Notes From the Field

# Practitioner Cognitive Reframing: Working More Effectively in Addictions

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**Working with patients with substance abuse disorders is challenging but rewarding when a practitioner embraces cognitive reframing to become more effective in the field and avoid burnout.**

I am a behavioral health-licensed clinical social worker, an approved motivational enhancement therapy provider, and the point of contact for substance use disorders at the Berks CBOC of the Lebanon VAMC in Wyomissing, Pennsylvania. Recently, an exasperated primary care provider at the Berks CBOC approached me about working with patients with substance use disorders and asked "How do you work with this challenging population?"

The question was cause for some introspection. When I started working in addictions, I had to modify my approach to work effectively with this population. I experienced a paradigm shift in which I no longer assigned myself credit or blame for a veteran's continued sobriety or relapse: Each patient is responsible for his or her progress in the recovery journey. When a patient has a relapse, I remind myself that statistically relapse is a probability for the majority of those in recovery; even multiple relapses are common. Therefore, another way of viewing relapse is that the relapse itself may bring the veteran a step closer to permanent abstinence.

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## COGNITIVE REFRAMING

Consider a toddler learning to walk. Parents and caregivers of the child expect the child to fall quite a few times before he or she has mastered walking. The parents and caregivers don't get angry, take the situation personally, or feel manipulated by the child's "failure." Instead, the parents offer the child emotional support and encouragement.

Arguably, the practitioner should take a similar stance—emotionally supportive and encouraging—in combination with dialogue guided by motivational interviewing to support change and help the veteran get back on track. Although not inevitable, relapse is a normal part of recovery.

Practitioners should avoid either scolding or praising patients. Scolding doesn't help in the recovery journey, and if the veteran learns that the practitioner reacts by scolding after learning of the relapse, then it is less likely that he or she will be open about future missteps. In fact, the veteran may not return at all. The goal is to have the patient come back when relapse occurs to help him or her progress to recovery.

Too much praise can cause similar problems. A veteran accustomed to praise when he or she is doing well, may be too embarrassed or ashamed to return to ask for help after a relapse. Instead the practitioner should use affirmations, which are widely discussed in motivational interviewing (MI) literature.

"I want to be clean and sober" or "I want to stop drinking" are vague statements that should raise a red flag for experienced practitioners. Is this patient just telling me what he or she thinks I want to hear to respond? That may be the case but also may be an assumption. Instead these assertions could be regarded as global treatment goals, and the task of the practitioner is to help the veteran develop objectives and interventions in relation to this goal. These broad statements can be a starting point in MI. These words can sound just as foreign to a patient who isn't sure whether becoming clean and sober is a possibility. The veteran may not have the confidence to reach the goal of being clean and sober, and these statements may seem awkward and out

of sync with his or her facial expression and body language.

Showing disbelief in a veteran also can have negative consequences. The veteran might feel that "even my therapist/health care provider doesn't believe I can become clean and sober." Instead, I remind myself that we all must manipulate our environment for survival. I find it more valuable to think of the veteran as being resourceful rather than manipulative.

This point may seem self-evident, but it took me a while to catch on: Most of the change in the recovery journey transpires outside the practitioner's office. I had to embrace this truism and be prepared when the veteran returned for the next session. The task, then, is to determine *at this moment* where the veteran is in his or her recovery journey instead of continuing the conversation from the previous session. The previous session may be irrelevant. Thinking this way was an adjustment for me. One of my favorite therapy approaches was to consciously continue a conversation from the previous session to demonstrate that I remembered what the patient had said, thereby showing that I care.

In addition, get to know the patient underneath, behind, and before the substance use disorder. Knowing and liking the veteran helps me avoid burnout, bringing me back to my values and the reason I became a therapist. I make efforts in my thinking process to convert "alcoholic" or "drug abuser" into a more helpful "client addicted to alcohol" or "client with a substance use disorder." The veteran should not be labeled.

## MOTIVATIONAL INTERVIEWING

Oftentimes what propels veterans forward in their recovery is the cognitive dissonance created between who they were and how they acted before substance addiction and how they act now. Conversation steered in this direction, fueled by MI, can enhance a veteran's motivation to change and ready the veteran to change behaviors. Listen to the veteran's account of loved ones and remember the names of these important family members and friends. Weave into the conversation the names of these loved ones when the veteran makes statements about becoming a better son/father/grandfather or daughter/mother/grandmother. These references make the goal concrete . A loved one can even be a pet; and for some, the desire to be a more competent and reliable pet owner can be a strong motivation. Give the veteran an opportunity to describe his or her strengths and bask in a self-description. In recovery, it is critical to identify strengths that can be built on to sustain recovery.

Veterans who are confronting a substance use disorder may approach the practitioner with a "fix it for me" attitude as a mental inventory is being taken of all of the negative consequences (eg, homelessness, legal issues, or unemployment). Getting the veteran to take ownership of the problem and the solution is key.

I don't promise to fix things, instead I engage the veteran in problem-solving. I offer to team up with the veteran in this process, and I promise my best efforts but not outcomes. I avoid giving advice and work to empower the veteran to make sound decisions. Veterans who make their own decisions feel as though they have more control over their lives.

Working with the substance use disorder population is challenging but rewarding when a practitioner can embrace some of the paradigms described in this article. Practitioners may need to do some cognitive reframing within their own thinking, as I described in this article, to become more effective in the field and to help avoid burnout. ●

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