# Cognitive-Behavioral Therapy (CBT) for Addictions

*Customizing your strategies to meet the needs of people from diverse backgrounds*

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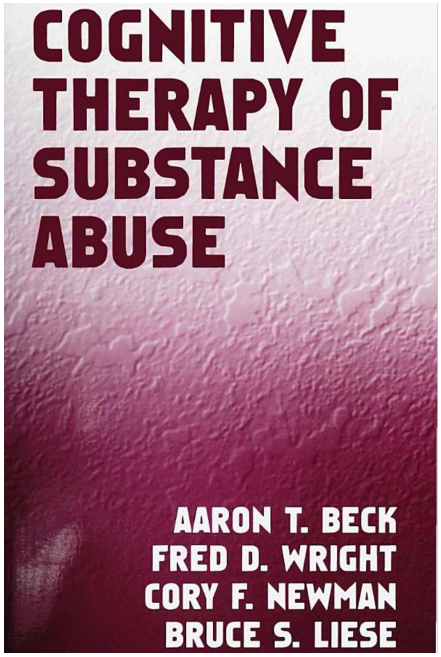
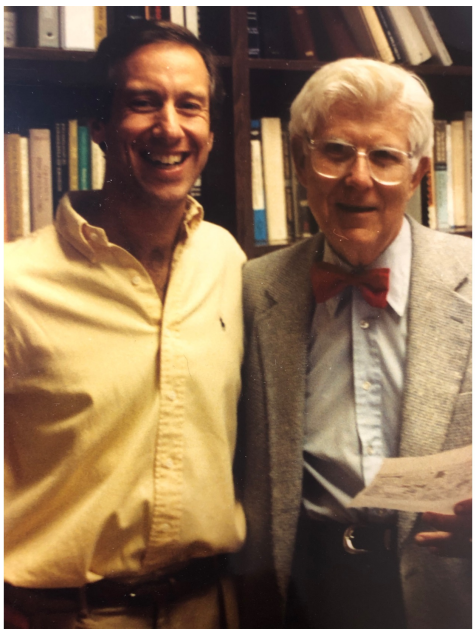
Bruce S. Liese, PhD, ABPP
Professor of Family Medicine, Community Health, and Psychiatry
Clinical Director, Cofrin Logan Center for Addiction Research and Treatment
University of Kansas Medical Center
bliese@kumc.edu

Back in 1993…



## Back in 1993…



## Addictions back in 1993…

- Cocaine epidemic (crack) "Greatest threat to the United States"
- Patients labeled "drug addicts" and "alcoholics"
- Stereotypes ubiquitous (addiction associated with race, class, etc.)
- DSM-IV - Substance abuse and dependence (dichotomous, legal)
- Each addiction (e.g., alcohol, nicotine, heroin) considered unique, different, and often stereotyped
- The sole aim of treatment was abstinence
- Focused on relapse prevention

## CBT back in 1993…

Misconceptions:

- CBT is superficial and mechanistic
- CBT focuses on symptoms, ignores personality
- CBT ignores importance of early life experiences
- CBT ignores interpersonal relationship factors
- CBT minimizes the therapeutic relationship
- CBT ignores motivational issues
- CBT disregards emotion
- One size fits all

Gluhoski (1994). Misconceptions of cognitive therapy. *Psychotherapy, 31*(4), 594-600.

## Addictions today: Changes and Advances

- Opioid epidemic; alcohol and nicotine use continue to cause high morbidity and mortality rates; cannabis increasingly accessible
- We are more aware of stigmatizing behaviors and language
- There is extensive data to recognize diversity and refute stereotypes
- DSM-5 – craving added, legal problems removed, behavioral addiction recognized, diagnoses on a continuous scale (mild, moderate, severe)
- We realize there's more to treatment than preventing relapse
- It's understood that clients/patients should determine their own goals
- MI has contributed to emphasis on collaboration
- Addiction Syndrome helps to understand diversity

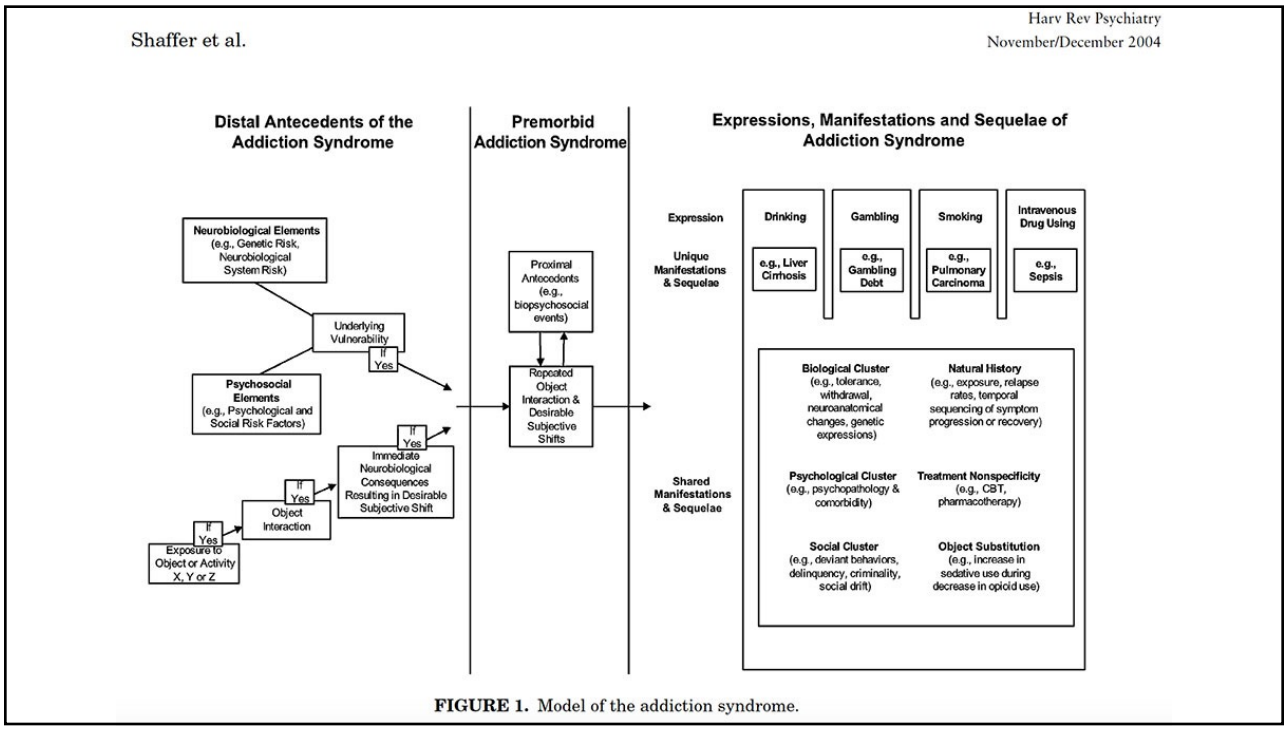
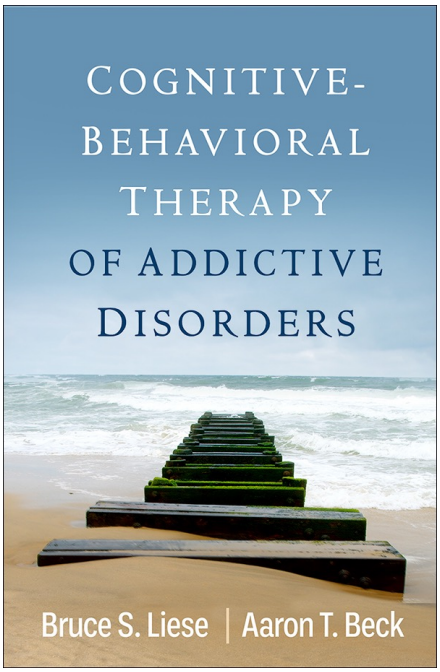



**FIGURE 1.** Model of the addiction syndrome.

In 2022…



## What we know today…

- Addictions are complex and diverse
- People with addictions are complex and diverse
- Individual differences, developmental history, culture, context, and coexisting mental health problems are relevant and important
- Interpersonal processes between provider and consumer matter (i.e., the therapeutic relationship)
- Clients deserve careful, respectful, empathetic, unbiased attention
- Motivation and emotion regulation are central to understanding clients
- Provider flexibility is vital, essential, necessary



## DSM-5 Substance-Related and Addictive Disorders

- DSM-IV (1994-2013) addictions were categorized as *Substance Abuse and Dependence*. No mention of behavioral addictions
- DSM-5: *Substance-Related and Addictive Disorders*
- *Continuous scale* introduced: mild (2-3 criteria), moderate (4-5 criteria), and severe (6 or more criteria)
- Term *addictive disorders* added; abuse and dependence removed
- *Craving* was added; Legal problems removed
- *Gambling* added as first behavioral addiction
- *Internet gaming disorder* added to Section III

## Diagnostic criteria (DSM-5) for chemical addictions

*Problematic pattern of use leading to impairment or distress in following areas:*

1) Larger amounts consumed – or taken over a longer period than intended
2) Persistent desire or unsuccessful efforts to reduce or control use
3) Great deal of time spent obtaining, using, or recovering from use
4) Craving or a strong desire to use
5) Failure to fulfill role obligations (work, school, home, etc.)
6) Continued use despite persistent social/interpersonal problems caused or exacerbated by use
7) Important social, occupational, recreational activities given up
8) Use when physically hazardous
9) Continued use despite problems
10) Tolerance
11) Withdrawal

American Psychiatric Association (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.).

## Ten Classes of Drugs

1) Alcohol
2) Caffeine
3) Cannabis
4) Hallucinogens
5) Inhalants
6) Opioids
7) Sedatives, anxiolytics
8) Stimulants
9) Tobacco
10) Other

## Diagnostic criteria (DSM-5) for gambling

*Problematic pattern leading to impairment or distress in following areas (4+):*

1) Needs to gamble with increasing amounts of money to achieve same level of excitement
2) Restless, irritable when trying to cut down or stop gambling
3) Repeated unsuccessful attempts to control, cut down, or stop gambling
4) Preoccupied with gambling (e.g., persistent thoughts, planning next venture, reliving gambling experiences)
5) Gambles when distressed
6) Returns after loss (chasing the high)
7) Lies to conceal extent of gambling
8) Has jeopardized or lost significant relationship, job, educational, or career opportunity due to gambling
9) Relies on other to provide money to relieve desperate financial situations caused by gambling

American Psychiatric Association (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.).

## DSM-5 (Section III) – Internet Gaming Disorder

*Problematic pattern leading to impairment or distress in following areas (4+):*

1) Preoccupation with Internet games.
2) Withdrawal symptoms when taken away.
3) Tolerance—need for increasing amounts of time engaged in Internet games.
4) Unsuccessful attempts to control the participation in Internet games.
5) Loss of interests in previous hobbies, etc
6) Continued use despite known problems.
7) Has deceived family, therapists, or others regarding amount of gaming.
8) Internet games to escape or relieve a negative mood (eg, loneliness, anxiety).
9) Has jeopardized or lost a significant relationship, job, or educational or career related in Internet Gaming.

American Psychiatric Association (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.).

## Six Core Components of Addiction

1. Salience – Importance; dominates thoughts, feelings, behaviors
2. Mood modification – Addictive behavior induces a desired state
3. Tolerance – Increase needed for same effect
4. Withdrawal symptoms – Unpleasant feelings and physical effects when activity is stopped or reduced
5. Conflict – Intrapersonal discomfort (e.g., anxiety, depression, guilt, shame, desperation); Interpersonal relationship problems
6. Relapse – Repeated slips or lapses; return to addictive behavior

Griffiths, M. (2005). A 'components' model of addiction within a biopsychosocial framework. *Journal of Substance Use, 10*(4), 191-197.

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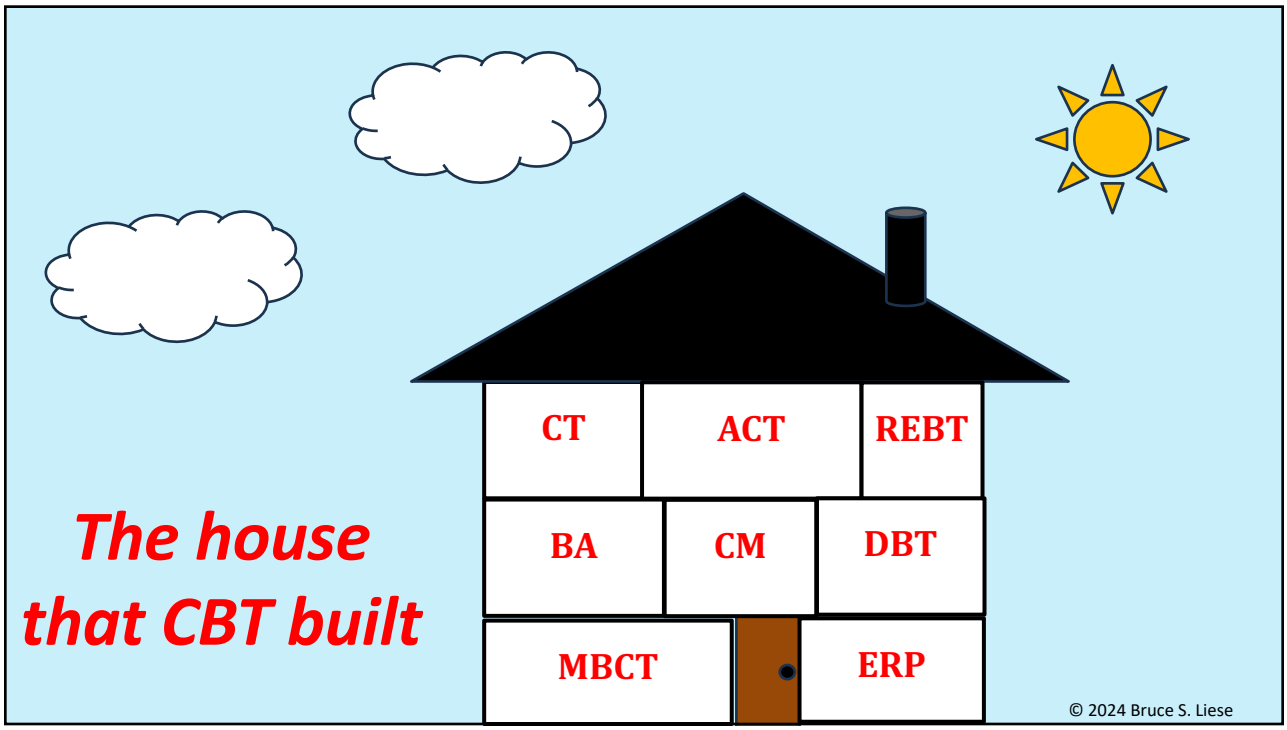
## What is CBT?

CBT is not a single approach to therapy;
CBT is comprised of many brands with more similarities than differences

- Cognitive Therapy (CT)
- Acceptance and Commitment Therapy (ACT)
- Rational Emotive Behavior Therapy (REBT)
- Behavioral Activation (BA)
- Contingency Management (CM)
- Dialectical Behavior Therapy (DBT)
- Cognitive Processing Therapy (CPT)
- Mindfulness-Based Cognitive Therapy (MBCT)
- Exposure and Response Prevention (ERP)




## Therapist focus influenced by CBT "brand"

- CT — Schemas, basic beliefs, conditional beliefs, ATs
- ACT — Psychological flexibility, acceptance, commitment
- REBT — Maladaptive thoughts, cognitive distortions
- BA — Values and corresponding behaviors
- DBT — Emotion regulation, distress tolerance, surviving crises
- MBCT — Mindfulness, awareness, being present
- ERP — Exposure and response prevention

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## CBT Content and Process

Content

***What*** is to being discussed for the purpose of facilitating change (especially symptoms)

Process

***How*** change is facilitated in session (e.g., interpersonal and intrapersonal dynamics)

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## CBT content: What is to be changed

Examples of clinical content areas (symptoms, skill deficits, etc.):

- Behavior change
- Emotion regulation
- Decision-making skills
- Problem-solving skills
- Self-compassion
- Improved judgement
- Interpersonal skills
- Mindfulness, awareness
- Relapse prevention
- Harm reduction

## CBT process: How change is facilitated

Five essential components of CBT:

Collaboration/alliance

Case conceptualization

Structure

Psychoeducation

Standardized Techniques

Liese & Beck (2022). *Cognitive-Behavioral Therapy for Addictive Disorders*. NY: Guilford Press.



## Patients' *goals* influence content and process

Substantial variability across patients' goals, including:

- Modification of addictive behaviors (e.g., abstinence, harm reduction)
- Feeling better
- Improving relationships
- Acquiring coping skills
- Receiving support from therapist and/or group
- Self-acceptance, self-forgiveness, self-understanding, etc.
- Resolving legal obligations
- Repairing broken family bonds

## CBT case conceptualization

- Collection and integration of clinically relevant information ***as an iterative process***
- Identification of problems and change targets
- Ongoing and ever-evolving hypothesis formulation and testing
- Influenced by theoretical model, professional and personal life experiences
- Vital to therapy; everything else depends on it
- Requires substantial attention, organizational skills, and effort

Liese & Beck (2022). *Cognitive-Behavioral Therapy for Addictive Disorders*. NY: Guilford Press.

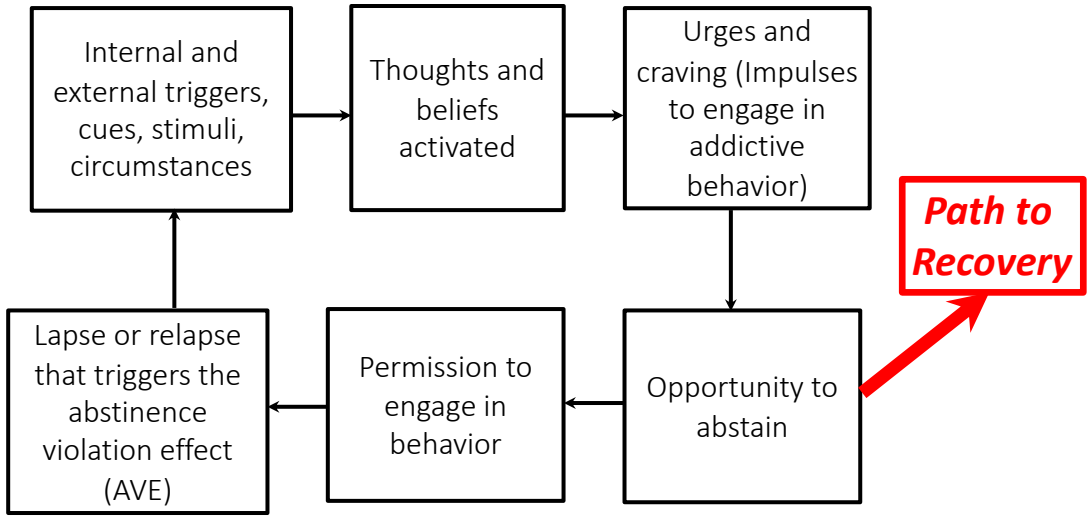


## CBT case conceptualization requires attention to cognitive *content* and *process*

- Content (*what* patients/clients think): e.g., automatic thoughts, basic beliefs, conditional beliefs, schemas
- Processes (*how* patients/clients think): e.g., ability to focus, psychological mindedness (insight), mindfulness, cognitive flexibility, inhibitory skills, experiential avoidance

Liese & Beck (2022). *Cognitive-Behavioral Therapy for Addictive Disorders*. NY: Guilford Press.

## CBT model for understanding addictive behaviors

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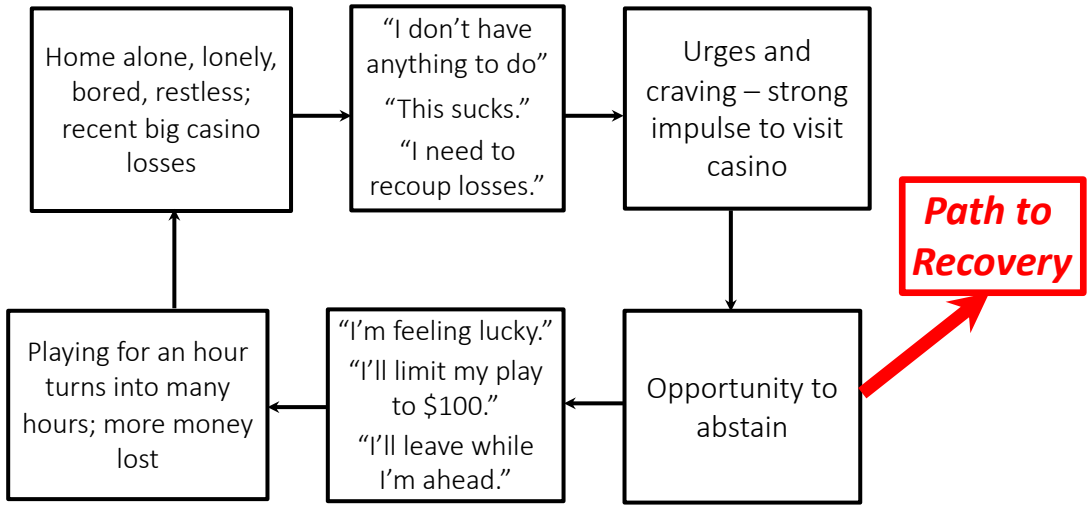
## CBT model for understanding gambling disorder

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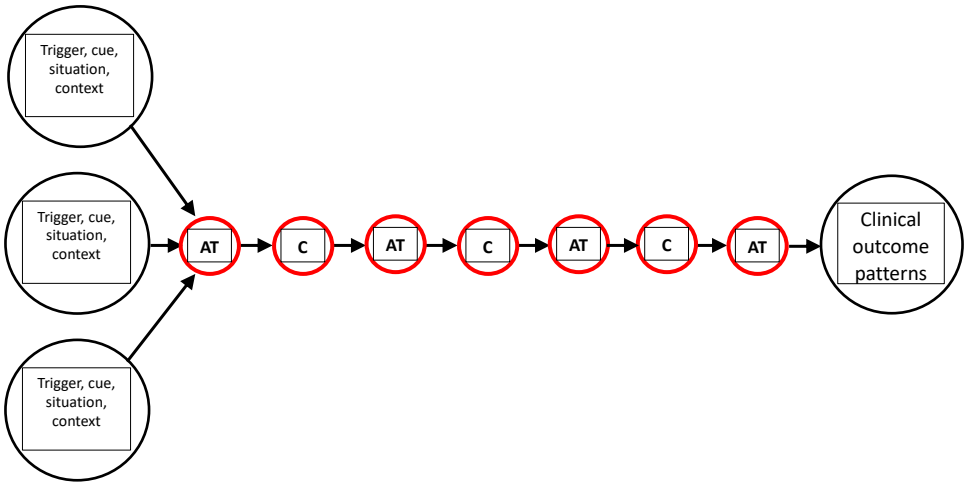
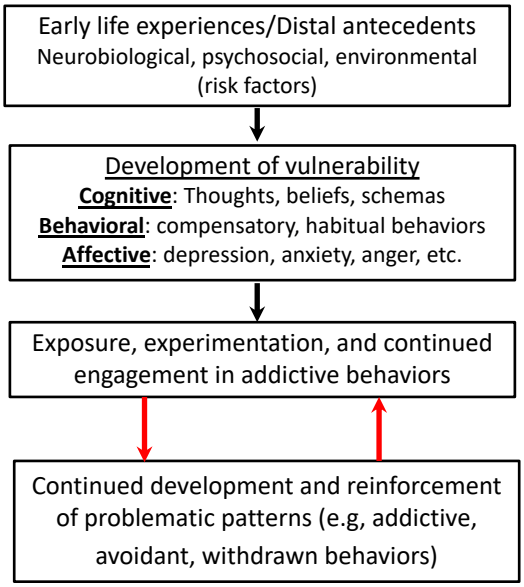
# Functional (chain) analysis






# Development of addictive behaviors

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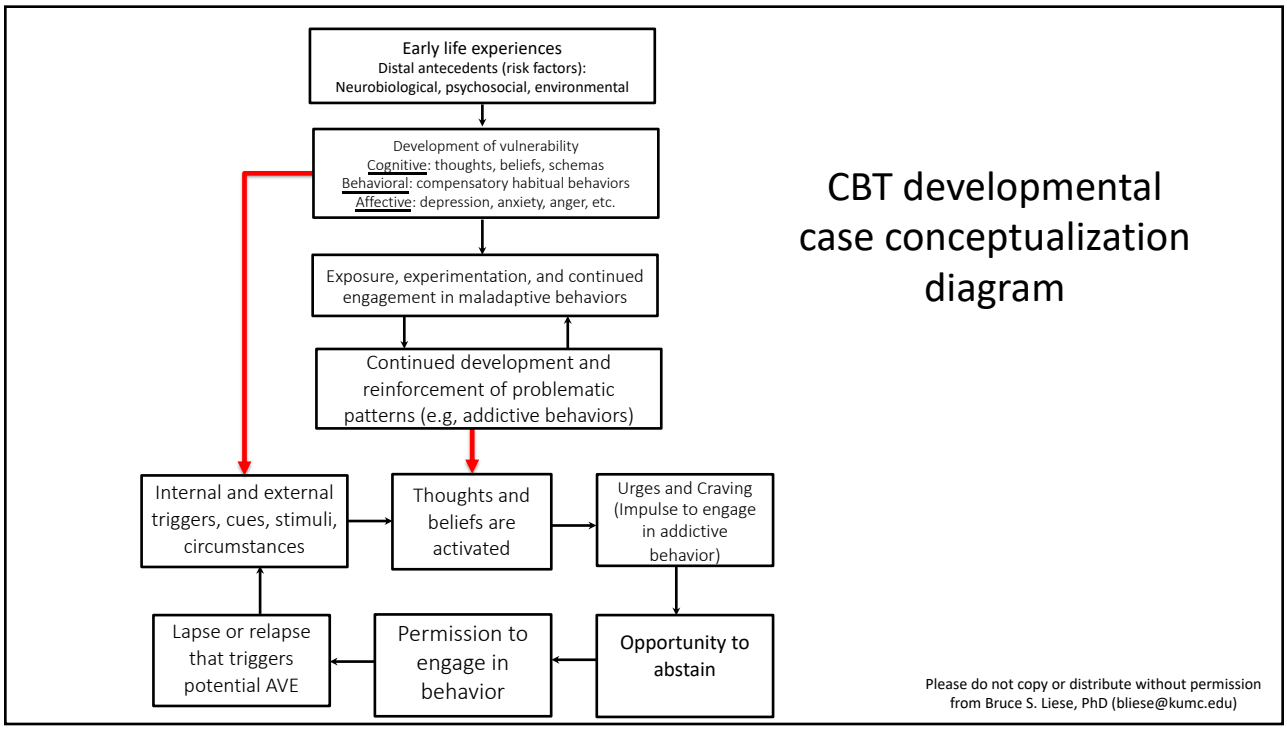


## CBT case conceptualization

1. Primary problems: Addictive behaviors, depression, anxiety, etc.
2. Social/environmental/health/cultural context: Current living situation; close relationships; sociocultural factors; economic circumstances; legal or safety concerns; Social Determinants of Health; community norms and expectations
3. Distal antecedents: Neurobiological, genetic, cultural, family, community, environmental influences
4. Proximal antecedents: Current internal and external cues, triggers, high-risk situations (circumstances, situations, physical conditions)
5. Cognitive processes: Relevant beliefs and thoughts; values, mindfulness skills; principles; cognitive distortions

Liese & Beck (2022). *Cognitive-Behavioral Therapy for Addictive Disorders*. NY: Guilford Press.

## CBT case conceptualization

6. Affective processes: Predominant emotions, feelings, moods, physiologic sensations; distress tolerance; emotion regulation skills
7. Behavioral patterns: Adaptive versus maladaptive behaviors; coping versus compensatory strategies; committed actions
8. Readiness to change and associated goals: Precontemplation, contemplation, preparation, action maintenance
9. Integration of the data: Salient processes and patterns; causal relationships between context, thoughts, feelings, behaviors
10. Implications for treatment: Strategies and techniques, based on data and hypotheses

Liese & Beck (2022). *Cognitive-Behavioral Therapy for Addictive Disorders*. NY: Guilford Press.



## Cognitive effort

- Understanding ***cognitive effort*** provides a key to understanding addiction and change
- Cognitive effort varies, depending on the load placed on it
- Simple functions place little load on people – ease
- The function of habits is to limit ease (reduce) cognitive effort
- Complex functions place heavy loads on people – strain
- Cognitive strain is experienced as work, effort, fatigue
- Meaningful change requires substantial cognitive effort
- All good therapy requires cognitive effort (often underestimated)

Kahneman, D. (2011). *Thinking Fast and Slow*. New York: Farrar, Straus and Giroux.

## System 1 thinking

- Automatic, fast, effortless, involuntary, reflexive, intuitive (scans)
- Biased to believe and confirm, suppress doubt
- Generates impressions, feelings, judgments
- Focuses on existing evidence and ignores absent evidence
- Responds more strongly to losses than gains (loss aversion)
- Seeks simple answers (i.e., heuristics) to complex questions
- Substitutes easy questions for difficult ones
- When System 1 thoughts are reinforced, they become core beliefs

Kahneman, D. (2011). *Thinking Fast and Slow*. New York: Farrar, Straus and Giroux.



## Heuristics

- System 1 short cuts that ease cognitive load
- Typically helpful, but not always
- Numerous categories, including:
  - Availability – first thoughts, most easily accessed, "top of mind"
  - Representativeness – assigns membership to categories
  - Framing – How stories are told influences perspective
  - Affect – Emotional reasoning; good feelings associated with cognitive ease; bad feelings associated with cognitive strain
  - Anchoring – The information first presented may have disproportionate influence on impressions

Kahneman, D. (2011). *Thinking Fast and Slow*. New York: Farrar, Straus and Giroux.

## How do heuristics influence clinical impressions?

- Availability – Do you have a clinical specialty? Do you have a home CBT theory or favored CBT model?
- Representativeness – Are there particular diagnoses that are common to your practice?
- Framing – How is the patient's story told? What's highlighted?
- Affect – Do you feel the same with all patients? When do you feel comfortable or uncomfortable with a patient?
- Anchoring – How does the reason for referral or prior diagnoses influence your clinical judgment?

Kahneman, D. (2011). *Thinking Fast and Slow*. New York: Farrar, Straus and Giroux.



## Cognitive bias

- When heuristics are employed, cognitive biases are inevitable
- Heuristics take multiple forms and provide insight into cognitive biases:
  - Availability – What you see is all there is (WYSIATI)
  - Representativeness – Categories may cause people to prejudge
  - Framing – Underemphasizing or overemphasizing certain facts
  - Affect – Just because it feels right/wrong doesn't mean it is
  - Anchoring – The first facts or ideas may be least important

*Heuristics and biases may be activated at first moment of contact*

Kahneman, D. (2011). *Thinking Fast and Slow*. New York: Farrar, Straus and Giroux.

## Cognitive bias and diversity

- Ask most practicing counselors/therapists/clinicians whether:
  - They have biases
  - They are aware of their biases
  - Bias is ever a problem when they're practicing
  - They need training in diversity
- What will they say?
- Most think they're "above average"

***Important question related to clinician bias:***

***"What is your definition of recovery?"***

## System 2 thinking

- Effortful, deliberate, intentional, reflective, slow
- Activated when cognitive load too much for System 1
- Searches memory
- Associated with attention, concentration, agency, choice
- Works by asking and answering questions
- Not the same as intelligence; more related to rationality
- Many people assume that their System 2 is in charge
- Smart, rational, but lazy

Kahneman, D. (2011). *Thinking Fast and Slow*. New York: Farrar, Straus and Giroux.

## System 2 might be important when patients…

- Say they are committed to change, but continue the same problematic behaviors – or chronically relapse
- Continually describe barriers to change
- Don't do homework they have agreed to do
- Seem disinterested or detached during sessions
- Say they can't think of anything to work on
- Tell rambling stories and digress when describing problems
- Miss sessions or regularly come late to them
- Trigger therapist boredom, frustration, or detachment



## System 2 is relevant when patients say things like…

- "I need to…"
- "I'll try…"
- "I'll just…"
- "I already tried that…"
- "Sure."
- "Maybe…"
- "I should…"
- "Ok…ok…ok…" (intermittently)
- "You…" (when it means "I")
- "If you say so."
- "You're the expert."

*Subtext important; may reflect lack of engagement, motivation*

## Individual CBT Structure

Agenda: "What do you want to work on?"

Mood

Bridge

Prioritize and discuss items

Guided discovery/Functional analysis

Facilitate skill development

Feedback

Homework

Liese & Beck (2022). *Cognitive-Behavioral Therapy for Addictive Disorders*. NY: Guilford Press.



## Cognitive-Behavioral Therapy Techniques

- Functional analysis
- Motivational interviewing
- Stimulus management
- Delay and distract
- Advantages-disadvantages analysis
- Hierarchy of values
- Activity monitoring and scheduling
- Behavioral activation
- Automatic Thought Records
- Acceptance and/or commitment
- Relaxation training
- Mindfulness and meditation training
- Contingency management
- Role playing

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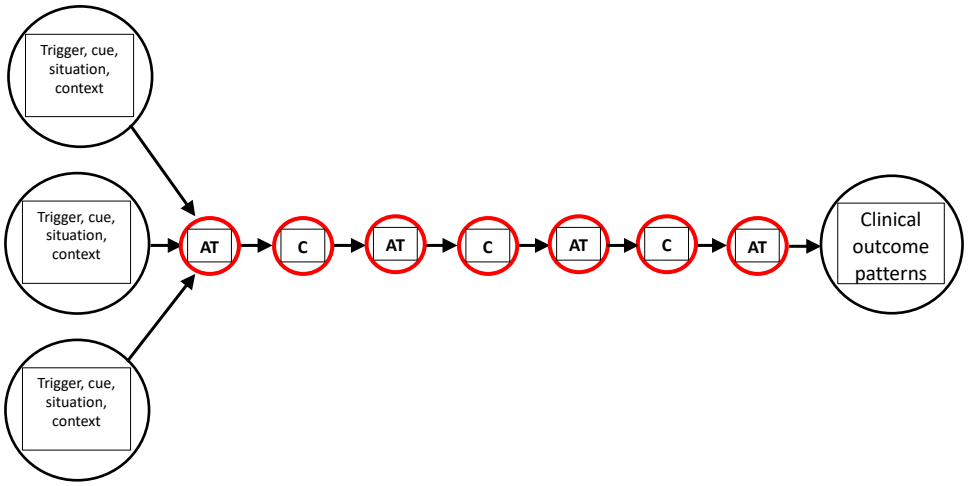
# Functional (chain) analysis






# Automatic Thought Record (ATR)

| Date and Time | Situations | Emotions (0-100) | Automatic thoughts or related beliefs (0-100%) | Alternative thoughts, beliefs, or responses (0-100%) | New Emotions (0-100) |
|---|---|---|---|---|---|
| | | | | | |

Liese & Beck (2022). *Cognitive-Behavioral Therapy for Addictive Disorders*. NY: Guilford Press.

# Advantages-Disadvantages Analysis

| | Continue addictive behavior | Stop addictive behavior |
|---|---|---|
| Advantages | • *Relief from tension*<br>• *Have fun*<br>• *Forget my problems*<br>• *Win back some money* | • *Feel better about myself*<br>• *Get family off my back*<br>• *Improve my health*<br>• *Might have some $$$ left* |
| Disadvantages | • *I don't like myself*<br>• *I can't afford it (lose $$$)*<br>• *Ruins my relationships*<br>• *Not good for my health* | • *Painful craving*<br>• *Might fail again*<br>• *No other coping skills*<br>• *Lose friends* |

Liese & Beck (2022). *Cognitive-Behavioral Therapy for Addictive Disorders*. NY: Guilford Press.



# Summary and conclusions

- Addictions – and the people who suffer from them – are far more complex and diverse than many clinicians realize
- CBT is far more complex and diverse than many clinicians realize
- We (clinicians) tend to overestimate our expertise – and underestimate the work it takes for patients to change
- Rigorous thinking – in System 2 – is essential to effective therapy
- Clinician uncertainty is an asset, rather than a liability
- Hypotheses generation and testing are essential to good therapy
- We benefit from understanding our own heuristics and biases

## Summary and conclusions

- Be cognitively flexible, curious, intentional, deliberate
- Fully understand the complex and nonlinear nature of change
- Continually formulate and revise clinical hypotheses
- Closely attend to context and functions of patient choices
- Identify barriers to change – especially when working with diverse, marginalized, and disadvantaged individuals
- Don't exaggerate skills or expertise; avoid attachment to a brand
- Remember: all brands of CBT provide wisdom and valuable technique; learn and draw from them all