

CHAPTER 1

OVERVIEW

The term *addiction* is ubiquitous, and we hear it applied to problematic use of alcohol and other drugs, as well as addictions that don't involve ingested substances—the so-called behavioral addictions. We hear the term used in everyday discourse, as people characterize certain habits as addictions. If you ask some people trying to lose weight why they just ate a pan of brownies, they might say, “I have a chocolate addiction” or “I’m a chocoholic.” If you ask some long-distance runners why they run long distances they might say, “I’m addicted to running.” But what exactly is an addiction? When is it appropriate to use this term to characterize human behavior?

In this text we focus on both chemical (or substance) and behavioral addictions. This is based on our understanding that certain cognitive, behavioral, affective, and physiological processes are analogous across addictions, as well as a substantial body of research that supports the reliability and validity of certain behavioral addiction diagnoses. We review various approaches to defining addictions, starting with the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013). In the DSM-5, the phrase *addictive disorder* is introduced as a mental disorder characterized by behaviors that persist despite their serious problematic consequences. Relatively new to the DSM-5 (and other diagnostic standards) is the notion that an individual can have varying degrees of addictive disorders, depending on the number of symptoms that are manifest. Also, relatively new to the DSM-5 is the inclusion of gambling disorder as an addictive disorder and problematic Internet gaming under consideration as an addictive disorder.

To assist in defining *addiction*, let's consider the case of Bob, who says he drinks “just one or two beers most nights of the week.” When Bob goes out to eat with his wife, Mary, he drives home despite having consumed several beers. At least once a week he wakes up with a hangover, goes to work feeling “fuzzy,” and

finds it difficult to do his job as a project manager. He denies other alcohol-related problems (e.g., unsuccessful efforts to cut down or quit, craving, withdrawal, tolerance, health problems). Mary, on the other hand, starts drinking before noon every day, even though she has been warned by her doctor that heavy drinking may be contributing to her hypertension. When she starts slurring her words and becomes “sloppy,” Bob urges her to stop drinking, which inevitably leads to arguments. When Bob tries to talk to Mary about her behaviors on a previous night, she has often forgotten (i.e., blacked out) much of the night. Though she would not admit this to Bob, Mary has tried to quit drinking after being fired from several retail sales jobs, but each time she quits she starts again because she feels restless and shaky after only a few hours of abstinence.

Bob likely has a *mild* alcohol problem. He regularly drives after consuming alcohol and his drinking results in hangovers that interfere with his work. From the information we have on Bob, it is not certain that he is addicted to alcohol. Mary likely has a more *severe* alcohol problem: She spends most of her day intoxicated, she has blackouts and has been warned to stop drinking because it is the likely cause of her hypertension, she has been unable to quit drinking, when she tries to quit she experiences alcohol withdrawal, she argues with Bob about her drinking, and she has been fired from several jobs as a result of drinking. Based on the information we have for Mary, it might be reasonable to conclude that she is addicted to alcohol.

Bob and Mary are hardly alone in having alcohol problems. In fact, when the United States Substance Abuse and Mental Health Services Administration (SAMHSA) conducted its 2019 National Survey on Drug Use and Health (NSDUH; SAMHSA, 2020), it was found that approximately 5.3% of Americans over 12 years old (14.5 million people) have alcohol use disorders (AUDs). Of particular interest when thinking about Bob (with mild AUD) and Mary (with severe AUD) is the fact that men are more likely to have AUD than women (7.8% vs. 4.1%; SAMHSA, 2017).

When our earlier text, *Cognitive Therapy of Substance Abuse* (Beck et al., 1993), was written, the United States was in the midst of a *cocaine* epidemic. Presently the United States is in the midst of an *opioid* epidemic, with almost 5% of Americans over 12 years old (approximately 12.5 million) admitting to misuse of prescription pain relievers (SAMHSA, 2017). It is likely that the primary reason for labeling the present situation as a *crisis* is the number of deaths associated with opioid misuse. In 2017, the number of Americans over 12 years old who died from all drug overdoses was 70,237. Approximately 68% of these deaths (47,600) involved opioids, which was a 12% increase from 2016 (Scholl, Seth, Kariisa, Wilson, & Baldwin, 2018). According to Scholl and colleagues (2018), the increase in all deaths was largely due to misuse of synthetic opioids (e.g., hydrocodone, oxycodone, tramadol, and fentanyl). The survey conducted by SAMHSA (2017) found that most of the 12.5 million people who misused prescription pain relievers did so to relieve

physical pain (62.6%). Other reasons cited for misuse were: to feel good or “get high” (12.1%), to relax or relieve tension (10.8%), for help with sleep (4.4%), to improve problematic emotions (3.3%), to experiment or “see what it’s like” (2.5%), “due to addiction” (2.3%), to increase or decrease the effect of other drugs (0.9%), and for other reasons (1.2%). Approximately 53.7% of individuals who misused opioids obtained them from friends or relatives, while 36.4% obtained their opioids with prescriptions obtained from a health care provider. Only 4.9% purchased their prescription pain relievers from drug dealers, and another 4.9% obtained their prescriptions in “some other way.”

Another change that has occurred since 1993 is that (as of this writing) marijuana has been legalized for medicinal use in 35 of the United States, and for recreational use in an additional 15 states, plus the District of Columbia (Bromwich, 2020); and these numbers are continually rising. For many years it was believed that marijuana was a “safe” drug. However, over the years it has become apparent that long-term consumption of marijuana may cause substantial physical and mental problems, especially in teenagers (National Institute on Drug Abuse, 2018b; Volkow, Baler, Compton, & Weiss, 2014).

Consider the case of John, an individual with serious marijuana-related problems. John is 30 years old. He has been smoking marijuana since high school, where he learned that selling pot was a convenient way to finance his daily use. He attended college for a while and made friends with other students who enjoyed getting high daily. By the middle of his first college semester he found himself unable to keep up with the academic challenges. Or more precisely, he found himself smoking marijuana instead of studying. He met and dated women, but none were interested in a serious relationship with a man who was always high. After dropping out of college, John found a landscaping job. He was fired after being arrested for possession of four ounces of marijuana, discovered when he was pulled over by police during a routine traffic stop—while driving the landscaping company truck. With the help of his family lawyer John was able to avoid incarceration. His parents allowed him to move into their home on the condition that he look for a job, but after more than a year, John gave up efforts and eventually reunited with old friends who spent much of their time high on marijuana.

Obviously, John has a serious cannabis-use problem. Instead of using recreationally or merely habitually, John uses marijuana in ways that cause severe consequences. And yet John does not choose to stop using marijuana, the cause of these severe consequences. Many would argue that John’s cannabis use has escalated to a level that would qualify as an addiction.

In comparison with John, consider the case of Jill, a 40-year-old woman with a long history of substance use disorders (SUDs) prior to her first experience with gambling. Beginning in high school, she smoked cigarettes and marijuana, used cocaine and methamphetamine, and drank heavily. Then, 11 years ago, she was

arrested for assault, disorderly conduct, and possession of cocaine, after police were called during a fight with her boyfriend. Following a brief period of incarceration, Jill made a conscious choice to remain abstinent from all addictive substances. She found a job working the evening shift at a local factory, moved into an apartment, and was eventually able to purchase a car. She regularly attended Alcoholics Anonymous (AA) meetings and found them to be helpful. In fact, this is where she met Gary, whom she dated for almost a year before they were married.

Jill's gambling problem began innocently enough: She was invited by a coworker to a casino after work "just to relax and have a little fun." Upon arriving there, Jill says she "felt like a kid in a candy shop." She could not believe there was so much activity anywhere this late at night: bright lights, flashing slot machines, bells and whistles throughout the casino. Wherever she turned, people were smoking and drinking. Much to her surprise, she was more drawn to the sight and sounds of slot machines than she was to alcohol and cigarettes. Before long, she began to have what she described as "a strange experience." She began to feel the familiar rush that she had experienced so often when using alcohol and drugs. In her words, "It felt amazing!" She was able to achieve a familiar high without ingesting an addictive substance. By the end of her first night of gambling Jill knew with certainty that she was hooked. Sure enough, within a few months Jill was going to casinos most nights of the week. Though she continued to abstain from addictive substances, she described "miserable hangovers after long nights of gambling." Before long she was having some of the same problems with gambling that she had with alcohol and drugs: No amount of gambling felt like enough; she was spending all her free time at casinos; when she was not gambling she would fantasize about gambling; she was taking money out of her meager savings account to spend at casinos; she was lying to Gary about spending time with friends; and perhaps most troubling, she felt like she had lost control and was unable to stop gambling. As hard as she tried, quitting seemed impossible. In fact, she described efforts to abstain from gambling as "harder than all her other addictions." Eventually she began to have severe financial problems that ultimately led to bankruptcy and the dissolution of her marriage. As illustrated by Jill's experiences, the suffering associated with gambling disorder—a behavioral addiction—can be as punishing as that from substance addictions.

CHEMICAL AND BEHAVIORAL ADDICTIONS: MORE ALIKE THAN DIFFERENT

Howard Shaffer has made an important contribution to the field of addictions by studying gambling disorder and pioneering *the addiction syndrome* (Shaffer, 2012; Shaffer & Hall, 2002; Shaffer et al., 2004). Shaffer and his colleagues describe

the addiction syndrome as a complex pattern that underlies all addictive behaviors. Instead of viewing individual addictions (e.g., alcohol, marijuana, opioids, gambling, gaming) as unique and separate, all addictions are understood to have similar distal (past) antecedents, proximal (recent) antecedents, and consequences (e.g., expressions, manifestations, and sequelae). According to this model, the various addictive behaviors and chemicals are mere *objects* that have the capacity to “shift subjective experience reliably and robustly” (Shaffer, 2012, p. xxxi). These chemical and behavioral *shifters* activate similar reward centers of the brain. The addiction syndrome provides an integration of neurobiological elements, shared psychosocial elements, and shared experiences: The brain’s reward system is similarly activated by addictive substances and behaviors; individuals with addictions tend to have similar psychological problems, and the course of addictive behaviors tends to be similar across addictions. Thus, the model emphasizes commonalities among the various addictive processes.

It is important to understand that the early consequences of addictive behaviors are positive, which is why people initially engage in them. Alcohol has the potential to relax, excite, and disinhibit; marijuana has potential to mellow; amphetamines have the potential to energize; opioids have the potential to relieve pain; and gambling has the capacity to generate excitement about the prospect of big winnings. It is important to understand that these effects in persons who are addicted overshadow the negative consequences of engaging in them—at least initially. As long as individuals believe positive consequences will outweigh negative consequences of addictive behaviors, they will be tempted to engage in them.

Obviously, there are numerous negative consequences associated with addictive behaviors. Shaffer and colleagues (2012, 2004) conveniently divide these into two categories: those that are unique to each addictive behavior and those that are shared across addictive behaviors. Examples of *unique* consequences include liver disease (alcohol), pulmonary and cardiovascular disease (smoking), financial problems (gambling), legal problems (illicit drugs), and death from overdose (opioids). Examples of *shared* negative consequences include tolerance, withdrawal, relapse, psychiatric comorbidity, object substitution, social drift, criminal behavior, stigma, and more. A major aim of CBT for addictions is to help individuals acknowledge the negative consequences of their addictive behaviors, while also understanding that their anticipation of positive consequences serves to maintain their addictions.

Another way to conceptualize both substance and behavioral addictions has been proposed by Mark Griffiths, who has done extensive research and published hundreds of scientific papers on behavioral addictions. Griffiths (2005) explains that “most official definitions [of addiction] concentrate on drug ingestion” (p. 192). He recommends the use of six components that focus primarily on addiction processes or patterns, rather than on any particular substance or activity:

1. ***Salience***: For a substance or behavior to be addictive, it has to be salient or important to an individual. Salience might be reflected in excessive use or engagement, or it might be reflected in frequent or intense thoughts about the substance or behavior. A high degree of salience might also be viewed as an obsession or preoccupation with the addictive behavior.

2. ***Mood modification***: For a substance or behavior to be addictive, it has to impact emotions, feelings, or mood. For some individuals the sought-after mood might involve feeling more “up” (i.e., exhilarated or energized), while for others the sought-after mood might be “down” (i.e., mellow or relaxed). And for many individuals, mood modification is experienced as decreased physical pain, anxiety, depression, anger, or withdrawal.

3. ***Tolerance***: Individuals who need greater amounts of a substance or behavior to experience the same effects have developed a tolerance, which is a strong indicator of addiction.

4. ***Withdrawal***: Many people who try to quit addictive behaviors experience negative physical or psychological consequences, or withdrawal. The nature and degree of withdrawal depends on various factors; among them is frequency and quantity of the addictive behavior, but also the specific substance or behavior involved. For example, alcohol withdrawal can result in seizures and death, opioid withdrawal can feel like a terrible bout of influenza, and abstinence from gambling may result in anxiety or depression.

5. ***Conflict***: The term *conflict* brings to mind a disagreement between two individuals. However, in the context of addictions this term relates to both interpersonal conflict (between people) and intrapersonal conflict (within oneself). Simply stated, the most common such intrapersonal conflict involves the thought, “I really shouldn’t be doing this.”

6. ***Relapse***: Trying to change, reduce, or quit addictive behaviors is not easy, and perhaps that is why many consider relapse the hallmark of addiction.

We find the Griffiths model to be simple and easy to explain to patients. For example, when John (from the case example above) initially came in for therapy he asked his therapist, “Do you think I am an addict?” In response his therapist explained Griffiths’ six components, and John agreed: “They all kinda’ sound like me.”

The approaches to SUDs and addictive behaviors described above are all useful, and there is substantial overlap among them. We suggest that therapists familiarize themselves with each one, since they all provide a unique and useful perspective. For example, the DSM-5 (American Psychiatric Association, 2013) provides specific diagnostic criteria; the addiction syndrome (Shaffer et al., 2004; Shaffer, 2012) provides a unique, evidence-based theoretical and developmental

perspective; and Griffiths' (2005) model relates to chemical and behavioral addictions in a way that is straightforward and easily understood by most patients.

As mentioned earlier, throughout this text we interchange the terms *addiction*, *substance use disorder*, and *addictive behavior*. We advocate for using terms that *minimize the stigma* associate with negative labels. For example, we avoid terms like *drug addict* and *alcoholic*, instead using phrases like “a person who has problems with [alcohol, drugs, gambling, etc.]” We even avoid terms like *dirty urine*, with the understanding that they may be pejorative (Kelly, Wakeman, & Saitz, 2015).

CBT FOR ADDICTIONS

Misconceptions of CBT are common (Gluhoski, 1994). In fact, during workshops we often hear participants say, “This CBT is different from what I’ve learned about CBT.” So before describing our approach to CBT for addictions, we thought it important to underscore what CBT *is not*. The following are some misconceptions regarding CBT:

- CBT is merely a collection of standardized techniques, like a bag of tricks.
- CBT is mechanical and linear, to be followed like a cookbook recipe.
- CBT minimizes the importance of patients’ early life experiences, and especially childhood experiences.
- CBT minimizes the importance of patients’ interpersonal relationships (e.g., family and friends).
- CBT minimizes the importance of the therapeutic relationship.
- CBT is necessarily brief, or short-term.
- CBT aims exclusively for abstinence from addictive behaviors without regard for other psychological problems.
- CBT is so effective that clinicians should expect all patients to resolve their addictions and experience substantial benefits from therapy.

Most stereotypical images of CBT portray therapists more as robots or computers than as real people. This has been the case stretching all the way back to the early days of CBT (Beck, Rush, Shaw, & Emery, 1979):

Cognitive and behavioral techniques often seem deceptively simple. Consequently, the neophyte therapist may become “gimmick-oriented” to the point of ignoring the human aspects of the therapist-patient interaction. When this occurs, [the therapist] may relate to the patient as one computer to another rather than as one person to another. Some young therapists who are most skilled in applying the specific techniques are perceived by their patients as

mechanical, manipulative, and more interested in the techniques than in the patient. It is important to keep in mind that the techniques . . . are intended to be applied in a tactful, therapeutic, and human manner by a fallible person—the therapist. (p. 46)

In reality, CBT employs a complex process, described briefly here and in much more detail in later chapters. Addictions tend to be chronic, self-reinforcing problems, characterized by intermittent relapses. Hence, CBT for SUDs and addictive behaviors often requires long-term patient engagement (McLellan, 2002; McLellan, Lewis, O'Brien, & Kleber, 2000). Of course, the length of engagement is dependent on many individual and contextual variables. Furthermore, addictive behaviors tend to occur in vicious cycles, initiated for the purpose of regulating emotions, but eventually causing emotion dysregulation that perpetuates and exacerbates the original addictive behaviors. As a result, treatment is rarely linear, with a distinct beginning, middle, and end. Instead there are often ups and downs for patients recovering from substance use problems. To be effective, CBT requires an accurate understanding (i.e., case conceptualization) of each patient. To be useful, the case conceptualization should include relevant information about early and current life circumstances (i.e., context). Unless we have such context, it is difficult (if not impossible) to understand an individual's addictive behaviors and barriers to change. For example, without knowledge of a patient's family history of addictions or close relationships with other addicted individuals it may be difficult to comprehend the intractability of their addictions. In addition, the absence of a thorough case conceptualization and collaborative therapeutic alliance increases the likelihood that a patient will disengage from therapy (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013; Liese & Beck, 1998).

There is no single, definitive approach to CBT. In fact, many knowledgeable CBT practitioners and researchers refer to CBT in the plural form (i.e., cognitive-behavioral *therapies*). The following CBT approaches have all been successfully applied to the treatment of addictive behaviors: acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2012), behavioral activation (BA; Daughters et al., 2018; Daughters, Magidson, Lejuez, & Chen, 2016), contingency management (CM; Petry, 2012), community reinforcement and family therapy (CRAFT; Meyers & Squires, 2001), dialectical behavior therapy (DBT; Linehan, 2015), mindfulness-based relapse prevention (Bowen, Chawla, Grow, & Marlatt, 2021; Witkiewitz, Marlatt, & Walker, 2005), and more.¹

¹We especially wish to credit Alan Marlatt for introducing relapse prevention (Marlatt & Gordon, 1985), which sowed the seeds of CBT for addictions. Dr. Marlatt and these other scholars have greatly advanced CBT for addictions, and we acknowledge that our work has been profoundly influenced by their vital contributions.

Five Major Components of CBT for Addictions

Since publishing *Cognitive Therapy of Substance Abuse*, we have been modifying and refining our approach to both individual and group CBT (Liese, 2014; Liese, Beck, & Seaton, 2002; Liese & Tripp, 2018; Wenzel, Liese, Beck, & Friedman-Wheeler, 2012). We find it helpful to view CBT as consisting of five major components: (1) structure, (2) collaboration, (3) case conceptualization, (4) psychoeducation, and (5) standardized techniques. In fact, we have observed that all CBTs place emphasis on these components, though to varying degrees. These components are briefly described in the following paragraphs, and then discussed in detail throughout this text.

Structure is best thought of as the process necessary for staying focused throughout a therapy session. Most therapists (and indeed many patients) have had the experience of being in the midst of a session wondering, “How is this conversation relevant to the presented problem?” or “Why are we talking about all these details and not the main problem?” When it is done well, CBT keeps the discussion in a session on track. By design, it is a structured, focused approach to helping people with addictions.

Structure also involves organizing sessions in such a way that problems are defined and addressed. Our approach to CBT can be conducted in individual, family, or group modalities. When provided individually, we start each session by setting an agenda. This process can be either formal or relaxed, depending on the patient and other circumstances. For example, patients who are generally well organized and in minimal distress might prefer sessions that are highly structured, while patients who are less organized or in substantial distress might benefit from a more flexible structure. Agenda setting is followed by a mood check, reflections from last session(s), prioritizing agenda items, and then problem solving. In group CBT, patients share their names, addictions, status of their addictions, goals, and contexts in which their addictions take place. Again, the structure of individual and group CBT will be discussed in detail in later chapters.

Collaboration is typically thought of as key to the therapeutic bond, alliance, or relationship. The ability to form alliances across a wide range of patients is essential to therapist effectiveness, and certain interpersonal skills enable such alliances to be established (Wampold, Baldwin, Holtforth, & Imel, 2017). We strongly advocate for therapists’ attention to their own interpersonal skills, which are needed to the fullest extent possible when practicing CBT. While this may seem simple and straightforward, many therapists find it difficult to be warm and empathetic with patients who struggle with lapses and relapses.

Mutual goal setting and goal achievement are also vital to the therapeutic relationship. The process of agreeing on goals is often more complex than most therapists expect. Many patients feel uncomfortable committing to goals they have failed to achieve in the past. Given the reinforcing nature of addictions, many

patients also find it difficult to maintain motivation to change. From minute to minute, day to day, week to week, patients' enthusiasm for achieving particular goals may wax and wane, corresponding with their moods, circumstances, and so forth. In order to maintain collaborative alliances with patients, it is important that therapists avoid being emotionally reactive to patients' goal-related failures and successes.

Case conceptualization involves the identification, organization, and integration of patients' thoughts, beliefs, schemas, triggers, predominant emotions, and behaviors—with close attention paid to how these have developed. Essential contextual components of the case conceptualization may include friends, family, and the communities in which patients live. Other components may include underlying medical, psychological, or psychiatric problems that might contribute to or exacerbate addictive behaviors. For example, many patients use addictive behaviors to self-medicate anxiety, depression, bipolar disorder, and schizophrenia—or opioids to treat physical pain. In order to develop accurate case conceptualizations, therapists must possess highly effective listening skills and the ability to accurately empathize with patients who often behave in self-defeating ways. Additionally, therapists must be able to formulate hypotheses regarding the etiology and function of addictive behaviors in patients' lives—and then test these hypotheses during their clinical encounters with patients.

Psychoeducation involves transmitting knowledge or skills: either directly, through modeling, or by the process of active, *reflective* listening. Sometimes it is appropriate for the therapist to explain CBT concepts or processes, while at other times doing so might be perceived by patients to be untimely or irrelevant. The determination of when it is most appropriate to teach CBT concepts is an essential part of the case conceptualization and collaborative therapeutic relationship.

Standardized techniques are formal activities designed to guide cognitive, behavioral, or affective changes. Just a few examples of CBT techniques are advantages–disadvantages analysis, automatic thought records, and functional analysis. These and other standardized techniques will be described in detail in Chapter 7. As mentioned earlier, one of the most pervasive misconceptions of CBT is that standardized, *cookbook-like* techniques are at the heart of therapy. In fact, choosing the right standardized techniques for patients requires careful consideration and attention to the case conceptualization and collaborative therapeutic relationship.

How Does Our Approach to CBT Compare to Others?

Years ago, Dr. Aaron Beck walked into a restaurant, looked around, saw that everything was run well, and said, “They must be doing cognitive therapy here.” When asked what he meant by this Dr. Beck explained, “Regardless of setting, good work requires good thinking.” We submit that all effective therapies facilitate “good

thinking.” For example, ACT therapists facilitate acceptance, behavioral activation therapists facilitate the identification of personal values and associated behaviors, mindfulness-based relapse prevention therapists facilitate greater mindfulness, and so forth. Strangers to 12-step programs might be surprised to learn many 12-step slogans involve good thinking that you might expect to learn in CBT, for example in the recurring reminders, “This too shall pass,” “Live and let live,” “Cultivate an attitude of gratitude,” and “Your worth should never depend on another person’s opinion” (12step.org, 2018).

Most clinicians are familiar with the process of motivational interviewing (Miller & Rollnick, 2012) and the stages of change model (Norcross, Krebs, & Prochaska, 2011; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Norcross, 2001). These terms have become commonplace in the treatment world because they are useful and relevant to all approaches to treating addictive behaviors. Simply stated, motivational interviewing (MI) is an approach to helping people that *meets them where they are* in order to facilitate change. MI requires active listening, empathy, flexibility, collaboration, and effective interpersonal communication. The stages of change model (also known as the transtheoretical model of change) provides a framework for understanding a person’s readiness to change, ranging from precontemplation (not yet considering change) to maintenance (life after change).

It is our position that all cognitive-behavioral therapists should have MI skills (e.g., effective listening, accurate empathy, collaboration). We also maintain that cognitive-behavioral therapists should have a keen awareness of patients’ readiness to change. In fact, an individual’s readiness to change should be part of the case conceptualization and influence how therapists decide to structure sessions, engage in psychoeducation, and facilitate standardized techniques. A therapist who attends to readiness to change is most likely to apply structure, psychoeducation, and techniques in ways that enhance collaboration, while a therapist who ignores a patient’s readiness to change may do irreparable damage to the therapeutic relationship.

One of the authors, Dr. Bruce Liese, was facilitating a workshop on CBT for addictions several years ago. During a break, one of the participants approached him and boldly stated, “You are teaching and demonstrating MI.” Dr. Liese responded by asking, “What makes you say that?” The participant explained that she was systematically rating his role-play demonstrations with the Motivational Interviewing Treatment Integrity scale (MITI; Moyers, Manuel, & Ernst, 2014), and all demonstrations received high MI scores. Examples of positive anchors on this motivational interviewing scale include:

- Uses structured therapeutic tasks as a way of eliciting and reinforcing change talk
- Does not miss opportunities to explore more deeply when client offers change talk

- Strategically elicits change talk and consistently responds to it when offered
- Rarely misses opportunities to build momentum of change talk
- Genuinely negotiates the agenda and goals for the session
- Indicates curiosity about client ideas through querying and listening
- Facilitates client evaluation of options and planning

The lesson to be learned here is simply that effective CBT incorporates basic MI skills.

Differences between our approach and other cognitive-behavioral approaches are minimal, but essential. We offer unique structure for individual CBT sessions (see Chapter 5) and group CBT sessions (see Chapter 12), which sets us apart from most other approaches. We also stress the mantra: “To do good CBT, it is necessary to *think* like a cognitive-behavioral therapist.” Highly effective therapists perpetually ask patients questions like:

“What was your thought when you made that decision?”

“What is the evidence for that thought?”

“What is your belief about [fill in the blank]?”

“How did you develop that belief?”

“What are the advantages and disadvantages of that choice?”

The goal of asking these questions is not solely to influence change. These questions are also intended to expand therapists’ understanding of patients, in order to facilitate patients’ self-understanding. Patients who continually hear therapists ask, “What were you thinking when . . . ?” and “What are your beliefs about . . . ?” come to understand that these questions are important, and they eventually develop the habit of asking themselves these questions as they strive to make effective decisions and solve life problems.

WHAT ARE THE GOALS OF CBT FOR ADDICTIONS?

People with serious addictions are at risk for many problems, including social, interpersonal, vocational, health, legal, and financial difficulties. To the extent that addictions have caused, exacerbated, or maintained these problems, the goal of CBT is to help people to abstain. However, many individuals seeking help for addictions do not wish to abstain from their addictive behaviors. Furthermore, most people who attempt to abstain from addictive behaviors experience multiple relapses prior to achieving sustained abstinence. In an excellent review of the recovery literature, Witkiewitz and her colleagues (2020, p. 9) remind us that there are “multidimensional and heterogeneous pathways to recovery.” So even though

abstinence might be a goal to strive for, therapists must be careful to avoid passing judgment on or of becoming frustrated with patients who do not abstain.

We strongly discourage debating with patients regarding abstinence versus control of addictive behaviors. Instead we suggest therapists encourage patients to set their own goals in a deliberate, intentional manner, and then review these goals over the course of therapy. We also emphasize that *failing to meet goals* (e.g., experiencing relapses) provides opportunities for patients to learn about themselves. To complicate matters, complete abstinence from some potentially addictive behaviors is not possible or realistic (e.g., a person who binge eats cannot completely abstain from eating food).

Understanding the principles of the harm reduction is especially helpful for therapists whose clients reject abstinence as their goal. In the spirit of harm reduction (Marlatt, Larimer, & Witkiewitz, 2012), we encourage collaborative goal setting that goes beyond addictive behaviors to include all changes that improve the quality of patients' lives. We offer a detailed discussion of harm reduction in Chapter 13.

It is also important to note that *medication-assisted treatment* (MAT) is among the evidence-based modes of therapy for addictions. For example, methadone, buprenorphine, and naltrexone are all used as medications for opioid use disorder (MOUD). It is reasonable to view these medications as harm-reduction approaches. And yet, many treatment programs do not accept the use of these medications as part of therapy, and many therapists still believe any drug use is wrong and bad.

Given the demonstrated efficacy of certain medications for certain addictions, it is important for cognitive-behavioral therapists to understand their mechanisms of action (i.e., why they are effective), and support patients whose goals include MAT. Supporting this goal is another way for therapists to express support for patients. In many cases, MAT provides a level of relief that enables patients to address other, perhaps more important, goals (e.g., the acquisition of skills). Therapists can find extensive detailed information about MAT and MOUD on the website of the National Institute on Drug Abuse (NIDA; <https://www.drugabuse.gov>).

SUMMARY

We often detect frustration in clinicians who treat people with addictions. This frustration may result from unrealistic and sometimes even judgmental beliefs about patients who engage in addictive behaviors (see Chapter 4). Frustration results also from unrealistic expectations regarding the clinical course of addictive behaviors. Therapists who hold negative, judgmental beliefs about people with

addictions will inevitably experience frustration, irritation, and disappointment as they try to provide treatment. And therapists who expect the clinical course of addictions to be brief are also likely to find themselves disappointed.

Yet helping people with addictions can be deeply rewarding. When CBT for addictions goes as planned, patients have better lives than they may have imagined possible. They realize that life without addictive behaviors is full of possibilities. And when all does *not* go as planned, and yet the therapeutic relationship remains strong, patients are often eternally grateful for the help and support they receive from therapists who have played an extraordinarily important role in their lives.

We hope you find this book helpful for conducting CBT with people who have chemical and behavioral addictions. And we hope you find this work as rewarding as we do.

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