Addendum
Handleiding 2

Individuele gedragstherapie bij middelengebruik en gokken

Individual Cognitive behavioural therapy for substance use and gambling

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VOORWOORD

Bij behandelcentra voor verslaving in ons land melden zich steeds vaker mensen die de Nederlandse taal niet of onvoldoende machtig zijn om een behandeling te kunnen volgen, maar wel de Engelse taal voldoende beheersen. Voor centra die toch aan deze behandelbehoefte tegemoet willen komen is nu een Engelstalige editie beschikbaar van Werkboek 2 cognitieve gedragstherapie bij middelen en gokken**: Workbook 2 cognitive behavioural therapy for substance use and gambling** (zie het overzicht Verschenen). Dit Workbook bevat de één-op-één vertaling en paginaopmaak van de Nederlandse editie, waarmee veel Nederlandse behandelaren bekend zijn. Om hen verder behulpzaam te zijn is het voorliggende Addendum gemaakt bij de eveneens bekende 'Handleiding 2 Individuele cognitieve gedragstherapie bij middelengebruik'. In dit Addendum zijn Engelse vertalingen opgenomen van de psycho-educatie in Handleiding 2, uitleg van begrippen en middeleninformatie. Het gaat om een keuze uit Handleiding 2 waarvan verwacht wordt dat daaraan behoefte is. Met name Nederlandse behandelaren krijgen daarmee steun in de rug om ook cliënten in de Engelse taal te behandelen. De paginacijfers in het Addendum verwijzen steeds naar de desbetreffende pagina's in Handleiding 2. Indien gewenst zullen uitbreidingen van dit Addendum verschijnen. Wensen en opmerkingen zijn welkom bij de samenstellers en redactie: info@perspectiefuitgevers.nl

== SESSION 1 ==

(BIJEENKOMST 1 VOORBEREIDEN OP VERANDERING)

Page 16

1.5 Summary intake and therapy agreements

● Ask the client to explain the reasons he / she has asked for treatment at this time. What are the changes (for the client or in his / her environment) that have influenced this choice?

● Check whether there is anything that has happened between the intake and this meeting that it is important to know about. What changes have increased the motivation for change? Has the client already made changes to his substance use / gambling? If so, what are these changes?

● Give a short summary of the intake, focusing on use, the amount and the consequences of the use. Mention any periods where use has been less (or where client has been abstinent). Ask the client to make any additions to the summary.

● Talk through the structure of the treatment, as explained in the intake – a treatment of in total 13 meetings focusing on changing in the client's substance use. The topics of the first 9 meetings is set, the topics for the last 4 meetings are agreed together.

1.6 Inventory of substance use

● Ask the client to describe how their substance use has been since the intake. If more than one substance is used, ask about each substance.

● Acknowledge and validate any positive changes in the substance use. Ask the client how they have been able to change their substance use. Check whether there are also positive changes for other substances.

● Give a short summary of the inventory, ask for any additions.

● Conclude this point and ask the client if it's ok to move on to the next point – making an inventory of the disadvantages of using and the advantages of changing my use.

Pages 17-18

INFORMATION ABOUT SUBSTANCES

Alcohol

Standardizing the amount of alcohol that is used by referring to units of alcohol is important. One unit is a standard glass, and by definition contains 10g alcohol. A 250ml glass of beer is one unit. A bottle of beer (300ml) is therefore 1.2 units and a half litre (500ml) is 2 units. So for British people, who drink pints, a pint of beer at average strength (5%) is approximately 2 units.

For wine with a strength of 13% a standard glass is approximately 100ml. A bottle of wine (750ml) is therefore 7.5 units of alcohol.

For drinks like port, sherry and vermouth one unit is 55ml. A bottle with 20% alcohol contains 14 units of alcohol.

For strong drinks and liquors, with an alcohol percentage of 40%, one unit is 30ml. One litre of strong liquor (e.g. whisky) is 32 units of alcohol.

Drugs

For drugs the preferred way to standardize is by using grams or milligrams. For cannabis the number of joints can be used and for cocaine the number of lines, shots or the amount of money spent.

Gambling

The amount of money spent is used.

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1.7 Disadvantages of using and advantages of changing substance use

● Introduce the topic – exploring and examining the disadvantages of using and the advantages of changing

Encourage ' the language of change' by:

- Allowing the client to talk about what problems will occur in the future if his use does not change
- Allowing the client to talk about which problems will decrease if he changes his use

● Ask the client where he would like to begin. Conclude this part with a short summary of the information given.

● Give additional objective information (psychoeducation) about the effects of substances and the expected positive consequences of long-term changes in use. Be explicit about the effect change will have on the client's lifestyle.

Pages 18-19

1.8 Rationale and content of the treatment

● Explain how substance use and gambling start. In the beginning the short-term positive effects of substance use play a maintaining role, they encourage us to keep using. Over time the short-term positive effects lessen and the substance use continues due to a decrease in the long-term negative effects, as a result of the substance use. Ask the client what he recognizes in this and validate the response.

● Sketch out the simple functional analysis. Explain that the FA constitutes a recurring theme throughout the treatment, that it gives insight (helps us to see) into the triggers and maintaining factors in the substance use. Treatment focuses on learning to manage these factors differently, leading to the client being able to gain control over the substance use.

● Ask the client to think of a few triggers for use and ask him to think about possible alternatives e.g. avoiding the triggering factor.

● Explain that the treatment focuses on both the triggers and maintaining factors, for example that learning alternative ways of dealing with risky situations is part of the topic self-control measures.

● Introduce the workbook. This includes homework and exercises for each trigger and maintaining factor for use discussed. In addition, there are also registration forms to use in between sessions to register use. The registration has 3 aims: providing information about triggers; providing information

about alternative ways the client manages a trigger; an indication of the extent to which the treatment goal (reducing use) is met.

● Emphasize the importance of the homework and continuity in the treatment.

● Ask whether there is anything that is not clear for the client.

● Ask the client for their opinion of the content of the treatment and which parts of the treatment he considers important, and why that is.

● Give a summary of this point.

Pages 19-20

1.9 Registration

● Explain that you will now look together at how to fill in the registration form.

● Explain that the form aims to gain insight in the substance use, the direct triggers and difficult situations where the client is used to using but hasn't.

● External triggers: - who, what, where.

● Internal triggers: - Thoughts: the triggering thoughts, as concise as possible.

- Physical sensations: description of the sensation, identify where in the body.

- Emotions: use the basic emotions: fear, anger, happy, sad.

● Behaviour: what the client does: amount of substance use and over what time period, or what the client does instead of using.

● Explain that use can be triggered by one factor, or several factors that happen at the same time.

● Ask the client for a recent situation where he has used, or where he would have normally used. How much was used, over what period of time?

● Explore this situation by distinguishing external and internal triggers. Keep it concise. Emphasize that the form is to help the client gain insight into the triggers and maintaining factor for his substance use. This insight is the first step in gaining control of the use.

● Provide objective information about the substance and the associated risks. Ask the client for permission to give the information and afterwards what the client recognizes or thinks about it.

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Information about Substances

Registration of primary substance

The registration gives a clear personal picture of the use and the triggers to use for the client. However, the triggers for use do not vary that much for the various substances. Thoughts and feelings that lead to substance use tend to be 'I've earned it', 'oh, now I can relax' or a feeling of togetherness with others, having fun, tension or feeling down. The actual situations where substances are used do tend to differ, depending on the social environment of the client.

Common situations that lead to **alcohol** use are certain groups of friends, a party, work-related situations (e.g. Friday drinks). Other situations related with the home could be coming home from work, a drink during dinner, being at home alone.

Situations that are often linked with **cannabis** use are certain friends, being alone, feeling bored.

Situation linked with **cocaine** use include certain friends, going out, particularly to clubs or big dance events, where cocaine is often used with relative strangers. Another situation specific to cocaine use is work-related stress. The higher energy level makes it easier to manage work stress in the short term.

Gambling does not tend to be triggered by the social environment but rather the lack of a social network. This is a clear difference from substance use.

== SESSION 2 ==

(BIJEENKOMST 2 DOELEN EN ZELFCONTROLEMAATREGELEN)

Pages 29-30

INFORMATION ABOUT SUBSTANCES

Goals

Agreeing goals is a negotiation between what the client wants and what the professional considers to be responsible substance use.

In the Netherlands there are two guidelines regarding responsible alcohol use. According to the Health Commission (*Gezondheidsraad, 2006*) alcohol use is responsible when:

● Women drink a maximum of one unit per day with at least 2 consecutive alcohol-free days a week.

● Men drink a maximum of 2 units of alcohol a day with at least 2 consecutive alcohol-free days a week.

The Multi-disciplinary guidelines for Disorders (*Multidisciplinaire richtlijn Stoornissen, NVP 2009)* distinguishes four different types of drinking, where moderate drinking can be considered as responsible drinking. The amounts that the NVP uses are a maximum of 14 units per week for women with no consecutive days where more than 5 units have been drunk. Responsible drinking for men is considered to be a maximum of 21 units per week with no consecutive days where more than 6 units have been drunk.

Even when the client chooses controlled drinking as their goal, it is advisable to encourage a period of no drinking. Firstly because any alcohol use leads to a loss of control which increases the chance of the client not reaching their goal. Secondly, for diagnostic reasons, it is only possible to responsibly diagnose co-morbid problems (e.g. anxiety or depression) when the client has been abstinent for 2 – 4 weeks.

For other substances there are no guidelines regarding responsible use. From a professional point of view the advice is not to use substances at all. If a client hesitates about abstinence then it is possible that the ambivalence has not been discussed enough or that abstinence does not feel like a realistic goal. Exploring other reasons for changing the substance use is then an option.

A third reason relates to the executive functions, the cognitive functions necessary for:

● planning and decision-making,

● adapting and changing mistakes in behaviour,

● learning new behaviour or series of actions,

● breaking out of ingrained daily patterns of behaviour.

Substance use has a negative influence on these executive functions. Clients who use substances have difficulty understanding, processing and remembering new information. The learning process is also slower. When the client chooses controlled use without abstinence as their goal the chance of a successful treatment is reduced. After 4 - 8 weeks of abstinence these processes appear to recover

(recovery period is dependent on the level of use). In addition, mild cognitive problems correlates with stopping the treatment prematurely.

If the client chooses for controlled use then it is better not to dispute this. Ideally a certain period of controlled use would be agreed with the caveat that if the client does not meet this goal then the next step is complete abstinence.

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2.8 Self-managing measures

● **Stimulus Control**: this type of self-managing measure involves avoiding, or not looking for, places or situations where, or people with whom, substance use is likely to take place.

● **Stimulus-response interventions:** this type of self-managing measure involves behaving and reacting differently in situations where you are used to using. What is important with this measure is the available alternatives, e.g. soft drinks instead of alcohol. An important intervention is making use of the help of a supporting person, e.g. calling them at a moment that craving is experienced.

● **Response consequences:** this type of self-managing measure involves rewarding reaching your goal, for example buying something the client always wanted or planning an enjoyable activity. The reward should be available, achievable and realistic.

Another form of response consequence is used in the situation where the client does not reach their goal. If a client uses, an alternative reward can help as a response consequence, for example doing a task that is not enjoyable and is always put off. This can help in preventing more substance use.

Page 31-32

INFORMATION ABOUT SUBSTANCES

Self-control measures

There are three types of self-control measures, stimulus control (avoidance), stimulus-response interventions (risk situations) and response consequences. The self-control measures related to stimulus control are substance specific, the other measures depend on the client and what they are able and want to do.

Self-control measures specifically related to **alcohol** include having no alcohol in the home, taking a different route in the supermarket to avoid walking past the alcohol, avoiding certain situations for a period of time (bars, parties) and not drinking when out for the evening (e.g. offering to drive).

For alcohol there are also some specific stimulus-response interventions, for example having an alternative drink (e.g. a favourite soft drink) ready. In many restaurants it is usual for wine glasses to be filled by the waiter. Asking for these glasses to be taken away can avoid this happening. For clients who want to control their drinking it can be helpful to not finish the drink in the glass, this makes it less likely that the glass will be re-filled. Other options for controlling drinking can be alternating an alcoholic drink with a non-alcoholic drink and putting the glass down in between sips rather than holding on to it.

Medication can also be used as a self-control measure. There are various medications that can be used in combination with a CBT intervention.

Cannabis use nearly always goes hand in hand with smoking tobacco. Stopping smoking can be an effective self-control measure when changing cannabis use. If the client wants to stop smoking then it can be useful to also address this in the treatment.

Stimulus control measures specifically related to **cocaine** use include removing the numbers of dealers out of the telephone, not drinking alcohol as it is often a trigger for using cocaine, not smoking as this can also be a trigger, avoiding certain situations (e.g. mega-parties, football matches) or people (other users) for a period of time. Another measure is not keeping money with you, or at least not enough to be able to buy cocaine. Restricting access to money by asking the support person to look after bank cards can also help.

Medication can also be used as a self-control measure for cocaine, when alcohol is a trigger for cocaine use. Disulfiram, a medication which makes drinking alcohol impossible, can be an effective measure.

Many people who have problems with substance use also **smoke**: 80-98% of people with a problem with alcohol or another substance also smoke, compared with 26% of the general population. It is often assumed that it is too difficult and too ambitious to expect someone to stop smoking as well as stopping using other substances, that the treatment of other substance use will be less effective and that there is a greater risk of relapse if the client also stops smoking. There is however no research evidence for this. Conversely, the research shows that stopping smoking carries no risk of relapsing in alcohol or drugs use, but rather increases the chance of abstinence in alcohol or drugs use. Stopping smoking can therefore be considered and used as a self-control measure (stimulus control) for changing substance use.

Stimulus control specifically related to **gambling** includes choosing a different route home that does not pass the casino or other place where gambling is possible, requesting a ban at the casino (which prohibits entry, at Holland Casino a ban or restricted entry applies to all of the sites in the chain), not carrying money with you and giving bank passes and credit cards to someone else to keep.

At home, stimulus control measures include no internet access, only using the internet in the presence of others, blocking gambling websites or buying a mobile with no internet access.

Treating underlying comorbid disorders is often considered to reduce the chance of relapse in substance use: in other words, that treating the comorbid disorder is a self-control measure. There is no evidence for this assumption. The treatment of an anxiety or mood disorder for someone with a substance abuse problem does not reduce the chance of relapse, although it is effective for reducing the anxiety or mood complaints. There is no evidence that supports the expectation that such a treatment leads to a reduction in the substance use.

== SESSION 3 ==

(BIJEENKOMST 3 ZELFCONTROLEMAATREGELEN EN FUNCTIE-ANALYSE)

Page 42

Many people who use know that there are certain situations where they will use. For one it might be that they drink when they have problems at work, for another it might be drinking too much at a party. People often feel that using is something that they have no control over. People say, for example 'before I knew it I was standing there with a beer in my hand'; or 'I had decided not to go out, but then a friend came round and we ended up going to the bar'.
A thought, feeling or craving can also lead to using. For example, thinking after an argument 'always the same argument, a drink will help me not to think about it anymore', then going to the fridge and getting a beer.
You feel yourself relaxing, you can let go of the argument. However, this also means that the problem does not get talked through. The person with whom you argued might for example not contact you anymore. This leads you to think 'no-one likes me' which makes you feel even more angry. This anger is itself likely to lead to using.
If we examine exactly what has happened then we are often able to see why we used, or did other things that we would rather not have done. The functional analysis is helpful in working out what happens before using as well as the consequences of using. The functional analysis distinguishes between different triggering factors and maintaining factors, all of which are discussed in the course of the treatment.

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Functional Analysis

The functional analysis is used to gain insight into the triggers and maintaining factors of the substance use.

People close to the client are often able to predict substance use based on the already-mentioned early warning signs in the client's behaviour. These triggering factors are the same for all substances: complaining about vague physical symptoms, restlessness, agitated, irritated, disturbed sleep, getting angry quickly etc. These complaints can be seen as symptoms of withdrawal.

The functional analysis should not be seen as an exploration of the reason for using, as if substance use is an inadequate coping strategy for underlying problems. The functional analysis does not explore the cause-consequence relationship, it rather provides a clear and complete picture which illustrates the substance use for the client.

TIP

Example questions for external risk situations:

Based on what you have registered, which situations usually trigger you to use?

Based on what you have registered, with whom do you usually use?

Based on what you have registered, what do you think are the risk situations where you are used to using?

Example questions internal risk situations

Based on what you have registered, which thoughts usually trigger you to use?

Based on what you have registered, what physical sensations do you feel in your body before you use, and where do you feel it?

Based on what you have registered, which emotions usually trigger you to use?

Example questions consequences / effect

In the short-term, what do you get out of your substance use?

What are the advantages of substance use for you?

What do you like about using?

What do you think are the consequences of substance use for you in the long term?

What would happen if you stopped using temporarily?

== SESSION 5 ==

(BIJEENKOMST 5 NOODMAATREGELEN EN OMGAAN MET TREK)

Pages 60-61

INFORMATION ABOUT SUBSTANCES

Craving

Craving is a physical sensation that results from a link that is created between a particular trigger and substance use. Some people do not experience craving. A possible explanation for this is that no links are made between a particular trigger and substance use. It cannot be explained by the incorrect distinction between physical and emotional addiction. This distinction does not exist.

TIP

Craving for a substance can be experienced in different ways. Some people experience it on a physical level, e.g. a racing heart, cramps in the stomach, being able to smell it. Others experience it more cognitively – 'I need it now', 'I can't think of anything else but using'. Still others experience it more emotionally – 'I'm stressed', 'I'm down'. It is important as a therapist to know how your client experiences craving to fit the explanation to their experience.

The principle of **Classical Conditioning** was discovered by Pavlov by observing his dogs. He noticed that his dogs already started drooling when they saw their bowls of food. By repeatedly ringing a bell before giving the dogs their food Pavlov observed that the dogs began to drool when the bell rang. They learned that the bell predicted the arrival of food.

With substance use a similar conditioning mechanism operates. Through long-term use the body learns that in certain situations substances will be used. Diverse environmental factors become a sort of bell, they are associated with use. In the same way that the dogs reacted to the bell, the body reacts to these factors which predict use. What happens, however, is that the body reacts in an opposite way to the effect that the substance has. This can be explained as follows:

The human body is continuously trying to maintain an internal balance, called **homeostasis**. Any slight change leads to an immediate reaction to restore this balance. This also happens when we drink alcohol or use drugs. These substances disturb the internal balance and the body then reacts to redress the balance. For example, drinking alcohol leads to the core body temperature dropping and the peripheral body temperature increasing (think of the flushed red cheeks of someone who has been drinking). The body responds with an opposing reaction to restrict the impact of the substance and restore the balance. This is a well-known phenomenon: the more often alcohol is drunk the greater the body's response. There is less enjoyment in the alcohol. This is known as **tolerance**. As a consequence people tend to drink more in order to gain the same effect.

Just as Pavlov's dog learned that he would receive a bowl of food once he heard the bell, the body of a user knows that walking into a bar or a coffee-shop is a good predictor for substance use. The body then responds with a compensatory reaction which opposes the effect of the substance, with the aim of as quickly as possible restoring the internal balance. This happens before the substance has been drunk or used. For alcohol, therefore, the body reacts before the drink has been drunk by increasing the core temperature and decreasing the surface temperature. For a heroine user, faced with certain triggers (seeing a spoon, the needle, the dealer) that are associated with using heroine, the body

prepares itself for the arrival of the substance with an opposing reaction to the impact of the substance: the heart rate increases, blood pressure increases etc.

It is important to know that when a substance is used in an unfamiliar setting this compensatory response does not take place or is much weaker. With heroine this can be dangerous. A dose that can usually be tolerated due to the compensatory mechanism becomes more difficult for the body to tolerate and can lead to an involuntary **overdose**.

The physical changes that occur during this compensatory response are noticed by the user and experienced as **craving**. They are very similar to the physical changes known as **withdrawal**. Even though each person experiences craving differently, common physical sensations are increased heart rate, sweating, restlessness. Users often find it difficult to cope with these feelings of craving which increases the chance of **relapse** into using the substance that reduces these sensations. Knowing which situations and triggers are cues for this compensatory response can help in learning to manage the feelings. For example, someone who has sat for years in the same chair by the window to use is likely to experience craving when they see the chair or sit in it.

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INFORMATION ABOUT SUBSTANCES

Craving

Alcohol: The anti-craving medications acamprosaat, naltrexone and nalmefene have been shown to be effective interventions to help with craving. If the client chooses to take anti-craving medication then they should be referred to the doctor.

== SESSION 6 ==

(BIJEENKOMST 6 OMGAAN MET TREK EN VERANDEREN VAN GEDACHTEN)

Page 71

TIP

Expectations, assumptions and thoughts about using can affect whether someone uses in a risk situation. Two different types of thinking patterns have been distinguished – the anticipatory thoughts and the thoughts giving permission:

Anticipatory thoughts: these are thoughts about the effect of the substance, about what the substance will do for you. They anticipate the feelings that will result from using. For example: 'alcohol relaxes me and stops me worrying', 'cocaine helps me to function better', 'by gambling I can compensate yesterday's losses'

Thoughts giving permission: these are thoughts that relate to the desire to use. With these thoughts the user gives themselves permission, or obliges themselves, to use. For example: 'I've earned it', 'one glass won't hurt'.

== OPTIONAL SESSION ==

(KEUZEBIJEENKOMST SOCIALE VAARDIGHEDEN: OMGAAN MET KRITIEK)

Page 115

Dealing with criticism

The theme for today's meeting is social skills, in particular how to deal with receiving criticism. What do we actually mean by social skills? A person who is seen as socially able is able to talk to others whilst at the same time being able to stand up for themselves. The word criticism comes from the Greek word *kriterion*, which means norm, and the word *kriticos,* which means to think critically. Criticism is a personal analysis or interpretation of a situation or behaviour by the person giving the criticism. Criticism is not the truth but an individual interpretation.

There are three ways of dealing with criticism – passively, aggressively, and socially able. People who react passively tend to assume that the person giving the feedback is always right. Criticism of behaviour is seen as a rejection, which can lead to feeling stressed or down and chips away at someone's self-confidence. Some people react by making a joke about the criticism or laughing it off, thinking that in this way no-one will know that they feel hurt by it. In the long term this way of reacting does not differ from always assuming that the person giving criticism is always right.

People who react aggressively see the criticism as a personal attack and become angry. The best defence is then to attack back. For example: "how dare you criticize me for being late once, when you are always late". In the short-term this behaviour leads to more conflict and aggression. In the long term, this reaction has the same result as the passive reaction, leading to feelings of depression, stress and a decrease in self-confidence.

Feeling angry is a normal human reaction and can be seen as a warning sign for a problematic situation. Rather than expressing the raw anger, it is possible to manage the anger in a socially adept ways, the third – socially able – way of dealing with criticism. This view accepts that, even though it is never nice to receive criticism, it is feedback about a behaviour rather than a judgement of the person. Criticism can then be received more calmly, without too much negative emotion.

== OPTIONAL SESSION ==

(KEUZEBIJEENKOMST SOCIALE VAARDIGHEDEN: GEVEN VAN KRITIEK)

Page 125

The theme for today's meeting is social skills, in particular how to give feedback or criticism. The word criticism comes from the Greek word *kriterion*, which means norm, and the word *kriticos,* which means to think critically. Giving criticism is when someone gives their own analysis or interpretation of a situation or behaviour.

Giving feedback implies an expectation that the other person will change their behaviour. Having that expectation is fine, particularly if the other person's behaviour is in some way hurtful or annoying. This does not mean, however, that the other person **will** change their behaviour. Many people find giving criticism difficult, particularly if it involves someone close to them – a parent, partner, friend. If is always better to talk about what it is in someone else's behaviour that irritates or hurts than not to say anything. Not saying anything leads to increasing tension and stress, with all the possible negative consequences, e.g. substance use.