Integrated Motivational Interviewing and Cognitive Behavioral Therapy (ICBT)

A Practitioners Guide



Joseph Hyde • Maria Torres • Win Turner • R. Lyle Cooper

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A Practitioners Guide

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We chose to write this guide for practitioners, using "plain English" and a practical approach. In developing the original manuscript, we sought to make it portable across settings. We came to later know that not only are these clinical interventions portable across settings, but also across most diagnoses. We looked at the work of Chorpita et al. (2005), who stated that across the majority of evidence-based practices, a common set of strategies and interventions addresses substance use disorder, depression, and anxiety. Portability is a value that informs our thought. This is more recently reflected in contemporary scholarship regarding process-based cognitive behavioral therapy that is transdiagnostic (Hayes & Hoffman, 2018).

Introduction

To Students and Fellow Practitioners

The treatment approach for mental disorders described in this guide follows a clinical method that draws on innovations and essential elements influenced by motivational interviewing (MI), motivational enhancement therapy (MET), mindfulness, values-based clinical practices, functional analysis, and cognitive behavioral therapy (CBT). Since the original guide was completed in 2013, we have continuously updated content to reflect (1) emerging science on behavioral health treatment and interventions, (2) recognition of gaps in what we have written, based on instructor and student feedback, and (3) a desire to incorporate our evolving social context reflecting social justice issues and lessons learned from the COVID-19 pandemic.

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Integrated Motivational Interviewing and Cognitive Behavioral Therapy (ICBT): A Practitioners Guide, First Edition. Joseph Hyde, Maria Torres, Win Turner, and R. Lyle Cooper.

The Following Features Help Make this Guide Practical

a) Across many evidence-based practices (EBPs) for a variety of behavioral health conditions, clinical researchers have identified a common set of practice elements (Chorpita et al., 2005; Chorpita & Regan, 2009). This guide is informed by the call to focus on training and to disseminate these essential skills across the health care system and to promote the use of these universal clinical interventions (Barlow, 2008).
b) The guide's 16 core interventions are designed to fit within conventional models of service and can span diverse practice settings (e.g., general outpatient services embedded within primary care settings, including federally qualified health centers and general outpatient substance use disorder [SUD] or mental health settings).
c) The evidence-based clinical skills and interventions presented in this guide are easily transferable from one setting to another.
d) The clinical sessions are clearly laid out without being overly prescriptive or restrictive. The interventions are flexible enough to be integrated into clinicians' personal styles and creativity (i.e., they do not have to be followed in a particular order).

The Guide is Organized Into Three Main Sections

- **Section 1** reviews MI, MET, CBT, the personal reflective summary as a treatment tool and some of the newest thinking on the processes of therapy.
- **Section 2** provides guidance for the implementation of 16 distinct clinical strategies. Sessions focus on engaging, building motivation, clarifying treatment priorities for the patient, and developing a patient–clinician agreement. Other sessions address skills training, effective and healthy replacement activities, building personal awareness and mindfulness, developing specific skills to manage cravings and urges to use substances, and managing distressing thoughts and emotions. Two sessions cover known beneficial strategies equally useful with all treatment approaches: (1) use of medications in support of treatment and recovery and (2) engagement with self-help. The format of each session facilitates delivery of sessions according to a common framework, while, at the same time, tailoring delivery of selected sessions to a patient's individual needs. Session tools will help clinicians learn and understand delivery of each session, facilitate specific session feedback, and reduce paperwork burdens. *Session handouts and forms, other supporting materials, and references appear at the end of the guide, along with a list of acronyms used throughout*.
- **Section 3** discusses techniques and tools that support adoption and sustained implementation of interventions, with a focus on enhancing fidelity. The techniques include a discussion of proven strategies for enhancing clinical supervision to increase competency in essential clinical skills.

We encourage users of this guide to first read it through and then to use the session outlines and fidelity tools to support delivery of the interventions with their clients based on their goals and needs. Worksheets, handouts, and other materials appear in corresponding sections at the end of the guide and may be copied and used as needed in sessions.

Earlier editions of this guide focused principally on addressing SUDs and co-occurring disorders. This edition reflects that these clinical strategies are trans-diagnostic.

Section 1

An Overview of Proven Tools and Techniques for Motivational Interviewing/Motivational Enhancement Theory, and Cognitive Behavioral Therapy Treatment

Current approaches to understanding the treatment of substance use, mental illness, and COD are driven by empirical advances in neuroscience and behavioral research rather than by theories alone. Good evidence now exists that biological factors, psychosocial experiences, and environmental factors influence the development, continuation, and severity of disorders. Contributing experiences may occur at home, at work, or in the community, and a stressor or risk factor may have a small or profound effect, depending on individual and environmental differences. The following review of motivational interviewing (MI), motivational enhancement therapy (MET), personalized reflective summary (PRS), and cognitive behavior therapy (CBT) informed by this evidence provides context for the treatment sessions in this guide.

Motivational Interviewing and Motivational Enhancement Therapy

MI is an effective, evidence-based method for helping patients with a variety of health and behavioral concerns. Motivational approaches, as developed by Miller and Rollnick (2012), seek to foster the intrinsic drive people have for healing, positive change, and self-development. Since Miller and Rollnick's original work was published in 1983, more than 25,000 articles citing MI and 200 randomized clinical trials of MI have appeared in print. MI's efficacy has been substantiated by several MI training research projects (Miller et al., 2004).

Integrating Motivational Enhancement and Cognitive Behavioral Skills Building to Elicit Change—How It Works

- Motivational enhancement is achieved by building rapport through reflective discussions, helping patients understand the pros and cons of use, and establishing collaborative goals based on the patient's needs and values.
- Motivational enhancement strategies assess and increase the patient's readiness, willingness, and ability to change.
- The clinician's first and primary task is to engage and collaborate with the patient to build internal motivation.

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- In CBT, behavioral health issues are viewed as interrelated intra- and interpersonal issues, recurring and habitual disorders that can be successfully treated.
- Through treatment, the patient learns to become aware of situations and emotions and of how to cope, solve problems, and build healthy replacement actions to achieve wellness.

Figure 1 The Three Types of Helping Interactions

MET is a structured intervention approach that uses MI techniques. MET interventions typically involve specific feedback and a reflective discussion with the client following screening or assessment and a goal-setting interaction (planning). The descriptions of MET sessions in this guide include scripts illustrating the effective use of MI techniques.

MET, a short-term technique originally used in the treatment of alcohol and SUDs, was later included in the treatment of anxiety and depression. This approach to treatment focuses on helping people feel more motivated to change their harmful behavior. It integrates aspects of MI and the transtheoretical model of change.

MI categorizes helping interactions according to the following three styles: directing, guiding, and following (see Figure 1). With a directing style, the helper provides information, instruction, and advice. This contrasts with the following style, which is defined by listening, understanding, and not influencing another's choice. In the middle of these styles is the guiding approach, which emphasizes listening and offers expertise and direction when requested or needed.

MI research has demonstrated that the clinician's choice of interaction style (i.e., directing, guiding, or following) directly affects the process for the patient's readiness for change. Intrinsic desires for change and accompanying "change talk" increase when the clinician helps the patient explore the discrepancies between current behaviors, values, and goals. Change talk refers to a patient's discussion of their desire, ability, reason, and need to change a behavior, as well as a commitment to changing. If the clinician mistakenly offers too much unsolicited advice, the patient's arguments against change increase and become "sustain talk," the opposite of the desired effect (Miller & Rollnick, 2012). Sustain talk is usually characterized by talking about why change cannot happen.

It is most helpful when the clinician seeks a collaborative partnership with patients. This partnership is characterized by a respectful evoking of their own motivation, wisdom, values, and goals and of the knowledge that whether or not change happens comes down to each person's choice, an autonomy that cannot be taken away no matter how much one might wish that at times. This approach is often referred to as encompassing the MI spirit. Buber (1971) describes such interactions as an "I–thou" manner of interacting that values the opinions of others and does not objectify them to manipulate ("I–it") (Miller & Rollnick, 2012). MI spirit respects that both clinicians and patients bring expertise to the session. Clinicians bring expertise in processes that support and facilitate change. Patients are experts in their lives. MI spirit invites clinicians to bring their true selves to the encounter. The authentic self goes beyond what you do for a living or who you are to someone else (e.g., mom, brother, and girlfriend). It is who you are at your core—your kindness, values, compassion, and empathy. Evidence suggests that as we bring and practice compassion, our patients begin to experience more self-compassion.

Several excellent clinician workbooks and easy-to-use competence scales can assist in learning and practicing the techniques described here. For those with limited exposure to MI, it would be helpful to read about MI and to participate in MI skills training. See http://www.motivationalinterviewing.org/mi-resources for more information. The first two sessions in Chapter 2 of this guide are based on MI and MET techniques.

Motivational Interviewing and the Process of Change

Change occurs all the time as a natural and self-directed event. Examples of natural changes that might take place over our lifetimes include moving to a new home, ending or beginning a significant relationship, or changing jobs. Many times, addressing a change in one domain affects another. For example, if a person is working to address depression, taking care of their physical body could be part of the treatment plan. Similarly, if a person just received a concerning diagnosis, the decision to work with a social worker or therapist to address the impact of the diagnosis on their mental health could be part of the treatment plan.

Three elements of any change are readiness, motivation, and ambivalence (see Figure 2). Miller and Rollnick (2012) break down readiness to change into three components: (1) an awareness of the problem, (2) a commitment to doing something, and (3) the action of making a change. This model is based on the theory of change developed by Prochaska and DiClemente (1998). The theory proposes a "stages of change" model consisting of precontemplation, contemplation, preparation, action, and maintenance. The model is viewed as cyclical rather than linear, with relapse occurring, so the individual may cycle back through the stages several times.

Traditional views of motivation held that it was static; therefore, clinicians had little or no influence over a patient's motivation. Patients were viewed as either motivated or not. If a patient was not motivated, this was considered the patient's problem or a sign of resistance to treatment, and sometimes the individual was blamed for not being motivated. Individuals who were motivated agreed to follow all instructions and accepted the labels (e.g., alcoholic) given to them. Individuals who were not motivated resisted the idea of having a problem and refused to follow treatment protocol.

It has since been discovered that motivation is fluid and changing rather than fixed. It is influenced by internal life and life circumstances and, in the case of therapy, by the style of the clinician (Miller et al., 1993), clinician's expectations (Leake & King, 1977), and patient's expectations. Motivation is influenced positively by clinicians who listen empathetically and negatively by

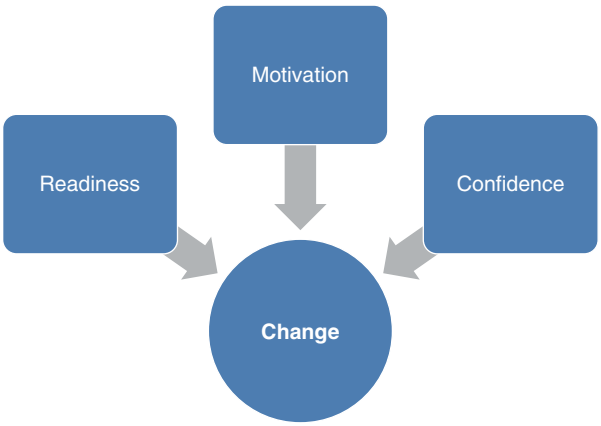

Figure 2 Three Elements of Change

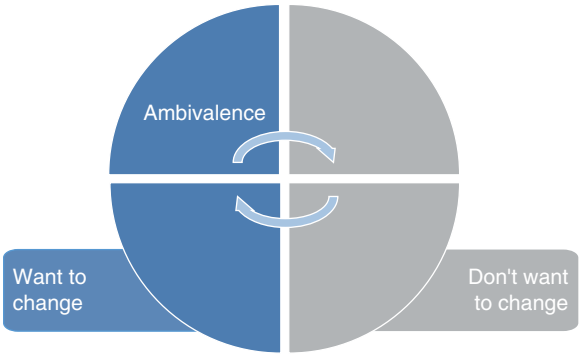

Figure 3 How a Patient Might Experience Ambivalence Toward Change

clinicians who are confrontational. A clinician's bias about a patient can also have an adverse effect on the patient's motivation.

Characterizing a patient as resistant, unmotivated, lazy, manipulative, or difficult often becomes a self-fulfilling prophecy that leads to more self-defeating attitudes (e.g., fear of failure, reluctance to being dependent on others, and hypersensitivity to feeling controlled by someone else). The MI approach suggests that if the clinician changes the way of interacting with a patient, the patient will interact differently with the clinician. Change is more likely when the clinician maintains a perspective of hope, optimism, and possibility and views the patient as capable of evolving and engaging meaningfully in a transformation process.

Others can elicit and reinforce motivation. Understanding motivation as interactional leads to clinicians viewing lack of motivation as a strategy to protect against fear of failure, loss, unwanted dependence on others, or having others in control. This understanding, in turn, increases the clinician's acceptance of the individual and decreases the need to control and confront the individual.

Ambivalence, the third element of change, is the result of simultaneous, competing motivations that lead in different directions (see Figure 3). Examples include the following:

- Desire to gain medication benefits and avoid side effects
- Desire to be strong and healthy and to relax and eat enjoyable foods
- Hope for change and fear of failure

MI is based on the idea that people generally are not unmotivated but, rather, have multiple, competing motivations. This is where people get stuck. Individuals might know they should make a change or that things could be better, but they also are attached to something that holds them back (e.g., drugs, friends, a relationship, convenience, familiarity, and security). Ambivalence is a normal component of psychological problems, although the specifics are unique to each person and sometimes to each situation. Ambivalence protects the side that does not want to change.

While a clinician's natural tendency might be to support or protect a viewpoint, it is wise to avoid "taking a side" prematurely because this will invoke reactance in the patient. Reactance is reluctance on the patient if they perceive a loss of autonomy. MI assumes people have the capacity to solve their own problems and to come up with resourceful solutions if given help removing the barriers.

The Two Phases of Motivational Interviewing

There are two phases of MI. In phase 1, the clinician helps the patient resolve ambivalence and build motivation. In phase 2, the clinician helps to strengthen commitment and to create a plan for change. Phase 1 generally demonstrates the patient-centered aspect of MI, with more directive

interactions taking place in phase 2. In some cases, it is first necessary to raise the awareness of ambivalence or conflicting motivations before resolving the ambivalence.

Phase 1 of Motivational Interviewing: Engaging, Resolving Ambivalence, and Building Motivation

The work of phase 1 is based on the MI spirit, applying specific principles using identified strategies.

Spirit. The MI spirit is the underlying assumption that individuals can develop in the direction of health and adaptive behavior, given the tools and opportunity to do so. This belief is essential for the full and effective use of MI, along with a willingness to entertain the possibility of:

- **Collaboration.** Work in partnership with the patient.
- **Empowerment.** Listen, elicit, and affirm from the patient.
- **Autonomy.** Accept the patient's ability to choose.
- **Compassion.** Nourish another's well-being and growth.

Steps. The four steps generally considered essential to MI include:

1) Developing discrepancy
2) Reducing discord
3) Expressing empathy
4) Supporting autonomy

The purpose of **developing discrepancy** is to create a disconnection between where the person has been or currently is and where the person wants to be. The goal is to resolve the discrepancy by changing behavior. Resistance is seen as a behavior and, as such, is a state and not a permanent trait of an individual.

The principle of **reducing discord** implies it takes two to resist. It is interpersonal. Fortunately, discord is highly responsive to the clinician's style. Specific suggestions for reducing discord are described below.

Expressing empathy is one of the most important elements of MI. High levels of empathy during treatment have been associated with positive treatment outcomes across different types of psychotherapy. The key to expressing empathy is reflective listening, a specific and learnable skill. By listening in a supportive, reflective manner, the clinician demonstrates understanding of the patient's concerns and feelings. An empathetic style will:

- Communicate respect for and acceptance of the patient and their feelings
- Encourage a nonjudgmental, collaborative relationship
- Establish a safe and open environment for the patient that is conducive to examining sensitive issues and to eliciting personal reasons and methods for change
- Allow the clinician to be a supportive and knowledgeable consultant
- Compliment rather than denigrate
- Gently persuade, with the understanding that change is the patient's choice

When a clinician **supports autonomy**, the patient's ability to make decisions and choices is recognized and respected. This implies that responsibility for the patient's behavior resides with the patient. The clinician also supports the patient as the only one who can make choices about changing behavior.

Motivational Interviewing Strategies

The first and core MI strategy is described using the mnemonic OARS, which consists of:

- **O**pen-ended questions
- **A**ffirmations
- **R**eflections
- **S**ummaries

Open-ended questions cannot be answered with a *yes* or *no* response or with brief, specific information (e.g., "I'm from Jefferson City"). Rhetorical questions are not open-ended and avoid socially desirable responses. Open-ended questions enable the clinician to explore widely for information and help uncover the patient's priorities and values. Open-ended questions engage and draw out the patient.

Examples of Open-Ended Questions

- *Where did you grow up?*
- *Tell me a bit about your work.*
- *What brings you here today?*

Affirmations affirm a person's struggles, achievements, values, and feelings. They emphasize the individual's strength or notice and appreciate a positive action. Affirmations should always be genuine and express positive regard and caring.

Examples of Affirmations

- *It takes courage to face such difficult problems. This is hard work you are doing.*
- *You really care a lot about your family. Your anger is understandable.*

Reflections are statements made after a patient's communications. They provide a way for the listener to confirm understanding of what was said or meant. A reflection can be a guess or hypothesis about what was really meant. Reflections are made as statements where the inflexion goes down at the end of the statement. They are the primary way to respond to patients. As a guess, the statement may not be accurate, and the patient will respond and clarify what was meant.

There are two types of reflections, simple and complex. Simple reflections express exactly what was heard. They rephrase (repeat with new words) the patient's comments.

Example of Simple Reflection

Patient: *I did not want to come in.*
Clinician: *I hear you do not want to be here today*

Complex reflections paraphrase (make a guess about unspoken meaning) or reflect the feeling or both. Generally, simple reflections are more common at the beginning of the relationship, and

complex (deeper) reflections occur more frequently as understanding increases. There are several types of complex reflections:

- Double-sided reflection presents both sides of what the patient is saying, which is extremely useful in pointing out ambivalence.
- Amplified reflection amplifies or heightens the resistance that is heard.
- Reframing or "getting a new pair of glasses" suggests a new way of looking at something that is more consistent with behavior change or change talk of the patient.

Examples of Complex Reflection

Patient (P): *I do not want to be here today.*
Clinician (C): *I hear that. So, how come you decided to show up?*
P: *I'm on probation for possessing weed, and, if I do not show up, I could end up in jail.*
C: *So, your freedom and calling your own shots in your life is really important to you.*

Summaries are statements that pull together the comments made and transition to the next topic. They are helpful for moving the conversation along. Summaries should only be used after a minimum of three reflections.

Example of a Summary

You mentioned a number of things about your current lifestyle, such as cutbacks at work and the stress you feel. You spoke of having little energy for doing some of the things you used to like to do and did to relax. What do you think might help you get back to doing some of the things you once enjoyed?

Giving Advice

Clinicians frequently ask when they may give advice or provide information during MI. Giving advice or information at the wrong time or with the wrong approach is one way to encourage resistance from patients. There are three situations where giving advice is appropriate:

- The patient asks for advice or information.
- The clinician asks permission to give advice.
  - "May I make a suggestion?"
  - "Would you be interested in some resources?"
  - "Would you like to know what has worked for some other people?"
- The clinician qualifies the advice to emphasize autonomy.
  - "A lot of people find that [____] works well, but I don't know if that's something that interests you."

Example of Giving Advice

You know, that's certainly something I can do, but I'm wondering if I really have enough information about the problem to give you good advice right now. Would you mind telling me a little bit more about the situation?

When a patient asks for advice, it is important that the clinician not jump in if the patient does not seem ready or sincere. In these situations, it is more appropriate to ask permission to get more information before giving advice.

Too often in treatment settings, patients are labeled "resistant" if they do not want to change and/or argue against recommendations to do so. Miller and Rollnick (2012) intentionally have moved away from using the term "resistant," as it is negative, inaccurate in its implications, and not useful in training MI skills to help patients with change. Instead, MI theory considers these interactions as composed of two elements: ambivalence residing in the patient and the skill level of the provider. When arguments or sustain talk are present, it is predictive of no change. These types of patient expressions are a signal of cognitive dissonance and often are reactions to the provider's counseling style.

In simple terms, cognitive dissonance is an uncomfortable feeling caused by contradictory ideas (e.g., when beliefs and values contradict one's behavior). People are motivated to reduce the dissonance by changing attitudes, beliefs, and behaviors or by justifying or rationalizing attitudes, beliefs, and behaviors. When encountering discord and/or expressions of sustain talk, it is important to avoid arguments with the individual. Do not push back, as this puts the individual in the position of defending the opposite side. The old term "rolling with resistance" implied that to help elicit change, the clinician would go with the direction of the conversation rather than confronting, preaching, or trying to control the conversation. The use of reflections, particularly complex reflections, is one way a clinician can help reduce sustain talk. It is also helpful to remind the patient (and for the clinician to remind themself) about autonomy and to let the patient know that change is ultimately their choice.

Phase 2 of Motivational Interviewing: Building Change Talk, Strengthening Commitment, and Building Confidence

Change talk can flow naturally by simply using OARS. The application of OARS is primarily a patient-centered mode and explores the patient's ambivalence about behavior change. Often through empathic, reflective listening, the patient's ambivalence shifts toward the "change" side and away from the "status quo" side of the ambivalence. During this phase, trust and rapport have been established to the extent that the patient is ready to collaborate in resolving the ambivalence.

Recognizing Change Talk Versus Sustain Talk

Change talk and sustain talk are opposites. Sustain talk supports keeping things the same. Change talk expresses movement in the direction of change.

Examples of Change Talk and Sustain Talk
Sustain talk: *"Marijuana has never affected me."* ***Change talk:*** *"It isn't worth it to be landing in jail."*

There are seven types of change and commitment talk, represented by the mnemonic DARN-CAT:

- **D**esire to change ("want, like, wish ...")
- **A**bility to change ("can, could ...")
- **R**easons to change ("if ... then ...")
- **N**eed for change ("got to, have to, need to ...")

- **C**ommitment ("I will")
- **A**ctivation ("making a plan, starting action")
- **T**aking steps ("I did, I started doing")

The MI goal in phase 2 is to increase the change talk and decrease the sustain talk.

Change Talk Discussion

When change talk does not occur naturally, tools can be used to elicit it. When trust is developed, questions that would earlier have been classified as roadblocks that engendered resistance are now classified as techniques for eliciting change talk. Thus, it is important to not introduce the change talk discussion too early (i.e., not before the patient has sufficiently explored the ambivalence about the behavior and is now ready to explore and resolve ambivalence about change). It is only at this point that the more directive techniques can be employed. The following are strategies for eliciting change talk:

- Ask evocative questions.
- Explore the decisional balance (weighing costs and benefits).
- Ask for elaboration or examples.
- Use a looking-back question (to a time when things were OK).
- Use a looking-forward question (how does the patient want life to be different?).
- Query the extremes (the worst that could happen if the patient quits and the best that could happen if the patient quits).
- Use the change/readiness rulers.
- Explore goals and values.

Commitment Talk

Commitment is the language that confirms something different will happen. The difference between change talk and commitment talk lies in the strength of the statement. During change talk, the idea of change is explored; with commitment talk, the intention to make the changes is expressed. Good questions to use for eliciting commitment talk are: "Will you do it?" If so, "Where, when, and with whom?" The more specific the answer generated, the more likely the action will take place. Being accountable to oneself and others is often part of the lesson learned in the treatment process. Clinicians are encouraged to elicit commitment talk and subsequent follow-through at the end of each session to affirm patient engagement and skills practice and to gradually shape commitment for dramatic behavior change.

Examples of Change Talk and Commitment Talk
Change talk: *"I know my kids want me to."* ***Commitment talk:*** *"I'll definitely give it a go."*

Bridging Screening and Assessment to Treatment: The Personalized Reflective Discussion

The MI and MET approach to building initial collaborations from the "get go" uses screening and assessment results to generate a specific type of reflective discussion, which results in this PRD. This discussion aims to increase the following: (1) awareness for areas of strength and risks, (2) readiness and the desire to change, (3) reasons and most needed targets of change, and (4) plans to work

together to develop the most helpful path toward wellness. Although individuals may be aware that they are using a particular substance or are depressed (or both), they may not realize they are at significant risk for negative health and other consequences. Simply hearing information reflected back—summarized to include the pros and cons/risks they themselves have shared—can be a powerful motivator.

Clinicians in clinic settings conduct evaluations or review results from assessments with patients in treatment. Earlier work using personalized feedback reports (e.g., Sampl & Kadden, 2001) often gathered the following information during the assessment sessions(s):

Personal Reflective Summary (Substance Use)

- Alcohol and/or substances used by the patient
- Perceived benefits of use
- Levels of use (e.g., frequency and quantity)
- Problems associated with using alcohol or other substances (e.g., physical/emotional health, relationships, work, and role functioning)
- Current and past misuse or dependence symptoms
- Reasons to quit or to make a change
- Current motivational level regarding substance use and change
- Feelings of confidence or efficacy in being able to accomplish desired changes
- Other co-occurring concerns

Personal Reflective Summary (Behavioral Health Issues)

- Symptoms (e.g., depression, anxiety, and trauma)
- Findings from validated screenings (e.g., Patient Health Questionnaire-9 [PHQ-9] and Generalized Anxiety Disorder 7-item Scale [GAD-7])
- Problems associated with behavioral health concerns (e.g., affect and self-limiting thoughts, physical/emotional health, relationships, work, role functioning, alcohol, or other substance misuse)
- Life stressors
- Current duration and history of symptoms
- Helpful/nonhelpful medications taken
- Reasons for seeking help or making a change
- Current motivational level regarding capacity to make a change
- Feelings of confidence or efficacy in being able to accomplish desired changes

The examples listed above represent themes for substance use and for mental health concerns, helping to develop a collaborative understanding, as well as themes for treatment goals and the most appropriate session skills to deliver.

MI/MET sessions make use of the PRS as an enhancement of previous reflective summary approaches, which focus on motivation only. The first clinical session, "the Life Movie," is an MET session.

The following describes the PRS process:

- Following the intake process and after the assessment meeting with the patient, the clinician should be aware of the following:
- A working hypothesis on the focus of treatment and that those services can be provided in this setting. The focus of treatment can include the primary areas of concern and examine the domains listed above, including severity (which includes history, benefits of use, problems caused by use, and reasons for considering change) and current motivation to change
- Client readiness (reasons for change)

- Client priorities for treatment
- Use of medications (if any) and medication adherence
- Resources for social support
- Additional life domains (e.g., passions or strengths, including hobbies or interests, spirituality, and employment)
- The clinician delivers "Clinical Session 1: The Life Movie" with the goals of better understanding the person's life and building a working collaboration to support the client on their path toward wellness. The session helps build a bridge from the intake assessment to the integrated motivational interviewing and cognitive behavioral therapy (ICBT) sessions by helping to clarify client priorities and to better understand the internal and external context for patient issues. Sessions 1 and 2 describe details.
- In Sessions 1 and 2, the clinician uses MI/MET reflective discussions and applies functional analysis strategies to help identify and plan treatment sessions (Carroll, 1998; Leahy, 1996; Longabaugh et al., 2005; Agostinelli et al., 1995; Davis et al., 2003; Juarez et al., 2006). This strategy helps patients and clinicians identify issues within a broader contextual framework and set treatment priorities that will help patients engage in specific treatment sessions that address those needs. Session 2 further details this process.

For the important Session 2, the primary objective is to identify functional relationships between patient intrapersonal and interpersonal processes that are linked and that can trigger substance use or emotional disruptions, traumatic responses, or other mental illness symptoms. Too often, such "functional analysis conversations" have occurred in a somewhat mechanistic fashion. Clinicians are encouraged to use a more dynamic approach that emphasizes rapport between the clinician and patient, stronger collaboration, and increasing awareness of the pros and cons of behaviors. The discussion can begin to shift toward a more specific identification of the patterns of behavior. Importantly, this process also facilitates a clearer understanding and builds personal awareness, a core CBT goal.

Functional analysis is a core skill and strategy for patient awareness raising. This awareness raising is the building block for nearly all behavioral therapies and helps the patient create the space between stimulus and response, where the patient has the opportunity to make a conscious decision.

Figures 4 and 5 illustrate personalized reflective discussions with the two interrelated processes.

The types of dialogue the two figures illustrate help build patient self-awareness and facilitate readiness for change. This allows the patient to focus on what needs to be done as preparation for

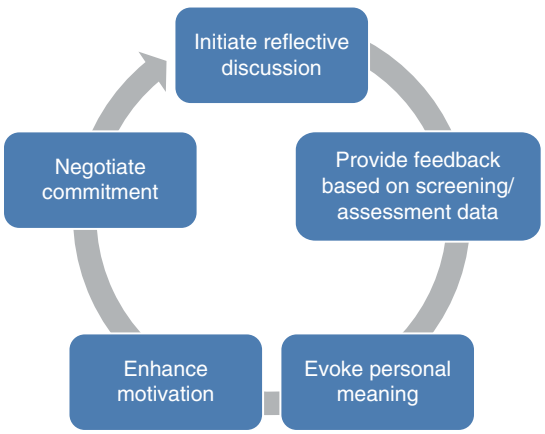

Figure 4 Personalized Reflective Discussions, Phase 1, Enhancing Motivation and Commitment to Treatment

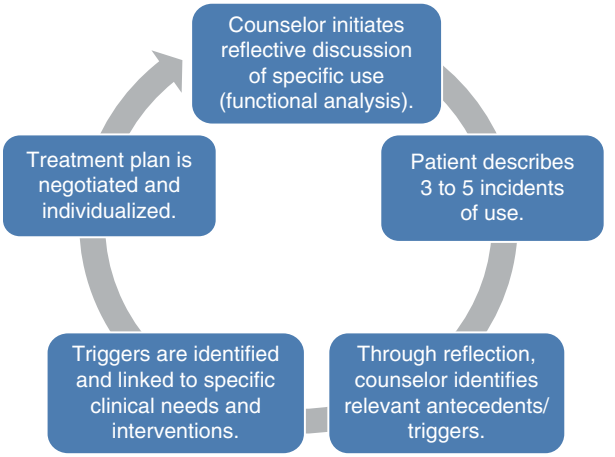

Figure 5 Phase 2, Using Functional Analysis to Raise Awareness, Identify Treatment Priorities, and Individualize Treatment

that change. The discussion following routine engagement conversations focuses on having the patient describe three to five previous incidents when they used substances or another target behavior of concern. The clinician elicits the antecedents, patient's internal experience, interpersonal or situational factors, perceived benefits, and consequences of the behavior.

Through this dynamic conversation, the clinician listens for and reflects on what the patient identifies as skills deficits and other needs that may be addressed within the treatment process. Following this discussion, the clinician summarizes the identified needs and seeks concurrence from the patient to address them within the proceeding treatment sessions. Through this process, every treatment experience is individualized and tailored to the unique needs of the person seeking services. The clinician gains insight into which specific skills-oriented and/or recovery-support sessions to cover in treatment.

Clinicians are encouraged to use the sample forms provided with the session descriptions in Chapter 2 or to develop their own format based on their particular style or the information collected at their clinics. Creating and sharing the PRS gives a focus to critical information in the screening and assessment process.

As a patient expresses increasing interest in modifying behaviors, the clinician carefully supports the efforts to change without directly prescribing the change. When the patient expresses a commitment to change, the clinician asks the patient about the steps that they will take to make the change. The clinician may provide a menu of self-change and clinician-assisted change options, depending on the patient's interests and experience in making personal changes. Self-change advice may be in the form of a brief handout about behavioral changes. The clinician-assisted change takes place through the agreed-upon treatment sessions.

Cognitive Behavioral Therapy

Models of CBT are the most extensively evaluated interventions for the treatment of both mental health conditions, including depression, anxiety, and trauma; alcohol/substance use disorders and CODs; and certain health conditions (e.g., chronic pain). Multiple meta-analyses (Magill & Ray, 2009) have demonstrated efficacy in the treatment of mental and substance use disorders. CBT originally was primarily based on the works of Marlatt and Gordon (1985) and Beck. From

these foundational works have grown models for relapse prevention for SUDs and newer applications (e.g., mindfulness-based CBT, dialectical and behavioral therapy, acceptance, and commitment therapy) addressing a range of behavioral health conditions and substance use. These interventions target cognitive, behavioral, affective, and situational triggers for substance use, mood disorders, and anxiety and provide clearly defined skills trainings in support of abstinence and recovery. CBT manuals have been developed since 1985 and adapted for use in a variety of clinical settings, with CBT interventions tested to examine their cost-effectiveness and utility in real-world settings (Carroll, 1996; Marlatt & Gordon, 1985).

All people develop habits to address life's complexities more efficiently and effectively. CBT clinicians view some mental health coping strategies, in part, as negative and repeated habits (often unconscious) reinforced by the neuropsychological effects of the behaviors. The role of the clinician is to elevate the seemingly repeated, ineffective, and unhealthy coping strategies (e.g., behaviors such as self-harm, avoidance, negative looping thoughts, and/or substance-linked habits) into conscious awareness. Awareness is created through a functional analysis discussion that reviews the relationships between the negative coping reactions (e.g., substance use, avoidant, and mood-dependent behavior) and internal and external factors.

The clinician's integration and proficient use of MI skills to create a therapeutic alliance is a critical element in utilizing CBT, especially the Life Movie and functional analysis, to realize and change negative habitual patterns (e.g., substance misuse, avoidance, and mood-dependent behaviors). Providing the therapeutic environment for honest dialogue more readily brings the triggers, feelings, thoughts, and underlying belief systems that help drive repeated patterns into conscious awareness. The clinician must be adept at using MI to promote readiness and to evoke awareness and equally adept at teaching and coaching to help patients develop new skills.

Previous writings on CBT (Monti et al., 2002) have described the value of skills training in the treatment of substance use and mental disorders. Determining the targeted skills to be addressed requires some form of assessment (functional analysis is sometimes defined as situational and personal awareness, situational awareness, the ABCs of CBT, etc.). For each issue defined as a priority, the clinician works in partnership with the patient to assess readiness to address the issue, identify mastering the necessary skills as priorities, and develop reasonable expectations about intended outcomes.

Skills deficits are significant factors to be addressed, as these challenges often lead to or perpetuate the use of maladaptive coping strategies. To the extent the individual does not develop more healthy coping skills, the risk for recurrence remains high if the deficits are not addressed. Similarly, certain kinds of skills deficits are associated with anxiety and depression (addressed in ICBT sessions). Managing these affective states is important in recovery and to the overall patient well-being.

This treatment guide organizes sessions into three broad and interrelated categories: intrapersonal skills training, interpersonal skills training, and recovery support. These categories are based on the most common factors supporting recovery:

- Situational awareness
- Managing uncomfortable feeling states
- Stronger communication skills (e.g., assertiveness)
- Healthy committed relationships
- Healthy replacement activities
- Guilt-free intimacy
- Engagement with a spiritual community/connection to something greater than the self

Skills training also addresses causes of relapse (e.g., interpersonal and intrapersonal challenges that result in negative emotional states), leading to a recurrence of the problem behavior (substance misuse) and/or other associated problems (Marlatt, 1996).

Why Focus on Skills?

Motivation Leads to Skills Development

Once the individual commits to changing their behavior, treatment focuses on building and/or strengthening skills for recovery from negative mental health symptoms and/or becoming and remaining abstinent from substance use. The patient's motivation and commitment may vary, so the use of MI techniques and MET strategies remains integral to treatment. The clinician begins by reexploring the patient's commitment to change and by using motivational strategies (e.g., identifying discrepancies, increasing change talk, and exploring values) when the patient's motivation wavers. In these sessions, the clinician and patient work on developing specific skills (e.g., assertive communication and coping with cravings or distress). This approach is usually slower and somewhat less structured than typical CBT approaches, but many individuals find this emphasis on collaboration and internal motivation helpful.

What Is a Skills-building Approach?

The treatment skills-building approach is founded on the CBT social learning model, which focuses on learning interpersonal and self-management skills (Center for Substance Abuse Treatment [CSAT], 1999). The emphasis is on skill building rather than a deficit-oriented counseling approach. Negative coping behaviors or thought patterns (e.g., SUD or depression) is considered a learned behavior that developed in response to external (e.g., environmental and relational) and internal (e.g., beliefs, feelings, thoughts, and neurobiology) conditions. The skills-building treatment model suggests that habitual negative responses (e.g., addictive behavior) have become a favored strategy because of repeated associations with predictable outcomes. For example, someone cuts themselves; avoids others; or uses substances when feeling sad, angry, lonely, or upset. The person feels less bad when cutting, alone, or using and associates the coping strategy with feeling better (at least in the short term). Over time, they select these immediately relieving strategies more and more often as the quickest way to escape negative feelings or thoughts.

A skills-building approach also can help in coping with depression, anxiety, and trauma, as well as in improving other mental illness symptoms (co-occurring or not).

Skill-building approaches view addictive behaviors, negative moods, or self-limiting coping strategies as learned and not the result of character defects. Because these behaviors are seen as learned, the patient can learn new and healthier behaviors that replace self-limiting behaviors. Change occurs through learning and practicing new skills and enhancing the patient's capabilities and self-efficacy. They develop skills to identify and cope with high-risk internal states and external situations that increase the likelihood of a recurrence. The clinician assigns the patient in-home challenges to practice the new skills and elicits patient commitment to when, where, and how they will practice the skills in the upcoming week. The patient's participation and the clinician's positive feedback enhance patient confidence in managing situations and create long-lasting behavior change. This perspective of substance use or depression as learned is therapeutic because it:

- Reduces blame and criticism
- Fosters hope and optimism
- Identifies development and improvement processes

This treatment approach differs from less structured "talking" models of treatment because it:

- Addresses interpretations of events as important cues for compulsive behavior
- Provides structure (i.e., every week, the clinician devotes a specific amount of time at a specific time in the session to a particular activity)

- Incorporates experiential strategies
- Informs and teaches but is still collaborative

With the use of the MI and CBT approach, the clinician selects skills sessions from a menu of possible choices, based on information that emerged during the earlier motivation enhancement sessions and functional analysis. The sequence of the sessions corresponds to those in many researched, combined MET and CBT intervention manuals (Moyers & Huck, 2011). The purpose of the sequence of sessions is to immediately offer patients methods for increasing awareness and developing coping strategies.

For example, one patient may describe struggling with depression or other difficult emotions and might benefit from sessions that focus on thoughts and emotions. Another patient may present with a history of difficulty expressing thoughts and feelings constructively and might be helped by assertiveness skills. Mindfulness and meditation may be helpful for the large majority of patients who are referred for treatment, as these strategies have broad applications for treating difficulties with mood, substances, and anxiety.

Intrapersonal Skills Training

Intrapersonal skills training begins with building personal awareness (mindfulness), identifying and managing thoughts and urges to use substances, managing powerful emotions (e.g., fear or anger), and addressing negative and self-defeating thoughts (e.g., those associated with depression, low sense of self-efficacy, catastrophic expectations, and feelings of helplessness and hopelessness). On the positive and strengths-based side of treatment, skills training helps patients learn how to become or remain calmer, problem solve, internally assess thoughts and feelings, and successfully manage and navigate what can be powerful and uncomfortable emotional states. Skills that have proven effective include relaxation training, mindfulness, skills for the positive use of unstructured time, mastering healthy physical and mental activities, decision-making, and planning for the unexpected.

Interpersonal Skills Training

Interpersonal skills target the management of situations where other people are an important factor or are actually part of the problem. Developing assertiveness skills in social situations is important for patients experiencing substance misuse because most will be confronted with the opportunity to use substances and faced with a choice. For people experiencing anxiety and depression, learning how to assert oneself convincingly and in a manner that works for the patient in their world and context is an important skill to develop.

Developing appropriate boundary management and assertiveness skills is important in multiple domains of a person's life. Failing to develop these skills often leads a person to feel unsafe, imposed upon, and resentful and can serve as a trigger for trauma, anxiety, depression, and/or substance use. Addressing potentially contentious situations is important. It is challenging to be the recipient or the bearer of criticism; both can provoke feelings of frustration or anger.

Building and strengthening intimate relationships is essential for most people's happiness. Many patients have trouble expressing their feelings, communicating their thoughts, and being sensitive to the thoughts and feelings of others, especially when there has been considerable conflict or trauma in the past. Skills sessions can help patients learn how to self-disclose appropriately, share both positive and negative feelings in appropriate ways, and develop listening skills to become better partners in relationships.

Too often, intimate relationships become problem saturated and problem focused. Strengthening intimate relationships can include learning how to make the best use of positive and restorative time for a couple or within a family. In one effective model for couples therapy (O'Farrell & Fals-Stewart, 2006), an initial task is given to plan and have an enjoyable time with each other in the coming week.

Enhancing Social Support

Adequate social support is fundamental for most people. When individuals have struggled with depression, trauma, social anxiety, and/or substance use, they can perceive their social networks as threats to continued safety and sobriety. Nurturing a vibrant social support system helps manage stress and reduce isolation and loneliness.

Treating Co-occurring Disorders

Large-scale, population-based epidemiological surveys have shown that people with a mental illness are more likely to have an SUD and that the more incapacitating disorders have a higher incidence of substance use problems. Lifetime prevalence rates of 25–30% of patients with depression or anxiety have co-occurring SUDs (Miller & Carroll, 2006). People with primary SUDs have similarly high incidents of co-occurring mental disorders (37% of adults with an alcohol use disorder [AUD] and 53% with a drug use disorder) (Regier et al., 1990).

The incidence rates of post-traumatic stress disorder in the US health care systems have increased in part because of the number of veterans returning home after serving in recent wars. Prevalence varies by a population's traumatic exposure but is estimated to be 12–14% among troops returning from Afghanistan and Iraq and 7% of all patients in routine primary care.

All clinicians in behavioral health care need to maintain a high sensitivity for trauma, traumatic stress, symptoms of depression or anxiety, or other signs of psychological distress, alcohol or substance use, or excessive health care utilization (Lecrubier, 2004). The continuing COVID pandemic increased depression, anxiety, and traumatic stress. Alcohol misuse and suicidality have also increased significantly. Further, people who are impacted by disparities are affected profoundly. The Kaiser Family Foundation's analysis of the US Census Bureau's Household Pulse Survey (Kaiser Family Foundation [KFF], n.d.) documented 35% of adults experiencing anxiety symptoms, 28% depressive symptoms, and 11% suicidal ideation. As reported in the *Journal of the American Medical Association*, there has been a significant increase in alcohol use and a 54% increase in US alcohol sales during the pandemic.

This MI/MET and CBT model helps to reduce the gap in care by providing a flexible and structured treatment protocol that integrates two effective clinical interventions (MET and CBT) and medications when appropriate. The session activities are common to many evidence-based interventions for substance use, mental, and co-occurring disorders. MI/MET and CBT employ a model for care that is staged and recovery based and uses MI and skill building. Clinicians can address the disorders and their symptoms in stages, while delivering the chosen session activities. The session activities known to be effective across common mental health conditions (i.e., depression, anxiety, and traumatic stress) and SUDs are the following:

- Reflective assessment discussions
- Motivational enhancement strategies
- Self-awareness (situational and mood)
- Monitoring (functional analysis)
- Cognitive restructuring
- Relaxation training
- Problem solving
- Communication skills
- Social support skills
- Increasing pleasant/mastery activities
- Relapse prevention

We have laid out the sequence of the sessions in this guide based on the session activities listed above and on our own clinical experience. However, this sequence should be modified based on your patient's needs. For example, if your patient has a high level of anxiety or a significant trauma history, we suggest that you sequence the clinical process differently in the beginning. The next section of the manual describes this approach.

Table 1 illustrates the functionality of the model addressing mental, substance use, and/or co-occurring disorders.

Table 1 Clinical Interventions Addressing Substance Use and Mental Disorders

Treatment Sessions	Substance Use	Depression and Anxiety	Traumatic Stress
Session 1 Eliciting the Life Movie	**P**	**P**	**P**
Session 2 Enhancing Situational Awareness	**P**	**P**	**P**
Session 3 Learning Assertiveness	**P**	**P**	**P**
Session 4 Supporting Recovery Through Enhanced Social Supports	**P**	**P**	**P**
Session 5 Supporting Recovery Through Healthy Replacement Activities	**P**	**P**	**P**
Session 6 Problem Solving	**P**	**P**	**P**
Session 7 Handling Urges, Cravings, and Discomforts	**P**	**P**	**P**
Session 8 Working with Thoughts	**P**	**P**	**P**
Session 9 Working with Emotions	**P**	**P**	**P**
Session 10 Making Important Life Decisions	**P**	**P**	**P**
Session 11 Enhancing Self-awareness	**P**	**P**	**P**
Session 12 Using Mindfulness, Meditation, and Stepping Back	**P**	**P**	**P**
Session 13 Addressing Suicidality	**P**	**P**	**P**
Session 14 Using Medication in Support of Treatment and Recovery	**P**	**P**	**P**
Session 15 Engaging with Self-help	**P**	**P**	
Session 16 Using the MET/CBT Approach for Traumatic Stress and Substance Use	**P**	**P**	**P**

Recovery Supports

While many recognized recovery support services have emerged over the past 20 years—driven substantially by an appreciation of recovery-oriented systems of care principles—this guide addresses only two widely used recovery supports: the use of medications and self-help. The reason for this choice is that firm evidence supports the benefits of medications as a method of recovery support (Kelly & Yeterian, 2011), and not all recovery support services are available and accessible in all communities. However, nearly every community in the United States and elsewhere is home to 12-step, self-help meetings.

Session 14 addresses decision-making related to the use of medications in the treatment of substance use and other disorders. Session 15 includes information about Alcoholics Anonymous and Narcotics Anonymous. The placement of these sessions after the skills training sessions is not intended to reflect when and how a clinician would use this information; the handouts and discussion tips may be used to inform patients about these essential recovery tools during any phase of treatment. In fact, depending on patient needs, it could be beneficial to introduce both substance use disorder medications and self-help strategies early in ICBT treatment.

Patient Activation Within the Context of ICBT

This model offers clinicians a structured and systematic approach to support the transfer of learning and patient empowerment. This is done by enhancing the patient's motivation to engage in the therapy process and working to maintain a high level of engagement with in- and out-of-session therapeutic activities. The goal of patient activation in ICBT is to systematically support and guide the patient to increase purposeful action such that the patient experiences opportunities to manage and solve life problems with newly acquired skills and to increase self-efficacy in their ability to do so. While meaningful work can be done during the session, patients learn to become more effective in their lives by applying what is learned to real-life situations. Patient activation focuses on supporting the patient to plan and take action outside the clinical session to address problematic thoughts, feelings, and behaviors that inhibit purposeful action and self-efficacy, replacing them with healthy internal and external coping skills. Evidence shows that the more actively engaged the patient is in doing planned and purposeful actions outside the clinical encounter, the greater the likelihood of their long-term success in recovery.

On Spirituality

Spirituality is more commonly referenced today in clinical literature than in the past (Hayes et al., 2012; Miller, 2003). It is important to define the term and to place spirituality and its relationship to the treatment of behavioral health conditions within a theoretical change framework.

We conceptualize spirituality not as an attribute that human beings possess but rather as activities we do. Spirituality emerges from our actions, which are informed by self-knowledge and activated skills. From our perspective, spirituality is an action verb, not a noun or adjective. To quote Erich Fromm (2007), "We are what we do." We define spirituality as mindful awareness of, and participation in, the process of choosing based on our core values. Spirituality means taking actions (risks) based on our values, being fully present in this moment, relating intentionally to others, and recognizing we are all works in progress.