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Treating Addictive Disorders with Cognitive Behavioral Therapy (CBT)

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Disclosures

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Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.

Goals of Talk

- Key Principles of CBT
- Overview of CBT Model
- CBT Adaptations for Addictive Disorders
- Case Example: Steve

Evidence-Base for CBT

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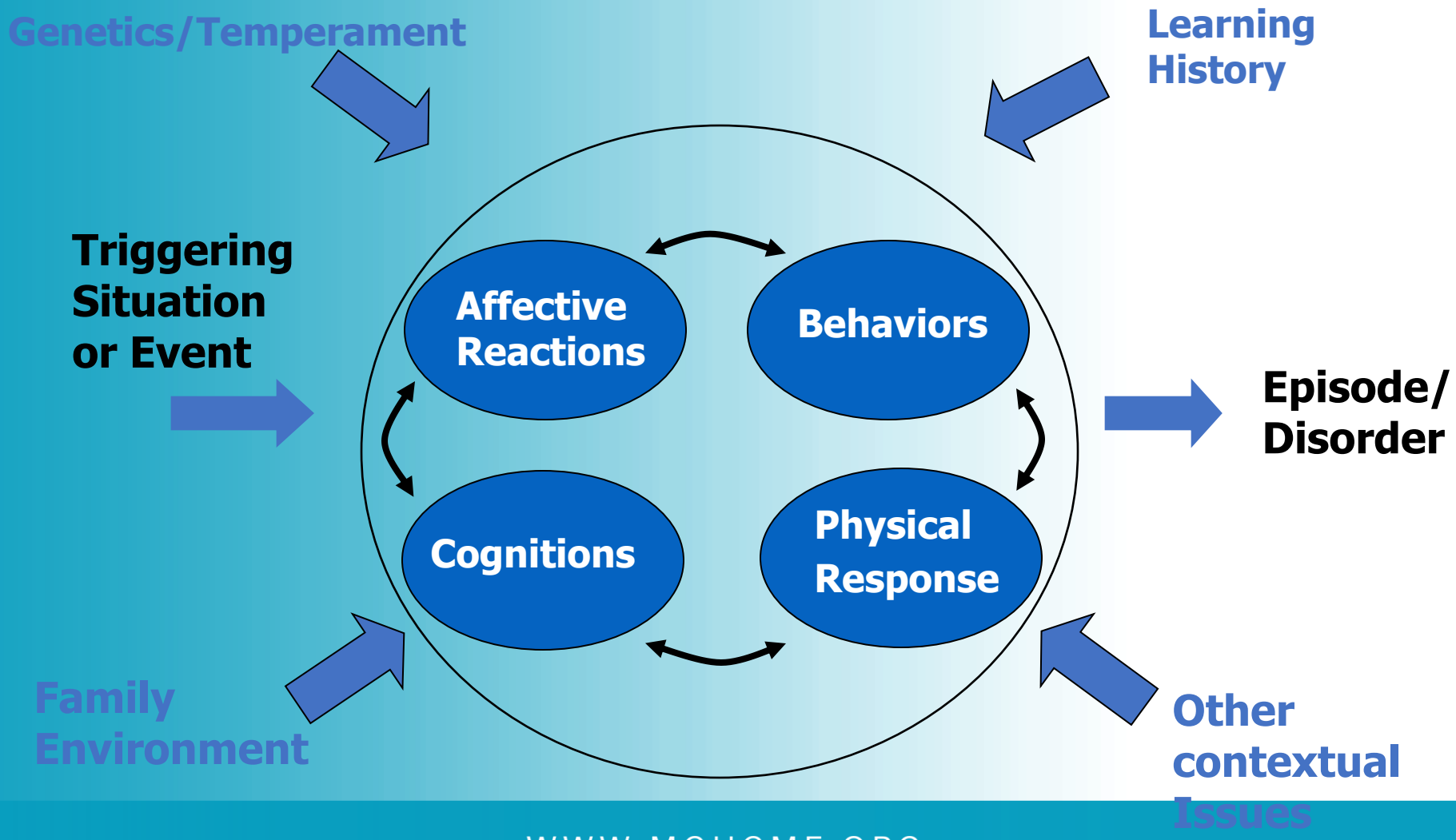
Citation	Study Focus	Key Findings
1. Magill, M., & Ray, L. A. (2020). "Cognitive behavioral therapy for substance use disorders." *Current Psychiatry Reports.*	CBT for alcohol and drug use disorders	This review summarizes the evidence supporting CBT's effectiveness across different substance use disorders, showing strong evidence for alcohol and drug abuse treatment.
2. Hester, R. K., & Miller, W. R. (2020). "The effectiveness of cognitive-behavioral therapy for alcohol use disorders." *Addiction.*	CBT for alcohol use disorder	CBT significantly reduces alcohol use and related problems in the short and long term, especially when combined with motivational enhancement.
3. Kelly, J. F., & Greene, M. C. (2020). "Cognitive behavioral therapy in addiction treatment." *Behavioral Therapy.*	CBT for addiction treatment	This study focuses on CBT's efficacy in treating both alcohol and opioid addiction, highlighting its use in both individual and group formats.
4. McHugh, R. K., et al. (2018). "The effectiveness of cognitive-behavioral therapy for alcohol and drug use disorders." *Journal of Clinical Psychology.*	Review of CBT for alcohol and drug use	Comprehensive meta-analysis shows CBT significantly reduces substance use and improves coping skills for individuals with alcohol and drug use disorders.

Why CBT works in Substance Use?

- Addresses patterns to use and relapse
- Insight into triggers: external/internal
- Provides concrete strategies to manage stressors
- Can concurrently address comorbidities
- Structured & time-limited
- Collaborative enterprise with patient around goals

CBT Model:

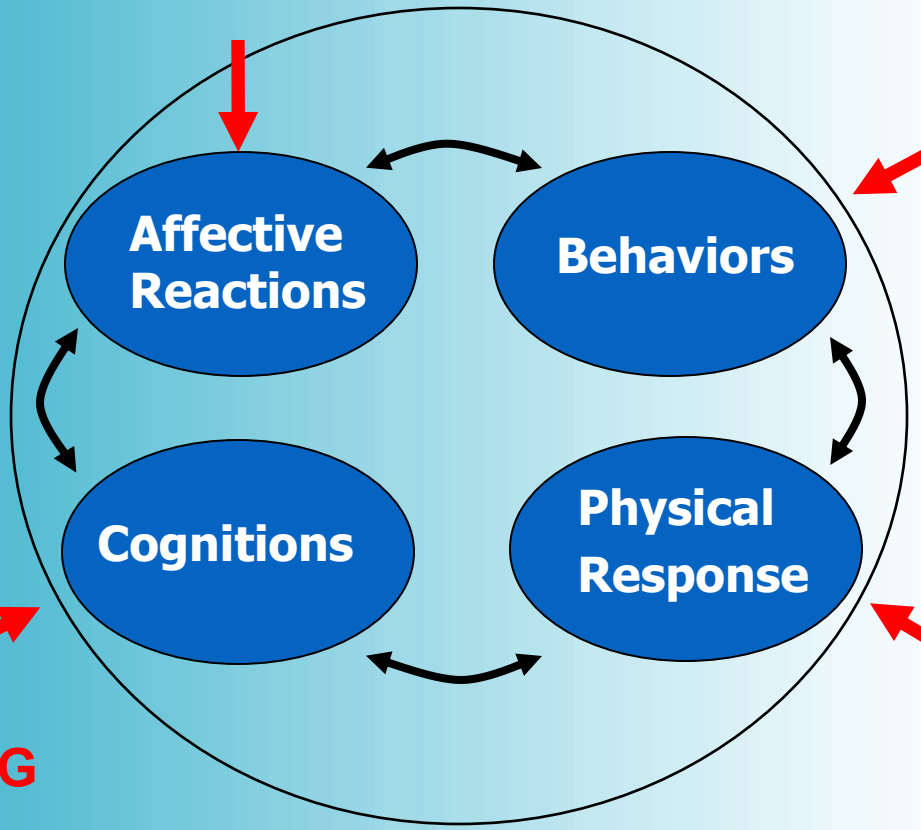

Genetics/Temperament
Learning History
Triggering Situation or Event
Affective Reactions
Behaviors
Cognitions
Physical Response
Episode/ Disorder
Family Environment
Other contextual Issues

CBT Treatment Principles

RECOGNIZE & ANTICIPATE

Triggering Situation or Event

AFFECTIVE EDUCATION & EMOTION EXPOSURE



ALTERNATE COPING RESPONSES; BEHAVIOR MANAGEMENTACTIVATION

Decrease in Sx/Remission

COGNITIVE RESTRUCTURING

RELAXATION TRAINING OR EXPOSURE

Effective Elements of CBT in SUD

- Functional Analysis of Triggers
- Education and monitoring of emotion and use
- Cognitive Restructuring
- Exposure: cues, non-use/sobriety samples & emotions
- Behavioral Activation/Management
- High Risk Coping/Relapse prevention planning

Example: Monitoring Log

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Date	Situation, Possible Contributing Circumstances, or Triggers	What emotion are you experiencing?	Rate intensity of emotion 0-100	What Thoughts, Images, or Impulses did you have? What did you do in response to these?	Amount/freq of substances used. If no use, rate urges to use (rate intensity 0-100)

FUNCTIONAL ANALYSIS FOR SUBSTANCE USE BEHAVIOR

External Triggers

1. Who are you usually with when you use?

2. Where do you usually use?

3. When do you usually use?

Internal Triggers

1. What are you usually thinking about right before you use?

2. What are you usually feeling physically right before you use?

3. What are you usually feeling emotionally right before you use?

Using Behavior

1. What do you usually use?

2. How much do you usually use?

3. Over how long a period of time do you usually use?

Short-Term +Consequences Good things (rewards)

1. What do you like about using with (who)?

2. What do you like about using (where)?

3. What do you like about using (when)?

4. What are the pleasant thoughts you have while using?

5. What are the pleasant physical feelings you have while using?

6. What are the pleasant emotions you have while using?

Long-Term -Consequences Not so good things

1. What are the negative results of your using in each of these areas:

a) Interpersonal:

b) Physical:

c) Emotional:

d) Legal:

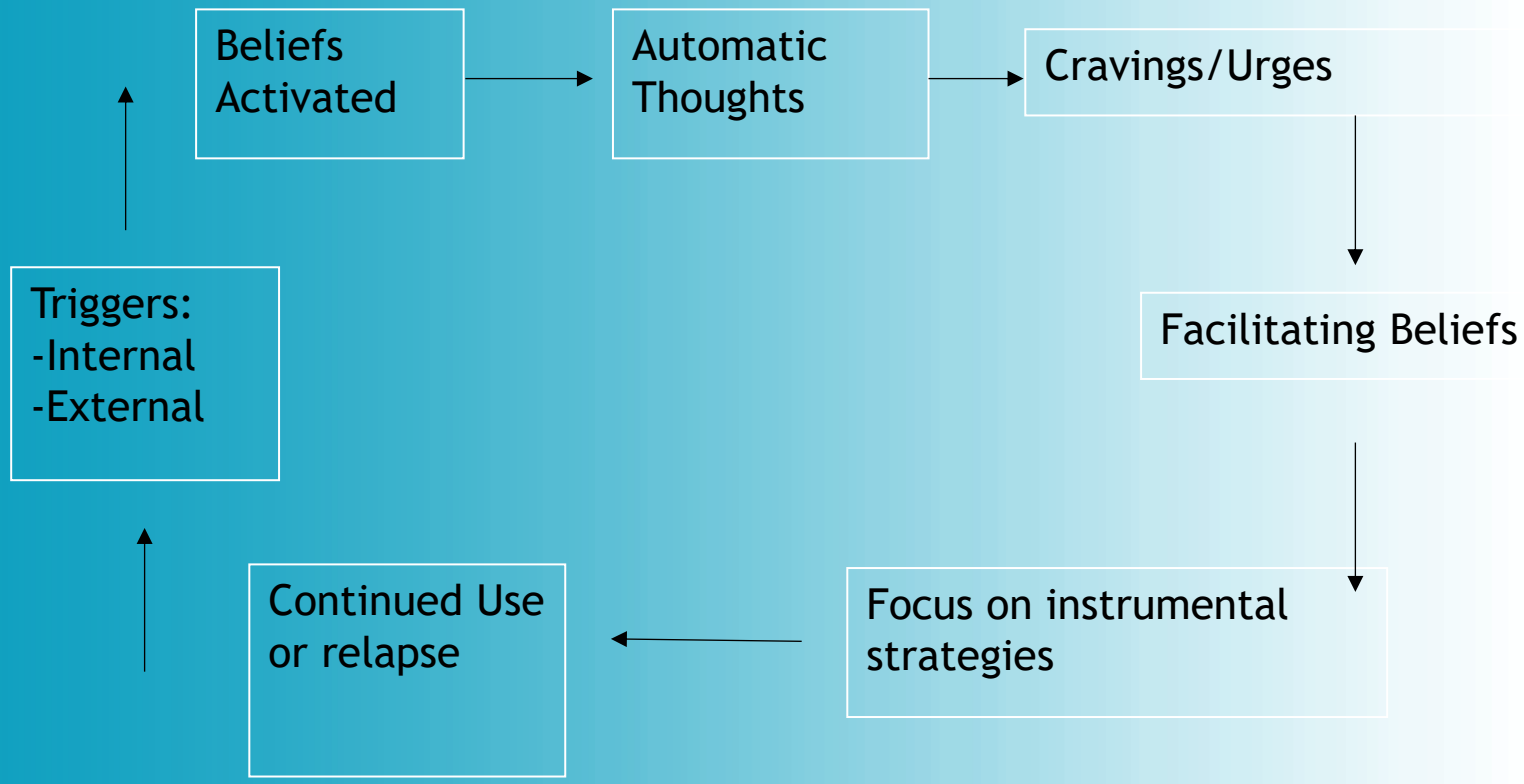
e) Job:

f) Financial:

g) Other:

(Meyers & Smith, 2003)

Specific Cognitive Model to SUD



Beck, Wright, Newman, Liese, 1994

Cognitions Specific to SUD

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- Three common types:
  - Anticipatory
    - Some expectation of reward
    - "It's going to feel so good." "Can't wait to score dope & chill."
  - Relief-oriented
    - Substance will alter mental state
    - → Social facilitation, feel pleasure, ease anxiety/tension
    - "I can't tolerate anxiety," "This will stop my withdrawal symptoms"
  - Facilitative or permission giving
    - Use as acceptable, necessary, or justifiable
    - "I'll stop after one," "I have to use cocaine to concentrate,"
    - "I'm clean from opiates, MJ isn't my problem."
    - "It's been a rough week, I deserve to kick back."

Case Example

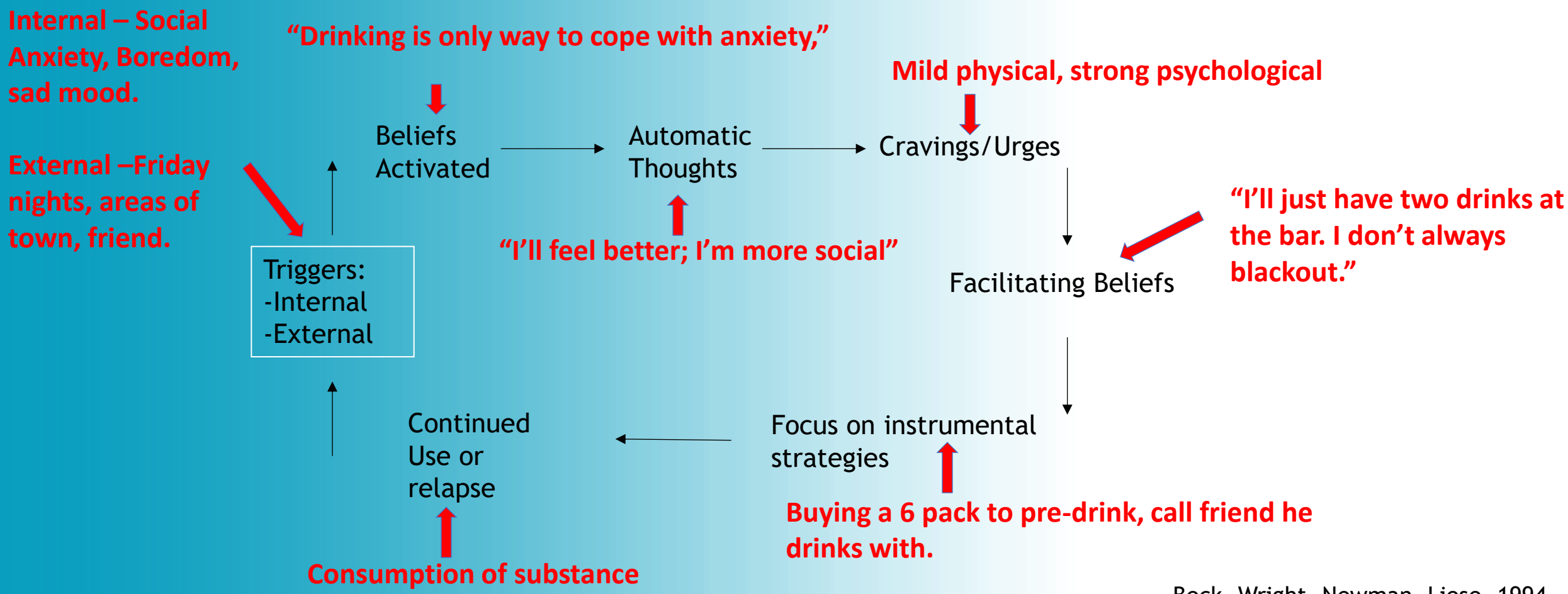
- Steve 20 y/o college sophomore:
  - Asked to seek addiction care after EMT called to dorm
  - Dx Alcohol Use Disorder - Moderate (binge drinking 2-3 x week 10 drinks, several blackouts, poor grades, tolerance)
  - Social Anxiety Disorder – avoids friends, talking in class, going out (unless drinking)
- Family Hx: Father: Past alcoholism prior to pt's

  Mother: Generalized Anxiety disorder on SSRI
- Extra-familial/learning hx: Picked on from grades 3 - 8th, then 10th grade changed schools. More recently, grades down since Freshman year – starting to struggle academically → possible academic probation.

Treatment Course

- Conduct initial assessment of substance use history as well as history of social anxiety
- Referral to psychiatrist
- Develop treatment goals – operationalize reduce use and what social goals he has
- Introduce Treatment Approach - CBT model and apply to his context (genetics, family, bully hx)
- Start with education about relationship between anxiety and alcohol use
- Self-monitor anxiety and drinking and conduct FA of use to identify High Risk situations
- Review Cognitive Model of drinking & cognitions relevant to social anxiety

Steve's Cognitive Model to SUD



Beck, Wright, Newman, Liese, 1994

Treatment Course Cont'd

- Challenge beliefs and automatic thoughts with cognitive restructuring
- Exposures: create fear & avoidance hierarchy and link with moderation of alcohol use in graded way
- Behavior modification: return to guitar playing, avoid area of town used to buy alcohol
- Engage in AA (make part of social exposures)
- Parental Involvement with parent coach

High Risk Planning

- Develop Relapse Prevention (RP) and Relapse Intervention (RI) plan
- Goal: Enhance coping self-efficacy
- High risk situations (Steve):
  - Isolation, Friday night, anxiety, certain peers
  - RP: Other activities, expand peer network, anxiety managing through CBT, avoid certain areas of town
  - RI: Escape/avoid, page therapist, call trusted peers
- Build coping language: “There are other ways to deal with anxiety.” “I can see friends without being drunk.”

Challenges in CBT with SUD

- Monitoring behaviors
- Practicing skills out of session
- Motivation
- Cognitive impairment
- Timing: severity of SUD
- Severity of co-occurring psychiatric issues
- Fidelity to CBT model

Take Homes:

- CBT is an effective intervention to address substance use and co-occurring psychiatry disorders

- Similarities to standard CBT:
  - Session structure, monitoring behavior/FA, CBT model, general thinking traps/cognitive distortions, use of exposure

- Key differences:
  - Present the additional substance use cognitive model
  - Address substance specific Beliefs: Anticipatory, Relief, Facilitating
  - Modify exposures – may be a gradual decrease of use concurrent with other exposure, cue exposure
  - High Risk situations – develop RP and RI plans

Thank You

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