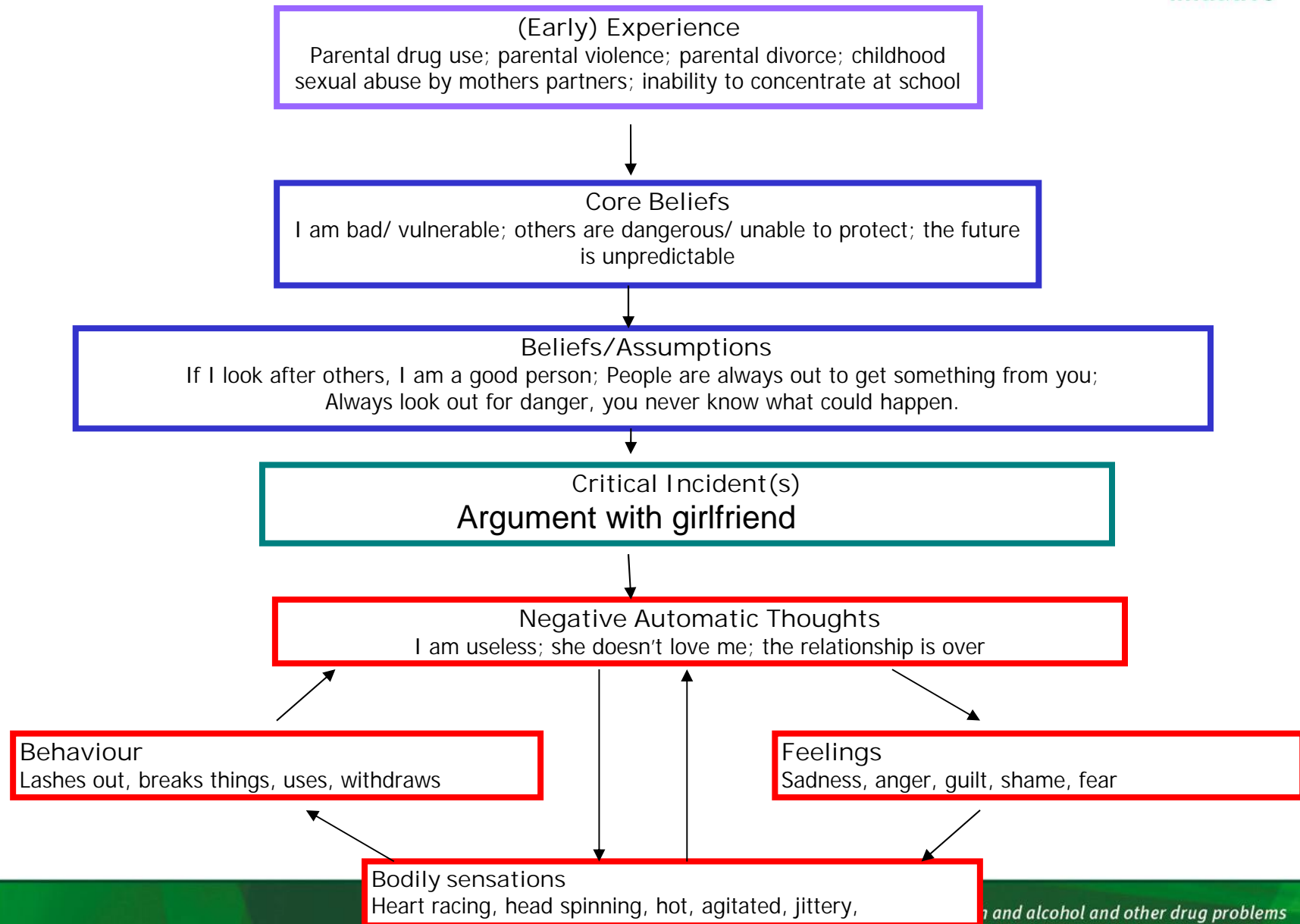


# Same formulation, different diagram

## Longitudinal



# BECK'S LONGITUDINAL MODEL



# SELF PRACTICE

Create a longitudinal model for a client you are working with right now

## Purpose of this??

- Aids understanding for both client and therapist (an outline map)
- Guidance (selecting interventions)
- Hypotheses (to generate curiosity)
- Sharing (explicitness and collaboration)
- Making links (past & present, processes)
- Revealing gaps and missing information

*A guide, not a rule; shared; dynamic*

- Can be positive or negative experience for a client
- ?more for the therapists benefit
- Don't forget to highlight strengths and resiliencies!!!
- Remember to look for info that disconfirms your hypothesis too

# INTERVENTIONS

# CBT strategies

**Cognitive strategies** involve learning to recognise the thoughts, beliefs and attitudes that make us feel bad, and reframing them into more realistic psychologically healthy ways of thinking

**Behavioural strategies** involve undertaking certain behaviours that help us to change the way we think and feel. Includes experimenting with new behaviours eg: confronting situations, abandoning perfectionist behaviours, using assertive communication, practicing relaxation, problem solving, goal setting and activity scheduling



# Therapy examples

Cognitive Therapy (Aaron Beck)

Relapse Prevention (G. Alan Marlatt)

Coping Skills Therapy (Peter Monti)

Mindfulness Therapy (Mark Williams)

Schema Therapy (Jeff Young)

Dialectical Behaviour Therapy (Marsha Linehan)

Acceptance and Commitment Therapy (Steven C Hayes)

# Strategy examples

Problem Solving

Goal Setting

Cue Exposure Therapy

Thought stopping/ disputing/ challenging

Urge surfing

Activity scheduling...

# What Did I Do with J???

- Full history taking – current situation, family history, school experiences, friendship experiences, relationships, work experiences, forensic history etc
- Psychoeducation on anxiety (fight & flight)
- Psychoed on anger and mapping intensity of emotion, thoughts/ behs linked to emotion
- Creating safety plans for using/ moods
- Seeking effective social support – role plays and identifying safe people

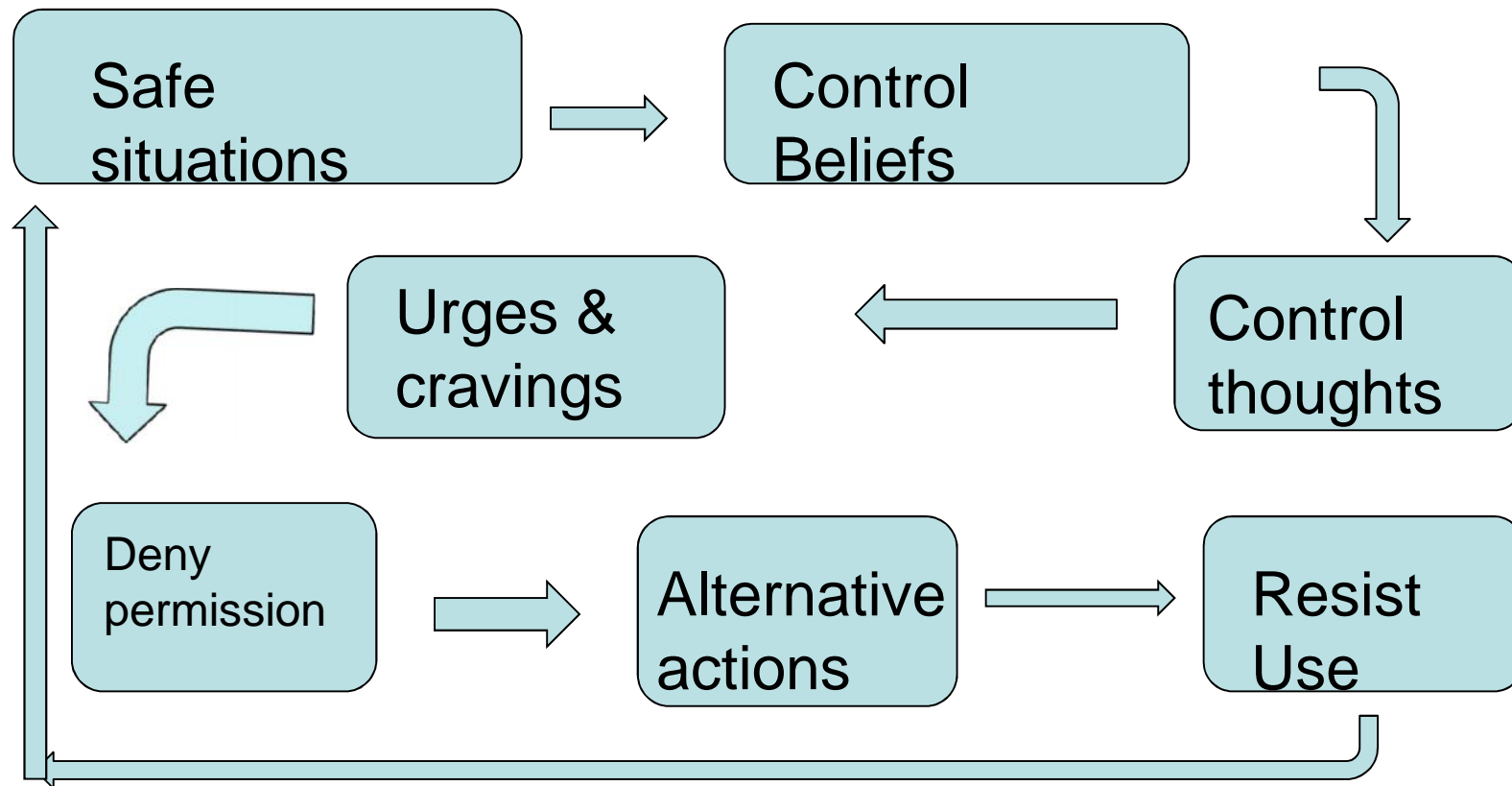
# Even more interventions.....

- Problem solving
- DBT wise mind/ distress tolerance techniques/ 'radical acceptance'
- Emotion identification and labelling
- Dealing with procrastination/ avoidance (“the difference between ‘a gonna’ and ‘a do – er’”)

## Interventions (cont.....)

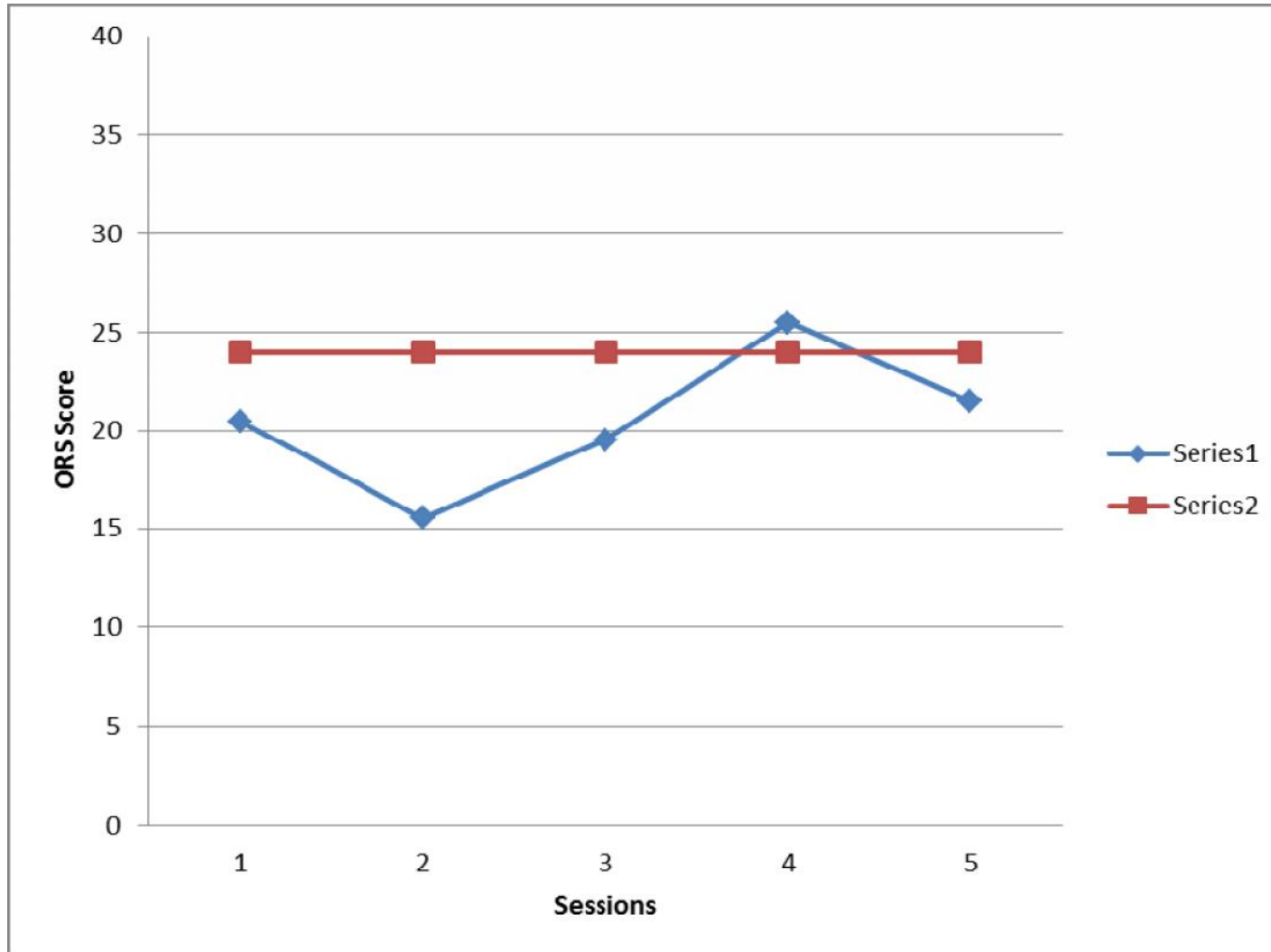
- Breathing exercises/ PMR for self soothing  
“keeping myself safe inside myself”
- Managing sadness – self compassion for abuse  
suffered – managing rumination/ “dwelling”
- Managing family relationships – mum still uses/  
dad physically unwell
- Psychoed on Xanax withdrawal
- Decreasing alcohol/ synthetic cannabis use
- Behavioural activation/ activity planning

# Where are we trying to get??

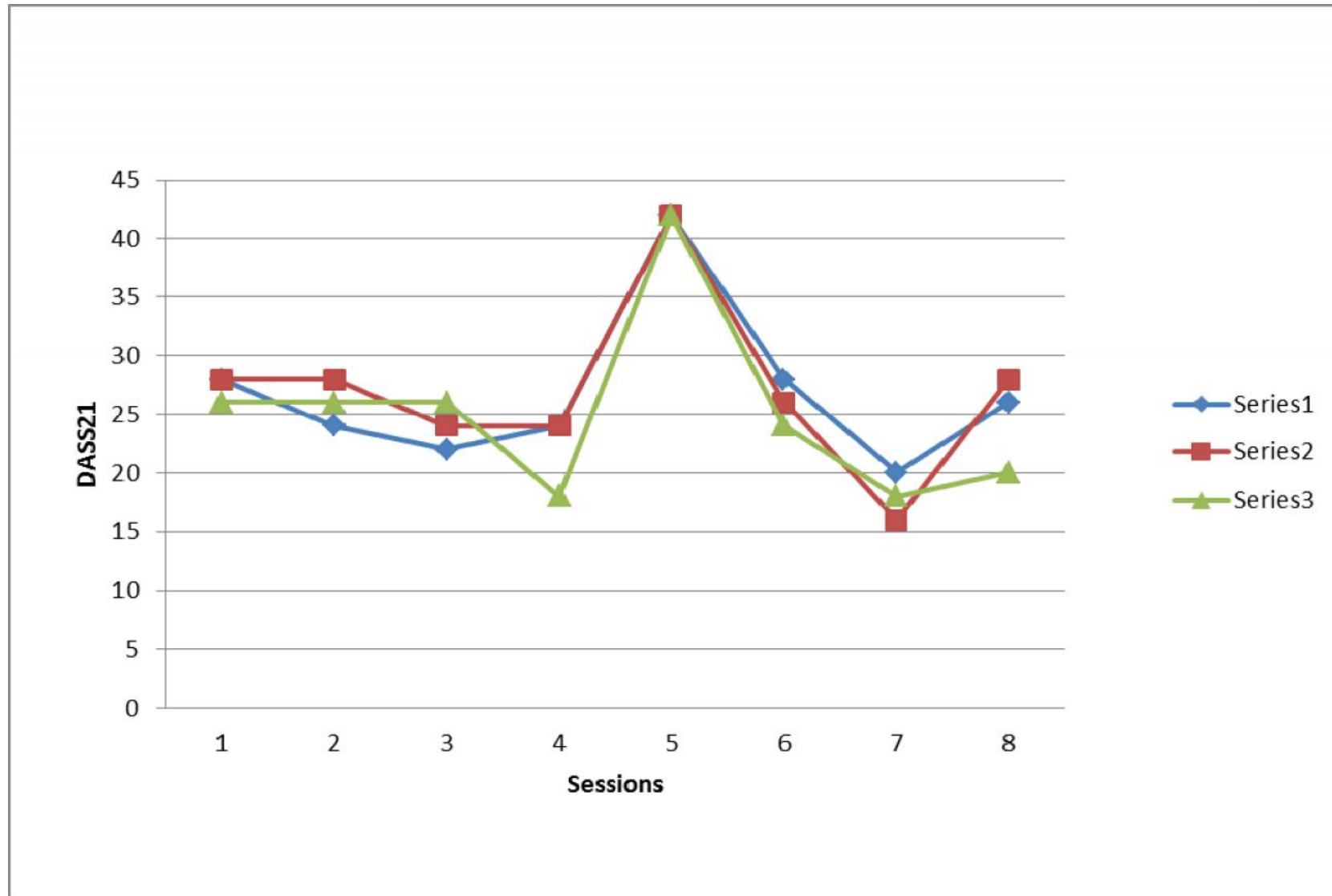


# Measuring Effectiveness

- How do we know our interventions are working?
- ORS/ DASS/ disorder specific measures for social phobia, trauma, OCD etc
- Share these with clients. Help focus interventions
- Therapeutic alliance – SRS – can predict retention?







# MOTIVATIONAL INTERVIEWING PLUS COGNITIVE BEHAVIOURAL THERAPY

# MI & CBT

Many studies showing additional benefits to clients when these methods are combined

Eg: in eating disorders, gambling, HIV medication adherence, generalised anxiety disorder, psychosis and substance misuse

# CBT & MI

- MI - best delivered in a few separate sessions prior to the start of therapy or best integrated in an ongoing fashion as CBT proceeds?
  - Depend on the specific disorder treated? Eg: most patients with anorexia nervosa may require considerable preparation with MI before they are ready to enter formal CBT but most patients with depression can likely be engaged in CBT from the outset (so long that it is done in the spirit of MI!).
  - Motivational issues may arise during the course of therapy as people begin to confront actual behaviour change.

# MIDAS

- Sample size (327); follow up (2 years), MIDAS (UK) is largest RCT for people with psychosis and substance use and is evaluating an integrated MI and CBT ("MiCBT") client therapy
- Attrition rates low. Majority received a substantial number of therapy sessions.
- Sample characteristics - substance use longstanding, with frequent use at moderate or severe level, low motivation for change, seen in the context of low levels of functioning and significant psychopathology.

# MIDAS 2010 results

- Integrated MI & CBT + standard care vs standard care alone.
- Phase 1 = "motivation building"- engaging patient, exploring and resolving ambivalence for change in substance use.
- Phase 2 = "action"- support and facilitate change using CBT.
- Up to 26 therapy sessions over one year

# MIDAS

- Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and substance misuse do not improve outcome in terms of hospitalisation, symptom outcomes, or functioning. This approach does reduce the amount of substance used for at least one year after completion of therapy

# Some last thoughts....



# IMPROVING CLINICAL EFFECTIVENESS

- Studies show that Workshops like this are not effective at changing Worker behaviour - unless they are followed up by supervision and practice
- Unless we change clinician behaviour, we will not improve client outcomes. Use of evidence – based treatments ‘by – the - book’ will create best outcomes for your clients
- Clinician interest may be determined by ease of implementation, fit with what clinicians believe and are already doing, demonstrated cost-effectiveness, and in response to clinician-expressed need

# Reflective practice

- How does this fit with your current practice?
- How does it fit with you as a practitioner?
- What is your 'message in a bottle' or 'headline' from today's workshop?
- What do you want to take forward into your practice?
- What do you need to do to ensure that this happens?

# Clinical Effectiveness

- Treatment begins with efforts to engage and motivate, transitions to specific skills-building to facilitate abstinence, with simultaneous encouragement to attend mutual support groups and involve concerned others in treatment

# References

Beck, Wright, Newman & Liese (1993) **Cognitive Therapy of Substance Abuse**

Graham (2004) **Cognitive Behavioural Integrated Treatment (C-BIT): A Treatment Manual for Substance Misuse in People with Severe Mental Health Problems**

Moorey (2010) The six cycle maintenance model: growing a vicious flower for depression **Behavioural and Cognitive Psychotherapy** **38 (2)** 173 – 185

# References

Barrowclough, Haddock, Beardmore, Conrod, Craig, Davies, Dunn, Lewis, Moring, Tarrier, & Wykes (2009) Evaluating integrated MI and CBT for people with psychosis and substance misuse: recruitment, retention and sample characteristics of the MIDAS trial **Addictive Behaviours 34** (10) : 859-66

Barrowclough, Haddock, Wykes, Beardmore, Conrod, Craig, Davies, Dunn, Eisner, Lewis, Moring, Steel & Tarrier (2010) Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and comorbid substance misuse: randomised controlled trial **British Medical Journal 341** : 6325

# References

Copello et al (2012) The impact of training within a comprehensive dual diagnosis strategy: the Combined Psychosis and Substance Use (COMPASS) experience **Mental Health and Substance Use** Volume 5 (3), 206-216

McGovern et al (2004) A survey of clinical practices and readiness to adopt evidence-based practices: Dissemination research in an addiction treatment system **Journal of Substance Abuse Treatment** 26, 305–312