

INTEGRATED COGNITIVE BEHAVIORAL THERAPY (ICBT)



CLINICIAN MANUAL

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INTEGRATED COGNITIVE BEHAVIORAL THERAPY (ICBT) ¹
CLINICIAN'S MANUAL

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Integrated Cognitive Behavioral Therapy (ICBT): Clinician Manual

Introduction

This is the “ICBT in addiction treatment: Clinician Manual”. You will want to use this manual to help you prepare and conduct the therapy in your actual practice. Like any manual, this is the “how to” of the approach. Initially, most clinicians experience an inherent awkwardness in using a manual for something they have been doing already. Bringing in a manual to a relationship, to a craft, seems artificial, distancing, or even rude. Interestingly, most patients do not report experiencing it that way. Some clinicians say something like, “I am going to be doing a relatively new form of treatment with you. I am still sort of learning it. So I am using the book, and you will be using yours (i.e. the ICBT in addiction treatment Patient Workbook) to make sure we get it right.” Nonetheless, it will be important for you to review the manual in advance before taking it into session. There is no substitute for being prepared for what might be on the next page! We suggest reading the entire manual in advance, but understand how things tend to work for the busy practitioner. You may also get by if you read one or two modules ahead. The key is to get familiar and comfortable with the material, to be organized, and to convey this in manner to your patient.

Modules, sessions and handouts

The Clinician Manual is organized by modules, sessions and handouts.

Modules are specific topics for the ICBT in addiction treatment. There are 9 core modules. Generally, we recommend delivering the core modules in the sequence by which they are numbered (1 through 9). Module 9 (Transition) deals specifically with concluding the ICBT. This module incorporates a review of the benefits and disappointments in the therapy, the gains made, preparing for discontinuation, referral to other treatment providers, and saying goodbye. In many programs, this will not be necessary, but in others acknowledging a formal ending will be entirely appropriate.

Sessions are the specific dates and times within which modules are covered. In our experience, weekly sessions, either individual or group, are best. In some instances, meeting multiple times (twice) per week has been a frequency used to deliver the ICBT, particularly in open group formats and in intensive outpatient program levels of care. Delivering ICBT at any less than a once per week frequency, given the need to build skills and practice, probably loses important therapeutic momentum.

Handouts are used to present the ICBT material to the patient. They are in The Patient Workbook. Handouts are worksheets and informational sheets ordered by their appearance in the Clinician Manual. There are 19 handouts in total. Initially, you and your patient will feel as though you are constantly shuffling handouts from one to the other, and constantly checking to be sure you are literally on the same page. This improves as you gain experience. Handouts are important for the patient to record their experiences, do practice between sessions, and use as a reference to the work they are doing. Questions arise as to whether to keep the handouts and/or entire Patient Workbook for the patient (in the clinician office or file). This way, the patient does not have to worry about remembering the handout or workbook, either for fear of loss or discovery. The more typical approach however is to give the patient the entire Patient Workbook with all the handouts included, but also to have multiple copies of blank handouts on hand for those patients who forget to bring their Patient Workbook to session. You will work out the best approach for you and for your patients.

The table below presents the Module, sessions (or parts of sessions) typically needed to cover the module, and the corresponding patient Handouts. As you can see, depending upon the content of the specific module, it can be delivered either within a single session, or over the course of several sessions, or several modules can even be delivered in one session. Please keep these parameters in mind as guidelines not requirements. Whether you are moving faster or slower than the guideline may be perfectly reasonable and clinically indicated. You and your patient's skill acquisition set the pace. Remember, slow and steady wins the race!

Core Modules	Number of Individual session(s) suggested	Patient Workbook Handout numbers and names
Module 1: Engagement	1-2	#1: Trauma Event Checklist & PTSD Checklist #2: Mental Health Problems and the Symptoms that Bother Me #3: Positive Psychology #4: Pros and Cons Worksheet #5: Personal Rulers
Module 2: Overview of ICBT: Recovery: Pulling Together in the Same Direction	1/2	#6: Introduction to ICBT
Module 3: Mindful Relaxation	1/2	#7: Mindful Relaxation
Module 4: Substance Use and Crisis Plan	1/2	#8: Relapse Prevention Plan
Module 5: Identifying, Labeling and Understanding Feelings	1-2	#9: Feelings from A to Z #10: Primary Negative Emotions and the Common Thoughts That Drive Them
Module 6: ABCs of Our Emotions	1-2	#11: ABCs of Our Emotions #12: ABCs of MY Emotions Worksheet #13: Common Styles of Thinking
Module 7: Flexible Thinking: The ABCDE of Emotion	2-3	#14: Flexible Thinking: ABCDE of Our Emotions #15: Flexible Thinking Worksheet
Module 8: Patient Education About Trauma and PTSD	1-2	#1: Trauma Event Checklist & PTSD Checklist #16: PTSD Fact Sheet #17: Trauma and PTSD Symptoms #15: Flexible Thinking Worksheet
Module 9: Transition	1	#3: Positive Psychology #18: Change and Acceptance #19: Serenity
Total Number of Core Modules: 9	8-12	

Familiarity with materials

We cannot emphasize enough that the more you are prepared and familiar with the materials, the smoother the implementation of the ICBT will go. Advance preparation is always helpful, however, in our conversations with counselors and clinicians who use the ICBT in their everyday practice, we hear that it comes very naturally by the third round. That is, the first time you deliver it you will feel very awkward, the second time increasingly comfortable, and by the third time you will feel quite competent.

What to do at the beginning and end of every session

Within each module, a stepwise approach is outlined for the coverage of the particular module. In the sections below, are suggested steps that are universal to each individual or group session. Of course these steps can be shuffled, altered, deleted or substituted for with others as clinically appropriate to your setting and program.

Individual Sessions

1. Welcome the patient and begin with the Mindful Relaxation technique.
2. Inquire about substance use, psychiatric symptoms, crises and treatment attendance since the last session.
3. Conduct a brief review of the previous session's content and ask a few questions to evaluate comprehension and understanding of the material.
4. Review the patient's practice assignment. Reinforce all attempts at adherence and emphasize the importance of homework in learning new skills.
5. Present a brief overview of the current module's content. Use examples and demonstrations.
6. Ask open-ended questions about the material to assess comprehension (e.g., "Today, we talked about the ABCs of Flexible Thinking. What is your understanding about what we did?"). Clarify as needed. Note areas of particular difficulty or confusion for future review.
7. Ask the patient for examples of how this information pertains to him or her. Ask the patient to identify how—and perhaps demonstrate how—the new skill or information can be directly applied to his or her situation.
8. Review any new material from the session.
9. Assign practice work for next session.
10. Close the session by asking what was helpful and what was not helpful.
11. Affirm and support patient's progress and continuation; confirm date and time of next session.

Record keeping and tracking

Incorporating ICBT in addiction treatment into your record keeping, either in medical records or patient charts helps integrate the service into routine practice. Identifying trauma and/or PTSD as a clinical problem, reduced symptoms and improved functioning as a goal, and ICBT as the intervention is an excellent line item on a treatment or recovery plan. With the caveats mentioned earlier about protecting the confidentiality of specific and detailed traumatic material the patient provides, it is also important to report on patient response to the ICBT in progress notes. In addition to patient symptoms, motivational stage to address both substance use and PTSD is an important factor for a treatment team to be aware of.

In addition to the more traditional aspects of record keeping, the ICBT Clinician's Guide provides two additional formats with which to monitor the delivery of the intervention: the *Clinician Checklist* and *ICBT Adherence and Competence Rating Scale*.

Clinician Checklist

The Clinician Checklist helps the clinician keep track of the session number, date of session, modules covered, and percent of time spent on: 1) ICBT manual; 2) Check-in on substance use and/or other mental health issues; or 3) Other issues. Monitoring this activity helps the clinician keep track of the percent of time (should add up to 100%) dedicated to the ICBT manual. In our experience, 75 to 80% of time is optimal. Thus, in a 45 to 50 minute individual session, at least 35 to 40 minutes should be dedicated to the manual. This self-monitoring has been reported by clinicians to be useful in keeping them on track, and in considering where they are getting derailed. The Clinician Checklist could also be collected by a clinical supervisor, to guide a discussion during supervision time.

ICBT Adherence and Competence Rating Scale

The ICBT Adherence and Competence Rating Scale is designed for the supervisor to monitor the clinician's adherence to the ICBT manual, and also to monitor the competence or skill with which the clinician delivers the intervention. The rating scale covers both fidelity (adherence) and competence (skill) aspects to the treatment. Benchmark items are rated on two seven-point scales for each dimension: adherence (1-Not at all to 7-Extensively) and competence (1-Very Poor to 7-Excellent). This tool can be useful in helping the supervisor more succinctly guide the clinician's professional development. The most valid ratings on this scale are typically obtained via direct observation (more likely in group formats) or review of audiotapes or videotapes of sessions (more likely in individual formats). In the absence of these types of clinical observations, the rating scale can be completed based on the clinician report about the process of the session.

Relationship factors: Therapeutic alliance and therapeutic frame

Is therapy an art or a science?

Many clinicians consider the movement toward “evidence-based” practices a takeover of the art or craft of the therapeutic process. They point to the importance of the therapeutic relationship and cite “practice-based evidence” to counter the field’s attempt to move scientific evidence into routine practice decisions and clinical work. This debate is beyond the present scope, however, utilizing treatments that have been found, thru scientific research, to be effective, does not have to be entirely offensive with those who value the potency of the therapeutic relationship. In fact, those who have studied evidence-based treatments, including within the large multi-site NIDA and NIAAA controlled trials, consistently found that not all therapists were equal, i.e. some had outcomes significantly more positive than their study counterparts. These therapists were characterized by factors not necessarily specific to the therapy being studied, but more so related to relationship and therapeutic alliance behaviors. We believe that the clinician who can establish a good therapeutic relationship, engage the patient in the therapy, be sensitive to the ongoing issues that will arise in the patient-clinician relationship, will do better by the patient than the clinician who is not sensitive to these issues.

Integrated Cognitive Behavioral Therapy (ICBT) in addiction treatment is going to be most effective when the patient experiences the therapist as tuned in to their needs and experience, competent, organized, and committed to their agreed upon plan. Research finds that measures of the patient’s experience of these factors, as early as the second session, are predictive of staying in treatment and benefiting from it.

We highlight two overarching concepts of the therapeutic relationship: The Therapeutic Alliance and the Therapeutic Frame.

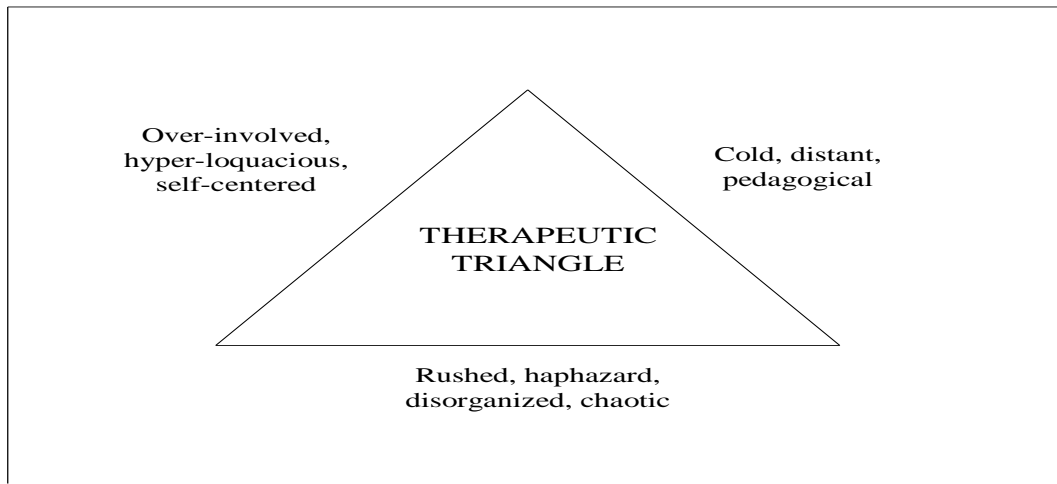
Therapeutic Alliance

The therapeutic alliance pertains to the goals, bond and rapport between the patient and clinician. The goals should be explicit and shared. In other words, when the patient and clinician both agree that they are working on improving the patient’s ability to manage PTSD symptoms without using substances, this is excellent concordance. When this is not the case, they may be “agreeing to disagree” and perhaps working towards a common goal of finding places where they do agree. With respect to bond, this refers to patient and clinician being on the same team. The patient experiences the clinician as being on his or her side. This does not mean to be in collusion or mutual denial, but rather experiences the clinician as supportive of his or her well-being, even (or maybe especially) when the patient is not acting so well on his or her own behalf. They are joined in the fight for the patient’s recovery. Rapport is the degree of comfort, good humor, non-verbal connectedness, or chemistry that seems to exist between patient and clinician. Being able to establish rapport early is very important. Most skilled clinicians do this via their capacity (either innate or developed) to empathize with the patient’s experience, be sensitive and compassionate with this information, and convey understanding and hope. Conveying hope, in the face of desperation, may be one of the most important contributions to the therapeutic relationship.

Therapeutic Frame

The term “therapeutic frame” has its origins in the interpersonal schools of psychoanalysis from Harry Stack Sullivan thru Stephen Mitchell. The psychoanalytic writers who particularly advanced the concept of the therapeutic frame included Robert Langs, Merton Gill and Irwin Hoffman. The latter two being supervisors of one of the authors of this clinician’s guide. The therapeutic frame refers to the outline or context within which the business of the therapy takes place. This could be the time spent between greeting the patient in the waiting room to sitting down together to begin the formal therapy session. It could also refer to phone calls or email communications about scheduling and other matters between sessions. It could pertain to time spent standing up together, versus sitting down, or negotiating scheduling, fees or paying bills. Further, it could pertain to accidental encounters outside the walls of the therapy or clinic, such as at a restaurant, peer recovery support group meeting, or convenience store. Apart from the content of the session, it could also refer to the manner the clinician brings to the exchange. Having experienced a great deal of inconsistency early in their lives, most persons with substance use disorders, particularly those with traumatic past histories, are exquisitely sensitive to the comings and goings of the clinician, and his or her reliability. Do they start and end the session on time? Do they follow-up on homework assignments? Do they remember my spouse’s name, my daughter’s name, my name? Can they recall where we left off last time, and what the plan is for today? The therapist behavior around each and every one of these issues has meaning to the patient, and conveys something important. The psychoanalyst might contend that the clinician’s attunement to the patient’s response to the clinician on these therapeutic frame issues is what the therapy is all about. We believe that the good clinician should be tuned into these matters while delivering the ICBT. In particular, it is important for the clinician to consider the concept of the Therapeutic Triangle. See Figure below.

We have outlined three key dimensions which we visualize as a triangle. “Good enough” therapy takes place within a field bounded by 3 margins. Think of these margins as sidelines or boundary lines, as if on a tennis court, football or baseball field. In most cases, we want to keep the ball in bounds, in play. Therapy outside of these relational or behavioral boundary lines may be less effective. One boundary line is set by the clinician who is rushed, haphazard, disorganized or chaotic in his or her behavior. The second sideline is for the clinician who can be over-involved and talks more than listens. This therapist may talk on and on, cut the patient off, and in some cases use inappropriate self-disclosure. The third margin is the clinician that is cold, distant and overly authoritarian. This type of line is crossed with preaching and lecturing. A clinician who is sensitive to matters of the therapeutic frame works within the margins of this Therapeutic Triangle much like the tennis player strives to keep the ball within the white lines.



Summary

ICBT will work best and perhaps only, in the context of a good therapeutic relationship. Although the therapeutic relationship likely has abundant subtle nuance and mystery as other relationships do, we have found two concepts helpful in understanding the good ones: the Therapeutic Alliance and the Therapeutic Frame. Sensitivity to these concepts, having a good connection with your patient, and being able to convey respect and understanding will likely improve your success with ICBT as well as your patients' outcomes.

MODULE 1

ENGAGEMENT

Goals:

- Gather assessment data about PTSD symptoms and their effects on the patient's life
- Link patient's goals with an opportunity for help in ICBT
- Determine patient's readiness and motivation for change
- Engage patient in the therapeutic process

Time:

1-2 individual sessions

45-50 minutes for each individual session

Handouts Needed:

Handout #1: *Trauma Event Checklist (TEC) and PTSD Checklist (PCL)*

Handout #2: *Mental Health Problems and the Symptoms That Bother Me*

Handout #3: *Positive Psychology*

Handout #4: *Pros and Cons Worksheet*

Handout #5: *Personal Rulers*

Suggested Session Outline:

Step 1: Establish rapport and alliance

Begin the session by checking in with the patient in terms of making the scheduled appointment and affirming his or her attendance. Acknowledge that for some people taking this step takes a lot of effort and courage; as the clinician, you should communicate this awareness and commend the patient for taking the first step.

Clearly state the session goal. You may use the following script:

“For today I would like to learn a little about the kinds of things that may be causing you some distress and figure out how or even if it is important for you to address these things. Most people have some mixed feelings about addressing problems, so it is important that you and I start out on the same page. If we’re not, that may be okay. We could discuss being on the same page later. But if we are on the same page, we find things go better. Does

this make sense as a good place for us to begin?”

Discuss the patient’s answer, providing clarification wherever necessary.

Step 2: Review Handout #1 Part 1: The TEC

Review Handout #1, Trauma Event Checklist (TEC) and PTSD Checklist (PCL), with the patient. Ask the patient if he or she would be comfortable completing the screening form, the first page of the handout. Assume the patient will complete it as a self-report, but stand by in case there are questions or comments. As an alternative, you can administer the TEC and PCL as a structured clinical interview. It may also be the case that the patient has already completed the TEC and PCL as part of a screening or assessment process, in which case you will have obtained these forms and will be discussing their responses.

You may use the following script to introduce the handout:

“For starters, I would like you to fill out this survey or Handout #1. First, it asks about things you may have experienced in your life. On the next page, you are asked about the possible effects these experiences have had on you and continue to have on you today. I know any traumatic experience is very personal to you, and I am here to be helpful. I will treat this information as confidential. Okay? Good, then can we take a look at the handout now?”

Review the instructions for both parts of the handout, making sure the patient understands what he or she is to do. (Page 1 is the TEC, where events that may meet Criterion A of the DSM-IV for PTSD will be marked. Page 2 contains the PCL, where the B, C and D symptoms associated with PTSD will be rated.)

Collect the handout once the patient has completed it and review page 1 for Criterion A of the DSM-IV for PTSD with the patient. Be sure to look at Item 17 at the bottom of the first page of the handout. If the patient checked that other stressful events or experiences may have occurred, be sure to take time and identify those experiences. To do so, you may use the following script:

“I see you checked Item 17. Could you please tell me a little more about what other experiences you’ve had that were very stressful?”

Note: Sometimes these other experiences are difficult and negative, but do not meet criteria by DSM-IV standards as “traumatic.” Nonetheless, because of its potential benefits, you may determine that you want to offer ICBT to all patients with trauma-related symptoms and significant negative emotions whether they meet full PTSD diagnostic criterion or not.

Step 3: Review Handout #1 Part 2: The PCL

On the second page of Handout #1, review the responses to the “symptom” questions and add up the scores. Scores of 44 or more on this scale are indicative of a PTSD diagnosis. These items pertain directly to the PTSD symptoms of re-experiencing (DSM-IV criterion B for PTSD), avoidance (DSM-IV criterion C for PTSD) and increased anxiety (DSM-IV criterion D for PTSD).

NOTE: The PCL symptoms pertaining to these DSM-IV criteria are categorized as follows:

Re-experiencing: Items 1, 2, 3, 4 and 5

Avoidance: Items 6, 7, 8, 9, 10, 11 and 12

Increased arousal (anxiety): Items 13, 14, 15, 16 and 17

Step 4: Review DSM-IV PTSD Score and Criterion Clusters

Review both the total diagnostic score and the item clusters for re-experiencing, avoidance, and increased arousal (anxiety) criteria with the patient. Acknowledge the endorsement of items, both individually and by criteria, that is to say, you can note if specific items fell into the re-experiencing, avoidance or increased arousal categories.

Step 5: Review Handout #2, Mental Health Problems and the Symptoms That Bother Me

In this step, the clinician's task is to link the symptoms identified in Step 4 with interferences in the patient's daily functioning. To complete this task, give the patient or distribute among group members Handout #2. To introduce this handout, you may use the following script:

“Given the form that you just filled out, I would like to get a more personal understanding of how these symptoms affect you. So, on this next handout, you and I can work together to list the primary symptoms or problems you recorded on Handout #1 (part 2), and how they specifically affect your life now. As you tell me, I can record the information in the appropriate box.”

Step 6: Review Handout #3, Positive Psychology

After completing the above form, give the patient a copy of Handout #3 and review the instruction with him or her. To explain the form, you might begin with the following script:

“Now, I would like to understand what you might be able to do if these symptoms weren't in your way. In other words, what would your life look like. What would you be able to do that you can't do now?”

The clinician reviews and discusses with the patient his or her responses to the handout, and connects at each point how the trauma and its symptoms have interfered in the patient's life and what he or she would otherwise do in life.

Note: Given that motivation to change is a process, perhaps best understood in stages that are dynamic, the next segment pertains to helping the patient give a voice to his or her ambivalence, the pros and cons of changing, and of addressing PTSD symptoms.

Step 7: Review Handout #4, Pros and Cons Worksheet

Before reviewing Handout #4, discuss the importance and emphasis on worksheets. You may use the following script:

“I know we are doing a lot of paperwork, but doing this foot work on the front end makes things go better. The worksheets help to focus you on how you are feeling about being here and taking some steps. Most people have mixed feelings about wanting to change. Even recalling and remembering upsetting experiences is difficult. But to heal, there may be no way around it but through it. It’s important that you recognize the pluses and minuses you have for dealing with these issues and talking about it with me. In this way, you can be sure, or at least sure enough, that you are ready.”

Have the patient list the symptoms from Handout #2 that he or she wishes to address at the top of Handout #4. Review and discuss the pros and cons for change, and use motivational enhancement techniques, including rolling with resistance, pointing out discrepancies between behaviors of avoidance and goals, and empathic communications, to aim to persuade the patient that the pros of change and treatment outweigh the potential cons. Help the patient fill out the boxes or write in the patient’s response yourself.

Note: Be sure to photocopy enough pages of Handout #4 and Handout #5 below for the patient to use on other problems or symptoms that bother them.

Step 8: Review Handout #5, Personal Rulers

Summarize the purpose of the previous handouts and prepare the patient for Handout #5. You may use the following script:

“So, to summarize, we have completed a couple of surveys to assess how much distress past events have caused you. We filled out some worksheets asking about how these events affect you now and what your life might be like without them. We also took a closer look at why you might want to do something about them or why you may not want to risk it --- and keep things the status quo.

The last handout in this session summarizes where you are with this. It’s called a personal ruler. It’s sort of like the pain assessment scale you use in medical situations. Doctors in the hospital or in ER might ask you to rate your pain on a 10-point scale. In this case now, I want you to rate your motivation.

So, given that your problem(s) is/are _____ (USE PATIENT’S OWN WORDS HERE), this personal ruler asks you to rate three things: first, how important is it for you to change this problem now. Second, on a 10-point scale, how confident are you that you can make this change now. And finally, on a 10-point scale, how ready are you to make this change (with my help) now.”

Note: It is not possible to manualize in steps how the clinician can close this session. But it is important to convey to the patient your utmost respect, either in words, manner, or tone. Expressing one's appreciation - if not admiration - for the bravery to deal with trauma is also critical. Some patients rate their traumatic events or problems as important, have confidence to address them, and are totally ready to do so. Other patients, however, will candidly acknowledge their anxiety, hopelessness, and reluctance. Some clinicians feel comfortable offering encouragement, while others attempt persuasion. Others still may adopt a more reflective even passive technique ("Now may not be the time for you."). In the authors' opinion, although any version of these tactics may be acceptable, it's imperative that the clinician conveys hope and optimism.

Having completed Module 1 and session 1, the patient and clinician should decide how and if to proceed. The sections that follow pertain to the next eight modules and remaining number of sessions.).

Step 9: Write Your Clinical Observations

Ask yourself the following questions to help you evaluate the effectiveness of this module. It might be more insightful if you record the answers on a separate sheet of paper.

Was the concept of PTSD new information for this patient?
How motivated is the patient to address PTSD here and now?
How motivated is the patient for continuing ICBT?

Step 10: Complete the Clinician Checklist

In conclusion, review the Clinician Checklist and record the appropriate information for the patient.

MODULE 2

OVERVIEW OF ICBT: RECOVERY: PULLING TOGETHER IN THE SAME DIRECTION

Goals:

- Affirm and support the patient's decision to address his/her PTSD or trauma symptoms.
- Briefly describe the ICBT program, including the three main components:
 - 1) Mindful Relaxation
 - 2) Flexible Thinking
 - 3) Education about trauma and PTSD and their affect on addiction and recovery
- Confirm the schedule, timeframe and expectations for the therapy

Time:

½ individual session

30 minutes for individual session

Handouts Needed:

Handout #6: *Introduction to ICBT*

Suggested Session Outline:

Step 1: Affirm the patient's decision to address PTSD and trauma symptoms

In our research with ICBT in addiction treatment, if the patient makes it to the second session the odds of them completing the therapy are substantially greater. Thus, if you are at Module 2, it is likely that this patient has made it to the start of the second session. They are engaged. Good work.

Because of this feat, it is important to recognize this accomplishment explicitly. As mentioned earlier, much like addiction, PTSD is characterized by increasing isolation and avoidance. Not wanting to think about it let alone talk about it is typical. The fact that this patient has made it to this point puts them into "elite" status. They are brave and courageous in their willingness to get better.

In the previous session they listed the ways in which the PTSD and trauma symptoms interfere with their life. They also noted the ways they could behave differently, perhaps more freely, without these symptoms. These are the patient's personal goals. It is these goals that are the primary motives to continue with you.

You might start by saying something like this script:

“I want you to know that I recognize how incredibly hard it is for you to be doing this. It takes a lot of courage and I commend you for this. You have decided to deal with some things that affect you. Not doing so would undermine your recovery from alcohol and drugs. Avoiding things doesn’t make them get better, at least in the long run, does it? I am hopeful that this therapy will work for you. It can give you some information and skills that help you to manage the symptoms related to your past in a better way.”

Step 2: Introduce the ICBT program, review Handout #6, Introduction to ICBT

The point here is to provide a brief overview of the ICBT. You want to address some basic parameters, as well as concisely convey what the patient will be doing.

You can use the following script:

“The therapy we are going to be doing together is called Integrated Cognitive Behavioral Therapy or ICBT. It is a proven therapy that is very effective for most psychological issues. But most people never get help for these kinds of issues, and if they do, they hardly ever get ICBT. The ICBT we’ll be doing is to help you better manage your thoughts, feelings and behavior related to your traumatic life experiences (or PTSD). In our experience, if you do this, you can increase your chances for recovery, not to mention lead a more peaceful life.

This ICBT has 3 key skills that we hope you can learn and become good at. The first is a relaxation technique we call “Mindful Relaxation.” It’s pretty simple to learn, and we’ll do it to relax at the start of every session. The second is a skill called “Flexible Thinking” to help you anticipate and deal better with situations, thoughts and feelings that upset you. Dealing with negativity is really important to your recovery. And learning to think more flexibly will help you feel and behave more freely. And third, in “Patient Education” you will gain knowledge about your symptoms so that you are better informed and prepared for your recovery.

How does this sound?”

It is important to give the patient some space and time to ask questions about ICBT or the work you will be doing together. At this juncture, most of the patient’s questions will probably be logistical (that’s Step 3). Be sure the patient understands the 3 key skills.

Step 3: Introduce the Schedule, Timeframe and therapy expectations

Note: This step can be combined with the one above, if desired. It is most important to define the program for the individual, including the amount of time for each session and the number of sessions and handouts. In addition, explain the importance of between session practice to the patient and that he or she will be asked to do assignments at home between sessions. It’s equally important that patients understand there is a limit and end to the ICBT modules and sessions.

The script below introduces the schedule (time limit, number of sessions, and handouts), which can be presented to a patient individually.

“For the ICBT to be effective, we’ll need to meet weekly (or more) over the next 2-3 months. This would be about 8 to 12 sessions. One thing that is important to know is that the therapy is time limited. Our goal is for you to be your own therapist eventually. To do this we try to teach you some skills so that you can learn them and do them on your own. This may be different from other therapy you have had.”

Ask about prior therapy experience or even experience dealing with trauma or PTSD.

Next you will need to address ongoing treatment for addiction, coordination of care and matters pertaining to privacy.

“Since you are also being treated for your drug and alcohol issues, those treatments will continue. I will be working with the addiction treatment team so your care is coordinated, but I want you to know I will not share any specific details of what we talk about exactly.”

Next introduce the concept of practice between sessions.

“So, in some ways, my role as your ICBT therapist will be like a teacher or coach. I will be presenting you with new information and teaching you some new skills to help you get by better. Likewise, since you’ll be in a learning mode, I will be asking you to do some things, or practice some things you learn between sessions. That way, you get more experience, and with repetition get better at the skills. How does this sound?”

Step 4: Summarize the Material

A patient may feel overwhelmed at the end of this module, so you may need to reassure the patient. To do this, you may use the following script:

“I know we’ve been talking about what we’re going to be doing rather than just doing it. This is so we are on the same page. Sometimes people at this juncture are a little nervous. They don’t really want to talk or even think about things from their past that have been upsetting and continue to bother them. (Personalize this using the TEC and PCL data). Plus, this may be one of the first and even only times where you experience these things without using drugs or alcohol to cope. In fact, that’s why we’re doing this. We’re providing you with new skills that work, so you don’t need to use drugs and alcohol, which only work briefly.”

“Please know I recognize how hard this is for you, and I want to reassure you we’ll take things at your pace. I will be checking in often, but you should also feel free to tell me how you are doing, thinking and feeling.”

Note: Since Module 2 (Overview) should take about one half to two thirds of a single individual or group session, you will likely be moving into Module 3 (Mindful Relaxation). Steps 5 and 6 would only be employed if the session were ending here. We recommend you get to Mindful Relaxation in this session however, as patients generally benefit from more rapid learning of the skill to reduce their anxiety and fear.

Step 5: Assign Practice/Homework

No practice/homework is assigned in this module

Step 6: Write Your Clinical Observations

Ask yourself the following questions to help you evaluate the effectiveness of this module. It might be more insightful if you record the answers on a separate sheet of paper.

How did the patient respond to your description of the structure of the ICBT program?
Has the patient had any prior therapy experience?
Will this help or interfere with the ICBT program?

Step 7: Complete the Clinician Checklist

In conclusion, review the Clinician Checklist and record the appropriate information for the patient.

MODULE 3

MINDFUL RELAXATION

Goals:

- Teach the patient the steps to do Mindful Relaxation
- Practice Mindful Relaxation with the patient in the session
- Assess and discuss the therapeutic alliance

Time:

½ individual session

30 minutes for individual session

Handouts Needed:

Handout #7: *Mindful Relaxation*

Suggested Session Outline:

Step 1: Introduce Mindful Relaxation, Handout #7

Increased arousal and severe anxiety are characteristic of persons with trauma and PTSD. Increased arousal or “hyper-arousal” is in fact Criterion D for the DSM-IV diagnosis of PTSD. Persons with substance use disorders also suffer from severe anxiety, especially in early recovery. Learning to manage an endless flow of fear and anxiety is part and parcel of experiencing unadulterated feelings no longer “medicated” with drugs and alcohol. For the person with both disorders, anxiety and fear can be overwhelming. Providing patients with a simple and portable tool to manage anxiety proves to be very helpful. In addition, at this stage of the ICBT program, it can help a patient to feel hopeful about a new way of dealing with negative emotions.

The Mindful Relaxation technique includes two components. The first component is a mindfulness or centering technique drawn from the work of Agazarian in her work with inpatient therapy groups (Agazarian, 1997). Centering or grounding techniques are also used in individual and group therapy for borderline personality disordered patients in Dialectical Behavioral Therapy (DBT; Linehan, 1999).

The centering technique is based on a simple principle of assisting the patient to tune into his or her self in a sitting or relaxed physical position with eyes closed, both feet on the ground, and to picture or imagine their center or core, somewhere between their navel (belly button) and spine. This center is at their core, and it is present, and stable. The patient is told to drop down from their head and experience this core. This centering will help the patient to be present, tuned in, and prepared for the relaxation exercise.

To introduce the centering technique, you can use the following script:

“Now, I would like you to try to get as comfortable as you can in your seat. Make sure both feet are on the floor. Close your eyes, breathe normally and try to relax. Be sure the balls of your feet are on the floor, press ever so lightly to check. Try to visualize your center or core. The core of you. Many people locate this somewhere between their spine and belly button. Try to relax, pay attention and experience this. Drop down from your head into your core. Feel this core at your center. Notice that it is calm, present, and yours.”

After a few minutes (2-3) of centering the patient in this relaxed position, you are going to introduce them to a breathing exercise. The breathing exercise is drawn from the work of Edna Foa (Foa & Rothbaum, 1998). It was used in previous versions of the ICBT model, and focuses on the balance between the inhale and the exhale. (For previous approach and description of Breathing Retraining, see KT Mueser, SD Rosenberg, HJ Rosenberg, Treatment of posttraumatic stress disorder in special populations, Washington DC: American Psychological Association, 2009).

Many people erroneously try to relax by taking deep breaths or inhales. This actually signals the physiological system that oxygen is needed and therefore a fight or flight response can be induced. More oxygen means more demand. This may actually precipitate agitation or even hyperventilation.

Instead, a normal inhale signals no threat, and calm or status quo for the physiological system, no need to flee or fight. An extended exhale can help further the relaxation. The exhale can be paired with a calming word or image, such as “serene”, “peace” or “calm”. Or for the visually-inclined an image of a soothing nature: a pleasant room, a place in nature, or simply a comfortable chair.

Thus, the ratio of breath is as follows: Normal inhale, extended exhale.

This focused shift in breathing, coupled with the centering technique, will assist in the management of anxiety.

To build on the centering technique using the relaxed breathing technique, you can use the following script:

“As you are now feeling relaxed and calm, I would like you to pay attention to your breathing. Please take a normal breath in through your nose, a normal inhale. But as you exhale, try to extend your breathing out through your mouth. Don’t do it so that it is uncomfortable, but just a little longer than you had been doing. Try it again. This is a meditative breathing exercise to assist you in relaxing.”

“If you want, to help you to relax even more, think of a word that calms you. This could be a word like “serene”, or “peace” or simply “calm.” Or if you want, picture a scene that is relaxing to you.

You’re doing great.”

As you are using your most soothing “therapist” voice, speak softly, slowly and clearly. Your calm influence is key to making the exercise possible. As patients learn this technique, in part, they will continue to draw upon this first experience to find their core, and to relax their breathing.

After about 10 to 15 breaths, ask everyone to “come back, open your eyes”.

“So how did that feel?”

Process the experience and try to lower any pressure or expectations people have placed upon themselves to do it right. The key is the centering and the ratio in breathing. The counts, thoughts, images are highly individualized and guided by the principle of “whatever works best for you.”

Some clinicians take the opportunity to demonstrate the technique at this juncture, or even before asking the patient(s) to do so. Other clinicians simply observe, answer questions and provide feedback.

It is important to let the patient know that they have just learned a skill called Mindful Relaxation. They can do this whenever they want, and will only get better at it the more they do it.

Sometimes patients will say they have learned other relaxation or meditative techniques. Some will insist that these are better or that they are more comfortable with what they know. We inquire about these techniques with sincere interest, but in order to insure patients are getting the benefit from the exercise, ask them to try Mindful Relaxation during the course of their treatment in the ICBT. Consider it sort of a “free trial offer”: If not completely satisfied you can return it and use your existing technique.

Step 2: Assign Homework/Practice

Mindful Relaxation is definitely a skill that improves with repetition and practice. It is also a practice that is easy to do in terms of degree of difficulty. Nonetheless, patients will find it hard to schedule, only want to do it when they are under extreme and acute anxiety if not panic, or practice it just before their next session. You can acknowledge that these are common approaches to learning the skill. It is important to emphasize that the more they do this, the better they get at it. Further, we sometimes use the fire drill analogy to say, it’s best to practice this under normal circumstances so that it becomes automatic or reflexive. This makes it more likely to be successful during times of stress such as during an actual fire (or anxiety or panic state). Most patients get this connection.

“You did great at Mindful Relaxation. Do you see how it might be helpful for you to do this on your own?”

“I am going to ask you to do it twice a day until we meet again. Remember it takes only 5 minutes tops, and you do about 10 to 15 breaths at each practice. When and where would be convenient and possible for you to do this twice a day?”

“The more you can do this, the more you can get the full benefits. Try to do it when you are already relaxed, so when a crunch time comes where you really need it, you are already pretty good at your centering and breathing.”

“Can we commit to doing it twice per day until we meet again?”

Step 3: Review and discuss the Therapeutic Alliance

This is a critical juncture to specifically ask about the patient’s experience with ICBT and about his or her time with you. Psychotherapy research consistently shows that the therapeutic alliance (as measured by the perceived bond, rapport and common goals) is predictive of retention in therapy and outcomes. At the end of the second session, the therapeutic alliance is critical.

“Since we are nearing the end of today’s session, I have been wondering how you think all this is going for you? Is it what you expected, or different? How so? Given what I told you the plan was, am I missing anything? Is there anything else?”

It is also useful to inquire how the therapy might be fitting in with his or her other professional treatment and/or peer recovery support group participation.

Affirming the patient’s willingness and courage to attend the first two sessions will be beneficial. He or she undoubtedly had many thoughts of not attending. In a gentle not authoritarian way, it may be useful to reinforce these key points:

- 1) In order to really benefit from the ICBT program, the patient will need to stay with it, even when at times that they want to run and hide. Remind him or her that research states that patients who stay with the treatment all the way through get better, not only with their PTSD symptoms but also with their substance use and other emotional and life problems.
- 2) Refer the patient back to his or her statements about how confronting and eliminating PTSD or trauma symptoms would make for a better life. Use the goals he or she used.
- 3) Getting better is something he or she deserves. This patient has been suffering a great deal with PTSD symptoms, and perhaps with addiction or other mental health issues. Taking the steps to address the substance use and PTSD at the same time says that he or she is worth it.

Step 4: Write Your Clinical Observations

Ask yourself the following questions to help you evaluate the effectiveness of this module. It might be more insightful if you record the answers on a separate sheet of paper.

Did the patient do Mindful Relaxation?

Do you have any sense of their capacity to do the practice between sessions?

How strong is the therapeutic alliance? What are your concerns?

Step 5: Complete the Clinician and Supervisor Checklist and Index

In conclusion, review the Clinician Checklist and record the appropriate information for the patient.

MODULE 4

SUBSTANCE USE AND CRISIS PLAN

Goals:

- Identify antecedents (A), behaviors (B) and (C) consequences for substance relapse prevention plan
- Ensure that the patient knows the protocol in the event of a crisis
- Identify the people and contact information for patient's support

Time:

½ individual session

30 minutes for individual session

Handouts Needed:

Handout #8: *Relapse Prevention Plan*

Suggested Session Outline:

Step 1: Practice Mindful Relaxation

Ask the patient to join you in one round of Mindful Relaxation (Centering technique; Breathing technique for 10-15 breaths).

Step 2: Review the assigned practice since the last session

Ask the patient if he or she continued to practice the Mindful Relaxation exercise twice a day as instructed. If not, encourage the patient to practice the technique for the coming week. Explore any issues the patient may have encountered that prevented him or her from practicing. If the patient did practice, explore the benefits.

Step 3: Review the process of relapse

Relapse prevention therapy is a generic cognitive behavioral therapy focused on the consequence of substance use as outcome. The functional analysis of this behavior tends to focus on those antecedents that make the substance use more likely. The research of addiction experts including Alan Marlatt, Helen Annis, and many others have helped articulate and specify common relapse triggers, including those internal and external to the individual. Much of this work is already covered in addiction treatment. However, if the clinician determines that the patient lacks sufficient awareness of the relapse process or if a relapse prevention therapy is not a component of the services the patient has or will be receiving, then this module should be implemented.

To introduce this module, the clinician will inform the patient that, as a person who has noted they have continued to use substances despite consequences, defining the process of their substance use behavior may be important to making this change. Especially during the course of ICBT, it is important for patients to be aware of the relapse process. This will allow them to monitor the impact of the treatment and of directly addressing trauma or PTSD material, perhaps for the first time. Knowing about the patient's supports or recovery environment deficiencies can help the clinician to determine the pace and focus (how hard to push the application of Flexible Thinking with trauma and PTSD-related material).

To start this session, we recommend a script such as the following:

“Since part of the reason we are meeting pertains to your use of substances, it is important for us to talk about how you understand the process of your use, and what kinds of things might be early warning signs that you may be about to use.

For some people, they know well in advance they are about to use, and actually make a thoughtful plan. For others, it seems to hit them out of nowhere. It's as if they just 'came to' afterwards and had no idea how it happened. They feel blindsided.

With that in mind, do you see yourself as a person who is pretty clear about the early warning signs or relapse triggers?”

Based on the patient's response, the clinician can reinforce the perception of insight, or state that it is even more beneficial that we are taking the time to focus on this now.

Great, then let's make your thoughts about this really clear. This way, you can make the most informed decisions, either closer to recovery, or closer to relapse, much earlier in the sequence of events. You may be able to catch it earlier and avoid the usual outcomes.”

Step 4: Complete and review Handout #8, Relapse Prevention Plan

“Let's start by looking at Handout #8.”

Walk the patient through the handout and either complete it for them, guided by their words and your probes, or ask them to fill it out while you observe and probe. The key is for the patient to think through the triggers to relapse and the coping skills and supports to help stave it off.

The Activating Situations (A) pertains directly to the people, places and things that are associated with substance use. The first order is to try to avoid these situations, but if not possible, consider ways to cope.

The Beliefs (B) or thoughts about using substances come into play next. What is my motivation, my attitude, my awareness of the pros and cons, the risks and benefits? Am I thinking things through to their logical conclusion? “Think the drink” is the traditional cliché to help the person do a functional analysis of the likely outcomes.

The C or Consequences pertains to the outcome of the A and B parts of the sequence. What are my feelings? What feelings are most associated with using or not? These may range from positive feelings (euphoria, excitement, stimulation) to negative (depressed, anxious) or even physical (sleepless, in pain).

This analysis helps the patient to specify the situations (people, places and things), beliefs (thoughts and motivations) and consequences (feelings) that can make it more or less likely he or she will relapse (or continue to use).

The fourth box on the handout pertains to coping strategies. For many patients, this can be a short list. Calling a sponsor, going to a meeting, talking with a recovery support group friend are all good examples of coping skills. Non-interpersonal coping skills could range from reading a book to taking a bath to going on a hike. Anything that is not included in the A list from above!

The fifth box, support person for my recovery, is very important. Patients with more supports have an arguably better prognosis than those with fewer or none. A test of the well-worn nature of the pathways between the patient and these individuals may be the memorization of the phone number. Either way, it is important for the patient to be able to recognize and consider whom he or she can count on during a time of a relapse crisis.

“I am glad we had a chance to do this together. What about this plan do you feel good about? What do you wish were different? Is there any way you could work on this to make it feel more solid to you? How will our work affect it do you think?”

From my perspective, the strengths are (list what you see from internal to external supports) but the risks are (list what you see as missing or as potential liabilities).”

Be sensitive but clear. If possible, recommend the patient strengthen this plan as soon as possible, and note that it will only be helpful to the work you are doing with them on the emotional aspects of trauma, PTSD and their addiction recovery.

Step 5: Photocopy Handout #8

After completing and discussing Handout #8, make three copies of it. Give one to the patient, place one in the patient’s medical record, and keep one yourself. If there is missing information on Handout #8, such as phone numbers of a contact person, remind the patient to locate this information and fill it in on the form and relay this information to you at your next meeting.

Step 6: Assign Homework/Practice

Remind the patient that he or she should still be utilizing the Mindful Relaxation techniques.

Step 7: Write Your Clinical Observations

Ask yourself the following questions to help you evaluate the effectiveness of this module. It might be more insightful if you record the answers on a separate sheet of paper.

What kind of capacity did the patient demonstrate for identifying triggers to substance use?

Were these triggers related to trauma or PTSD related symptoms or experiences?

What kind of capacity did the patient demonstrate for identifying and labeling thoughts and feelings in general?

Does the patient seem connected to other health care providers?

Does the patient have any non-using social supports outside of treatment providers?

Step 8: Complete the Clinician and Supervisor Checklist

In conclusion, review the Clinician Checklist and record the appropriate information for the patient.

MODULE 5

IDENTIFYING, LABELING AND UNDERSTANDING FEELINGS

Goals:

- Identify common emotional issues among persons with trauma, PTSD and addiction
- Identify primary negative emotions and the thoughts associated with them
- Apply Flexible Thinking to negative emotional situations

Time:

1-2 individual sessions

45-50 minutes for each individual session

Handouts Needed:

Handout #9: *Feelings from A to Z*

Handout #10: *Primary Negative Emotions and the Common Thoughts That Drive Them*

Suggested Session Outline:

Step 1: Practice Mindful Relaxation

Ask the patient to join you in one round of Mindful Relaxation (Centering technique; Relaxation technique for 10-15 breaths).

Step 2: Review the assigned practice since the last session

Ask the patient if he or she continued to practice the Mindful Relaxation exercise twice a day. If not, encourage the patient to practice the technique for the coming week. Explore any issues the patient may have encountered that prevented him or her from practicing. If the patient did practice, explore the benefits.

Review the Relapse Prevention Plan (Handout #8) developed at the last appointment.

Step 3: Review the common emotional issues among persons with trauma, PTSD and addiction

It has been said that addicted persons have disordered affects or emotions. They have been described as feeling too much, or nothing at all. Persons with traumatic life event backgrounds and PTSD would also have disordered affects, and in many ways through the symptoms of avoidance (including numbing and detachment) and increased arousal (including vigilance and exaggerated startle responses) be quite similar to those descriptions of the way people with substance use disorders feel. Further, when these disorders co-exist, it is likely the case that intense emotions are typically responded to with drugs or alcohol. The capacity to identify, label and manage emotions

has either never developed, or if it has, these capacities are arrested at the time and age when negative emotions were last experienced without substances.

This module is designed to be implemented before Module 6 (ABCs of Our Emotions). The skills obtained via this module should position the patient well to identifying the links between thoughts and feelings. In addition, learning the terms to identify and label the feelings is critical to comprehending and applying the Flexible Thinking skills.

You can use the following script to introduce this module.

“This session (module) deals with emotions or feelings. Many people who have experienced traumatic life events, and who have substance use issues as well, often have trouble with emotions. Emotions are part of normal human experience. In fact, it is what makes us human. People with traumatic life events often have overwhelming emotions or are so frightened of their emotions that they run from them. One of the best ways of running is by using drugs or alcohol. Does any of this ring true for you?”

For the next part of this step you will use Handout #9, Feelings from A to Z. The goal in using this handout is to expose the patient to a full range of feelings or affects using a visual aid (illustrations of faces). Have the patient examine the handout, and then talk about which of these emotions they experienced over the past week. If possible, ask for a description of the feeling, the situation and the thought.

You can use the following script for this segment:

“Please take a look at Handout #9 in your workbook. This may look familiar to you. Take a moment to take a look at it, on both sides. Now, let’s talk about any of these emotions you may have experienced over the past week. Let’s go through it from top to bottom, left to right. Which ones have you experienced? Could you tell me about the feeling? Could you tell me a little about the situation? Can you relate any thoughts that may have led up to the feeling?”

A teaching point here is to help the patient to see the range of their emotional experience, and the linkages between the feelings and situations as well as thoughts. Reinforce the patient when making these connections.

Observe also the patient who experiences a full range, vs. one who experiences a narrow range. Also, observe the patient who experiences emotions of a negative variety, and assess if characteristic of depression, anxiety, anger or shame/guilt.

Step 4: Review Handout #10, Primary Negative Emotions and the Common Thoughts That Drive Them

In this segment of the module you will be helping patients to more specifically identify negative emotional states. Remember that these states, often having clear interpersonal correlates, are the number one factor in relapse to substances. In addition, these negative emotions, including depression, anxiety, guilt and shame, and anger are associated symptoms of PTSD and trauma-related symptoms.

For this module, we have grouped the negative emotions into four categories: depression or sadness, anxiety or fear, shame or guilt, and anger or irritability.

The goal of this segment is to introduce the terminology for these negative emotions, define each, and then describe the thoughts typically associated with them. In doing so, you are preparing the patient for Flexible Thinking, but also immediately helping to develop improved affect management skills. Having the skill to identify, label and communicate negative emotions, versus acting on them, is a strong deterrent to substance use relapse and the isolation that can be associated with mental health symptoms.

For this segment, you can use the following script:

“Since some of these emotions are sort of negative, we want to pay particular attention to them. You noted that you experienced some of them. Negative emotions are related to substance use and relapse to substances for people in recovery. Negative emotions are symptoms for people with traumatic life experiences and who have PTSD. It is important for you to be able to know if you are experiencing these emotions, name these emotions, and communicate them in an appropriate way to a trusted person. Not being able to do this can lead to acting on them without being aware. Or maybe worse, trying to numb or stuff them deep down inside. These emotions have a way of getting out, one way or another.”

The first emotion to address is anxiety and fear. (Refer to Handout #10 Primary Negative Emotions and the Common Thoughts That Drive Them).

“Anxiety and fear is probably the most common negative emotion. In the literature of Alcoholics Anonymous fear is described as the “chief activator” of many other mental issues. In psychiatric diagnosis, anxiety is the most common symptom for most mental disorders. Fear and anxiety are big. Fear is usually related to something quite specific. ‘I am afraid of spiders.’ Or, even bigger but specific, ‘I am afraid of losing my job.’

Anxiety is often a broader group of fears, and not so specific. ‘I am afraid of people.’ Or even broader, ‘I am afraid of going crazy.’

Fear and anxiety are typically related to something about the future. Something bad or something that I don’t want is going to happen.

Fear and anxiety often are also related to our thinking we can predict the future.

Let’s look at Handout #10. The first row pertains to anxiety and fear. Do you experience fear and anxiety? Can you write down what specifically you have fear and anxiety about? In the next column are the thoughts that might go along with these emotions. Do any of these connect with your feelings? Could you talk about which ones? Write the thoughts that drive the fear or anxiety down in the last column.

You have done great with this.”

The clinician will next turn to depression and sadness. These emotions are also associated with trauma and PTSD, particularly depressive symptoms. These symptoms may include hopelessness, lack of connection with the world or others, loss, loneliness and feeling unlovable. These negative

emotions are often globalized (very broad), with a sense of permanence (“I will always feel this way”) and internal (“because of me”). To introduce depression and sadness, you can use the following:

“Next we are going to review depression and sadness. Are these emotions you can identify with? These are also very common. These emotions are usually focused on the past, but lead to certain assumptions about how the future will go. In short, they involve situations where you feel you didn’t get what you wanted, and this in turn will have a long-term effect on you. For example, you may have felt rejected by a person whom you cared about or loved. This is definitely not what you wanted. In addition to feeling the sadness and loss of this rejection, you may also go on to believe that you are unlovable or undesirable, or that you will spend the rest of your life alone.

Let’s look again at Handout #10. The second row pertains to depression and sadness. If you have these emotions, can you write down what specifically you have these about? In the next column are the thoughts that might go along with these emotions. Do any of these connect with your feelings? Could you talk about which ones? Write the thoughts that drive your depression and sadness feelings down in the last column.”

Shame and guilt are the next set of negative emotions. These are often very key negative emotions to persons with trauma-related experiences. These may range from feelings of worthlessness or as though they did something to cause or deserve the traumatic experience. Sometimes they may also have guilt because they witnessed but did not directly experience the trauma, such as watching a fellow soldier get killed by an explosive device. This is termed “survivor’s guilt.” Shame often involves the experience of not living up to a perceived standard, and being negatively judged. Guilt often involves the experience of causing harm to another, or causing damage of some kind. Shame and guilt are often quite rational, and serve as the margins of morality (they help us to behave well). However, among those with PTSD and substance use disorders, these emotions often run amuck. Persons with substance use disorders have shame and guilt for many of the consequences of their substance use. In some cases, they lack this awareness and the clinician’s job is helping them to see the causal link between their substance use and consequences.

“Guilt and shame are another set of negative emotions. We may feel guilty for things we have done to harm others, or ways we have let others down. We may feel ashamed about things we have done, or even things that happened to us, as if that means we are less than, or as if we exposed something very, very bad about ourselves. The blame is on you. Sometimes it’s possible that shame and guilt are justified, sometimes though, these emotions are driven by irrational and excessive self-judgment. Do you experience either of these negative emotions? How? What are the thoughts that you have that drive your shame? What are the thoughts that you have that drive your guilt?”

The last negative emotion is anger and irritability. These are also powerful emotions, sometimes secondary to fear, anxiety and depression, but deeply experienced nevertheless. Anger is often associated with an experience of disrespect, of being treated unfairly, or of being on the verge of not getting something one feels he or she deserves. A related emotion is resentment. Persons in twelve-step recovery often cite the literature which notes that holding resentments is a “dubious luxury of normal” people, but treacherously dangerous for the alcoholic. For men, anger and irritability often mask emotions that can feel more vulnerable. For women, anger and irritability may be deeply felt but masked by sadness or guilt. Either way, this emotion will be frequently identified.

“Irritability and anger are the final set of negative emotions. Last but not least. In addition to anger and irritability, you can add resentment. These emotions are often associated with feeling disrespected, treated unfairly or unjustly, or harmed. They signal an experience of not getting what you wanted or what you feel you deserved. The blame is on the other person or people. Anger, irritability and resentment are often related to fear and anxiety. They are also very dangerous emotions to a person in recovery. Could you identify with the emotions of anger and irritability? How? Can you relate to the thoughts that are listed here? Which ones pertain to your experience?”

You have covered all of the primary negative emotions. You want to give the patient an opportunity to reflect on this list, to normalize their experience, to affirm and empathize as appropriate.

This completes the segments on helping the patient to identify, label and perhaps begin to communicate their emotions (after all, they have just done this in session with you).

This module also sets the stage for Module 6 and 7 on Flexible Thinking, by helping the patient begin to make connections between negative emotions and thoughts.

Step 5: Assign Homework/Practice

You may elect to assign completion of Handout #10 if you have started but not finished it in the first session of this module.

Remind the patient that he or she should also still be utilizing the Mindful Relaxation techniques.

Step 6: Write Your Clinical Observations

Ask yourself the following questions to help you evaluate the effectiveness of this module. It might be more insightful if you record the answers on a separate sheet of paper.

Was the patient able to identify feelings easily?

What are the primary negative feelings that the patient is experiencing? Can you identify what Common Styles of Thinking (Handout #13) they use that leads them to these negative feelings?

Can you see any connections between substance use, PTSD or trauma-related symptoms and these negative feelings?

Step 7: Complete the Clinician and Supervisor Checklist and Index

In conclusion, review the Clinician Checklist and record the appropriate information for the patient.

MODULE 6

THE ABCs OF OUR EMOTIONS

Goals:

- Introduce the concept of the ABCs of Emotions
- Define and review **A**ctivating Situations, **B**eliefs and **C**onsequences
- Teach the patient to identify Common Styles of Thinking
- Practice applying ABCs of Emotions and Common Styles of Thinking to examples in session

Time:

1-2 individual sessions

45-50 minutes for each individual session

Handouts Needed:

Handout #11: *The ABCs of Our Emotions*

Handout #12: *The ABCs of MY Emotions Worksheet*

Handout #13: *Common Styles of Thinking*

Suggested Session Outline:

Step 1: Practice Mindful Relaxation

Ask the patient to join you in one round of Mindful Relaxation (Centering technique; Breathing technique: 10-15 breaths).

Step 2: Review the assigned practice since the last session

Ask the patient if he or she continued to practice the Mindful Relaxation exercise twice a day as instructed. If not, encourage the patient to practice this technique for the coming week. Explore any issues the patient may have encountered that prevented him or her from practicing. If the patient did practice, explore the benefits.

Review the Identifying, Labeling and Understanding feelings worksheets from last session. These should be Feelings from A to Z (Handout #9) and Primary Negative Emotions and the Common Thoughts that Drive Them (Handout #10).

Step 3: Introduce The ABCs of Emotions

In clinical practice, we often use the acronym HALT (H-hungry; A-angry; L-lonely; T-tired) to help patient's tune-in to possible precipitants to relapse. Actually, research studies have consistently found that negative emotions are the number one trigger to relapse to substances. Negative emotions may include fear, anxiety, disgust, frustration, grief, sadness, loneliness, suspicion, confusion, rejection, shame, anger, irritability or resentment.

It has been said that addicted persons either feel too much or nothing at all. At the very least, during the course of addiction, it is likely that negative emotions were not experienced head on, but rather through a fog of chemicals, or, when possible, pre-empted by rapid intoxication.

In early abstinence, early recovery, or in the initial phases of addiction treatment, persons with PTSD are often flooded with negative emotions associated with the trauma. These emotions often include feelings of guilt or shame. That is, they feel they did something wrong to deserve it or could have prevented it from happening. One 40 year-old female patient felt that her trauma (being raped at a party as a college freshman) was obvious to people just by looking at her. Having anxiety and fear is also very common among those who have experienced a trauma or who have PTSD. In fact, as we discussed, increased arousal or anxiety is diagnostic of PTSD. The fear could be very specific: That memories or thoughts will intrude. Or more diffuse or vague: Someone is going to hurt me. Anxiety is best understood as fear that is unspecified or global. Fear is specific. Anger and resentment are also characteristic of persons with PTSD and trauma. Often these are directed at the perpetrator of the trauma, but sometimes anyone with his or her characteristics. Sometimes the anger can be expanded to people in general. Depression is also common among those with trauma in their backgrounds. This can take the form of feeling sad, rejected, unworthy, doomed, defective, abandoned, unloved and unlovable, or grieving.

Patients with co-occurring substance use and PTSD are usually caught in a vicious cycle. They start with PTSD symptoms: re-experiencing of memories, nightmares, flashbacks; intense arousal and anxiety; and the compulsion to avoid. Substances of abuse provide rapid but only temporary relief. So when a person with PTSD senses the risk of these symptoms coming on, substances are the antidote. In addiction treatment, we advise them to stop using substances, and with ICBT we hope to provide them with tools to manage these emotions. This module is the beginning of being able to do this.

The goal of this module is to help patients recognize that emotions are triggered by situations, which in turn trigger beliefs. Much as we teach patients that they are not struck drunk or sober, we try to teach them in this module that they are not struck with guilt, fear, anger or sadness either. These feelings are triggered by situations and the thoughts or beliefs that are derived from these situations. The feelings are actually the third part of the sequence.

You might introduce this module by using the following script:

“Today we are going to be learning the ABCs of emotions. We all have emotions or feelings. Many of us tried to block them out with drugs and alcohol, but now that we are not using we are poised to experience them - for better and for worse. People who have experienced a trauma in their lives (or who have PTSD), often experience very powerful emotions. Ultimately, even though you might not agree just yet, experiencing feelings is a good thing. It is about living life on life's terms. It is also about using our feelings to guide us, and also help us to understand what needs to change.”

“We say that people aren’t struck by lightning to be drunk or sober. The process of using drugs or alcohol, or of relapsing, is a culmination or end point in a series of events. If you were able to look at the process in a kind of slow motion, you might see that things started with certain decisions made earlier.

One example is the 30 year-old man who received an invitation to his college roommate’s wedding. He knew this could be a risky situation given he had only 20 days clean, but he figured he would have another 40 by the time of the wedding. He decided not to tell his sponsor about the invitation, and made his own “executive decision” and attended the wedding. Before the wedding even began he felt the excitement as he was snorting cocaine in the parking lot. When did his relapse start, in the parking lot?”

Using an example familiar to those wrestling with addiction (versus a PTSD example) may be easier to start this module. But now you demonstrate the ABCs of Emotions in a non-substance related example.

“Ok, let me use another example. I wake up and notice that it’s raining outside. I feel harassed and agitated—this is not going to be my day. Why? Well, I think that I am going to get my new shirt wet because it’s going to be a hassle getting under cover at the bus stop on the way to work.”

“So I mentioned this is the ABCs of Emotions. The A is the Situation, or Activating Situation; the thing that began the process. The B is the Belief or Thought about the situation. Sometimes things happen so quickly in our minds that we don’t catch the B part. We miss the belief. The C stands for Consequence. The consequence could be a feeling or even a behavior. Generally, we don’t miss the feeling though, do we? But sometimes it seems like we go directly from the situation to the behavior without even noticing the feeling until later. Either way we go from A to C in a nanosecond.

Step 4: Review the Figure of the ABCs of Emotions

Introduce the Figure (Handout #11) showing the ABCs. A useful exercise is to walk the patient through the first example (cocaine relapse) using the A (Wedding invitation) to B (I’ll be ok my sponsor doesn’t need to know) to C (Feeling: Excitement; Behavior: Cocaine use).

Once you have done this and the patient seems to comprehend it, then try the second example: The rainy day. (A=Raining outside; B=Not my day; C=Feeling: Harassed and Agitated).

Step 5: Apply the ABC approach to patient’s experience

Ask the patient if he or she can generate his or her own example from something that happened today, or if not this week. The place to start is usually with identifying a feeling, a negative feeling, and then connecting it to the situation. Since most of us do not automatically practice ICBT on ourselves, we often miss the Belief too. Have the patient complete the blank handout (Handout #12). Ask them to explain it. Guide them through it. Explore how we often skip the B part.

It is important at this juncture to not try to use the approach with highly charged and emotional situations, including trauma-related experiences or PTSD symptoms. At this point, you are teaching

the fundamentals of a new skill and want to foster a sense of self-efficacy. We want patients to feel that “this is easy, I can do this.”

Later, once you build the D and E of Flexible Thinking into the process, the patient may be more ready to take on these kinds of situations, thoughts and feelings.

As you present the handouts it is also important to note the cycle. This is to suggest that the A, B and C sequence can cause a cascade of events. Sometimes these go fast and get worse. So after the young man did the cocaine his relapse then became a new situation (A: I screwed up). This in turn precipitated more thoughts (B: I am a failure, my sponsor will hate me). Obviously, consequences continue (C1 Feeling: Guilt, shame; C2 Behavior: More cocaine).

Step 6: Reinforce how thoughts connect to feelings and behaviors

At this point you want to underscore how thoughts drive feelings. This is a core principle to cognitive psychology and cognitive behavioral therapy.

“So the bottom line message to these exercises is that your thoughts play an incredibly important role to your feelings. In some ways, feelings are very natural, organic states. They are what they are. It’s the thoughts that give rise to them. Ultimately, it’s the thoughts that we can change. That in turn, can help us regulate our feelings in more balanced ways. It’s the flexibility in our thinking that can give us this freedom.”

NOTE: At this juncture, you may be ending a session (if not already). This is a good place to stop. The next session in this module can review these first six steps, and then introduce “Common Styles of Thinking”. This is Step 7 in this module.

Step 7: Common Styles of Thinking

This is a key step to learning Flexible Thinking.

To introduce Common Styles of Thinking, you might start with this script:

“Now we can see that thoughts (B) drive our feelings (C), and that maybe we have some potential to flex our thinking about those situations (A) which trigger the thoughts (B) (refer to the figure as a visual or use the letters A, B and C to verbally describe).

Many of us use certain styles of thinking or have typical patterns of interpreting situations. For example, the fellow we talked about who relapsed on cocaine. His thoughts about the wedding invitation really underestimated or minimized the risk of going didn’t it? If he didn’t minimize the risk things may have turned out different for him. In the second example, my reaction to the rainy day, I had some very stinkin’ thinkin’ going on. It was overly negative and “worst-case scenario” wasn’t it?

Let me give you another example. George was walking down the hallway at the clinic and passed by Serena. Serena walked by him without saying hello. (So the A or the situation is Serena not saying hello to our guy George.) George feels hurt, rejected

and sad (C). If we slow the process down, we might guess that George interpreted Serena's behavior as ignoring him or disrespecting him in some way (B). So George's thought is highly personalized and kind of self-centered (all about George) and may not take into account what may have been going on for Serena that day or even that moment (which, by the way, may have had nothing to do with our guy George).

But, do you see how George's interpretation of the situation led to his negative feelings?"

Introduce Handout #13 Common Styles of Thinking. Review the three examples one at a time. Have the patient select which one seems to be involved in the scenario. Advise the patient that there are no right or wrong answers. Mention that some beliefs, thoughts or interpretations may actually involve more than one Common Style of Thinking at the same time.

In case you are also learning to apply the categories to situations, we suggest that in matching the Common Style of Thinking type to the clinical examples, the cocaine relapse is "Magnification/Minimization", the rainy day is "Worst Case Scenario Thinking", and George used "Personalization" to draw his conclusions.

The key learning point is for the patient to recognize the importance of the B—the thought.

Likewise, we want the patient to recognize that this belief has some give or flex to it.

If time permits, a good exercise is to have the patient use their own example to generate an ABC situation, and then select the Common Style of Thinking they used. The clinician who can engage patients in this process using a sense of humor (rather than "right" and "wrong" judgment) is doing well. All of us who are human employ Common Styles of Thinking on a regular basis!

Step 8: Assign Homework/Practice

Between now and the next session ask the patient(s) to complete 2 ABCs of MY Emotions Worksheets (Handout #12) using current examples from the past week. If you do not get to the Common Styles of Thinking step the practice can simply be recognizing a real life example of an ABC process, and being able to use the skill to organize their experience. If you get to the Common Styles of Thinking step you can ask the patient(s) to choose from the list on Handout #13, and check one (or more) of the type of styles from the list at the bottom of the handout. If you get to Step 7 of this module at a second or third session, ask the patient to choose from the list of Common Styles of Thinking on examples they have already generated, or preferably, for practice ask for two new examples. Remember, mastery of any newly acquired skill comes with repetition.

Remind the patient that he or she should also still be utilizing the Mindful Relaxation techniques.

Step 9: Write Your Clinical Observations

Ask yourself the following questions to help you evaluate the effectiveness of this module. It might be more insightful if you record the answers on a separate sheet of paper.

Did the patient comprehend the situation, thought to feeling connection?

Was the patient able to demonstrate the capacity for flexible interpretation of the situation and engage the Common Styles of Thinking concept and practice?

Step 10: Complete the Clinician and Supervisor Checklist and Index

In conclusion, review the Clinician Checklist and record the appropriate information for the patient.

MODULE 7

FLEXIBLE THINKING: THE ABCDE OF EMOTION

Goals:

- Review the ABCs of Emotion and Common Styles of Thinking skill acquisition
- Define and introduce the **D** and **E** to the ABCs:
Disputing Beliefs and Thoughts, and Entirely new Beliefs or Behaviors
- Practice applying ABCDE to examples in session

Time:

2-3 individual sessions

45-50 minutes for each individual session

Handouts Needed:

Handout #14: *Flexible Thinking: The ABCDE of Our Emotions*

Handout #15: *Flexible Thinking Worksheet: The ABCDE of MY Emotions*

Suggested Session Outline:

Step 1: Practice Mindful Relaxation

Ask the patient to join you in one round of Mindful Relaxation (Centering technique; Breathing technique 10-15 breaths).

Step 2: Review the assigned practice since the last session

Ask the patient if he or she continued to practice the Mindful Relaxation exercise twice a day. Review the practice materials assigned at the last session. This should be Handout #12, completed for 2 experiences the patient had over the past week. Have the patient walk you through the handout, and explain step by step the A, B, C and Common Styles of Thinking step. Affirm where appropriate. Gently correct where appropriate. If patient did not complete assignment between sessions, we recommend doing one Handout #12 in session together. In cases where it is clear the material is not being grasped, it may be necessary to go through Module 6 again.

Step 3: Introduce Flexible Thinking: The ABCDEs of Emotions

This Module builds upon the ABCs of Emotions by adding the cognitive behavioral therapy strategy of disputing the belief. Evaluating the evidence for and against the belief and considering the potential use of a Common Style of Thinking can help loosen the conviction with which troubling beliefs are held and which consequently lead to negative emotions and behaviors. Disputing or

evaluating the beliefs of a patient can be a delicate matter. The extreme reaction is the patient experiences you as disregarding or discounting his/her experience or reality. This reaction may also feature a rigidity or even hostility when the beliefs are challenged. The other extreme reaction is where the patient is too quickly willing to take on your belief, so waits until they can read you (please you) and provide the “correct” answer. Although seductively gratifying to the clinician, this passive compliance is in some ways more hazardous than the overt disagreement. The tactic here is to be inquisitive, curious, collaborative, doubting, uncertain and tentative. “I wonder if there are any other possible interpretations of that situation?” “That belief rings true. But I wonder if we were to say, as in a film or TV show, present this situation to a group of people or an audience, what would they think about the situation? Would they all see it exactly the same way?” In addition to using the “reality show” format, other approaches to evaluate the belief for accuracy include more legal setting of a courtroom. “So you’re saying that this is not beyond reasonable doubt, there is only one possible explanation or cause?”

The tone to avoid is prosecutorial, judgmental or argumentative (See Page 8).

In our experience, if on any given example, you encounter rigid adherence without flexibility to a particular belief, move on. Gather another example.

To introduce this Module, you might consider the following script:

“Last session(s) we covered the ABCs of Emotions. The A is the Activating Situation, the B is the Belief, and the C is the Consequence, which could be a feeling or a behavior. In talking about how important thoughts or beliefs were in the whole process, we used the Common Styles of Thinking handout to get us thinking more flexibly, right? We learned that we often distort the situation and that can lead to feelings or behaviors that are potentially negative. In addition, we learned that the more flexible our thoughts, the more options we have in both our emotions and behavior. This gets us out of repeating the same things, or feeling the same things, over and over again.

Today I am going to add D and E to the alphabet. So we now have A, B, C, D and E. No “Worst Case Scenario Thinking”! This is it. We’re not going to go all the way to Z. Going to E is complicated enough!

Let’s look together at your Handout #14. This shows the D and the E.

As you can see D stands for Disputing the Belief. In other words, this step is to evaluate or challenge the belief or thought about the situation.

So remember the cocaine relapse. His belief was that the wedding invitation was not that serious. We considered that to be a Minimization given what we know about cocaine. The C for him wasn’t so great. Now if we were going to Dispute his thought, that it wasn’t such a big deal for him to tell his sponsor, what other thoughts or beliefs might we suggest about the wedding invitation?”

Invite alternative explanations or disputing thoughts. Review other examples, preferably ones the patient(s) have already generated or the rainy day or George scenarios. You will notice that these initial examples will become touchstones for the ongoing skill development and internalization process.

Next you want to focus on E, Entirely new thought or behavior. In this step, the task is to consider the evaluation of the first thought (no big deal, don't need to tell my sponsor; my day is ruined it's raining; Serena hates me) and either replace it with a new thought (which will hopefully result in a less negative emotion) and/or behavior (hopefully less negative or avoidant).

“Let’s look at E on the Handout. E stands for Entirely New Thought or Behavior. That may sound slightly dramatic but the idea here is that if you can slow down the process and really evaluate the evidence for your belief or interpretation of a situation, you can end up with not only a new thought, but possibly even a new behavior or feeling. The key is to wedge that first thought, to wiggle it and replace it if it’s leading to trouble.

So, our cocaine relapse guy who minimized. His new thought, based upon further review might be what? What kind of behavior could this have led to? Correct.

Let’s look at George. Can you generate some alternative thoughts or interpretations for him about Serena’s behavior? Could this lead to any changes in his behavior towards her or in his feelings, either about himself or her? You bet.”

Step 4: Practice applying ABCDE to examples in session

This is an important exercise for patients. You will try to engage them in Flexible Thinking practices using examples from their own lives. As with earlier use of patient material, you want them to start out with situations that are not supercharged emotionally, that are specific, and recent. The kind of situation they can wrap their arms around. Anything too emotionally charged (depressed mood), too broad (situation: I am unemployed) or chronic (have not worked for 3 years) is not the situation for them to use Flexible Thinking on at this point in skill development. So, for the example above, the situation might be honed-in to the last job interview and not getting hired.

To gain momentum in individual sessions you can illustrate the steps with the 3 examples we have been using so far, or preferably by using an example the patient has already provided. You and your patient should be developing a set of these experiences to utilize.

Once you teach the skill, we recommend one session of application to patient examples from real life.

Step 5: Review and discuss the therapeutic alliance

This is a good point to remember to check in with the patient on the therapeutic alliance: How are we doing? How are you doing with this ICBT?

There has been no specific therapeutic focus on trauma-specific material though undoubtedly as patients are raising negative emotions to address using Flexible Thinking they are either directly or indirectly related to these experiences. If patients are experiencing distress and a desire to get to PTSD-specific issues the next session provides the avenue to do this. Many patients, who prefer a more gradual if not avoidant approach, have probably been more comfortable approaching the matter in this way.

Step 6: Assign Homework/Practice

Between now and the next session, ask the patient(s) to complete 2 Flexible Thinking Worksheets: ABCDE of My Emotions (Handout #15) using current examples from the past week.

Since learning Flexible Thinking, and practicing it between sessions, is a critical component to ICBT, it is important to consider these guidelines:

- a. Be sure to assign between session practice and review it at the start of each session.
- b. Be sure patients understand how to identify a situation on which to practice Flexible Thinking. Some patients will search their week for a situation itself, other patients will red flag a negative emotion they experienced and then track back to the activating event.
- c. In the early stages of teaching Flexible Thinking, application to trauma-related thoughts and feelings may not be advisable. However, delaying the application to trauma-related thoughts and feelings is equally unadvisable. Once the Flexible Thinking skill seems appropriately demonstrated if not mastered, the clinician can either ask the patient directly to apply the skill to trauma-related material, allow the patient who's been asking to use the skill to do so, or use the material stimulated by Module 8 to bring it into play.

Remind the patient that he or she should also still be utilizing the Mindful Relaxation techniques.

Step 7: Write Your Clinical Observations

Ask yourself the following questions to help you evaluate the effectiveness of this module. It might be more insightful if you record the answers on a separate sheet of paper.

Did the patient comprehend the Flexible Thinking concepts?

Was the patient able to demonstrate the capacity for flexible interpretation of the situation and engage the Common Styles of Thinking concept and practice, generate alternatives, and consider new thoughts or behaviors?

Step 8: Complete the Clinician and Supervisor Checklist and Index

In conclusion, review the Clinician Checklist and record the appropriate information for the patient.

MODULE 8

PATIENT EDUCATION ABOUT TRAUMA AND PTSD

Goals:

- Help the patient understand the nature of trauma
- Introduce and define the three symptom clusters of PTSD
- Explain how the symptoms intersect with the patient's substance use and/or other emotional difficulties
- Provide ample opportunity to use Flexible Thinking skill on trauma or PTSD symptoms

Time:

1-2 individual sessions

45-50 minutes for each individual session

Handouts Needed:

Handout #1: *Trauma Event Checklist (TEC) and PTSD Checklist (PCL) (already completed or blank)*

Handout #16: *Posttraumatic Stress Disorder Fact Sheet*

Handout #17: *Trauma and PTSD symptoms*

Handout #15: *Flexible Thinking Worksheet*

Suggested Session Outline:

Step 1: Practice Mindful Relaxation

Ask the patient to join you in one round of Mindful Relaxation (Centering technique; Breathing technique for 10-15 breaths).

Step 2: Review the assigned practice since the last session

Ask the patient if he or she continued to practice the Mindful Relaxation exercise twice a day. Review the practice materials assigned at the last session. This should be the Handout #15, completed for 2 experiences the patient had over the past week. Have the patient walk you through the handout, and explain step by step the A, B, C, D and E. Affirm where appropriate. Gently correct where appropriate. If patient did not complete assignment between sessions, we recommend doing one Handout #15 in session together. In cases where it is clear the material is not being grasped, it may be necessary to go through Module 7 again.

Step 3: Review trauma and effect on substance use

The focus of this module has two components: 1) patient education about trauma-related and PTSD symptoms; and 2) application of Flexible Thinking to these symptoms. Since the module has these two components, we suggest you allow 1-2 sessions (individual or group) for patient education, and 2-3 sessions for application of Flexible Thinking to the PTSD-related phenomena. Thus, the Flexible Thinking skill is repeated in Module 6 and Module 7, mastered, then applied to more challenging material in Module 8. Patient education, although very important, is less of a focus in this version of ICBT in addiction treatment.

The module starts in content with a description of trauma and then proceeds to the three primary symptoms of PTSD. As each symptom cluster is presented, we want to provide the patient the opportunity to use Flexible Thinking on a symptom they may identify with. Using either the initial TEC and PCL forms, or preferably ones completed during the module, the clinician can help the patient identify which symptoms are being experienced, and invite the patient to try Flexible Thinking to address the symptom.

“Our goal today is to help increase your knowledge about trauma and its effects on you. Many people experience a traumatic event in their life. Most people, in fact over 90% of people with addiction, have experienced a traumatic life event. Sometimes these events happen in childhood, sometimes in adulthood. Sometimes they happen once or multiple times. They can occur before you began to use drugs or alcohol, or traumatic events may have occurred during the period of your using.

Common examples of trauma include physical abuse or assault, being a victim of violence or crime, sexual abuse or assault, a serious accident, a natural disaster or a military experience that included combat exposure. You can either have experienced these horrible events yourself, or witnessed in person them happening to another person. Either way, it may be traumatic.”

You can either have ready or ask the patient to have ready his/her Trauma Event Checklists (TEC) they completed at the first session or module. A preferable option is to ask the patient to complete the TEC now. The clinician should review the TEC, or ask the patient to review the TEC at this time.

“On this survey is a list of traumatic events. I am grateful you took the time to complete this. Based on what I have just described do you have any questions so far?”

Next the clinician should go on to describe the effects of trauma.

“It’s amazing that most people who experience these traumatic life events are affected only for a short time afterwards but do not have longer-term symptoms or after-effects. Many people, however, go on to develop the anxiety disorder called PTSD or posttraumatic stress disorder. We talked about this when we first met. Do you remember if we determined that your symptoms met criteria for PTSD diagnosis?”

Some people do not get over the trauma, but do not have PTSD. Such people still suffer some residual effects of the traumatic experience. The effects could be symptoms of anxiety, depression, anger issues, irritability, relationship problems or

staunch avoidance of anything that might put them in a situation or even cause a memory of the traumatic life event. For example, some victims of Hurricane Rita moved far away from coastal areas to avoid any future experiences with this sort of natural disaster.

Another outcome of trauma is substance use. As you probably know, substances can take away a lot of feelings, help with sleep, enable a person to confront things they might not be able to while straight (like having sex, or even talking with a member of the opposite gender), or even simply feel ok. The problem is substances like drugs or alcohol don't really work.”

Ask the patient to talk about how their experience with trauma may have been affected by substance use, or how substance use affected their trauma. Empathize with statements about the “self-medicating” benefits of substance use, and reinforce statements about the lack of symptom resolution and the perpetuation of avoidance (or not dealing with the root cause).

Step 4: Review Handout #16, Posttraumatic Stress Disorder Fact Sheet

The Posttraumatic Stress Disorder Fact Sheet (Handout #16) outlines the definition of PTSD. It also includes sections on:

- What is PTSD?
- What PTSD is not
- What are the symptoms of PTSD?
- What is the cause of PTSD?
- What are the usual treatments for PTSD?
- How do the use of alcohol and other drugs affect PTSD?
- How does PTSD affect addiction treatment and recovery?
- Treatment for co-occurring PTSD and a substance use disorder
- Resources

The clinician has several options here: 1) Review the material from Handout #16 in session. Ask patients to read quietly, or aloud, or clinician can either read verbatim or summarize at patients follow along; or 2) Assign the material for reading between sessions in advance of this session (you would have to know this material is coming) or assign it following this session. The second option is preferable. We recommend that if you do cover the material in session you check for comprehension and elicit some interactive discussion. If you assign it for homework, it is best to review it by going through the handout section by section, summarizing it (or asking for the patient to summarize) and addressing any questions.

Step 5: Discuss Handout #1: The PCL, and review re-experiencing, avoidance and increased arousal symptoms

In this step, you can directly refer to the patient's responses on the PCL (page 2 of Handout #1).

The Re-experiencing symptoms are reflected in items 1 (repeated disturbing memories, thoughts or images), 2 (repeated disturbing dreams), 3 (suddenly acting or feeling as if the experience was happening again), 4 (upset when something reminds you of the experience) and 5 (having physical reactions – heart pounding, trouble breathing, sweating – when reminded).

Review the patient's response to these items and use the following script:

“Now we are going to look specifically at the symptoms you may have that are directly related to your traumatic experiences. These really fall into 3 major types: Re-experiencing, avoidance and increased anxiety symptoms. First we are going to talk about the re-experiencing symptoms.

Re-experiencing symptoms are some of the most stressful symptoms to people who have PTSD. These symptoms are pretty much as titled. You have memories, dreams, thoughts or images, even when you try not to, of the traumatic event. You can also feel as though the event is literally happening all over again, as if you are reliving it. When you have these kinds of experiences you might get upset, or even have physical reactions.

Check out how you rated how much you were bothered by these symptoms on the PCL. These symptoms are on items 1 through 5.

Which ones jump out at you as being most true for you?”

Next, you will review avoidance symptoms. Avoidance symptoms are ways the patient has of not dealing with the re-experiencing and increased arousal symptoms. As such, they try to avoid these experiences as much as possible, actively (by not thinking, relating, remembering, or attending situations or activities) or passively (feeling cut off, detached, numb or having no sense of the future). By dealing with PTSD and trauma, the patient is running head on into their avoidance tendencies. This is a big step. In addition, patients with co-occurring substance use disorders obviously use substances to deal with re-experiencing and increased arousal symptoms. These efforts are effective only in the short term, and are not great solutions.

Once again, you can use the PCL to review the patient's avoidance symptoms. Relevant items are 6 (avoiding thinking, talking or feeling anything about the stressful event), 7 (avoiding activities or situations), 8 (having trouble remembering important parts of the event), 9 (loss of interest or activities), 10 (feeling distant or cut off from people), 11 (feeling numb or not having loving feelings) and 12 (feeling no sense of future).

You can use the following script for this criterion:

“The next set of symptoms is avoidance symptoms. These are the ones on the PCL numbered from 6 to 12. These symptoms are really common among people with substance use problems. Most people who have had a traumatic experience and who use substances, use the substances to help avoid, anesthetize, numb out or just forget about the traumatic event or experience. Some of the avoidance strategies are active ones. In these, you try to avoid thinking, talking, feeling or remembering anything about the event. You may also avoid any situations or activities you used to enjoy because they remind you of it. There are also more passive avoidance strategies. These include losing interest in things, feeling disconnected from the world and others, and lastly feeling as if there is no future.

Do any of these ring true for you? Which ones?

It is important to affirm the patient's willingness to deal with trauma and PTSD during this discussion. Note that avoidance symptoms are so powerful that many people never get help because

of them, even though they have really bad re-experiencing and increased arousal symptoms. This suffering is endured out of fear and avoidance. Unfortunately, avoidance also perpetuates re-experiencing and anxiety symptoms. Only by dealing with them is there a chance to overcome them.

“I want to again commend you for dealing with your symptoms head on. It takes courage not to avoid. We know that it is the best way for you to get better.”

The last set of symptoms is the increased arousal or anxiety symptoms. Most people associate these symptoms with increased tension or stress. (Note: It may be that the word “arousal” is associated with “sexual arousal”. Be sure when you use the term you clarify that it means increased anxiety or fear). This set of symptoms is related to autonomic nervous system response to stress including increased vigilance and fight or flight preparations. Items from the PCL here are: 13 (trouble falling or staying asleep), 14 (irritability or anger), 15 (difficulty concentrating), 16 (hyper-vigilance) and 17 (heightened startle response). It is as if the person is always “on guard” or a round-the-clock sentinel on their own behalf. There is little to no trust in the world or the people who inhabit it.

You can use the following script to address the increased arousal symptoms:

“The last and final set of symptoms is the increased arousal or anxiety symptoms. Most people associate these with being tense or under extreme stress. Another way to think about these symptoms is that these come with being on guard, not trusting that everything is ok or safe. So it is as if you need to be a security guard or on watch. All the time. Accordingly, with these symptoms sleep is a problem, and feeling irritable or angry, having difficulty concentrating and feeling jumpy are all prominent features.

Do you identify with any of these?”

It is important at this point to review the definition of trauma and the three major symptom clusters.

“So in summary, we talked about trauma, and what it is. We next talked about the 3 major symptoms of trauma or PTSD. Do you remember what they are? That’s correct: Re-experiencing, avoidance and increased anxiety. Can you give me one example of each of the three symptom types?”

Step 6: Apply Flexible Thinking to trauma and/or PTSD related symptoms

Now you want to provide the patient with the specific opportunity to apply Flexible Thinking to a symptom of PTSD that they indicated on the PCL. This is the second component to Module 8, and critical to the success of ICBT. You will want to allow adequate time (1-2 sessions) to deal with this material and skill development.

As this is not exposure therapy, we do not force the re-experiencing of events through *in vivo* or imaginal work. On the other hand, we want to directly decrease avoidance and the risk of you as clinician colluding with avoidance. Thus, we want to be sure that we directly follow up the patient education with the opportunity to do Flexible Thinking. This can be potently therapeutic, by providing a window to reframe otherwise avoided symptoms and explanations of traumatic life events.

“Ok, so on the next handout (#17), let’s list the symptoms that bother you most in each of the three areas: Re-experiencing, avoidance and increased anxiety. Make a note next to the symptom: a word or sentence about your own experience of this.”

Next you want the patient to see where this is heading. We are inviting the patients to apply the skill of Flexible Thinking to the symptom experiences.

“OK. Now in the last column I want you to rate where on a 10-point scale you would be willing to try to use your new Flexible Thinking skill on one of the 17 experiences. Use that Readiness Ruler we used before.

Let’s talk about the pros and cons. Which ones can we try first?”

The clinician can then provide Handout #15, Flexible Thinking (The ABCDE) Worksheet, and run through one or two of the symptoms the patient is willing to address. Be sure this material is processed at the patient’s own pace, and because of the nature and severity of these symptoms, the clinician may need to take on a more active and support role early on.

THE GOAL OF THIS SESSION AND THE ICBT IN ADDICTION TREATMENT APPROACH is to provide the patient with skills to manage trauma and PTSD symptoms without using addictive substances.

- Applying **Flexible Thinking** to trauma and PTSD related symptoms is a potent ingredient to the effectiveness of ICBT **to reduce re-experiencing, avoidance and increased arousal or anxiety symptoms.**
- Applying **Mindful Relaxation** to trauma and PTSD related symptoms is a potent ingredient to the effectiveness of ICBT **to reduce increased arousal or anxiety symptoms.**
- Applying **Patient Education** to trauma and PTSD related symptoms is a potent ingredient to the effectiveness of ICBT **to reduce avoidance symptoms.**

Step 7: Assign Homework/Practice

Be sure the patient has at least 2 copies of Handout #15 Flexible Thinking Worksheet. Ask them to try to complete at least 2 based on negative situations encountered during the week. If at all possible, encourage them to try to use Flexible Thinking on the list of trauma or PTSD related symptoms. They are not required to do this but we are suggesting it.

Remind the patient that he or she should also still be utilizing the Mindful Relaxation techniques.

Step 8: Review Therapeutic Alliance

In our experience, having the Flexible Thinking skill already in place as the patient receives education about trauma and its effects on symptoms is very useful and empowering. It will be important for the clinician to reinforce the utility of this skill and hopefully the patient’s proficiency in their earlier use of it. Nonetheless, it is important for the patient to feel joined by the clinician in the fight (“You are not alone”). Checking in on how the patient is feeling and doing, appreciating their hard work, and conveying a sense of confidence and commitment are excellent clinician behaviors at the end of this module.

Step 9: Write Clinical Observations

Ask yourself the following questions to help you evaluate the effectiveness of this module. It might be more insightful if you record the answers on a separate sheet of paper.

Based on your understanding of the trauma history and your earlier PCL assessment information, did the patient freely describe the symptoms they are struggling with?

What was the patient's emotional response to the material?

Was the patient willing and able to try Flexible Thinking on any of the trauma or PTSD-related material?

Step 10: Complete the Clinician and Supervisor Checklist and Index

In conclusion, review the Clinician Checklist and record the appropriate information for the patient.

MODULE 9

TRANSITION

Goals:

- To help the patient transition from the ending of the face-to-face meeting with the ICBT clinician
- To reflect upon progress, benefits and disappointments
- To acknowledge what has changed, what has not, and the plan for what's next
- Define the specific plan

Time:

1 individual session

45-50 minutes for individual session

Handouts Needed:

Handout #3: *Positive Psychology*

Handout #18: *Change and Acceptance*

Handout #19: *Serenity*

Suggested Session Outline:

Step 1: Practice Mindful Relaxation

Ask the patient to join you in one round of Mindful Relaxation (Centering technique; Breathing technique for 10-15 breaths).

Step 2: Review the assigned practice since the last session

Ask the patient if he or she continued to practice the Mindful Relaxation exercise twice a day. Review the practice materials assigned at the last session. This should be the Handout #15, completed for 2 experiences the patient had over the past week. Have the patient walk you through the handout, and explain step by step the A, B, C, D and E. Affirm where appropriate. Gently correct where appropriate. If patient did not complete assignment between sessions, we recommend doing one Handout #15 in session together.

Step 3: Reflect upon progress, benefits and disappointments

The intent of this module is to formally help the patient reflect upon his or her accomplishments, to have the clinician communicate his or her regard for the patient's work, and to be clear about the future recovery plan.

It may be important to formalize the ending of the ICBT program for several reasons. First, it is a time-limited, not open-ended program. This is what was communicated to the patient at the outset and is integral to the principle of the approach: To teach the patient to become his or her own ICBT therapist. Second, the patient has expended a considerable amount of time and effort in this relationship, and this should not go unnoticed. Third, and most important, both PTSD and substance use are disorders more often neglected and for which treatment is not sought. It takes an enormous amount of courage to do so. Having reached this module indicates that this patient has stuck with the program. He or she is a completer, a graduate. This is to be wholeheartedly affirmed and celebrated.

The sentiments of the formal ending as outlined above should commence this module and session. No script is offered since it can only be conveyed in a highly personal manner, unique to every clinician's style, manner and personality. Nonetheless, do not abandon your awareness of the Therapeutic Frame and the boundaries of the Therapeutic Triangle. Your work is not yet complete.

Step 4: Review Handout #3, Positive Psychology

Handout #3 Positive Psychology is where the patient indicated his or her goals at the outset of the ICBT program. In addition to identifying their symptoms and the ways these symptoms were interfering with life, the patient forecasted what he or she could do, how their behavior would be different, if these symptoms were gone. This was the vision for the future. Since goals motivate us, and hope sustains us, referring back to this handout is an important tactic.

“When we first started you completed a Handout (#3) called “Positive Psychology.” Do you remember? (Either provide the completed form to the patient at this point if you have retained it, or ask them to look in the patient workbook for Handout #3). On this handout you visualized what your life would be like if you were free of trauma-related or PTSD symptoms. You first identified what these symptoms were, how they interfered, and then set a goal for yourself.

Since we are ending, this is a good time to see where you are in your journey.

Of the things you listed at the bottom of Handout #3, where are you with each of them?”

Give the patient ample opportunity to share their sense of progress towards these goals. Share your perspective based on your knowledge of the patient. Try not to be defensive. If the patient's goals seem more long-term (i.e., probably unrealistic to achieve in 2-3 months) it is ok to express that some goals may take longer to achieve, and progress is best measured one step at a time. Where the patient has achieved the goal by doing this behavior, do not dismiss or minimize. This is an excellent outcome. Congratulate one another. This was the point of doing all the hard work.

Where patients have clearly not made progress it is important to openly acknowledge this. The next two handouts will address this more directly.

Step 5: Review Handout #18, Change and Acceptance

In this step we ask the patient for direct feedback regarding the specifics of the ICBT in addiction treatment program. We do this not only to learn about what was helpful (or not) for this patient, but also we should likewise learn how to do this work better for future patients. Perhaps there is something in the way we delivered the ICBT or perhaps in the sequence that made it more or less effective. Perhaps there was something confusing in our presentation. Or, perhaps we should consider alterations in the sequence of presentation of the core modules or including or not the optional modules.

“Since, as you know, we used a specific therapy for you during this time, I would like your opinion about it. Ok? Remember, there were really 3 key components: Mindful Relaxation, Flexible Thinking, and Patient Education.

The Mindful Relaxation, how was that for you in terms of helpfulness?

How about the Flexible Thinking? Were you able to do the ABC part? What about D and E, which are sometimes more challenging?

We spent some time learning about trauma and PTSD and how it affected you, and how it interacts with substance use. Was this new information? Was it helpful?

Do you have any suggestions about what could have made this better for you?

What do you suggest would make it better for future patients?

Step 6: Review Handout #19, Serenity

For this segment, we try to address what has been accomplished and has changed, but also honestly acknowledge what hasn't. In some cases, we may have run into psychological bedrock, in which no more change is possible, and acceptance must be practiced. In other cases, more or different treatment may be necessary. Handout #19 reviews these options with the patient. You can either ask the patient to complete this with you, or have asked them to complete this in advance of the session. Either way, the information should be openly discussed and acknowledged.

Step 7: Transition plans

The clinician should be prepared for this segment in advance of this point in the treatment. If referrals need to be arranged, this should have been done already. This way the patient is clear about the plan even if they have not yet had contact with a clinician (mental health and/or substance use), prescriber (for psychotropic or addiction medication), or agency. All necessary information should already have been authorized for release and exchange.

Peer recovery support groups, such as Alcoholics Anonymous, Narcotics Anonymous, and Dual Recovery Anonymous are excellent sources of ongoing support for recovery from both substance use and mental health issues. In our experience, it is likely that you have already actively addressed the patient's attendance, participation and connection with these groups. But if you have not done so, referring the patient to a clinician who can facilitate this connection would be recommended. (If possible, the clinician may also consider the Integrating Combined Therapies curriculum of the

Hazelden Co-Occurring Disorders Program, in particular the Phase III Twelve-Step Facilitation component).

An open discussion about the role of the patient's family and/or other social supports at this juncture is also important. Did the family and social supports know about the patient's involvement in the ICBT program? Do they know it is ending? What is their observation about any changes the patient may have displayed?

If the patient is also a parent it will be important to talk about the effects of the treatment on their parenting behavior. Is this noticeable to them? Would it be noticeable to their children? What effect will ending the ICBT have on their parenting?

If the patient is involved in the criminal justice system (e.g., mandated to treatment) what effect will ending have on this requirement? Are reports needed? Does the patient feel it was worth doing more than what was originally ordered? Was he or she open with their probation, parole or other official about their involvement in this program?

It is also important at this juncture to be very clear about the nature of addiction and mental health recovery. Neither condition is, at this point in our health care technology, curable. Both are best understood as chronic conditions that will need ongoing monitoring, recovery check-ups and some degree of vigilance.

On the other hand, people in recovery from these disorders are among the happiest and most successful and socially connected individuals in the world. They are excellent citizens.

One does however need to respect the nature of these disorders (diseases) and be attentive to signals for relapse. Hopefully, during the course of this treatment these signals have become increasingly clear, and skills have been provided as to how to successfully cope when they do arise.

Step 8: Saying goodbye

There is no prescribed way to say goodbye in social circumstances, but doing so face-to-face and openly communicating about it is a good start. Avoiding this can be experienced as a rejection or abandonment. This lack of closure can leave the patient with a sense that something was missing, not enough was accomplished, or their work wasn't good enough. Make sure to say some sort of farewell, thank the patient for their effort, share your admiration for their bravery, and acknowledge that they are continuing their journey without you. (They are in their own capable hands!) Do this in addition to expressing your individualized sense of your collaborative work together.

Step 9: Complete the Clinician and Supervisor Checklist and Index

In conclusion, review the Clinician Checklist and record the appropriate information for the patient.

Frequently Asked Questions (FAQs)

Clinicians may encounter a variety of challenges conducting ICBT in persons with an addiction. In this chapter we describe possible solutions to common problems in this population. Additional strategies for teaching Flexible Thinking skills to patients with PTSD can be found in Mueser, Rosenberg, and Rosenberg (2009).

Avoidance of Symptoms and Engagement

Avoidance is a core characteristic of PTSD. Avoidance of trauma-related stimuli can range from avoiding involvement in activities that remind the person of the traumatic event (e.g., physical intimacy, driving) to wide scale avoidance of practically everything, including social relationships, work, and the pursuit of recreational activities. In people with substance use disorders and PTSD, the substance frequently plays a major role as an avoidance strategy by dulling the person's emotional reactions to trauma-related stimuli or providing a temporary escape altogether from meaningful involvement in the world.

Since avoidance is such a common symptom of PTSD, it is no great surprise that it can present a challenge to engaging patients in treatment in the first place. Furthermore, once a patient is engaged in treatment, avoidance can undermine its effectiveness by preventing the person from actively practicing skills that can help them overcome their PTSD symptoms. Therefore, clinicians need to be aware that avoidance in patients with PTSD is a core characteristic of the disorder, but must also take steps to minimize such avoidance and to maintain engagement in treatment.

When engaging a patient in treatment, it is important to demonstrate empathy regarding concerns the patient may have about re-exposure to trauma-related stimuli, such as memories of their traumatic experiences. The clinician should point out that the treatment program is not focused on prolonged exposure of the person to traumatic memories, like some other treatment programs for PTSD, but rather focuses on teaching people more effective thinking skills for overcoming their PTSD symptoms and helping them get on with their lives. During the engagement process, patients may naturally be ambivalent about participating in an intervention designed to help them overcome the effects of their traumatic experiences. The clinician can normalize this ambivalence, while also pointing out that his or her attempts to avoid all memories of their traumatic experiences have not been totally successful. Being empathic about the apprehension about getting involved in trauma-based treatment and explaining how the ICBT program works, are usually sufficient to overcome ambivalence and avoidance that may initially impede the person's involvement in the program.

Once the patient has been successfully engaged in the PTSD treatment program, avoidance can still present a challenge to active participation and benefit from the program. Two types of avoidance are especially important. First, patients may miss (avoid) treatment sessions. Second, they may fail to follow up on practice assignments between sessions. Both of these problems need to be recognized and addressed as soon as they become apparent.

Although avoidance is a symptom of PTSD, it is rarely fruitful to simply point out to the patient that his or her avoidance is the natural result of their PTSD. Rather, it is preferable to take a practical, problem-solving approach to addressing avoidance problems that may crop up during treatment. Such problems occur most often during the early sessions of the program, before the patient has learned skills for examining and challenging the beliefs that contribute to upsetting feelings. The clinician should follow up missed sessions by contacting the patient (or other treatment provider), exploring why the patient missed the session, scheduling another session as soon as possible, and

considering any real obstacles that may have interfered with the ability to attend the session. When discussing missed sessions, it can be helpful for the clinician to remind the patient that the ICBT program is based on learning new skills for dealing with anxiety and trauma-related thoughts and beliefs that cause distress on a day-to-day basis. In order for the person to learn these skills, it is important for him or her to participate in regular teaching sessions (i.e., therapy sessions), and to practice the skills as home assignments outside of the sessions. This approach, including a concerted effort to identify and remove any obstacles to participation in sessions, is frequently effective at restoring regular attendance at sessions.

For some patients, the avoidance of treatment sessions is a more significant and pervasive problem. Multiple sessions may be scheduled and missed, and efforts on the part of the clinician to problem solve obstacles to attending sessions are consistently unsuccessful. In these situations it is important for the clinician to directly address the ambivalence or outright reluctance to participate in the program. Rather than continuing to engage in efforts to reengage the patient in the program, it is preferable to meet with the patient to discuss his or her lack of recent involvement in the program, and to explore whether the patient is still interested in participating in it. During this discussion, it is important that the clinician avoided conveying to the patient that he or she wants the patient to participate in the program, or would be disappointed if the patient chose not to. The choice to participate in the program must be the patient's, and he or she should know that they can choose to drop out of treatment without any negative repercussions. When exploring with the patient about whether he or she wants to continue to participate in the program, it can be especially useful to discuss how PTSD has affected the person's life, and the initial goals for treatment expressed by the patient. Typical motivating goals for continuing to participate in the ICBT program include being a better parent, returning to work or school, making or renewing friendships, participating in a rewarding intimate relationship, being able to enjoy leisure and recreational activities, and perhaps most importantly—it will help them to stay clean and sober.

If the patient decides to drop out of the ICBT program, then that session serves as the transition session (Module 9), and some discussion can be devoted to what the patient should do if he or she changes their mind and decides they want to participate in the program. If the patient expresses a genuine desire to participate in and complete the program, then the clinician should work out a plan with the patient to ensure regular attendance at therapy sessions. With some patients it may be helpful to establish a specific contract of expectations regarding regularity of session attendance in order for the person to continue participation in the program.

The clinician can encourage the patient to continue with addiction treatment even if the ICBT program is being discontinued.

Not following through on practice assignments can occur for a wide range of reasons, some of which may be related to avoidance. The most common reasons for not doing homework are: the assignment lacks sufficient clarity, the patient forgets to do the assignment, or the patient does not grasp the importance of the assignment. It is important to review all of the patient's efforts to complete a homework assignment, including efforts that do not involve written worksheets, at the beginning of each session, and to explore obstacles to completing home assignments. Home assignments are most likely to be completed when they are specific (including identifying specific times or places for completing the assignment), when the patient has practiced the assignment in the session to ensure that he or she knows how to complete it, and when the assignment has been mutually agreed upon between the clinician and patient (rather than simply assigned by the clinician).

Sometimes despite all of these steps, patients may not practice because it reminds them of their traumatic experiences, and thus is a type of avoidance. In these situations, it can be helpful to plan with the patient how he or she can use the relaxation exercises before doing homework in order to reduce the anxiety associated with completing the assignment. In addition, when homework focuses on practicing Flexible Thinking skills, the clinician and patient can identify several upsetting feelings and situations that the person has recently experienced, but are not obviously related to the patient's traumatic experiences, and make a plan to practice the Flexible Thinking assignment by addressing those situations. This provides a certain degree of safety in the homework assignment, and gives the patient an opportunity to become more familiar with Flexible Thinking.

During sessions, patients may avoid doing some work related to Flexible Thinking if it triggers trauma-related memories. In these situations, the clinician can empathize with the patient's discomfort, and then prompt him or her to use their relaxation skills before going on with the Flexible Thinking work. Multiple breaks in some treatment sessions to calm down and relax may be necessary when working on especially difficult thoughts and beliefs.

Active Substance Use and Engagement in Treatment

Active substance use can interfere with the patient's ability to participate and benefit from the ICBT program. If substance abuse is severe (e.g., person is dependent on alcohol or drugs) and the patient is routinely intoxicated or high for the session, it is sometimes best to postpone treatment of PTSD until it is better under control or the patient has achieved abstinence. The primary problem encountered when treating an individual with substance dependence is that the substance use is so heavy that he or she has little opportunity to learn and practice the skills taught in the PTSD program when not under the influence of drugs or alcohol.

Although it is best if the patient is abstinent from drugs and alcohol, safe and effective treatment in the ICBT program can be conducted in patients who are continuing to use if appropriate precautions are taken. When engaging the patient in the program, it is important to establish an open and honest dialogue about the patient's ongoing substance use. This includes discussion about the patient's current substance use patterns, and a willingness to talk openly about substance use over the course of the treatment program. To verify self-report, collecting laboratory data (urine and breath samples) is also strongly recommended. This is critical for the clinician to monitor the severity of the patient's substance use, and take rapid action to prevent an escalation or a full-blown relapse of substance use from occurring during the course of treatment.

When discussing the ICBT program with a patient who is actively using substances, it is important for the clinician to establish at least two preconditions for the patient to participate in the program. First, the patient must commit to attending therapy sessions before using any drugs or alcohol on that particular day. Second, the patient must agree to set aside at least some time every day before using drugs or alcohol in which he or she can practice the homework that was collaboratively agreed upon at the end of the session. Homework assignments in ICBT are designed to teach new and more effective skills for managing negative feeling such as anxiety, and dealing with upsetting trauma-related thoughts and beliefs. If individuals use drugs or alcohol to deal with or escape their negative feelings, they don't get the opportunity to practice and become competent at newly taught skills. Furthermore, attempts to practice the skills after using substances are often futile as drugs and alcohol can interfere with learning. Most patients with PTSD who are actively using substances are willing to agree to these two conditions of participating in the ICBT program.

If you are delivering the ICBT within an addiction treatment program (outpatient, intensive outpatient or residential levels of care) it is likely that the patient's substance use will influence their continuation in that program in addition to the ICBT. Most often, patients with continued problematic use in a current level of care will be recommended to a more intense level for stabilization. The ICBT can either continue through the patient's process through levels of care or resume the ICBT once the patient returns to the setting where the treatment is being offered.

The ICBT program also involves developing a crisis or relapse prevention plan designed to minimize the possibility of relapses back into substance use (Module 4). This Relapse Plan handout can be shared with other important people in the patient's life after it is completed. If the patient experiences an increase in substance use, or a full-blown relapse, when that problem has been successfully contained the relapse prevention plan should be re-examined and modified if possible in order to make it more effective. Thus, relapse prevention plans should be thought of as "living documents" that can change over time based on the experience of using the plan.

Once treatment has been initiated, the clinician should routinely check in with the patient about his or her substance use over the past week. Check-ins about substance use can occur on a weekly basis or once every several weeks, depending on the perceived risk of the patient resuming or increasing his or her use of substances. When an increase in substance use is detected, a plan should be established to address the substance use, and identify any precipitants. In addition, the clinician providing the ICBT treatment should coordinate care with the patient's addiction treatment providers in order to ensure that both treatments are working in a harmonious fashion.

Increases in substance use that become apparent over the course of treatment can be addressed through a combination of problem-solving aimed at; 1) being sure the patient is being treated for their addiction at the appropriate level of care; 2) increasing skills to support sobriety, such as attending and participating in peer recovery support groups; and, 3) prompting the use of Flexible Thinking skills designed to address feelings and thoughts in situations that preceded substance use. Situations that trigger urges to use substances or increases in substance use may provide important clues as to critical aspects of the trauma (e.g., beliefs, situations) that cause distress and need to be addressed over the course of the program. For example, if the patient has an increase in substance use or a full-blown relapse around the anniversary of her rape, it may be important for the clinician to help the patient use Flexible Thinking to address beliefs that she may have about the rape, such as whether she was responsible for it, whether the event makes her less worthy or desirable to other people, whether it means that the world is a dangerous place, or whether it means one can no longer have a hopeful, promising future. When an increase in substance use occurs of such severity that the patient is out of control and unable to participate in treatment based on the agreement reached with the clinician at the beginning of the program, then a more intense level of care is required. If the ICBT clinician cannot continue with the patient at the more intense level of care program, then the clinician can explore with the patient whether or how to resume the ICBT program.

Heightened Fear of Re-experiencing Symptoms and Substance Use

As we have frequently noted, patients may be afraid of and avoid treatment for their PTSD because they are concerned that it will involve significant exposure to memories of their traumatic events. If unchecked, this fear can also contribute to substance use as a way of avoiding dealing with the memories. The best guard against concerns about re-experiencing symptoms is to explain to the patient that the ICBT program does not take an exposure-based approach to treatment, and instead focuses on teaching skills for managing negative emotions and for dealing with upsetting trauma-related thoughts and beliefs that are already being experienced. The patient may choose to discuss

traumatic experiences during the treatment program, but doing so is up to him or her and not a requirement of the program. During the initial engagement phase, the clinician should also reassure the patient that they can also develop a relapse prevention plan early in the program to minimize the chances of relapse.

Occasionally during the first several sessions of treatment patients may experience mild increases in some of their PTSD symptoms, including re-experiencing the trauma. This increase in symptoms needs to be carefully monitored, as well as the potential for any associated changes in substance use. If patients experience a modest increase in PTSD symptoms early in treatment, the clinician should explain that this is a natural part of the recovery process, and that it is common for individuals to have a slight increase in re-experiencing symptoms as they begin to deal with memories of traumatic events that they have long been trying to suppress. The clinician should also praise the patient for his or her courage and determination in deciding to overcome the effects of their traumatic experiences by participating in the program. This can reframe an increase in re-experiencing symptoms as a natural part of healing and recovery from trauma, while also acknowledging the distress experienced by the patient due to the increase in symptoms.

Difficulty Disputing Thoughts

It is common when teaching patients Flexible Thinking that some have difficulty disputing the accuracy of their thoughts or beliefs. People naturally find it easier to identify evidence supporting their thoughts than evidence against their thoughts (Kahnemann, Slovic, & Tversky, 1982). Yet being able to see both types of evidence is critical to successful Flexible Thinking. When using the steps of Flexible Thinking, if the patient is able to identify that a particular thought reflects a Common Style of Thinking, this recognition should be used by the patient as a clue to evidence against the accuracy of the thought in question. If the thought indicates a Common Style of Thinking, the patient is on the verge of recognizing that it may not be entirely correct. The patient should be taught to ask him/herself why this thought may be distorted, with any identified reasons used as evidence against the thought. Thus, the review of the types of Common Styles of Thinking as a step in Flexible Thinking should be taken as a cue that a particular thought is not accurate, and the reason for describing a thought as distorted should be elicited.

When helping patients identify and evaluate upsetting thoughts, it is always helpful to encourage them to think of the upsetting thought in the most extreme terms possible. For example, it is easier to dispute the thought that “the world is an extremely unsafe place and you can’t trust anybody” than the thought “the world as an unsafe place.” For another example, it is easier to dispute the thought “Nobody could love me because I have been tainted by my childhood sexual abuse” than the thought “I am an undesirable person.”

When teaching the patient how to dispute his or her thoughts, it can be helpful to focus on identifying single exceptions to it. If a person believes that their thought is completely true, then finding one or two exceptions is sufficient to establish that it is not accurate. Rather than seeking radical changes in thoughts based on amassing a great deal of evidence against a particular thought, it is often preferable to gather small amounts of evidence against negative, trauma-related thoughts that lead to slight modifications in the thought and modest reductions in associated distress. Gradually over time, as the patient becomes more skilled at Flexible Thinking and experiences relief from distress from using the skill on multiple occasions, more substantial benefits in overall distress and PTSD symptoms occur.

People are often the harshest judges of their own behavior. For this reason, patients may hold themselves responsible in situations where others would not. This can interfere with identifying evidence against a particular belief because the patient believes they should abide by a higher standard of behavior than others. In order to overcome this tendency, it is important to remind the patient that when examining the evidence supporting a thought or belief, a premium should be placed on objective evidence, such as evidence one could use in a court of law. One strategy for accomplishing this is to ask the patient how someone else might evaluate the situation, and what types of evidence another person might identify that do not support the patient's belief. This is often effective at identifying convincing evidence against a particular thought. If the patient persists in believing that he or she should be able to abide by a higher standard of behavior than other people, and discounts evidence based on other people's perspectives, the clinician can reframe this by explaining that the person can strive to achieve a higher standard of behavior without "beating him/herself up" when he or she is not entirely successful. The clinician can note that "to err is human," and endeavor to help the patient adopt a more compassionate appraisal of his or her own actions (Gilbert & Irons, 2005). Of course, in group formats the clinician can draw upon the perceptions and interpretations of other group members to help loosen an individual patient's beliefs.

A final consideration when helping patients evaluate evidence against a particular thought is that there may be insufficient information to evaluate the accuracy of the thought. Sometimes additional information is needed before the accuracy of the thought can be determined. In these situations, a determination about the accuracy of the thought should be postponed, and a plan should be made for the patient to obtain the needed information. The patient can do more research. When the necessary information has been obtained, the accuracy of the thought or belief can then be re-evaluated. This can be done either alone by the patient or in collaboration with the clinician.

Difficulty Identifying Feelings and Emotions

It is common for patients to mix up thoughts and feelings, because in the common vernacular thoughts are sometimes used to convey feelings (e.g., "I feel like a failure"). It is also common when people feel upset for them to experience a range of different negative emotions, without any one single feeling predominating. These are very normal occurrences and do not pose obstacles to teaching Flexible Thinking.

Less commonly, patients may have difficulty identifying or articulating specific feelings when they are distressed. This can be problematic as the thoughts associated with different negative feelings need to be examined as a part of Flexible Thinking. In teaching patients how to recognize different feelings, it is useful to focus on four broad categories of negative feelings, including: anxiety and fear, depression and sadness, guilt and shame, or anger and resentment. These four emotions are the most common negative emotions, and focusing on them when teaching Flexible Thinking simplifies the task of identifying the upsetting feeling.

After reviewing the four broad categories of negative emotion, the clinician can explain that each type of feeling is typically associated with a different type of underlying thought or belief. Feelings of anxiety are associated with thoughts of threat or lack of safety, and thus if the patient is thinking about being hurt in some way, the associated feeling is anxiety. Feelings of depression are associated with thoughts or beliefs of a loss or permanent damage. Feelings of guilt or shame are associated with thoughts or beliefs of wrongdoing or failure. Feelings of anger and resentment are associated with thoughts or beliefs of having been wronged by another person. Understanding the types of thoughts associated with different negative feelings can facilitate the identification of specific

negative feelings. Using Handout #10 (“Primary Negative Emotions and the Common Thoughts that Drive Them”) can be helpful in teaching patients about these issues.

Occasionally, patients have an even more profound difficulty recognizing specific negative feelings when they are distressed. In these situations, it can be useful for the clinician to do some basic teaching about the nature of different negative feelings, and situations that typically give rise to each type of feeling. Using a variety of strategies to teach emotion recognition is most effective. One strategy is for the clinician to describe different situations and to then ask the patient what type of feeling the person would have in that situation (e.g., if someone came home from a program and learned that his or her sibling had died recently, how would the patient feel?) Another strategy is to use pictures in magazines or books to help patients consider what is happening in the situation, and what the feelings of the different people are, based on both the situation and their facial expressions. In social skills training groups, a therapeutic tactic is to watch soap operas with the patient with the sound turned off, and to have the patient try to explain what is happening in the situation and to identify the different feelings expressed by each of the actors. Although you may not be able to do this technique in your practice, it should give you some ideas about how to help the patient gain some objectivity in identifying the feelings of non-related others first, so that they may eventually get better at understanding their own.

Inability to Use the Flexible Thinking Skill

Not everyone is able to master Flexible Thinking, but this is not a barrier to benefiting from participation in the ICBT program. Flexible Thinking, or cognitive restructuring, is a broad skill that can be used in a variety of ways, and Flexible Thinking is only one way or version of the skill. The most important goal in teaching Flexible Thinking is for the patient to recognize that negative feelings are due to thoughts or beliefs that are not always accurate, and that by examining the underlying thought, relief from distress often occurs. There are several alternatives to Flexible Thinking that still embody the basic goals of Flexible Thinking or cognitive restructuring.

If the patient has had success recognizing different Common Styles of Thinking associated with their thinking, and correcting these distortions accordingly, the clinician can simply encourage the patient to use this strategy for coping with distress, and abandon all the components of Flexible Thinking. For patients who gravitate towards this approach, the self-help books by David Burns are especially useful in honing this skill (David D. Burns, 1999; D.D. Burns, 1999).

Another alternative to Flexible Thinking is to teach a simpler approach developed by Eric Granholm and colleagues (Granholm et al., 2005): the 3 C’s, which stand for Catch it- Check it- Change it. The “Catch it” refers to identifying the upsetting thought. The “Check it” refers to evaluating whether the thought is completely accurate or not. The “Change it” refers to modifying the thought to make it more accurate.

Yet another simplified approach to Flexible Thinking is to teach patients how to brainstorm multiple perspectives (or thoughts) on a problem situation. Sometimes just being able to see a situation from multiple perspectives in and of itself can reduce distress (Suarez, Mills, & Stewart, 1987). Being able to conjure up multiple perspectives of an upsetting situation suggests that no one perspective is the absolute “truth.” After brainstorming multiple perspectives, the patient may choose a particular one that he or she feels is most accurate and most useful under the circumstances.

Last and certainly not least, the patient can use the Serenity Prayer to find the wisdom to know the difference between the thoughts that can be changed and those that can't. Acceptance may be the answer in those relatively rare cases where the patient considers the thought valid and unalterable.

Anxiety, Panic, or Hyperventilation with Mindful Relaxation

Sometimes people feel a paradoxical increase in anxiety when they practice relaxation skills such as Mindful Relaxation. This can occur for some people because they have been feeling so tense and anxious for so long that feelings of relaxation are foreign to them and therefore upsetting. Some patients find it helpful to learn that these new feelings are in fact feelings of relaxation that will become more comfortable over time as a person becomes more used to experiencing them.

When people experience anxiety or panic during either the centering or relaxation segments of Mindful Relaxation, it can be helpful to take a break, or to modify the exercise to make it less intense, and to make the learning process more gradual. For example, a person could do the exercise with his or her eyes open. Or the exercise could be practiced for relatively brief periods of time, with the practice period gradually increased as the person feels less anxiety while practicing the skill. For the centering technique, the key is to try to get out of one's head and be still. For the relaxation technique, the key is to focus on the ratio of breathing, i.e. inhale and exhale.

Some patients benefit from learning a different anxiety management skill than Mindful Relaxation. For example, some patients may prefer learning how to focus on pleasant imagery or muscular relaxation strategies such as tensing and relaxing one's muscles. Mindful Relaxation can be adapted in any way that is suited to the patient's needs. If Mindful Relaxation fails, involving the patient in adapting the strategy can maximize the chances that he or she will practice it and find it useful.

It should also be reiterated that the practice of Mindful Relaxation for home assignments should always be done initially in a safe, comfortable, and non-stressful situation. Initial practice of Mindful Relaxation should not occur under stressful circumstances since patients do not yet have sufficient competence at the skill to reduce their experience of stress. Over time and with practice, Mindful Relaxation or another anxiety management strategy can be used in increasingly more challenging and stressful situations, and is often then effective at reducing anxiety and tension.

Lack of Follow-Through on Practice

Practicing the skills taught in the ICBT treatment program outside of therapy sessions is of critical importance to the overall effectiveness of the program. The program works primarily by helping people learn new and more effective skills for dealing with negative emotions in general and with distressing trauma-related thoughts and feelings in particular. Therefore, ensuring that the patient practices the skills outside of the session is a major goal of the clinician.

Early in treatment it is common for patients not to follow through on all of their practice assignments. It is important that the clinician demonstrate the importance of these assignments by always following up with patients about the assignment at the beginning of the treatment session, praising any efforts to practice the skill, and taking a problem-solving approach to obstacles encountered in completing the home assignments. When helping patients get into the routine of practicing skills on their own, the clinician should take a *shaping* approach to facilitating homework follow-through. Shaping refers to the reinforcement of successive approximations to the desired behavior. Therefore, in order to shape patients' completion of homework assignments, the clinician should praise any efforts to use the targeted skills between sessions, even if no written assignments

were completed. Thus, homework should be broadly conceptualized as attempts to practice the skills, and not just the completion of some written assignment.

A number of other strategies can be useful in promoting follow-through on home assignments. Each assignment should be collaboratively agreed upon between the clinician and the patient to ensure that the patient feels he or she has played a role in determining it. When patients have not completed homework assignments, the clinician should review the rationale for practicing skills outside of the session with the patient. When a home assignment is developed, the clinician should verify that the patient knows how to do the assignment, preferably by practicing it for a brief period of time at the end of the session. Any mistakes or misunderstandings on how the assignment should be completed should be corrected in the session before the patient tries it on his or her own.

Home assignments should be easy enough that the patient has a high level of confidence that he or she can complete the assignment. This can be evaluated by simply asking the patient the likelihood that he or she will be able to follow through on the assignment. It can also be helpful to make specific plans with the patient about when the assignment will be completed, such as on what day the assignment will be done, at what times, where homework materials can be placed, what obstacles might interfere with completing the assignment, and what strategies could be used to deal with those obstacles. The more specific the plan for the home assignment, the more likely the patient will follow through on it. Finally, some patients with memory difficulties may benefit from the involvement of a family member, other significant person, or other clinician in prompting or helping them do their homework assignment. Significant others can play an important role in prompting people to do assignments, and in creating a safe, comfortable, and non-distracting environment in which the assignment can be completed.

Summary

This section outlines a number of clinical problems that are frequently encountered by clinicians using ICBT. Not all problems encountered can be predicted and possible solutions prepared for in the Clinician's Manual. We trust that as you gain experience in delivering the ICBT with each successive patient or group, that you will develop confidence and develop your own strategies for overcoming barriers and resolving apparent impasses. Be conscious of these therapeutic dilemmas, and how you do navigate your way through and sometimes around them. Further, we must emphasize talking about your work with other professionals, as well as the importance of good clinical supervision and case consultation.