

Common Mistakes Encountered in Skills Training

Balance

The structure of CBT sessions (and the 20/20/20 rule) is intended to integrate skills training with effective, supportive therapy that meets the needs of each patient as an individual. Novice therapists, particularly those with little experience in treating substance abusers or unaccustomed to a high level of structure in treatment, often let sessions become unfocused, without clear goals, and do not make the transitions needed to deliver skills training effectively. Such therapists often wait to introduce skills training until the last few minutes of the session. This results in rushing through important points, failing to use patient examples or get patient feedback, and neglecting review of the practice exercise—all of which gives the impression that skills training is not very important.

Other therapists allow themselves to become overwhelmed by the constant substance abuse-related crises presented by a patient and fail to focus on skills training or use it as an effective strategy to help the patient learn to avoid or manage crises. Falling into a crisis-driven approach tends to increase, rather than decrease, patient anxiety and to undermine self-efficacy. On the other hand, maintaining a relatively consistent session routine and balancing the patient-driven discussion of current concerns with a focus on skills and strategies is also a means by which the therapist can model effective coping and problem-solving.

Conversely, some therapists become overly fixed and inflexible in their application of skills training and adherence to the manual. Anxious to get it right, they present the material in the manual more or less verbatim and fail to adapt it to the specific needs, coping style, and readiness of the particular patient.

For example, even though skills training requires considerable activity and commitment from the patient, some therapists launch into it with patients who are still highly ambivalent or even resistant to treatment. It is important to remind such therapists that the manual is not a script but rather is a blueprint or set of guidelines that provides a clear set of goals and overall structure for the treatment. This often requires considerable familiarity with the didactic material so that therapists can alter the material for each patient and present it in a way that sounds fresh and dynamic. Patients should never be aware that the therapist is following a manual.

Speeding Through Material

Many of the skills-training concepts, while seemingly straightforward and based on common sense, are quite complex, particularly for patients who have cognitive impairment, dual diagnoses, or low baseline levels of coping skills. A common error made by many therapists is to fail to check back with patients to make sure they understand the material and how it might be applied to their current concerns. When this occurs, it often takes the form of a lecture rather than a dialog between the patient and therapist. Ideally, for each concept presented, therapists should stop and ask patients to provide an example or to describe the idea in their own words.

Overwhelming the Patient

Some therapists try to present to each patient all of the coping strategies in the order given in the manual. For many patients, this is overwhelming. Learning and feeling comfortable with one or two coping strategies is preferable to having only a surface understanding of several strategies. Similarly, if too much material is presented, the time available for practice is limited.

A good general tactic is to start by presenting one of the coping strategies the patient already uses and is familiar with, and then to introduce one or two more that are consistent with the patient's coping style. Furthermore, new coping strategies can be introduced over two sessions.

Unclear Strategies

Therapists should attempt to teach general coping strategies using specific examples. However, some therapists use the coping strategies during the session but do not effectively communicate the basic underlying strategy. For example, they may effectively apply problem solving strategies to patients' problems but fail to make the problem solving steps explicit or assure that patients understand the concepts. It is essential that therapists use examples to teach the general, underlying strategy, but it is equally important that the general strategy be made clear.

No Specific Examples

Just as some therapists do not effectively communicate underlying principles, others fail to make the coping skills material alive by using specific examples, based on material provided by the patient, to illustrate their points. Skillful therapists make the transition from the patient's report of current concerns to the skill-focused section of the session by using specific examples.

"Earlier, you talked about how hard it was to deal with Joe and his continuing to use, and today, I thought we would talk about some ways you might be able to effectively say no to him. How does that sound?"

Again, skills training should be presented as a dialog between the patient and therapist, with the therapist attempting to convey the message, "Here is something I think can help you with what you're struggling with right now."

Downplaying Practice Exercises

Although most patients do their practice exercises, and those who practice outside sessions have better cocaine outcomes, a number of therapists do not sufficiently attend to practice exercises. This takes the form of cursory review of completion of tasks in the beginning of sessions. It also leads to rushing through task assignments at the end of sessions, not being creative in task assignments, and letting practices slide if the patient does not do them. Often,

this reflects a therapist's low expectations about the patient's attempting the exercise (and, often, low expectations about the patient's prognosis).

A review of the assignment provides some structure to the first part of the session and sends the message that outside practice is important. Generally, therapists who expect their patients to practice outside of sessions have patients who do so. Also, therapists and patients are by no means limited to the practice exercises suggested in the manual. In fact, it is preferable for patients to come up with their own extra-session tasks.

Abandoning the Manual with Difficult Patients

Many patients present with a range of complex and severe co-morbid problems. Therapists may become overwhelmed by concurrent problems and drift from use of the manual in an attempt to address all the patient's problems. In such cases, therapists often take a less structured approach rather than the greater structure needed by the patient.

Generally, if the patient is sufficiently stable for outpatient therapy, the treatment described in the manual is adequate, even for fairly disturbed patients. CBT provides short-term therapy that includes the major attributes of an effective initial approach to cocaine abuse.

- A highly structured approach to treatment
- Prioritizing of concurrent problems
- Limited case management
- A primary focus on achieving abstinence

Source: Carroll, K. M. (1998). *A Cognitive-Behavioral Approach: Treating Cocaine Addiction*. (pp. 100–103).