What to Consider When CBT for Addictions is not Working

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How effective is treatment?

- While studies have demonstrated the efficacy of CBT for the treatment of addictions, no therapy is 100% effective
- People respond differently to different treatment modalities
- Some people with addictions benefit most from psychotherapy
- Some benefit most from mutual help groups
  - 12-step groups
  - SMART Recovery groups
- Some benefit most from MAT or MOUD
- Some benefit most from self-guided change

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What makes therapy effective?

- People respond differently to the same therapy or therapist
- Some patients benefit most from directive therapy
- Some benefit most from nondirective therapy
- Some benefit most from a high degree of structure
- Some benefit most from much less structure
- Some benefit most from a close therapeutic relationship
- Some benefit most from specific techniques (e.g., thought records, advantages-disadvantages analyses, scheduling, behavioral activation, etc.)
- Implication: therapists' range is vitally important

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How does a clinician know when therapy is not working?

Patients:

- Say they are committed to change, but continue to use or relapse
- Don't do homework they have agreed to do
- Repeatedly describe barriers to change (e.g., "I can't…because.")
- Say they can't think of anything to work on
- Miss sessions or regularly come late to them
- Seem disinterested or detached during sessions
- Trigger therapist boredom, frustration, or detachment during sessions

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What to do when psychotherapy fails

- "Sometimes patients withdraw from unhelpful treatment; but if they do not, the therapist and patient might continue a resigned hobbled dance in which neither of them believes."
- "Clinicians can fall back on a vague, interminable, unarticulated, and unfocused so-called supportive therapy, comforting themselves with the hope that some human contact and support is probably better than nothing…"
- "…Such treatment could consolidate chronicity and risk, creating dependence on the therapist that is never addressed or worked through, worsening the patient's sense of helplessness and powerlessness. (p.186)

Markowitz & Milrod (2015). Lancet Psychiatry, 2, 186-190

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Case study #1

- Mrs. Brown is in her 60s; her physician has referred her for help with alcohol use, gambling, and cigarette smoking
- Mrs. Brown readily admits to a history of IV drug use 30 years ago, but hasn't used IV drugs since then; says NA was beneficial
- She drinks one pint of vodka daily, smokes 1 ppd, and gambles several times every week. She admits that these activities have caused significant harm and says, "I know I should stop."
- Near the end of a session her therapist asks for feedback and she says, "This helps; that's why I keep coming back. Other therapists have [done therapy differently] and that didn't help me."

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Case study #2

- Mrs. White is in her 60s; her physician has referred her help with alcohol use, gambling, and cigarette smoking
- Mrs. White readily admits to a history of IV drug use 30 years ago, but hasn't used IV drugs since then; says NA was beneficial
- She drinks a six pack of beer daily, smokes 1 ppd, and gambles several times every week. She admits that these activities have caused significant harm and says, "I know I should stop."
- Near the end of a session her therapist asks for feedback and she says, "This helps; that's why I keep coming back. Other therapists have [done therapy differently] and that didn't help me."

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Case study #3

- Mr. Smith is in his 30s. He has a history of heavy alcohol use and he comes to each session with his wife, who is supportive, but firm in her desire to have him quit drinking
- Over several months he reduces his alcohol consumption, but his wife says they still have problems due to his drinking
- When asked in session #12, what he wants to work on in the session, he says, "I don't know. Things are pretty good."
- In response the therapist says, "At some point when things are pretty good, we can stop therapy. But, since you're here…
- In the next visit, only Ms. Smith shows up

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Case study #4

- Mr. Jones is in his 30s. He has a history of heavy alcohol use and he comes to each session with his wife, who is supportive, but firm in her desire to have him quit drinking
- Over several months he reduces his alcohol consumption, but his wife says they still have problems due to his drinking
- When asked in session #12, what he wants to work on in the session, he says, "I don't know. Things are pretty good."
- In response the therapist says, "At some point when things are pretty good, we can stop therapy. But, since you're here…
- In the next visit, both arrive, ready to work

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Case study #5

- Ms. Clark is in her 50s. She is single, has lived a rough life and experienced a lot of trauma; she has seen the same therapist for at least 10 years and is very fond of her; her therapist has helped Ms. Clark to stop using a variety of addictive substances
- The only addictive behavior Ms. Clark hasn't completely overcome is gambling; she gambles only once a week now, and says she would gamble much more if it weren't for therapy
- The therapist now sees Ms. Clark for 30-minute sessions, since she rarely has substantial items to discuss; whenever her therapist hints about their lack of current progress, she says, "If it weren't for you, I'd gamble every day and live under a bridge."

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What is CBT?

- CBT is not a single approach to therapy
- More accurately, there are multiple CBTs
- For example:

- Cognitive Therapy (CT)
- Rational Emotive Behavior Therapy (REBT)
- Acceptance and Commitment Therapy (ACT)
- Behavioral Activation (BA)
- Dialectical Behavior Therapy (DBT)
- Cognitive Processing Therapy (CPT)
- Contingency Management (CM)
- Mindfulness-based cognitive therapy (MBCT)

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Essential Components of CBT

- **Structure** – organization, use of time (order, scheduling)
- **Collaboration** – setting goals and expectations jointly, both inside and outside of sessions
- **Case conceptualization** – collecting personal information in order to establish context, distal and proximal antecedents, consequences of using, readiness to change
- **Psychoeducation** – what therapists wants patients to learn
- **Specific techniques** – activities that facilitate lasting change

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Cognitive-behavioral therapy (CBT) may be conveniently divided into content and process domains

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The content of CBT

- Often thought of as ***what*** needs to be changed
- ***Skills*** and ***knowledge*** that are considered important – often determined by theoretical model
  - ACT – Acceptance and commitment
  - CT – Maladaptive thoughts and beliefs
  - MBCT – Mindfulness and awareness
- ***Psychoeducation*** aims to provide knowledge
- ***Specific techniques*** aim to provide skills

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The process of CBT

- Often thought of as ***how*** change is facilitated
- Associated with ***common factors***
- **Structure** involves order, organization, rules of engagement, pace, focus
- **Collaboration** involves the establishment of common goals, therapeutic alliance, rupture identification and repair
- Personal style also influential

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Recommended structure

- Collaboratively set agenda, including addiction and non-addiction issues
- Check mood, including today and since the past visit
- Bridge from prior sessions (including any homework assigned, problems encountered, addictive behaviors, major life changes, and so forth)
- Prioritize and address agenda items (through guided discovery, education, collaborative empiricism, the application of structured techniques, etc.)
- Provide capsule summaries throughout
- Agree to homework as needed
- Elicit feedback throughout
- Provide closure and plan for follow-up

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Case conceptualization

- Collection and synthesis of information related to problem(s)
- Should be viewed as an ongoing, ever-evolving process of formulating and testing hypotheses
- Requires a solid foundation of empathy
- Profoundly influenced by theoretical model (focal points)
- Identifies deficits, as well targets for change
- Most important of the five components of therapy because management of other components depends on it

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Case conceptualization

1. ***Primary problems***: SUDs/addiction; related mental and physical health conditions
2. ***Social/environmental context***: Current living situation; close relationships; socio-cultural factors; economic circumstances; any legal or safety concerns
3. ***Distal antecedents***: Neurobiological, genetic, psychosocial, environmental influences
4. ***Proximal antecedents***: Current internal and external cues, triggers, high-risk situations
5. ***Cognitive processes***: Relevant schemas, beliefs, thoughts; cognitive distortions, System 1 and System 2 thinking

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Case conceptualization

6. ***Affective processes***: Predominant emotions, feelings, moods, physiologic sensations
7. ***Behavioral patterns***: Adaptive versus maladaptive behaviors; coping versus compensatory strategies
8. ***Readiness to change and associated goals***: Stages, from precontemplation to maintenance for all problem areas; short-term and long-term goals for all problems
9. ***Integration of the data***: Salient processes; significant patterns; causal relationships between context, thoughts, beliefs, emotions, behaviors
10. ***Implications for treatment***: Identification of cognitive and behavioral strategies and techniques, based on the data collected

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Patient factors that may influence outcome

- Pressure to enter treatment (context)
- Feelings of shame (affective process)
- Tendencies to minimize addiction or lack of motivation
- Being stigmatized by professionals in the past (antecedents)
- Stereotypical views of therapy and therapists (context)
- Fear that self-disclosure will result in punishing consequences (cognitive process)
- Patient resources and degree of impairment in other areas (problems)
- Lack of alternative behaviors (context)

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What is an alliance rupture?

- "An alliance rupture consists of an impairment or fluctuation in the quality of the alliance between the therapist and client. Alliance ruptures vary in intensity, duration and frequency... In more extreme cases, the client may overtly indicate negative sentiments to the therapist or even terminate therapy prematurely. At the other end of the continuum are minor fluctuations in the quality of the therapeutic alliance which may be extremely difficult for the outside observer or for even the skilled therapist to detect."

Safran, Crocker, McMain, & Murray (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy, 27*(2), 154-165.

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Seven potential alliance rupture markers

1. Overt expression of negative sentiments
2. Indirect communication of negative sentiments or hostility
3. Disagreement about the goals or tasks of therapy
4. Compliance
5. Avoidance maneuvers
6. Self-esteem—enhancing operations
7. Non-responsiveness to interventions

Safran, Crocker, McMain, & Murray (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy, 27*(2), 154-165.

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Resolving alliance ruptures

1. Attend to ruptures
2. Be aware of own feelings
3. Accept responsibility
4. Empathize with the client's experience
5. Maintain the stance of the participant/observer

Safran, Crocker, McMain, & Murray (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy, 27*(2), 154-165.

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Therapist and relationship factors to consider

- Therapist factors
  - Knowledge, skills
  - Flexibility (versus rigidity)
  - Temperament (e.g., warmth, authenticity, immediacy, openness…)
  - Willingness to be deliberate, intentional, rigorous
- Relationship factors
  - Common goals
  - Shared expectations
  - Alliance
  - Recognition and repair of ruptures

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Summary: Patient factors to consider

Personal resources/skills

- Interpersonal/attachment style
- Intellectual/abstraction
- Emotion regulation
- Impulse control
- Cognitive flexibility
- Motivation to change

Social determinants of health

- Economic stability
- Education
- Social and Community context
- Health and healthcare
- Neighborhood and built environment
- Close relationships

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