The 30-year evolution of CBT for addictions

A long, winding, and profoundly enlightening road

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Back in 1993…

- Cocaine epidemic, crack greatest threat
- Patients labeled addicts and alcoholics
- DSM-IV – ***Substance*** abuse/dependence
- Each addiction was considered unique
- The sole aim of treatment was abstinence
- Focused on RP: acute relapse episodes
- CBT brand wars had not yet begun
- History: a backdrop for understanding barriers

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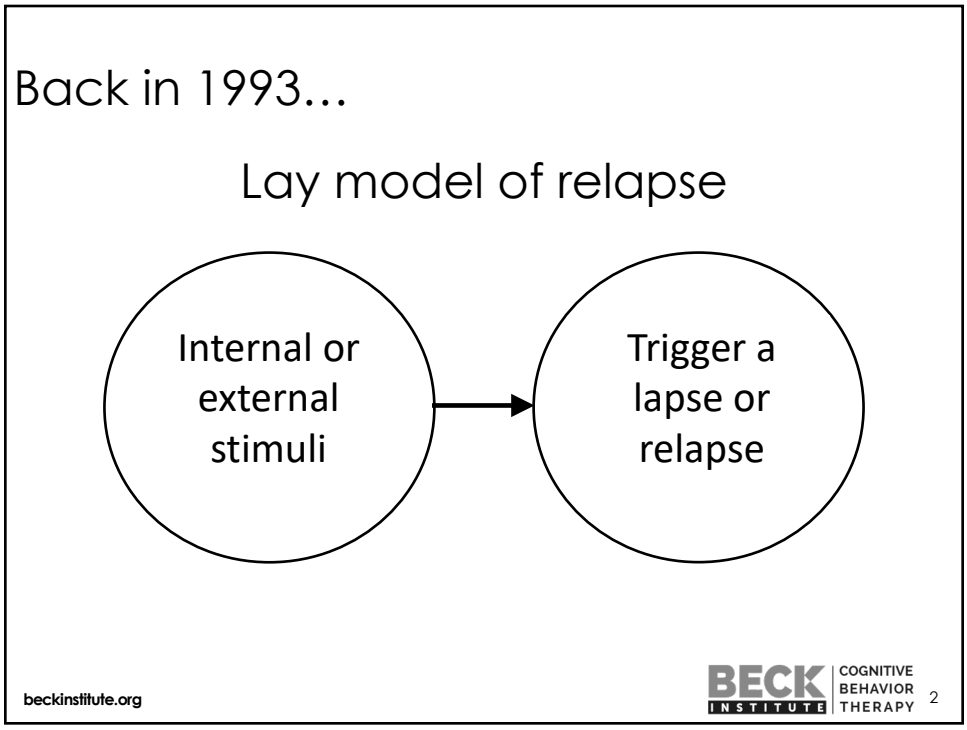

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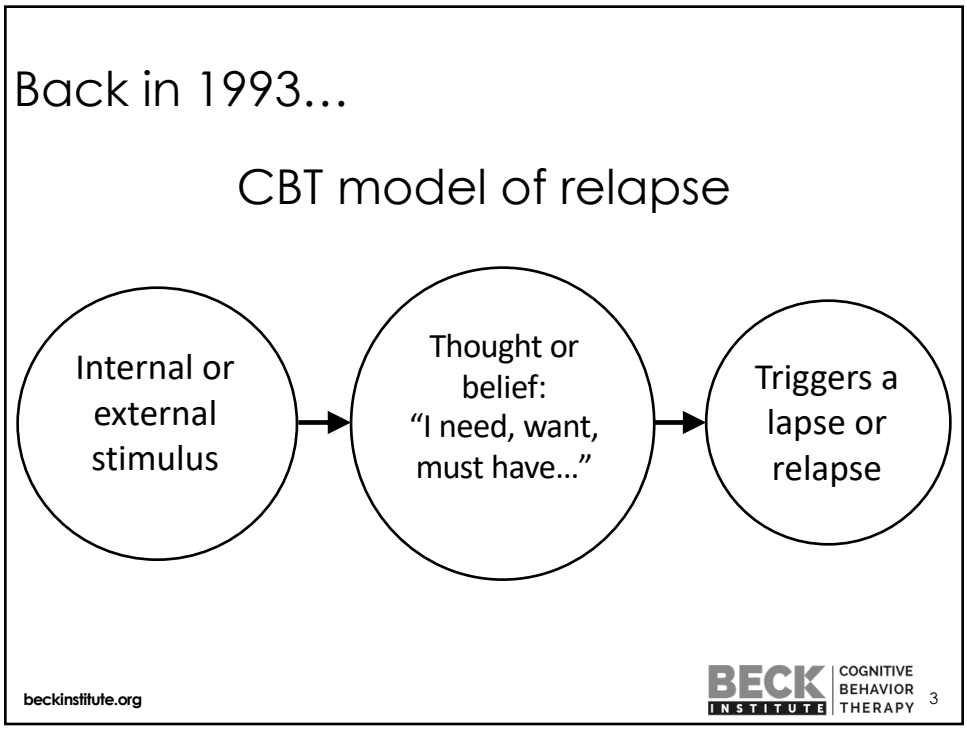

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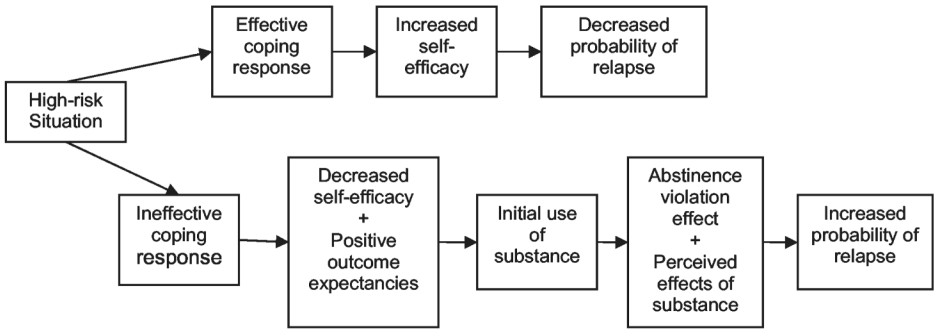
Back in 1993...

Alan Marlatt Relapse Prevention Model



Marlatt, G. A., & Gordon J. R. (1985). *Relapse Prevention: Maintenance strategies in the treatment of addictive behaviors.* New York: Guilford.

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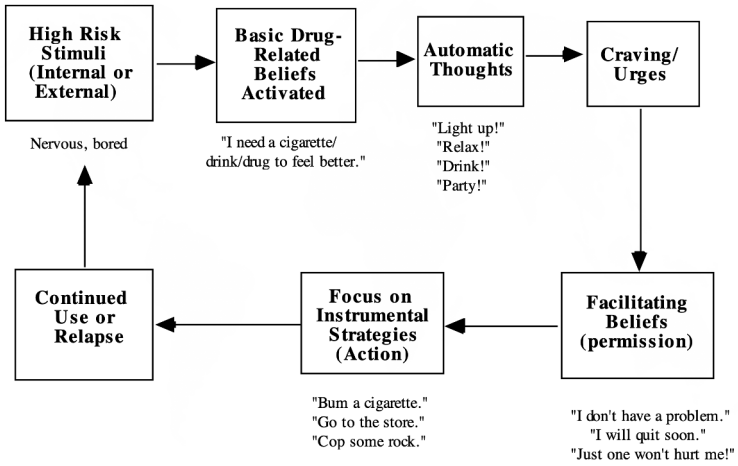
Back in 1993...



Beck et al. (1993). *Cognitive therapy of substance abuse.* New York: Guilford.

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Date and Time	Situation	Emotion (0-100)	Automatic thoughts (0-100%)	Alternative thoughts (0-100%)	New Emotion (0-100)

Beck et al. (1993). *Cognitive therapy of substance abuse.* New York: Guilford.

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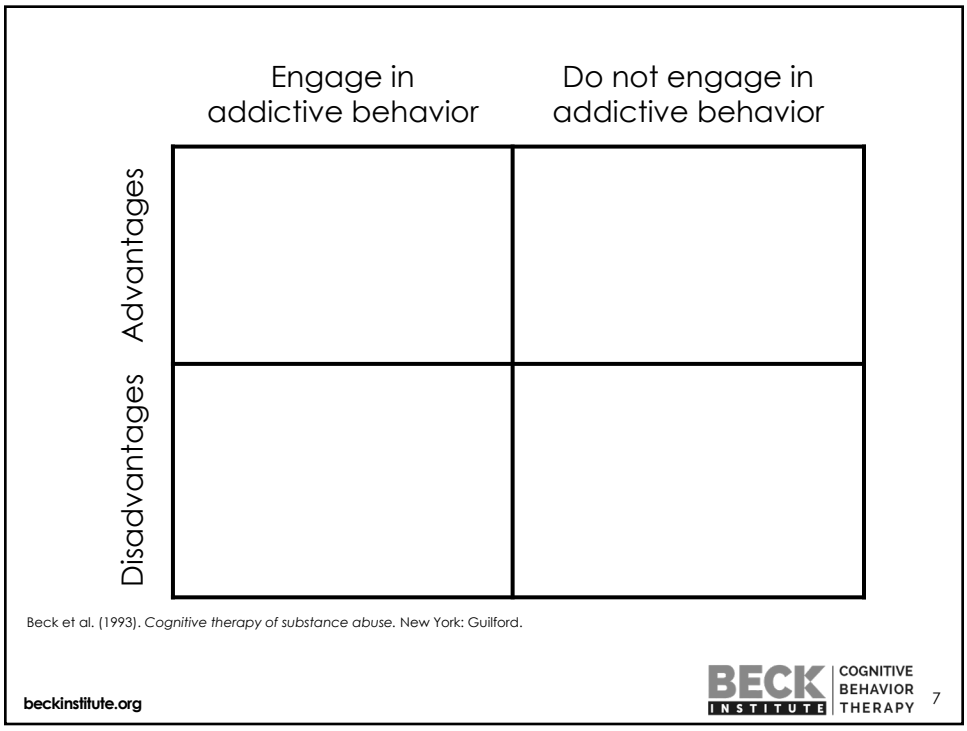

Beck et al. (1993). *Cognitive therapy of substance abuse.* New York: Guilford.

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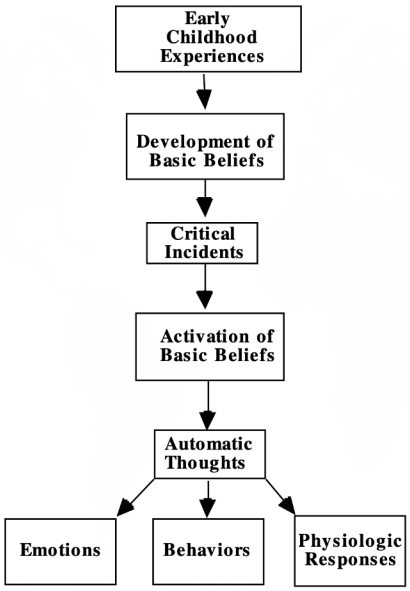
Early 2000s…



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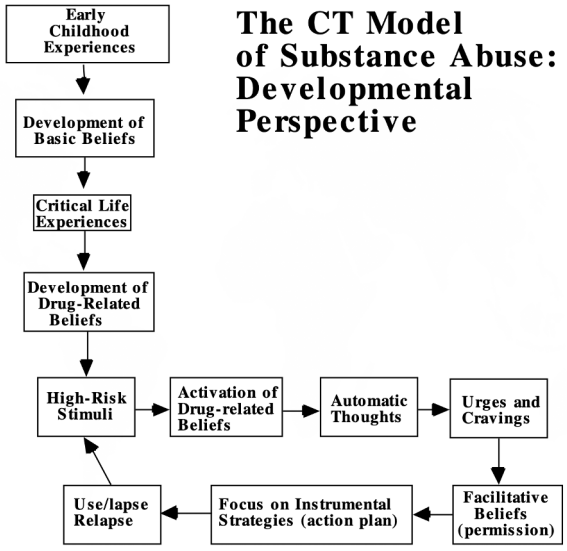
Early 2000s…



The CT Model of Substance Abuse: Developmental Perspective

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The Addiction Syndrome

- Provides a sharp departure from earlier perspectives
- Addictions result from an underlying syndrome with multiple opportunistic expressions (like AIDS)
- Empirical evidence for the addiction syndrome and organize it into three primary areas:
  1. Shared neurobiological antecedents;
  2. Shared psychosocial antecedents, and;
  3. Shared manifestations and sequelae
- Proximal ***and*** distal antecedents important to understanding dynamics of therapy (and barriers)

Shaffer, LaPlante, & Nelson (2012). *Addiction Syndrome Handbook*. Washington, DC: APA Press.

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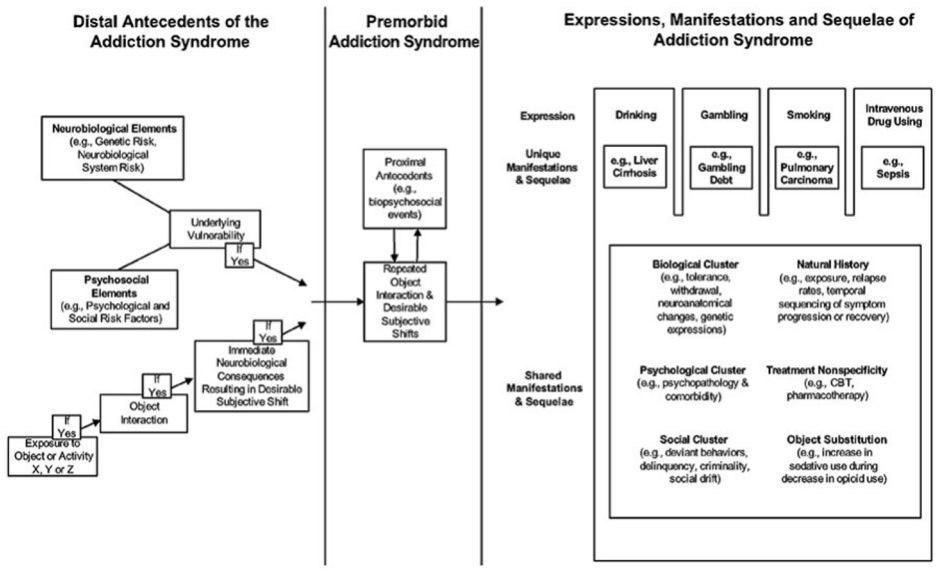

Shaffer et al. (2004). Toward a syndrome model of addiction: Multiple expressions, common etiology. Harvard Review of Psychiatry, 12. 367-374.

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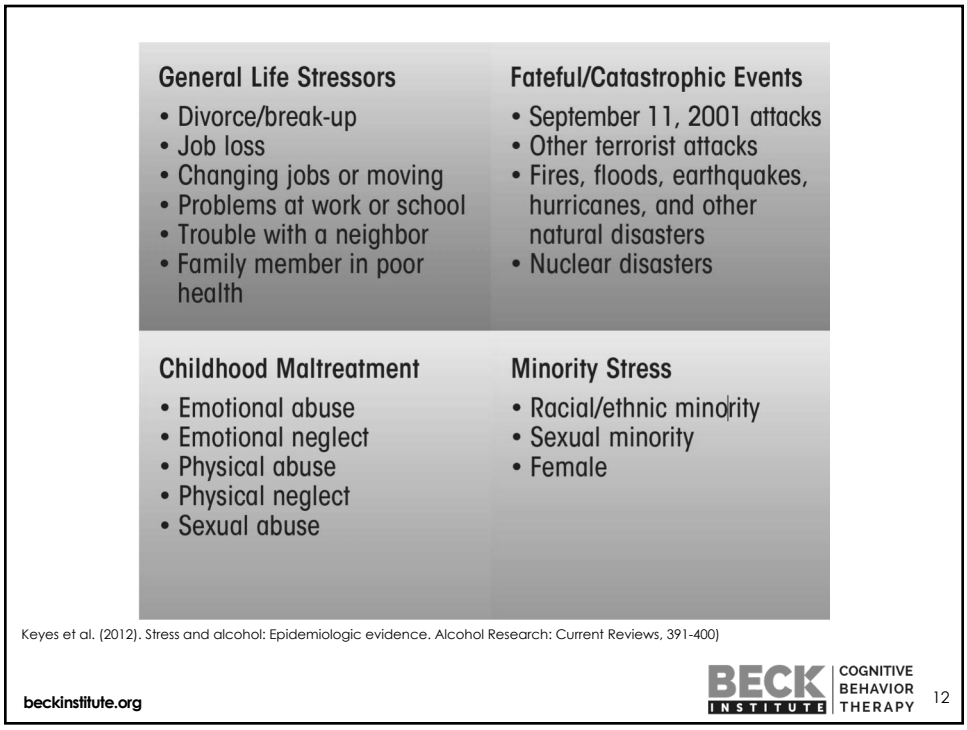

Keyes et al. (2012). Stress and alcohol: Epidemiologic evidence. Alcohol Research: Current Reviews, 391-400)

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Cannabis Use Disorder

Diagnostic Criteria

A. A problematic pattern of cannabis use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
   1. Cannabis is often taken in larger amounts or over a longer period than was intended.
   2. There is a persistent desire or unsuccessful efforts to cut down or control cannabis use.
   3. A great deal of time is spent in activities necessary to obtain cannabis, use cannabis, or recover from its effects.
   4. Craving, or a strong desire or urge to use cannabis.
   5. Recurrent cannabis use resulting in a failure to fulfill major role obligations at work, school, or home.
   6. Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis.
   7. Important social, occupational, or recreational activities are given up or reduced because of cannabis use.
   8. Recurrent cannabis use in situations in which it is physically hazardous.
   9. Cannabis use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by cannabis.
   10. Tolerance, as defined by either of the following:
      a. A need for markedly increased amounts of cannabis to achieve intoxication or desired effect.
      b. Markedly diminished effect with continued use of the same amount of cannabis.
   11. Withdrawal, as manifested by either of the following:

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Gambling Disorder

Diagnostic Criteria **312.31 (F63.0)**

A. Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
6. After losing money gambling, often returns another day to get even ("chasing" one's losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

B. The gambling behavior is not better explained by a manic episode.

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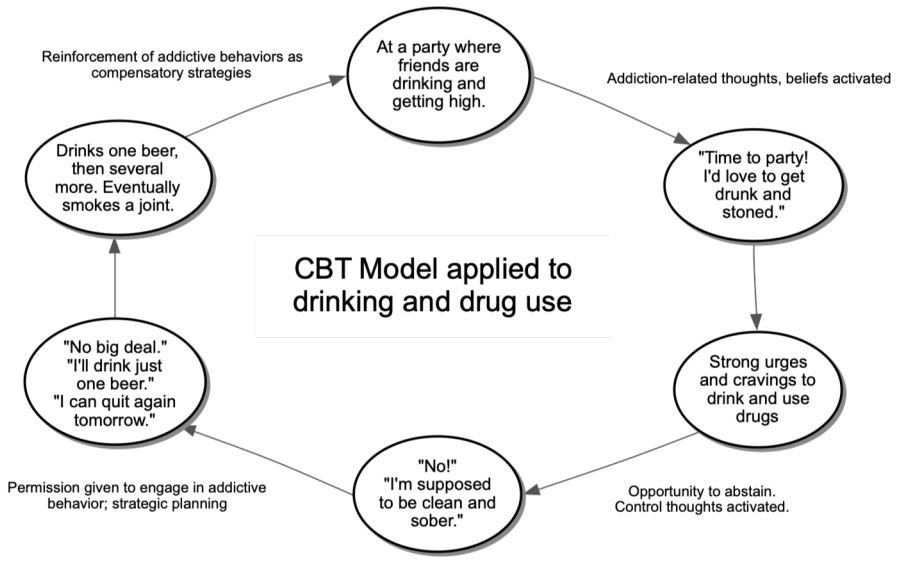

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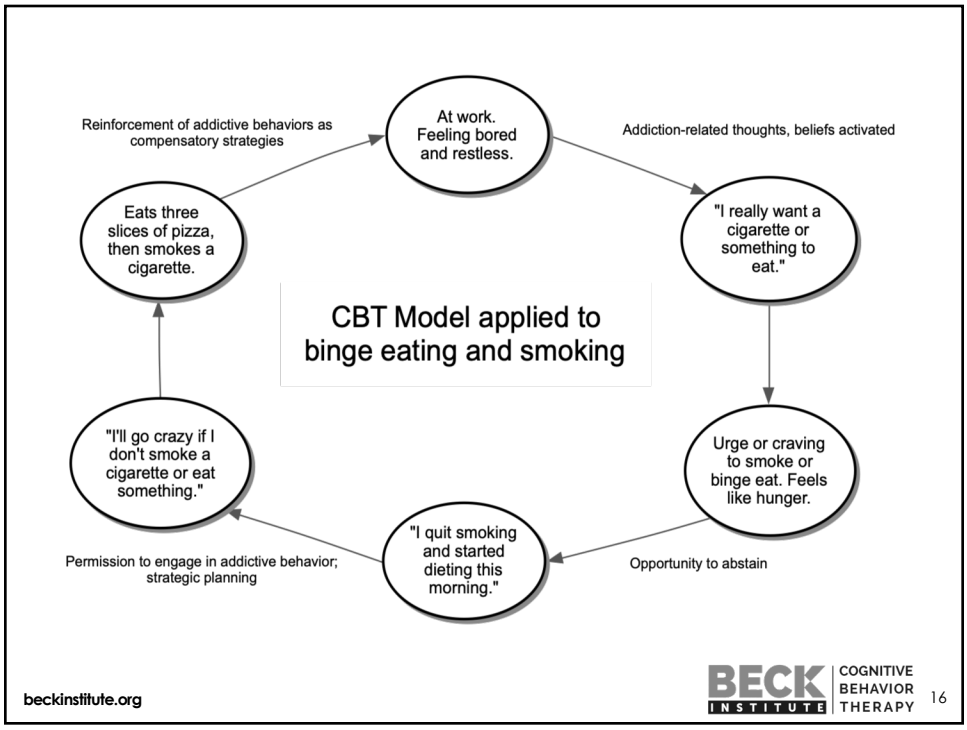
CBT Model applied to binge eating and smoking
At work. Feeling bored and restless.
Addiction-related thoughts, beliefs activated
"I really want a cigarette or something to eat."
Urge or craving to smoke or binge eat. Feels like hunger.
Opportunity to abstain
"I quit smoking and started dieting this morning."
Permission to engage in addictive behavior; strategic planning
"I'll go crazy if I don't smoke a cigarette or eat something."
Reinforcement of addictive behaviors as compensatory strategies
Eats three slices of pizza, then smokes a cigarette.
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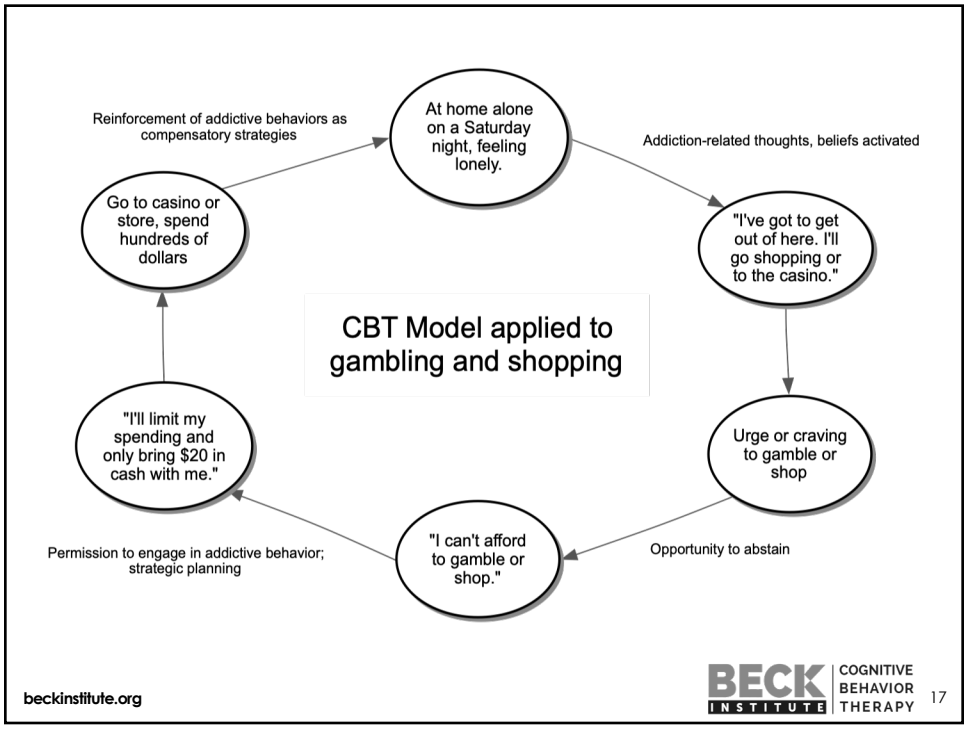
CBT Model applied to gambling and shopping
At home alone on a Saturday night, feeling lonely.
Addiction-related thoughts, beliefs activated
"I've got to get out of here. I'll go shopping or to the casino."
Urge or craving to gamble or shop
Opportunity to abstain
"I can't afford to gamble or shop."
Permission to engage in addictive behavior; strategic planning
"I'll limit my spending and only bring $20 in cash with me."
Reinforcement of addictive behaviors as compensatory strategies
Go to casino or store, spend hundreds of dollars
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The Course of CBT

- May be more like a roller-coaster than a carousel ride
- Goals may change; relapse common
- External barriers to change likely
- Homework likely to be challenging
- Motivation, attendance may be variable
- Patients may trigger therapist boredom, frustration, detachment, irritation, apathy

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System 1 and System 2 thinking

System 1 thinking	System 2 thinking
• Fast	• Slow
• Mindless	• Mindful
• Automatic	• Deliberate
• Reflexive	• Intentional
• Effortless	• Effortful
• Efficient	• Conscious

Kahneman, D. (2011). *Thinking, fast and slow*. New York: Farrar, Strauss, and Giroux.

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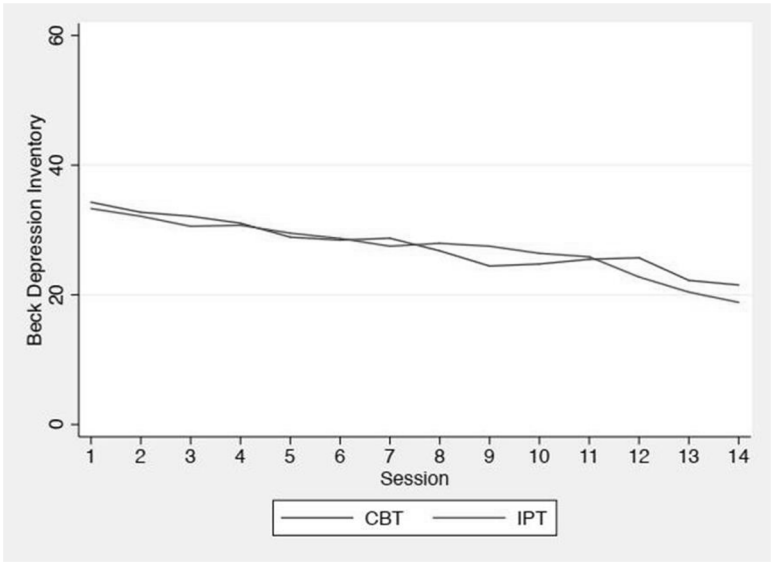

Lundh (2019). Towards a person-oriented approach to psychotherapy research. *Journal for Person-Oriented Research, 5*(2), 65-79.

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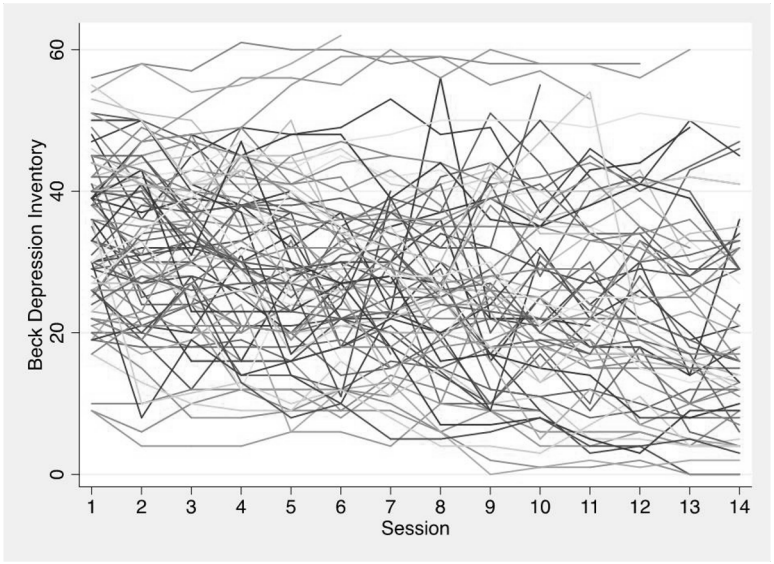

Lundh (2019). Towards a person-oriented approach to psychotherapy research. *Journal for Person-Oriented Research, 5*(2), 65-79.

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0:03 – "Well, I'm ready to give up gambling" (Fear, remorse)

0:50 – "Sunday I won some and…it was such a good high" (Excited)

1:31 – "Oh my God, this is definitely going to be my last time" (Despair)

1:48 – "Everybody knows me now. Everybody knows my name" (Excited)

2:27 – "Recognition by others" (Gratification)

3:10 – "I actually just think about it almost every day" (Excited)

3:43 – "I hope I win some money on this one" (Wishful)

3:47 – "I haven't won any games yet" (Agitated)

4:01 – *Moans and sighs* (Despair)

4:05 - "What was causing you to cry?" (Fear)

4:23 – "Do you believe you'll gamble again?"

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One size does not fit all

- Some patients benefit from changing addiction-related beliefs; some from changing permissive beliefs; some, schemas
- Some need to accept; some need to commit
- Some need to activate behaviors
- Some want contingent rewards along the way
- Some benefit from becoming more mindful, learning to meditate
- Some have families eager to help; some don't

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Today…

- We've moved on from the cocaine threat
- Stigma, dirty language strongly discouraged; person-first language encouraged
- *DSM-5* – Addictive disorders include behavioral addictions - on a continuum
- Goals collaboratively set (focus on HR)
- Therapy process better understood
- CBT brands all have value; flexibility is vital

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Final thoughts…

- Most cognitive behavioral therapists don't think of themselves as treating patients with addictions
- However, treating patients with other psychological problems makes it likely that we are treating people with addictions
- Treating people with addictions can be among the most profoundly rewarding, educational, enriching, and potentially life-saving of all clinical experiences

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