Back to Basics: Fundamental Cognitive Therapy Skills for Keeping Drug-Dependent Individuals in Treatment

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INTRODUCTION

Dr. A is conducting his third cognitive therapy session with Mary, a depressed, cocaine-dependent 34-year-old woman. As she describes a recent relapse, Mary begins to cry. Dr. A says he has no tissues and he makes no effort to find any. Instead he urges her to think carefully: "Now Mary, what goes through your mind right before you use cocaine?" Mary's crying escalates and in the absence of tissues she blows her nose and wipes her tears with the wrapping paper from the sandwich she ate for lunch. Dr. A persists in asking about Mary's drug-related thoughts. She responds to his queries, but does not show up for their next two scheduled sessions. Eventually she drops out of therapy.

Dr. B is meeting with Bob for their second session. Bob, diagnosed with cocaine dependence and narcissistic personality disorder, describes himself as "extraordinarily successful and gifted." As evidence of his brilliance, Bob offers a long list of accomplishments. Bob doubts whether anyone, including Dr. B, can really understand or help him. In this session, Bob graphically describes a sexual encounter. Dr. B interrupts with the question, "What cocaine-related beliefs were you having at this moment?" Bob responds incredulously, "What the hell are you talking about?" Dr. B insists that cognitive therapy will help Bob eliminate the thoughts and beliefs that led to his drug use. Bob responds, "Good luck!" He never returns to see Dr. B.

Dr. C is conducting his first psychotherapy session with Gina, an unmarried 18-year-old woman dependent on alcohol, marijuana, nicotine, and cocaine. Gina explains that she dropped out of school at age 16 to take care of her newborn baby. She admits to using drugs when she is overwhelmed. In this first session, Dr. C spends 35 minutes of a 50-minute session describing cognitive therapy. He gives detailed technical descriptions of schemas, conditional beliefs, cognitive distortions, facilitative beliefs, and instrumental strategies.

Dr. C completes his lecture by asking, "Does this make sense?" Gina replies, "I guess so." Satisfied with this answer, Dr. C finishes his lecture and schedules Gina for their next session. Gina shows up for the following session, but attends only a few more sessions before she eventually drops out of treatment.

For several years, cognitive therapists have been trained to provide treatment to drug-dependent patients. These case examples reflect actual incidents observed during this training process. The authors have witnessed scenarios such as these and realized the extraordinary challenge and importance of retaining drug-dependent patients in treatment. This chapter reviews the literature on premature termination (i.e., dropout). The cognitive model of substance abuse is presented, along with the authors' conceptualization of missed sessions and dropout. And finally, strategies are proposed for retaining drug-dependent individuals in treatment.

THE LITERATURE ON THERAPY DROPOUTS: A BRIEF REVIEW

A substantial literature addresses the problem of dropout from psycho-therapy (Wierzbicki and Pekarik 1993). Dropout has been found to relate to several factors, including quality of the therapeutic alliance (e.g., Mohl et al. 1991; Grimes and Murdock 1989; Strupp et al. 1992; Tryon and Kane 1990) and severity of psychopathology (e.g., Avasthi et al. 1994; Kazdin 1990; Kazdin et al. 1993; MacNair and Corazzini 1994; McCallum et al. 1992; Ravndal and Vaglum 1994; Sterling et al. 1994). Generally, research has revealed inconsistent relationships between demographic variables and dropout (e.g., Beckham 1992; Gilbert et al. 1994; Mosher-Ashley 1994; Sledge et al. 1990). Nonetheless, in a recent meta-analysis of 125 studies, Wierzbicki and Pekarik (1993) found significant relationships between three demographic variables (race, education, income) and dropout.

A number of studies have demonstrated positive relationships between substance abuse and dropout from psychotherapy. In a study of 142 outpatients with various psychiatric diagnoses, Swett and Noones (1989) found that patients with drug or alcohol problems were more likely than other patients to drop out of individual psychotherapy. In a study of 65 depressed adolescents, Gilbert and colleagues (1994) found that those with alcohol and drug histories were more likely to drop out of a 12-week psychotherapy group than those who did not report alcohol or drug use. MacNair and Corazzini (1994) studied 155

university students enrolled in interpersonal therapy groups and found that those with alcohol and drug problems were more likely to drop out than those without such problems.

Recently, investigators (Simpson and Joe 1993; Smith et al. 1995) have begun to examine the relationships between the processes and stages of change (Prochaska et al. 1992) and dropout. Studies have tested the hypothesis that individuals' stages of change relate to their retention in treatment; thus far, only modest support has been found for this hypothesis.

Estimates of dropout from psychotherapy have ranged from approximately 30 percent to 60 percent (Wierzbicki and Pekarik 1993). In their meta-analysis, Wierzbicki and Pekarik found the mean dropout rate of 125 studies to be approximately 47 percent. Dropout from drug and alcohol treatment is common and retention rates are extremely variable. Carroll and associates (1994) reported that only 49/121 (40 percent) of subjects in their study completed treatment for cocaine dependence. In a study of inpatient alcoholics, Carver and Dunham (1991) reported that only 71/141 (50 percent) of subjects completed treatment. Simpson and Joe (1993) studied dropout patterns in methadone maintenance clinics participating in the Drug Abuse Treatment for AIDS-Risks Reduction (DATAR) project funded by the National Institute on Drug Abuse (NIDA). These authors found that 12 percent of methadone maintenance patients terminated within 30 days, 24 percent within 60 days, and 35 percent within 90 days (N = 311). Sterling and colleagues (1994) found that only 43/194 (22 percent) of individuals successfully completed treatment for crack cocaine dependence.

No single variable has uniformly been associated with dropout from drug or alcohol treatment. For example, in one study (McCallum et al. 1992), severity of psychiatric symptoms predicted dropout, while in two other studies (Ravndal and Vaglum 1994; Sterling et al. 1994), no such relationship was found. Similarly, in one study (Carver and Dunham 1991) renewed drinking was predictive of dropout, while in another study (Ravndal and Vaglum 1994), renewed substance use was not predictive of dropout. Two studies (Carroll et al. 1994; Simpson and Joe 1993) reported that being married was positively correlated with completing treatment. No such relationship was reported in the other studies reviewed above.

An interesting finding, relevant to cognitive therapy, was reported in two of the above-mentioned studies. Carver and Dunham (1991) and

Simpson and Joe (1993) found that patients' expectations for success were related to reduced drug use and completion of treatment. Expectations of success involve thoughts and beliefs about the potential effectiveness of treatment. This finding is consistent with the cognitive conceptualizations of substance abuse and dropout described in the following sections.

THE COGNITIVE THERAPY OF SUBSTANCE ABUSE: A BRIEF REVIEW

The authors' basic model of substance abuse (Beck et al. 1993; Liese 1993, 1994*a*, 1994*b*; Liese and Chiauzzi 1995; Liese and Franz, in press; Wright et al. 1992) is presented in figure 1. The model assumes that certain activating stimuli (e.g., anxiety, interpersonal conflicts) trigger basic drug-related beliefs and automatic thoughts about substance use (e.g., "Drinking/smoking relaxes me!"). These beliefs and thoughts, in turn, heighten individuals' urges and cravings to use drugs. But not all urges and cravings lead individuals to drug use. Instead, individuals who have facilitative beliefs about drugs (e.g., "Just one won't hurt me") are likely to use drugs. In the presence of urges, cravings, and facilitative beliefs, many individuals focus on actions that prepare them for continued use and relapse, though some rare individuals are able, at this critical point, to "just say no."

COGNITIVE CONCEPTUALIZATION OF MISSED SESSIONS AND DROPOUT

The model for conceptualizing missed sessions and dropout is presented in figure 2. This model is based on extensive discussions with cognitive therapists and their drug-dependent patients. First, therapists were asked to speculate about their patients' reasons for missing sessions and dropping out. After formulating a tentative model based on therapist responses, patients were asked: "What circumstances and thoughts would

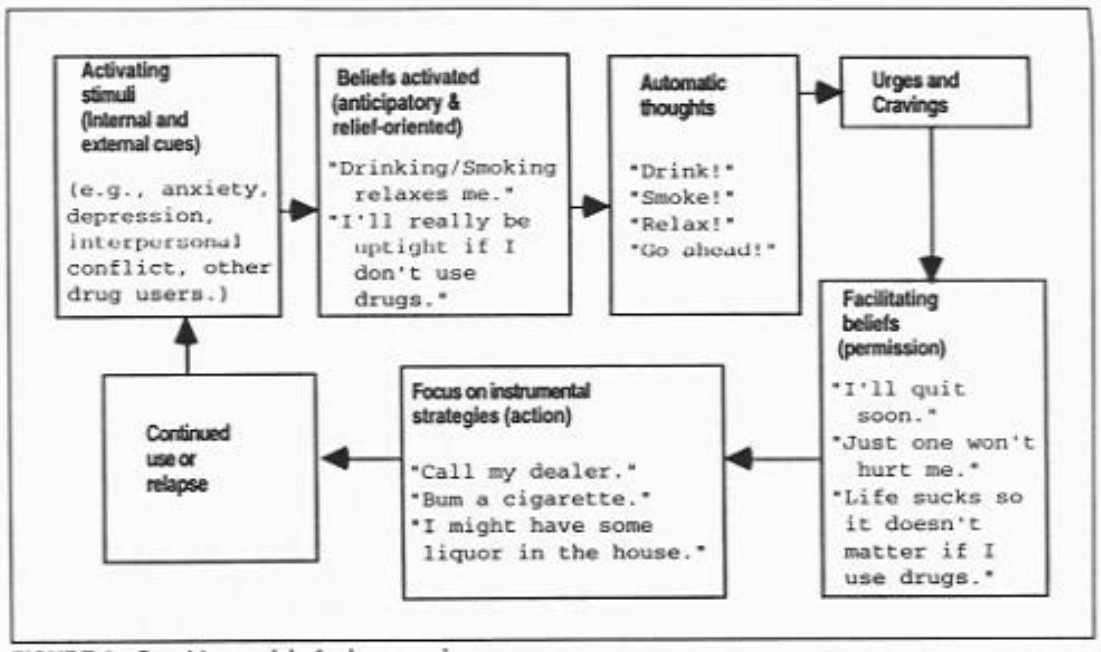

FIGURE 1. *Cognitive model of substance abuse.*

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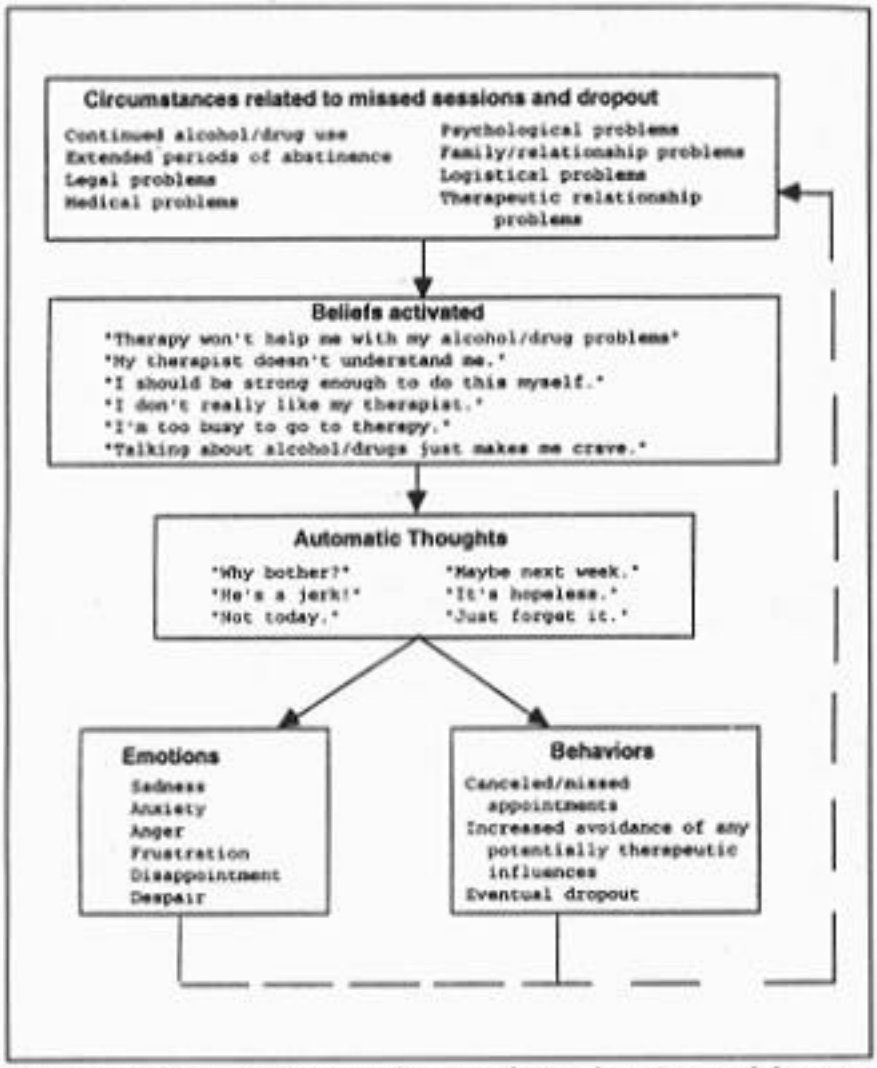

FIGURE 2. *Cognitive conceptualization of missed sessions and dropout.*

lead you to miss sessions or drop out of therapy?" Initially, many patients denied any risk of dropout, exclaiming: "This is my last chance for recovery. I won't drop out!" These individuals would then be ask to respond hypothetically: "Let's assume that you won't miss sessions or drop out. But if it were to happen, what circumstances or thoughts would be involved?" Patients also were asked to reflect on the circumstances and thoughts associated with past missed sessions and dropout. The model presented in figure 2 is based on answers to these queries.

According to the authors' conceptualization of missed sessions and dropout, certain circumstances (e.g., continued alcohol or drug use) place people at high risk for missed therapy sessions and dropout. These circumstances activate certain beliefs about therapy or the therapist (e.g., "Therapy won't help me," or "My therapist doesn't understand me.") that are manifested as automatic thoughts (e.g., "Why bother?" or "What a jerk!"). These beliefs and thoughts lead to emotions and behaviors associated with dropout.

The thoughts, feelings, and behaviors associated with missed sessions and dropout tend to be self-reinforcing (i.e., they function in a cyclic fashion; see figure 2). Certain emotions (e.g., despair, anger, anxiety, guilt) and behaviors (e.g., drug use, missed sessions) function as circumstances that increase the likelihood of future missed appointments and dropout. Beckham (1992), for example, found that missed sessions early in therapy were highly predictive of later dropout. In the typical course of outpatient treatment for drug dependence, individuals may become skeptical, believing that "treatment isn't working" (especially in response to strong urges, craving, or lapses). This belief may lead to missed sessions. Missed sessions may lead to increased emotions of apathy, discouragement, or guilt. These emotions may lead to additional missed sessions until eventually this vicious cycle ends in dropout. In the following paragraphs the authors' conceptualization of missed sessions and dropout is described in more detail, including the associated circumstances, beliefs, automatic thoughts, emotions, and behaviors associated with missing sessions and dropping out.

Circumstances Related to Missed Sessions and Dropout

Many circumstances potentially relate to missed sessions and dropout. These circumstances include (but are not limited to) continued alcohol or drug use, extended periods of abstinence, legal problems, medical problems, psychological problems, family/relationship problems, logistical problems, and therapeutic relationship problems. It is

important to note that these circumstances do not necessarily result in missed sessions or dropout. Instead, they may activate beliefs or thoughts that in turn result in missed sessions and dropout. Some individuals drop out of therapy when they have lapses or relapse, while others continue to attend therapy sessions when they are using drugs or alcohol. Some individuals drop out of treatment when they have legal, psychological, medical, or relationship problems, while others drop out of treatment when they resolve these problems (especially if they have entered treatment to avoid the negative consequences of using, such as loss of children).

Continued Alcohol or Drug Use. Unfortunately, relapse is prevalent among individuals attempting to abstain from alcohol and drugs (Hunt et al. 1971; Marlatt and Gordon 1985, 1989). Lapses and relapses may trigger distress, discouragement, helplessness, and hopelessness in patients that, in turn, may lead to dropout. In addition to distress, continued drug use may result in other problems in patients' lives, which may further contribute to missed sessions and dropout. For example, drug use can cause legal problems, medical problems, psychological problems, family problems, logistical problems, and problems in the therapeutic alliance. These circumstances (listed in figure 2) are all discussed in this section.

Extended Periods of Abstinence. Just as there are individuals who have slips, lapses, and relapses, there are others who succeed at being abstinent from drugs and alcohol. These individuals, despite their abstinence, are likely to have residual skill deficits. For example, they may lack effective communication skills or mood-management strategies that facilitate abstinence. If these individuals do not perceive therapy as offering relevant skill development, or if they perceive themselves as not needing to develop skills, they are likely to miss sessions and drop out of treatment.

Abstinent individuals with substantial family or personal responsibilities are at even higher risk for dropout. For example, consider Gina, the young mother described above. At present Gina is struggling to manage multiple life demands. She is likely to view time, rather than therapy, as being her most precious resource. While abstaining from drugs and alcohol, she is likely to view addiction treatment as taking time away from her baby rather than being beneficial to her continued abstinence.

Legal Problems. Drug-dependent individuals are at heightened risk for legal problems. Many psychoactive drugs (e.g., cocaine, heroin,

hallucinogens) are illegal; the purchase, sale, and possession of these drugs constitutes a punishable crime. Likewise, the use of legal drugs, like alcohol, may also be associated with illegal behaviors (such as driving under the influence). Psychoactive drugs are also expensive and some individuals resort to illegal activities (e.g., robbery, theft, prostitution) to acquire them. Even nicotine dependence can lead to shoplifting if the smoker does not have the financial means to purchase cigarettes. Chronic drug use may also lead to significant impairment in judgment, resulting in uncharacteristic illegal behaviors.

While many drug-dependent individuals do not engage in illegal activities themselves, they may associate with others who do. Mary (described above), for example, has never engaged in significant illegal behaviors. However, when she is actively using cocaine she is drawn to one particularly violent, aggressive, antisocial, drug dependent man who deals drugs.

As drug-dependent individuals become increasingly involved in illegal activities, they are at heightened risk for dropout for several reasons. First, they may be ashamed of their behaviors. Second, they may be afraid of the potential legal consequences of discussing their behaviors with others (e.g., therapists). And third, they may be incarcerated for their illegal behaviors, making treatment inaccessible. It is important to acknowledge that some individuals are mandated to enter treatment as a result of their legal problems. These individuals are particularly prone to drop out when their legal problems are resolved (for example, when criminal charges against them are dismissed).

Medical Problems. It is well known that psychoactive drugs are associated with numerous medical problems. For example, cigarettes are associated with almost half a million deaths per year (from heart disease, pulmonary disease, a variety of cancers, and numerous other medical problems). Alcohol is associated with almost 100,000 deaths per year (from liver disease, gastrointestinal disorders, vascular diseases, malnutrition, and trauma). Cocaine has been linked to heart attacks, strokes, hypertension, and trauma. Marijuana smoking is associated with pulmonary disease, depression, and amotivational syndrome. Medical problems resulting from drug abuse often result in the initiation of drug treatment. However, when individuals become seriously ill or hospitalized they are less likely to continue treatment and more likely to drop out.

Psychological Problems. Just as psychoactive substances lead to medical problems, they may also lead to psychological problems. Many psychoactive drugs act as central nervous system stimulants and

depressants and their chronic abuse may lead to serious psychological problems which may, in turn, lead to missed sessions and dropout.

For example, Mary suffers from recurrent depressive episodes, exacerbated by her cocaine use. One of the most salient symptoms of Mary's depression is hopelessness. Any indications that Mary is "failing" in therapy might activate hopeless thoughts (e.g., "It's useless to attend therapy; I'll never improve."). Hopelessness may eventually lead to complete withdrawal from treatment.

Family/Relationship Problems. It is well known that chronic substance use has a negative impact on families and interpersonal relationships. These problems may lead to missed sessions or dropout. Gina, for example, currently has almost no social or family support. At one time Gina's mother would help her with money and child care so Gina could work and attend therapy. However, Gina's mother decided to stop providing assistance to Gina after discovering that Gina was using her money and free time to use drugs. At the urging of her Al-Anon group, Gina's mother elected to take a tough love stance with Gina by withdrawing all support from her. The inadvertent effect was the escalation of missed sessions and eventual dropout.

Similar to legal and medical problems, family and relationship problems may also result in the initiation of treatment. Many individuals enter treatment to avoid the negative consequences of their drug use (e.g., loss of a marriage or children). These individuals are particularly vulnerable to dropout when they believe that their family problems are resolved.

Logistical Problems. Many drug-dependent individuals are vulnerable to logistical problems, including difficulties with finances, transportation, and child care. It is common for addicted individuals to lose their drivers' licenses, jobs, and even homes as a result of their drug use. At one time, Bob was a financially successful attorney. However, as a result of his drug use he lost his wife, job, savings, car, and home. Like Mary and Gina, Bob did not have enough money to pay the taxi fare to attend treatment. Given his narcissistic personality, he attributed these problems to events outside of himself (e.g., getting "ripped off" by others who were envious of him). He dropped out after concluding that he had "more important things to do than go to therapy."

Therapeutic Relationship Problems. Given the numerous problems encountered by drug-dependent patients, the development and

maintenance of collaborative therapeutic relationships may be difficult. Patients are likely to feel ashamed, depressed, or angry at themselves for their problems. They may fear that therapists will judge them or be upset with them. Therapists may, indeed, have strong negative feelings towards their drug-dependent patients and convey these to patients. When this occurs, therapy becomes aversive and patients are likely to drop out.

Most treatment models strongly encourage, require, or demand that patients be fully abstinent from drugs and alcohol during and after treatment. These models may convey the messages: "If you use drugs or alcohol we can't help you," or "If you use drugs or alcohol you have failed and disappointed us." Such messages may intimidate, discourage, frustrate, and anger drug-dependent individuals, who may drop out of treatment following any drug use. In each of the three case examples described above, therapists viewed drug or alcohol use as catastrophic and intolerable. While they did not overtly express anger or frustration, they conveyed disappointment and disapproval in subtle ways.

Unfortunately, inexperienced cognitive therapists are likely to underestimate the difficulty and importance of developing collaborative relationships with their drug-dependent patients. In response to certain patient behaviors (e.g., missed appointments, relapse, dropout), therapists are likely to experience emotional distress, including feelings of frustration, irritation, anger, boredom, and despair. Therapists' distress, of course, can be attributed to their negative beliefs. Among the therapist beliefs that lead to distress are the following (Liese and Franz, in press):

- This patient is a typical drug addict!
- After detox this patient will just relapse again!
- This patient thinks I'm stupid!
- This feels like a waste of my time!
- All addicts are the same!
- Lapses and relapses are catastrophic!
- Missed sessions are awful/terrible/intolerable!
- This patient doesn't want to change!
- I'm working harder than this patient!

Hence, a vicious cycle may emerge wherein both therapist and patient reinforce each other’s worst fears. When patients sense their therapists' distress they, of course, become vulnerable to dropout.

To illustrate the cyclic nature of missed sessions and dropout, consider the example of Mary, presented earlier. At the beginning of her third session with Dr. A, Mary felt discouraged about her recent drug use. During the session she became visibly distressed. Instead of attending to her despair and responding empathetically, Dr. A focused exclusively on Mary's recent drug use. By the end of the session Mary felt ashamed, confused, and angry at herself for "being so weak." As Mary's fourth session approached she thought, "I never succeed at anything I do, so why bother with therapy? Besides I don't like my therapist." She canceled her fourth and fifth sessions, which heightened her belief that therapy would not help her. Eventually she made another therapy appointment, but in this session Dr. A was very confrontive about Mary's missed sessions and her commitment to therapy. Mary again felt extreme despair. Her corresponding thoughts were, "It's hopeless. I can't quit using drugs. Talking about my problems only makes me feel worse. If I return to therapy I'll only disappoint Dr. A." When it was time to return for her next scheduled appointment, Mary reflected on the last visit and decided, once and for all, "I'm just not getting anything out of therapy." She never again returned for therapy and her drug abuse worsened.

Beliefs Activated

As the model was being developed, the authors began to search for the idiosyncratic beliefs leading to dropout, for example: "Therapy isn't likely to help me," "My therapist doesn't understand me," "I don't want to quit using drugs yet," and "It's uncomfortable to talk about my problems." It was assumed that knowledge of these beliefs would facilitate increased empathy for drug-dependent patients and lead to specific techniques for retaining patients in treatment. With the help of therapists and patients, the search generated hundreds of beliefs associated with missed sessions and dropout. From these, a list of 50 beliefs was distilled (see appendix). In the following paragraphs, the three case examples are used to illustrate these beliefs.

Mary, discussed earlier, began crying in her third therapy session. When the therapist did not offer tissues or act in a conciliatory manner, she probably began to think: "I can't quit using drugs" (item 7); "I'm helpless, so what's the point of trying to quit?" (item 12), and; "I never succeed at anything I set out to do" (item 22). Of course these beliefs, consistent with her depression, put her at high risk for missing future sessions and dropout. Unfortunately, these beliefs also put her at high risk for continued drug use. As Mary continued to use drugs while in therapy, she developed such additional

beliefs as: "I really, really can't quit using drugs" (item 7); "I don't deserve help since I'm still using drugs" (item 25), and; "I'll just get upset if I go to a therapy session" (item 38).

Bob, who was narcissistic, was likely to hold the following beliefs: "My therapist doesn't understand me" (item 11), "I don't really like my therapist" (item 23), and "I have more important things to do than go to therapy" (item 39). As a result of these beliefs, he would feel annoyed at his therapist and see little value in attending sessions.

Gina, an educationally and economically disadvantaged young mother, was likely to react to her therapist's lecture with such beliefs as "I'm not smart enough to benefit from this therapy" (item 8), "I don't like this type of therapy" (item 24), and "I can't make the necessary arrangements so I won't go to therapy" (item 41). Naturally, these beliefs led her to avoid therapy until she eventually dropped out.

Automatic Thoughts

As previously mentioned, automatic thoughts are brief, abbreviated versions of basic beliefs. Automatic thoughts exert powerful effects on emotions and behaviors, yet they often manifest themselves in ways that are undetectable to the person experiencing them. Examples of automatic thoughts leading to missed sessions and dropout include, "Not today," "It's hopeless," and "He's a jerk!" (referring to the therapist).

Emotions and Behaviors Related to Missed Sessions and Dropout

As drug-dependent individuals encounter the above-mentioned circumstances, beliefs, and thoughts, they are likely to experience significant negative emotions (e.g., sadness, anxiety, anger, frustration, disappointment, and despair). Furthermore, they are likely to miss and cancel appointments.

As mentioned previously, these feelings and behaviors are likely to function in a cyclic fashion. That is, they are likely to become the circumstances that further perpetuate beliefs leading to dropout. To illustrate, again consider Gina. When Gina received her 35-minute lecture from Dr. C, she thought "I don't really like my therapist." This thought contributed to several missed sessions. When she missed a session, Dr. C would demonstrate his frustration by lecturing Gina about the importance of attending sessions. Thus, Gina's negative beliefs about her therapist were confirmed and the pattern of missed

sessions escalated. These missed sessions, in turn, led to therapeutic relationship problems, which finally resulted in dropout.

SKILLS FOR KEEPING DRUG-DEPENDENT INDIVIDUALS IN TREATMENT

The final sections of this chapter present fundamental skills for keeping drug-dependent individuals in treatment. These skills correspond with the five components of cognitive therapy described by Liese (1994*b*; Liese and Franz, in press): (1) collaboration, (2) case conceptualization, (3) structure, (4) socialization, and (5) cognitive-behavioral techniques.

Establish and Maintain Collaborative Therapeutic Relationships With Drug-Dependent Patients

Certainly the most important strategy for reducing dropout is to develop and maintain genuine, warm, caring, empathetic relationships with drug- dependent patients. While most experienced therapists possess basic collaboration skills, many seem to forget these skills when working with drug-dependent patients. It is assumed that therapists' distress is a result of their negative beliefs about their effectiveness with drug-dependent individuals (e.g., "It's hopeless; they'll never change" and "My patients' success is a function of my competence"). Many therapists are unaware of their own negative reactions to drug-dependent patients; the process of collaboration can begin only when they acknowledge their negative feelings towards such patients.

It is essential for therapists to recognize that their negative emotions magnify patients' problems and increase their likelihood of dropout. Patients often recognize their therapists' distress and respond by withdrawing from therapists (i.e., by dropping out). Patient dropout further exacerbates therapists' distress. In fact, Magnavita (1994) described dropouts as potentially demoralizing to therapists. Therapists are strongly encouraged to carefully monitor their own thoughts and feelings throughout the treatment process.

The authors of this chapter believe that abstinence is the most appropriate goal for drug- and alcohol-dependent individuals. Nonetheless, cognitive therapists are encouraged to "meet patients where they're at" in their readiness to change. This can be accomplished by helping patients learn important lessons from each

episode of drug use. This attitude is consistent with harm-reduction philosophies advocated by Marlatt and colleagues (Marlatt and Tapert 1993; Marlatt et al. 1993). Simply stated, therapists are encouraged to accept the fact that their addicted patients may occasionally (or even frequently) use drugs. Therapists who attempt to persuade and cajole patients to be abstinent are likely to be ineffective. Drs. A, B, and C all felt an urgency to stop their patients from using drugs. Their patients, recognizing this urgency, felt uncomfortable with these therapists and eventually withdrew from treatment. One might assume that any of these patients would have continued treatment if relationships with their therapists had been better.

Develop an Accurate Case Conceptualization for Each Drug-Dependent Patient, Paying Careful Attention to Factors Associated With Dropout

Cognitive therapists learning to treat drug-dependent patients often underestimate the importance of the case conceptualization. As a result, they fail to anticipate and adequately address dropout. The models of substance abuse and dropout (figures 1 and 2) were reviewed earlier in this chapter because the authors believe they will be helpful in conceptualizing dropout.

For example, with an accurate case conceptualization, Dr. A would have realized that Mary's drug use was linked to her depressed feelings and underlying helpless and hopeless beliefs about herself. Rather than focusing on her most recent binge, which resulted in her heightened despair, Dr. A would have recognized and addressed her despair.

With an accurate case conceptualization, Dr. B would have recognized that Bob's drug use was linked to his frantic (narcissistic) efforts to view himself as powerful and superior to others. Rather than focusing on Bob's maladaptive thoughts about cocaine, Dr. B would have focused on Bob's belief that others do not understand him.

Without an accurate case conceptualization, Dr. C overestimated Gina's interest in, and ability to comprehend, the cognitive model of substance abuse. Rather than lecturing Gina, Dr. C should have explored how overwhelmed she generally feels and how she would manage to attend therapy given the many demands already on her.

The list of beliefs leading to missed sessions and dropout in the appendix is particularly helpful for conceptualizing patients' beliefs

about dropout. Therapists are encouraged to memorize these beliefs and use open-ended questions to elicit beliefs that potentially lead to dropout. For example, therapists are encouraged to ask: "When you don't feel like coming to therapy, what thoughts go through your mind?" and "How do you respond to inevitable thoughts of not continuing therapy?"

Use the Structure of Cognitive Therapy To Anticipate and Address Potential Dropout

Therapists are encouraged to utilize the structure of cognitive therapy to detect and address potential dropout. The structure of a typical session includes: (1) agenda setting, (2) mood check, (3) bridge from the last session, (4) discussion of current agenda items, (5) feedback, and (6) homework. Each step may be used in unique and important ways to reduce the likelihood of dropout, as discussed in the following paragraphs.

Cognitive therapy sessions begin with agenda setting wherein therapists ask, "What would you like to work on today?" In response to this question, patients often respond, "I don't know," or "Whatever you want to work on." Another common response is, "Everything's going great! I can't think of anything to work on." Such responses might reflect problems with motivation or commitment to therapy. Thus, it is important for therapists to seriously address such responses when they occur. The best initial response to the absence of an agenda item is, "That's okay. Just take some time and think about what you'd like to work on." When patients persist in having no agenda items, it might be appropriate to say, "It's interesting that you can't think of anything to work on. What are your current thoughts about being in therapy?" As the patient responds to this question, it is particularly important to be attentive to beliefs potentially associated with dropout.

The mood check is the next step in a typical cognitive therapy session. Since mood disturbances reflect negative feelings and beliefs, the mood check provides an opportunity to elicit beliefs and feelings related to dropout. Thus, it may be an excellent time to detect skepticism, pessimism, or hopelessness about therapy. In addition to asking, "How is your mood today?" therapists are encouraged to specifically ask, "How do you feel about being here today?"

The bridge provides another excellent opportunity to evaluate potential for dropout. During the bridge the therapist asks the

patient, "What do you remember from our last session?" or "What did we work on in our last session?" It is during the bridge that therapists also ask patients about any drug use, urges, or cravings since the last visit, as well as upcoming situations potentially leading to drug use. Patients' responses to these questions might reveal circumstances potentially leading to dropout. For example, patients who cannot recall any significant benefits from previous visits might not view therapy as beneficial. Patients who have been using drugs since the last visit, of course, might be vulnerable to dropout. Minimization or denial of urges and cravings might reflect patients' fears of being honest with their therapists.

Before discussing agenda items, therapists are encouraged to prioritize these items with patients. While it might seem appropriate to focus exclusively on drug use, neglecting other matters important to the patient might convey the message, "I don't care about you; I only care about stopping you from using drugs." Such messages increase the likelihood of dropout. During the discussion of agenda items, it is essential for therapists to remain focused. Focusing involves listening carefully and remaining attentive to current agenda items until some resolution or closure is achieved. In contrast, some therapists enable patients to drift from topic to topic, leaving both parties feeling unfulfilled. When this occurs, the patient is vulnerable to thinking, "Therapy is not likely to help me," which, of course, may lead to dropout.

Another structural aspect of cognitive therapy is feedback, wherein therapists ask patients to discuss their reactions to therapy. Typical questions for eliciting feedback are, "What are your thoughts and beliefs about therapy?" and "What are you getting out of therapy?" By regularly asking for feedback, therapists may directly assess patients' potential for dropout. The list of beliefs in the appendix is likely to be helpful in this process. Each item can be reworded as a question, for example:

"How do you think therapy will help you with your alcohol/drug problems?" (item 1)
"How do you feel about my monitoring your drug use?" (item 3)

"Since you still have strong urges and cravings, how do you think therapy is helping you?" (item 9)

"Since you've been abstinent for 6 months, what's motivating you to continue therapy?" (item 21)

After asking these questions, it is important for therapists to listen carefully to patients' responses. Specifically, if patients' answers are vague or negative, it is essential to ask for elaboration. In the case of Gina, Dr. C asked whether she understood his lecture. When she answered "I guess so," he failed to recognize the tentativeness of her response. If he had responded to her skepticism, he might have anticipated and addressed the beliefs leading to her eventual dropout.

The final component of cognitive therapy sessions is homework. Homework, in many ways, is a direct measure of individuals' readiness to make changes in their lives. Both the assigning and reviewing of homework may facilitate retention in treatment. For example, by assigning appropriate homework consistent with patients' readiness to change, patients are likely to remain engaged in the treatment process and be less likely to drop out. In contrast, if homework assigned is inappropriate (e.g., too difficult or irrelevant to the patient's main problems), the patient will begin to develop beliefs leading to dropout. In reviewing homework, the therapist can infer, to some degree, patients' commitment to the treatment process. For example, patients who do not do homework might be conveying (indirectly) thoughts of helplessness or hopelessness. It is important to address these matters.

Socialize Patients in a Timely, Effective Manner

Socialization is an important and popular feature of cognitive therapy. Socialization is synonymous with the term "education," and it involves teaching patients to better understand themselves and their drug use. Socializing may occur in several different content domains. For example, therapists may teach patients about the cognitive model of substance abuse, about cognitive distortions, or about the medical consequences of drug abuse. Two ingredients of socialization appear to render it more or less effective: appropriateness and timing of the information presented.

Appropriateness is defined as the degree to which the information presented is relevant to the patient's interests and needs. Timing is defined as the delivery of the information at the appropriate moment. Appropriateness and timing require that the therapist listen carefully and empathetically to the patient. The effective delivery of information requires an accurate case conceptualization, including an understanding of the patient's readiness to acknowledge problems and make changes.

Two examples of inappropriate, poorly timed socialization attempts are apparent in the examples of Drs. B and C with Bob and Gina. Neither patient was particularly interested in their therapists' lectures, and neither seemed ready to integrate the information provided by their therapists. At times therapists believe that their patients need or want information. However, to test this assumption, therapists are encouraged to first ask questions to evaluate their patients' interests and knowledge levels. For example, rather than telling Bob how therapy works (i.e., by "eliminating thoughts and beliefs that lead to drug use"), Dr. B might have asked him, "Have you ever wondered how you could give up cocaine when you enjoy it so much?"

Use Cognitive and Behavioral Techniques Appropriately and Sparingly, and Base the Selection of Techniques on Accurate Case Conceptualizations

When cognitive therapy was originally introduced as a treatment for the acute psychiatric problems of depression and anxiety, emphasis was on structure, socialization, and techniques. This emphasis was appropriate for patients with these acute disorders. However, the simplicity and effectiveness of cognitive and behavioral techniques with these disorders led to their overemphasis and overuse. In response, Beck (1991) stated: "One of the misconceptions of cognitive therapy is the notion that it can be defined simply in terms of a set of cognitive techniques" (p. 195).

There are many potential techniques in the cognitive therapy of substance abuse. For example, the advantages-disadvantages analysis is useful for evaluating the negative and positive consequences of patients' drug use. The daily thought record is useful for helping patients examine and evaluate their beliefs leading to drug use. And cue cards provide reminders of reasons for abstaining from drugs and alcohol. (For detailed discussions of these and other techniques, see Beck et al. 1993.)

For cognitive-behavioral interventions to be effective, they must be timed well and they must be delivered appropriately. When either of these criteria is unmet, the likelihood of dropout is increased. Poor timing is characterized by delivery of a technique at the wrong time, while poor delivery is defined as the ineffective execution of a technique.

Similar to the process of socialization discussed earlier, there are appropriate and inappropriate times to deliver techniques. In the examples above, Drs. A, B, and C all delivered interventions at inappropriate times. Mary, Bob, and Gina were all ill-prepared for their therapists to tell them how to fix their problems. Instead, each patient probably would have responded best to empathy, support, validation, and encouragement. Regarding the delivery of cognitive-behavioral techniques, some styles are more collaborative than others. Debating and lecturing, for example, tend to be less effective than guided discovery (i.e., therapist-guided exploration of problems and solutions).

SUMMARY

Cognitive therapists who treat drug-dependent patients are likely to lose at least 50 percent of their patients to dropout. This chapter has presented a cognitive model for conceptualizing missed sessions and dropout, along with strategies for reducing the likelihood of missed sessions and dropout. The following should serve to highlight these strategies.

1. Therapists are encouraged to offer warm, empathetic, collaborative relationships in which drug-dependent patients can feel accepted, understood, and validated.

2. Therapists are encouraged to develop comprehensive, accurate case conceptualizations, with attention paid to the potential for missed sessions and dropout. Case conceptualizations should ultimately guide cognitive and behavioral techniques.

3. Therapists are encouraged to structure sessions and elicit feedback regarding their patient's thoughts and beliefs about therapy and the therapist. This feedback is facilitated by such questions as, "What do you like most about therapy?" "What do you like least?" "What has changed in your life as a result of therapy?" "How do you view our relationship?"

4. Therapists are encouraged to socialize patients in a timely, appropriate manner.

5. Similar to the process of socialization, therapists are encouraged to use cognitive and behavioral techniques in a timely, appropriate manner.

It is unrealistic to think that the problems of missed sessions and dropout from drug treatment will ever be fully resolved. Nonetheless, the authors believe that the conceptual models and fundamental strategies presented in this chapter represent a significant step in addressing these problems.

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APPENDIX: Beliefs leading to missed sessions and dropout.

1. "Therapy won't help me with my alcohol/drug problems."
2. "My therapist can't help me because he or she has never been addicted."
3. "I don't want some therapist breathing down my neck."
4. "Talking about alcohol/drugs just makes me want to use more."
5. "I'm better off just trying to forget my alcohol/drug problem."
6. "If I continue therapy I'll just disappoint the therapist."
7. "I can't quit using alcohol/drugs."
8. "I'm not smart enough to benefit from this therapy."
9. "I keep getting urges and cravings so therapy isn't helping me."
10. "Alcohol/drugs are a big part of my life. I'm not ready to give them up."
11. "My therapist doesn't understand me."
12. "I'm helpless, so what's the point in trying to quit?"
13. "A psychotherapist can't help me."
14. "Psychotherapists are for crazy people."
15. "No one can tell me what to do."
16. "I don't see how talking about my problem can help me."
17. "Alcohol/drugs are my only source of enjoyment and relaxation."
18. "My problem is physical, not mental, so I don't need a psychotherapist."
19. "The therapist is never there when I really need him or her."
20. "I should be strong enough to do this myself."
21. "I haven't used in some time so I don't have a problem anymore."
22. "I never succeed at anything I set out to do."
23. "I don't really like my therapist."
24. "I don't like this type of therapy."
25. "I don't deserve help since I'm still using alcohol/drugs."
26. "Talking about my problems only makes me feel bad about them."
27. "I'm too busy to go to therapy."
28. "I'll just relapse anyway so it's stupid to go to therapy."
29. "I'm not getting anything out of therapy."
30. "I'll never stop using alcohol/drugs."
31. "I'm not going to therapy because I used recently."
32. "I know more about addictions than my therapist."
33. "I can't stand it when my therapist confronts me."
34. "I just don't feel like talking."
35. "It won't hurt to miss a session here or there."
36. "I don't know what to talk about so I won't go to therapy."
37. "I can't go to my therapy session because I haven't done the homework."

38. "I'll just get upset if I go to a psychotherapy session."
39. "I have more important things to do than go to therapy."
40. "I'm too upset to talk right now."
41. "I can't make the necessary arrangements so I won't go to therapy."
42. "I need to be in the right mood to go for therapy."
43. "Only people who are screwed up go to therapy."
44. "My therapist never believes what I say."
45. "I don't like it when my therapist says my head is messed up."
46. "I have a right to do what I want with my body."
47. "No other treatment has helped so this won't."
48. "I don't want to have to explain myself to anyone."
49. "If I tell my therapist what's really going on, he or she will abandon me/criticize me."
50. "I just want to forget my problems."

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