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CHAPTER 22

Cognitive Therapy

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Kim is a 32-year-old woman with a complex history of substance abuse that began when she was 13 years old. At various times, Kim has experimented with most illicit substances (including marijuana, heroin, LSD, Ecstasy, and cocaine) and she has been dependent on nicotine, alcohol, amphetamines, and barbiturates. She also suffers from chronic depression. She has been treated intermittently for depression since age 15 and has cycled in and out of substance treatment programs since age 19. Kim has never been married. She works as a night janitor at a fast-food restaurant.

Currently, Kim smokes marijuana several times daily. She says, "I smoke so much, I don't even get high anymore." She smokes to deal with feelings of depression, emptiness, and loneliness. She views herself as hopeless but says she has no plans to kill herself, because she is afraid of dying. She has gained over 50 pounds in the last few years, and she says she wants to "do nothing but sit around the house all day."

Kim meets criteria for avoidant personality disorder with dependent and borderline features. She describes constant boredom and isolation. Nonetheless, she refuses to take social or occupational risks, saying "If I put myself out there, I'll only get burned." She has a history of numerous failed relationships and jobs.

Eventually Kim joins a self-help group for women with depression, where she admits to daily marijuana use. Another group member, Jenna, explains that she, too, was a heavy marijuana smoker at one time. Jenna warns Kim that she will only feel better when she quits smoking marijuana.

After listening, Kim feels motivated to stop but finds it impossible to quit. After only a few days of abstinence, she feels more depressed and anxious, so she picks up smoking again.

For over a decade cognitive therapy has been refined to help people like Kim who are addicted to a variety of substances, including alcohol, cocaine, opioids, marijuana, prescription medications, nicotine, and other psychoactive substances (A. T. Beck, Wright, Newman, & Liese, 1993; Carroll, 1998, 1999; Liese & Beck, 1997; Liese & Franz, 1996; Najavits, Liese, & Harned, 2004; Newman & Ratto, 1999). Cognitive therapy is also used for compulsive gambling, shopping, and sexual behaviors. Applications of cognitive therapy to substance-abusing adolescents (Fromme & Brown, 2000; Waldron, Slesnick, Brody, Turner, & Peterson, 2001), dual diagnosis patients (e.g., Barrowclough et al., 2001; Najavits, 2002a; Weiss, Najavits, & Greenfield, 1999), older patients (Schonfeld et al., 2000), and other important subgroups are additional recent developments. Patients like Kim have taught us a great deal about the development, maintenance, and treatment of addictive behavior (Liese & Franz, 1996). Currently, cognitive-behavioral therapy (CBT) approaches to substance abuse are considered among the most empirically studied, well-defined, and widely used approaches (Carroll, 1999; Thase, 1997).

The cognitive therapy of substance abuse is quite similar to cognitive therapy for other psychological problems, including depression (A. T. Beck, Rush, Shaw, & Emery, 1979), anxiety (A. T. Beck & Emery, with Greenberg, 1985), and personality disorders (A. T. Beck, Freeman, & Associates, 1990; Young, 1999). Each places emphasis on collaboration, case conceptualization, structure, patient education, and the application of standard cognitive-behavioral techniques. In addition, when working with substance abuse patients, cognitive therapists focus on the cognitive and behavioral sequences leading to substance use, management of cravings, avoidance of high-risk situations, case management, mood regulation (i.e., coping), and lifestyle change. The cognitive therapy of substance abuse is an integrative, collaborative endeavor. Patients are encouraged to seek adjunctive services (e.g., 12-step and other programs) to reinforce their progress in cognitive therapy.

In cognitive therapy of substance abuse, thoughts are viewed as playing a major role in addictive behavior (e.g., substance use), negative emotions (e.g., anxiety and depression), and physiological responses (including some withdrawal symptoms). Although strategies and interventions vary based on the individual and particular substance, the basic conceptualization of the patient in cognitive terms remains constant (A. T. Beck et al., 1993; see Figure 22.1 for the basic cognitive model of substance abuse).

Cognitive therapists assess the development of their patients' beliefs about themselves, their early life experiences, exposure to substances, the development of substance-related beliefs, and their eventual reliance on substances

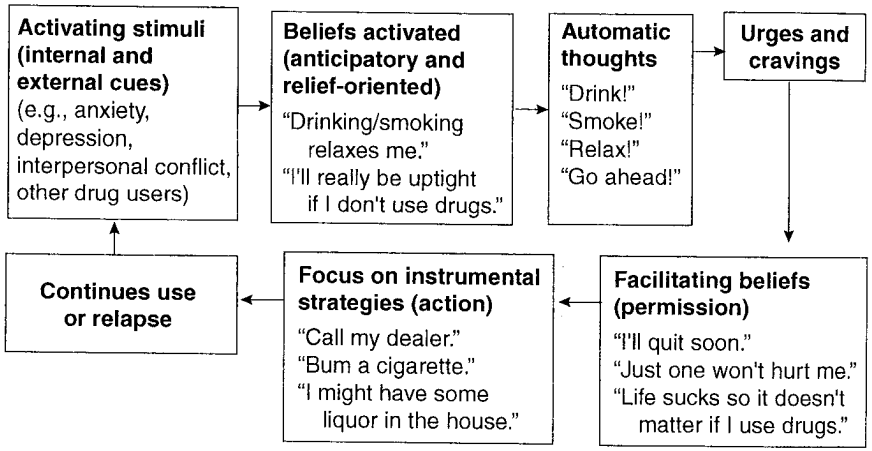

FIGURE 22.1. The cognitive model of substance abuse. From A. T. Beck, Wright, Newman, and Liese (1993, p. 47). Copyright 1993 by The Guilford Press. Adapted by permission.

(Liese & Franz, 1996; see Figure 22.2). An important assumption is that substance abuse is in large part learned and can be modified by changing cognitive-behavioral processes.

Our model for cognitive therapy of substance abuse has been substantially influenced by other cognitive behaviorists. For example, Marlatt and colleagues (Dimeff & Marlatt, 1998; Marlatt & Gordon, 1985) presented an important model of relapse prevention that has contributed greatly to our own work. Identifying high-risk situations, understanding the decision chain leading to substance use, modifying substance users' dysfunctional lifestyles, and learning from lapses to prevent full-fledged relapses are all integral to the relapse prevention model and the cognitive models of addiction.

There are numerous CBT approaches for substance abuse (Najavits et al., 2004), and the past several years have seen a variety of major empirical studies on CBT for substance abuse (e.g., Crits-Christoph et al., 1999; Maude-Griffin et al., 1998; Project MATCH Research Group, 1997; Rawson et al., 2002; Waldron et al., 2001). In this chapter, we focus primarily on the cognitive therapy model defined by Aaron T. Beck and colleagues. The cognitive therapy model, or some of its various components, is often part of other CBTs.

We address four key topics: cognitive case conceptualization; principles of treatment; treatment planning (including specific cognitive and behavioral interventions); and comparison to some other major psychosocial treatments for substance abuse. Our patient, Kim, is used as an example throughout.

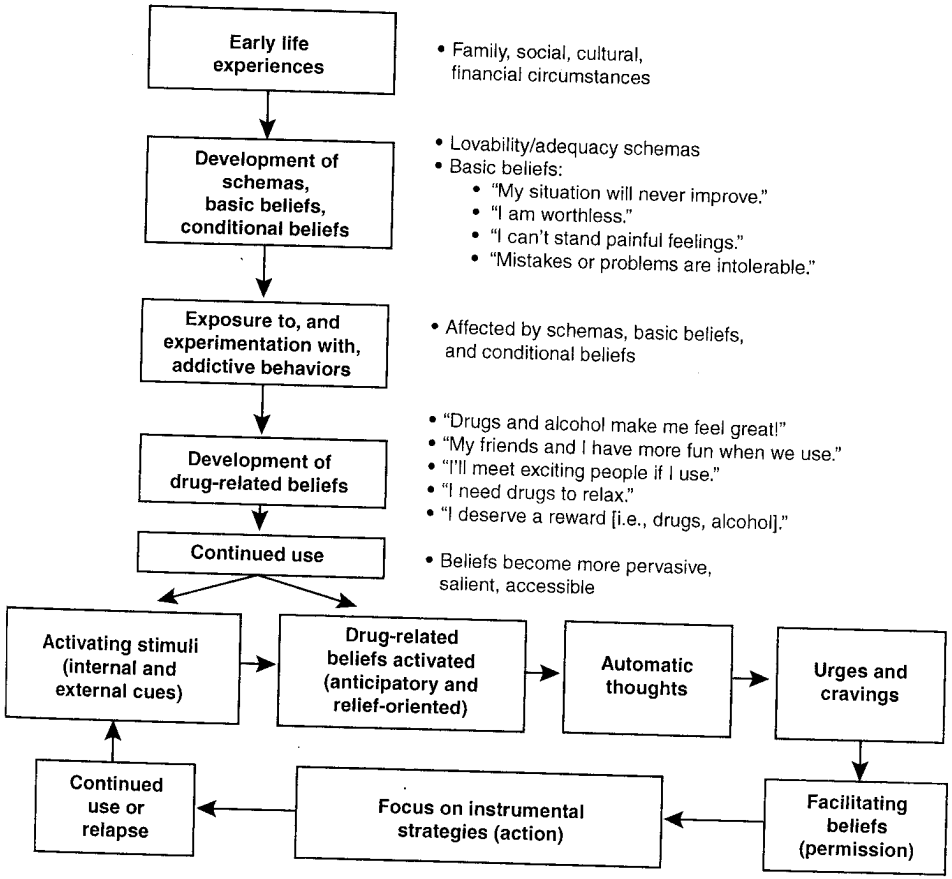

FIGURE 22.2. The cognitive developmental model of substance abuse. From Liese and Franz (1996, p. 482). Copyright 1996 by The Guilford Press. Reprinted by permission.

THE COGNITIVE CONCEPTUALIZATION DIAGRAM

Cognitive therapy begins with a formulation of the case, using a standardized form for structuring the case conceptualization (J. S. Beck, 1995). An example using Kim's current difficulties is provided in Figure 22.3. She holds fundamental beliefs that she is helpless and incompetent, bad, unlovable, and vulnerable. These beliefs originated in childhood and became stronger and stronger as time went on. The next to last of eight children in a poor family, Kim was emotionally neglected by a depressed, alcoholic mother. Her father was cold, distant, and uninterested in Kim. He abandoned the family when Kim was 7 and never contacted them again. Kim had few friends, felt rejected by her family, did poorly in school, and dropped out when she was halfway through 11th grade.

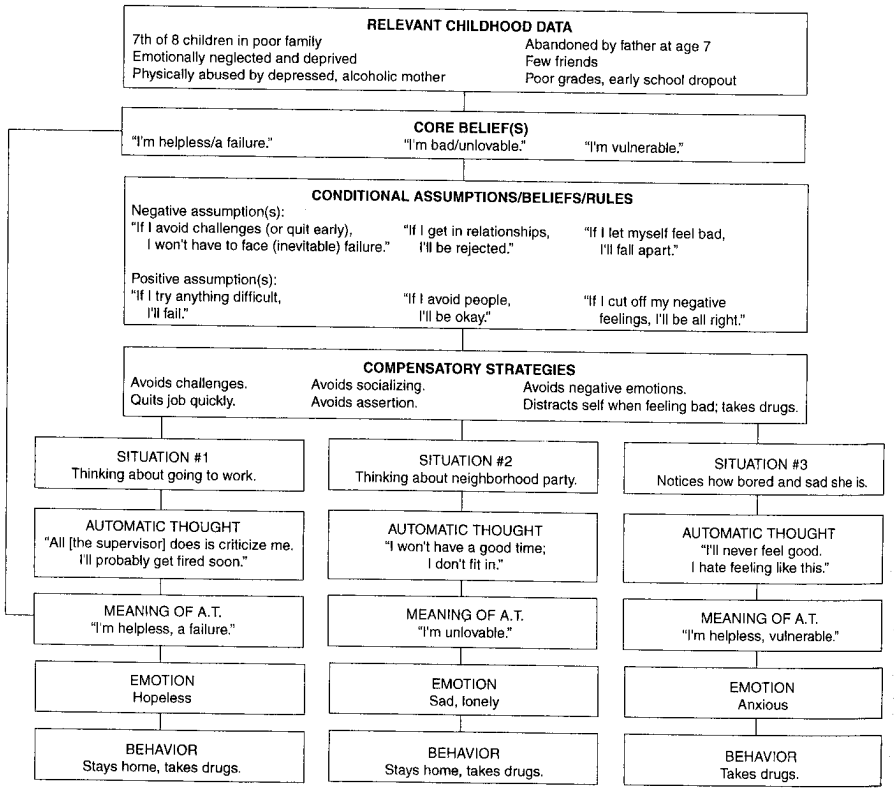

FIGURE 22.3. Cognitive conceptualization diagram. From J. S. Beck (1995, p. 139). Copyright 1995 by Judith S. Beck. Adapted by permission.

Kim's core beliefs of helplessness, badness, and vulnerability have caused her great pain, and over the years, she has developed rules (i.e., conditional assumptions) for survival. One such conditional assumption is, "If I avoid challenges, I won't have to face failure." Thus, Kim uses a typical compensatory strategy: She avoids applying for any but the most menial jobs. She then quits these jobs when small problems arise, believing she is helpless to solve problems. Likewise, she tries only halfheartedly in substance abuse treatment programs and drops out prematurely, believing she cannot abstain from substances. She also avoids conflicts with others, believing that she does not deserve to get what she wants.

Kim's core beliefs of badness and unlovability permeate virtually all of her relationships. In addition to her conditional belief, "If I try to get what I want from a relationship, I'll fail" (which stems from a core belief of helplessness), she also believes, "If I assert myself or let others get too close, they'll reject me, because nobody could possibly love me." Therefore, she uses compensatory strategies such as isolating herself, avoiding assertion, avoiding intimacy, and, perhaps most obvious, taking substances. Most of her social contacts are with other substance abusers who manipulate and take advantage of her.

Kim also has a core belief that she is vulnerable, especially to negative emotion. Her conditional assumption is, "If I start to feel bad, my emotions will get out of control and overwhelm me." She avoids even mildly challenging situations in which she predicts she will feel sad, rejected, or helpless. Avoidance itself, however, often leads to boredom and frustration, which increases her sense of failure and helplessness.

Kim discovered at an early age that she could feel better by drinking alcohol and taking substances. As a result, she failed to develop healthier coping strategies (e.g., learning to tolerate bad moods, solving problems, asserting herself, or looking at situations more realistically). For much of her life, she has tried to cope with a combination of avoidance and substance use.

The cognitive conceptualization diagram in Figure 22.3 demonstrates how Kim's thinking in specific situations leads to substance use. In situation 1, for example, Kim thinks about going to work. She has a mental image of her supervisor looking at her "with a mean face" and she thinks, "All he ever does is criticize me. I'll probably get fired soon." This is an *automatic thought*, because it seems to pop into Kim's mind spontaneously. Prior to receiving therapy, Kim had little awareness of her automatic thoughts; she was much more aware of her subsequent negative emotions. As a result, she felt helpless, and her behavioral response was to stay home and take substances.

Why does Kim consistently have these thoughts of failure and helplessness? Kim's negative core beliefs about herself influence every perception. She *assumes* she will fail, never thinking to question such beliefs about herself. Given this tendency, it is no surprise that Kim avoids challenges. She thinks it is just a matter of time until her failure becomes apparent.

In situation 2 (see Figure 22.3), Kim considers whether to attend a party given by neighbors. Because of her core belief that she is unlovable, she automatically thinks, "I won't have a good time. I don't fit in." Accepting these thoughts as true, she feels sad and chooses to stay home and get high. Whereas many automatic thoughts have a grain of truth, they are usually distorted in some way. Had Kim evaluated her thoughts critically, she might have concluded that she could not predict the future with certainty, that several neighbors had seemed pleasant in the past, and that the reason for the neighbors on the street to have the party was to get to know one another better. Kim's core belief of unlovability once again leads her to accept negative thoughts as true and to use her dysfunctional strategies of avoidance and substance use.

In situation 3, Kim becomes aware of how bored and sad she feels. She thinks, "I'll never feel good. I hate feeling like this." Her negative prediction

and intolerance of dysphoria are again linked to her core beliefs of helplessness and vulnerability. Again, she copes with her anxiety by turning to substances.

The cognitive conceptualization diagram can serve as an aid to identify quickly the most central beliefs and dysfunctional strategies of substance abusers, to recognize how their beliefs influence their perceptions of current situations, and to explain why they respond emotionally and behaviorally in such ineffective ways. An important part of the cognitive approach is to help patients begin to question the validity of their perceptions and the accuracy of automatic thoughts that lead to substance abuse.

A first step in therapy is to help patients recognize that their negative automatic thoughts are not completely valid. When they test their thinking and modify it to more closely resemble reality, they feel better. A later step is to help them use the same kind of evaluative process with their core beliefs, to guide them in understanding that such beliefs are ideas, not necessarily truths. Once they see themselves in a more realistic light, they begin to perceive situations differently, feel better emotionally, and use more functional strategies learned in therapy. When this occurs, they become less likely to "need" substances for mood regulation, because they have developed internal strategies for coping.

Cognitive therapy for substance abuse, therefore, aims to modify thoughts associated with substance use (both surface-level "automatic thoughts" and deep-level "core beliefs"). The goal is to develop new behaviors to take the place of dysfunctional ones. An additional focus, described later in this chapter, is practical problem solving and modifying the patient's lifestyle to decrease the likelihood of relapse. The modification of patients' long-term negative beliefs about the self is crucial to their ability to see alternative explanations for distressing events, to use more functional coping strategies learned in therapy, and to create better lives.

At some point, cognitive therapists may explore childhood issues that relate to patients' core beliefs and addictive behavior. Such exploration helps both clinicians and patients understand how patients came to such rigid, global, and inaccurate negative ideas about themselves.

Figure 22.4 reflects the basic cognitive model of substance abuse as applied to Kim's substance abuse behavior. It illustrates the cyclical nature of substance abuse. Kim, like most substance abusers, believes that taking substances is an automatic process, beyond her control. This diagram helps her identify the sequence of events leading to an incident of substance use and identifies potential points of intervention in the future. In this example, Kim feels hopeless, because she predicts she will lose her job. As she searches for a way to cope with her dysphoria, a basic substance-related belief emerges ("If I feel bad, I should smoke") and she thinks, "I might as well use." She then experiences cravings and gives herself permission to use ("My life is crummy. I deserve to feel

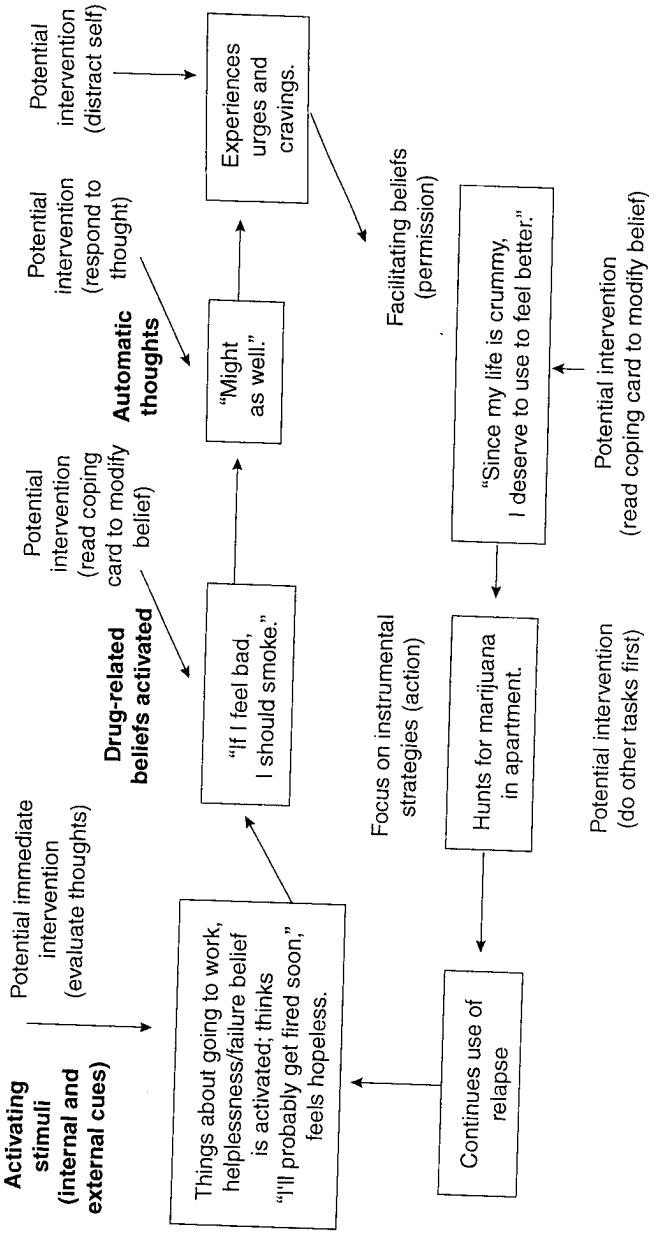

FIGURE 22.4. Cognitive model of substance abuse applied to case example.

better"); she hunts for her marijuana and smokes a joint. This typical sequence of events takes place in seconds, and Kim initially believes it is automatic. By breaking it down into a series of steps, Kim can learn a variety of ways to intervene at each stage along the way.

PRINCIPLES OF TREATMENT

A cognitive therapist could use hundreds of interventions with any given patient at any given time. In this section, we discuss cognitive therapy principles that apply to all patients, using substance abuse examples.

1. Cognitive therapy is based on a unique cognitive conceptualization of each patient.
2. A strong therapeutic alliance is essential.
3. Cognitive therapy is goal-oriented.
4. The initial focus of therapy is on the present.
5. Cognitive therapy is time-sensitive.
6. Therapy sessions are structured, with active participation.
7. Patients are taught to identify and respond to dysfunctional thoughts.
8. Cognitive therapy emphasizes psychoeducation and relapse prevention.

Principle 1: Cognitive Therapy Is Based on a Unique Cognitive Conceptualization of Each Patient

Conceptualization of the case includes analysis of the current problematic situations of substance abusers and their associated thoughts and reactions (emotional, behavioral, and physiological). Therapists and patients look for meanings expressed in patients' automatic thoughts to identify their most basic, dysfunctional core beliefs about themselves, their world, and other people (e.g., "I am weak," "The world is a hostile place").

They also identify patterns of behavior that patients develop to cope with these negative ideas. Such patterns might include taking substances, preying on people, and distancing from others. The connection between their core beliefs and compensatory strategies becomes clearer when therapists and patients identify the conditional assumptions that drive patients' behavior (e.g., "If I try to do anything difficult, I'll probably fail because I'm so weak").

Therapists and patients look at patients' developmental histories to understand how they came to hold such strong, rigid, negative core beliefs. They also explore how these beliefs might not be true today and, in some cases, were not completely true even in childhood. They look at patients' enduring patterns of interpretation that have caused them to process information so negatively.

Therapists also draw diagrams of scenarios in which patients take substances (Figure 22.4) to illustrate the cyclical process of substance use and the many opportunities to intervene and avert a relapse.

Principle 2: A Strong Therapeutic Alliance Is Essential

Successful treatment relies on a caring, collaborative, respectful therapeutic relationship. Effective therapists explain their therapeutic approach, encourage patients to express skepticism, help them test the validity of their doubts, provide explanations for their interventions, share their cognitive formulation to make sure they have an accurate understanding of the patient, and consistently ask for feedback.

Therapists who are very collaborative typically find that they can establish sound therapeutic relationships with most substance abuse patients. However, even the most skilled therapists, who embody the essential characteristics of warmth, empathy, caring, and genuine regard, find it challenging to develop good relationships with occasional patients who are suspicious, manipulative, or avoidant. Therapists are encouraged to examine relationship problems with the same careful cognitive exploration of session-related behavior as is done for all other behaviors. See Figure 22.5 for a cognitive conceptualization diagram of missed sessions and dropout.

An effective therapist seeks to avoid activating patients' core beliefs through his or her own behavior in therapy and helps patients test the validity of their ideas about the therapist. For example, Kim's therapist asked for evidence when Kim said she believed the therapist was judging her as "bad" for having a substance abuse problem. Of course, effective therapists need to examine their own thoughts, feelings, and behaviors periodically to ensure that they are not viewing their patients in a negative light. When therapists maintain true nonjudgmental attitudes, they can sincerely tell patients that they are not negatively evaluating them. They can further explain that they view patients as using substances to try to cope with the difficulties inherent in their lives.

At times, a persistent problem in the therapeutic relationship arises from a clash of patient and therapist beliefs. Therapists are advised to do conceptualization diagrams of patients and of themselves to identify dysfunctional ideas they may have about interacting with difficult people.

For example, one substance abuse patient held the core belief, "If I show any weakness, others will hurt me," and a related assumption, "If I listen to my therapist, he'll see me as weak." As a result, the patient was very controlling in the session, kept criticizing the therapist, and would not do any self-help assignments suggested by the therapist. The problem persisted, at least in part, because the therapist too had a broad assumption, "If people don't listen to me, it means they don't value me, and therefore don't deserve my best effort." The

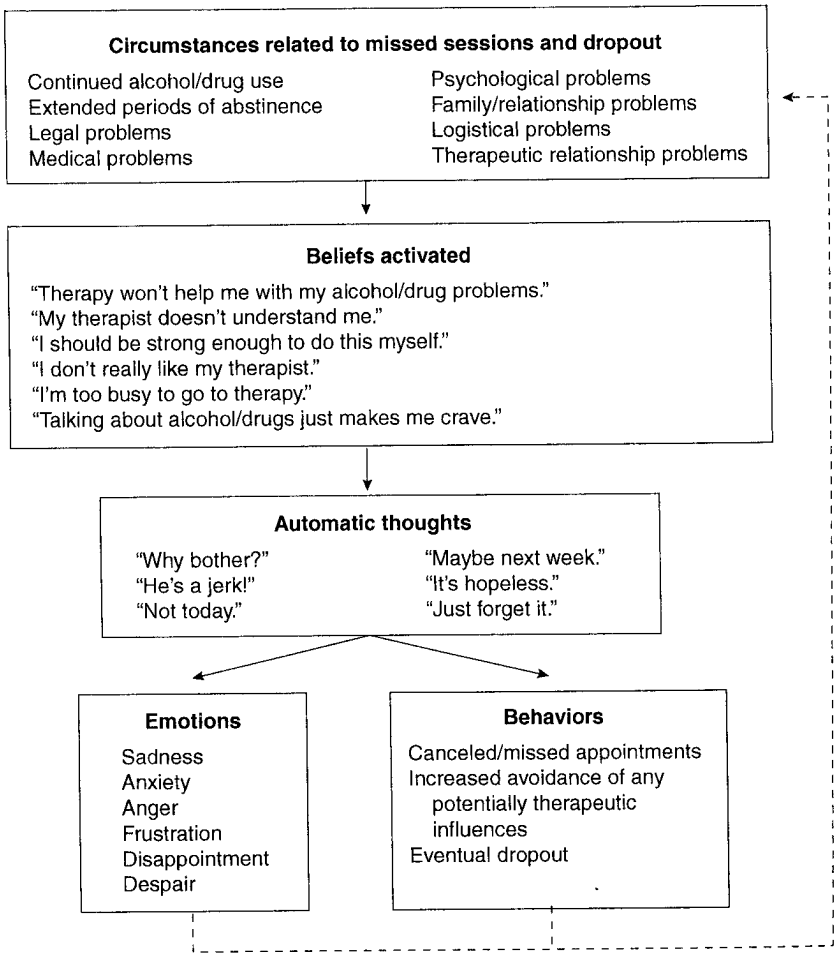

FIGURE 22.5. Cognitive conceptualization of missed sessions and dropouts.

therapist became irritated with the patient, expressing dissatisfaction through body language and tone of voice. The patient, already hypervigilant for possible harm from others, perceived the therapist's negative attitude and dropped out of therapy prematurely.

Liese and Franz (1996) have identified common dysfunctional beliefs of therapists that interfere with delivering therapy to substance abuse patients. Although many patients may minimize their substance use, confronting them in a harsh manner is likely to result in diminished therapeutic efficacy and dropping out.

When patients report no substance use during the previous week, it is often useful to inquire about times when they felt cravings. Thus, therapists can obtain relevant cognitive material to help patients continue effective responses in the coming week.

Because patients with substance problems have high dropout rates (Simpson, Joe, Rowan Szal, & Greener, 1997), it is essential to build a strong therapeutic relationship. Liese and Beck (1997) describe how cognitive therapy skills can maximize retention in treatment. Figure 22.5 presents their model for missed sessions and dropout.

Therapists increase the alliance by emphasizing that they and the patient are on the same team, working toward long-term goals. The patient can learn that therapy is not an adversarial relationship. The therapist and patient collaboratively make most of the decisions about therapy. However, therapists should know that a common compensatory strategy of substance abuse patients is avoidance (e.g., minimizing difficulties in abstaining from substances). It is important, therefore, to help patients recognize in a nonconfrontational manner that the advantages of avoidance are clearly outweighed by the disadvantages.

Principle 3: Cognitive Therapy Is Goal-Oriented

At the first session and periodically thereafter, therapists ask patients to set goals. They identify objectives in specific behavioral terms by asking, "How would you like to be different by the end of therapy?" It is important to give patients feedback about their goals, because they sometimes harbor unrealistic expectations. Therapists also help to identify short-term goals and propose ways the patient can meet those goals.

For example, Kim's therapist helped her specify her goal of "being happy" in behavioral terms: getting a job she enjoyed, entering into a romantic relationship, getting along with her family, and staying abstinent. He helped her set smaller goals along the way. A first step in getting a new job was to improve her attendance at her current job, so she could get a good letter of reference.

Therapists also question patients about the degree to which they *really* want to meet their goals. A helpful technique is the advantage–disadvantage analysis (Figure 22.6), adapted from Marlatt and Gordon (1985). In this exercise, the therapist explores the benefits of achieving a goal, while also reframing the disadvantages.

For some patients, a goal of harm reduction is more acceptable and achievable than complete abstinence (Fletcher, 2001; Marlatt, Tucker, Donovan, & Vuchinich, 1997). While abstinence is generally the safest goal, a decrease in substance use is more desirable than early dropout from therapy, which can occur if the therapist tries too early or too strongly to impose a total ban on all substances.

Advantages of Abstinence	Advantages of Taking Drugs (with reframe)
1. Feel better about myself. 2. Feel more in control. 3. Get to work on time. 4. More likely to keep my job. 5. Save money. 6. Better for my health. 7. Not get so criticized by my sister. 8. Not hang around other "druggies" so much. 9. Spend my time better.	1. Escape from feeling bad (**BUT** it's only a temporary escape and I don't really solve my problems). 2. Have people to hang out with (**BUT** they're druggies and I don't really like them). 3. It's hard work to quit (**BUT** I'll do it step-by-step with my therapist).
Disadvantages of Abstinence (with reframe)	**Disadvantages of Taking Drugs**
1. I may feel bored and anxious (**BUT** it's only temporary and it's good to learn to stand bad feelings). 2. I don't know what to do with my time (**BUT** I can learn in therapy how to spend time better). 3. I won't be able to hang out with my "friends" (**BUT** I do want to meet new "nondruggie" friends).	1. Seems to make me depressed. 2. Costs money. 3. Bad for my health. 4. Makes me feel like I'm not in control of my life. 5. Makes me feel unmotivated. 6. Hard to solve my real problems. 7. May make me lose my job. 8. Makes relationship with my sister worse. 9. Stops me from going out and making new friends. 10. Makes me feel like I'm wasting time. 11. Makes me feel stuck, like I'm not getting anywhere.

FIGURE 22.6. Advantages–disadvantages analysis.

Principle 4: The Initial Focus of Therapy Is on the Present

Therapists initially emphasize current and specific problems that are distressing to the patient. When the patient has a comorbid diagnosis, it is important to address problems related to both. For example, Kim needed help in problem solving about a critical supervisor at work and in learning alternate coping strategies (instead of using substances) when she was distressed about a work problem. She and her therapist discussed how to respond to the hurt she felt when the supervisor rebuked her for lateness, how to decrease her anger by rehearsing a coping statement addressing her activated core belief, how to use anger management techniques such as controlled breathing and time-out, and how to talk to the supervisor in a reasonable manner.

The therapist also helped Kim respond to automatic thoughts. Through a combination of Socratic questioning and modeling, Kim learned to change the thought, "I should tell my supervisor off," with "He's just trying to do his job; I want to keep this job; I can just say OK for now and stay calm." Toward the middle of therapy, the therapist and Kim began discussing her past as well—to see how she developed her ideas about relationships, and how they related to her current difficulties.

Principle 5: Cognitive Therapy Is Time-Sensitive

The course of therapy for substance abuse patients varies depending on the severity of the substance use. Weekly or even twice-weekly sessions are recommended until symptoms are significantly reduced. With effective treatment, patients stabilize their moods, learn more tools, and gain confidence in using alternate coping strategies. At this point, therapist and patient may experiment with decreasing sessions. For example, in a major study of cognitive therapy for cocaine dependence (Crits-Christoph et al., 1997), the frequency of sessions went from once a week to once every 2 weeks, then to once every 3 or 4 weeks. After termination, an "open door" approach is helpful, in which patients are invited to return to therapy if they are tempted to use substances again.

Principle 6: Therapy Sessions Are Structured, with Active Participation

Typically, therapists use a structured format, unless it interferes with the therapeutic alliance. Usually therapists first check the patient's mood and recent amount and type of substance use (including, if possible, objective assessment of these). They explore the patient's progress or worsening, and elicit the patient's feelings about coming to therapy that day. Next the therapist sets an agenda and decides with the patient what problems to focus on in the session. Standard items include the successes and difficulties the patient experienced during the past week and upcoming situations that could lead to substance use or dropout.

The therapist then makes a bridge from the previous session, asking the patient to recall the important things they discussed. If the patient has difficulty remembering the content, they problem-solve to help the patient make better use of future sessions. Encouraging patients to take notes and review these during the week helps them integrate the lessons of therapy. Also, during this part of the session, the therapist reviews the therapy homework completed during the week. If therapists suspect that patients have reacted badly to a previous session, they may ask for feedback about the session.

Next, they address specific topics of concern to the patient. As they discuss the first problem, they collect information about it, conceptualize how it arose, evaluate thoughts about it, modify relevant beliefs, and problem-solve as needed. In the context of discussing the problem, the therapist teaches the patient skills in various domains: interpersonal (e.g., assertiveness), mood management (e.g., relaxation, anger management), behavioral (e.g., alternate behaviors when cravings start), and cognitive (e.g., worksheets on dysfunctional cognitions).

Homework is customized to the patient. Typically, it includes monitoring substance use and mood, responding to automatic thoughts and beliefs, practicing new skills, and problem solving.

Throughout the session, the therapist summarizes the material the patient has presented and checks comprehension by asking about the "main message." At the end of the session, they summarize what occurred, checking that the patient understands and is likely to do the homework. Finally, the therapist asks for feedback. Skillful questioning of the patient's honest reactions and nondefensive problem solving by the therapist promote progress and lessen dropout.

Adhering to this structure has many benefits: The most important issues are discussed; there is continuity between sessions; substance use is monitored; and problems are directly addressed. In addition, patients learn new skills and are more likely to use these in the coming week. The structure also ensures that patient and therapist understand the lessons of the session, and that the patient is given the opportunity to provide feedback, so therapy can be modified if needed.

Principle 7: Patients Are Taught to Identify and Respond to Dysfunctional Thoughts

The therapist emphasizes the cognitive model at each session—that patients' thoughts influence how they react emotionally, physiologically, and behaviorally, and that by correcting their dysfunctional thinking, they can feel and behave better. The therapist does not assume that automatic thoughts are distorted; instead, therapist and patient investigate whether a given thought is valid. When thoughts *are* accurate (e.g., "I want a fix"), they either problem-solve (discuss ways to respond to the thought) or explore the validity of the conclusion the patient has drawn (e.g., "Wanting a fix shows I am weak"). When evaluating thoughts, the therapist primarily uses questioning rather than persuading the patient, and standard tools such as the Dysfunctional Thought Record (J. S. Beck, 1995) are used when possible.

Principle 8: Cognitive Therapy Emphasizes Psychoeducation and Relapse Prevention

From the first session, the goal is to maximize patients' learning. The therapist encourages patients to write down important points during the session or does the writing for them, if necessary. When patients are illiterate, the therapist uses ingenuity to create a system for helping them remember (e.g., audiotaping the session, a brief summary of the session, or brainstorming whom the patient might ask to read therapy notes).

The therapist teaches patients how to best use the new strategies. The goal is to make the patient her own best "cognitive therapist." For example, the therapist teaches Kim how to identify her negative thoughts when she feels upset, how to respond to these thoughts, how to examine her behaviors, how to use coping strategies when she has cravings, how to communicate effectively, how to avoid high-risk situations, and many more cognitive, behavioral, mood-stabilizing, and general life skills.

Prior to termination, relapse prevention is emphasized. The therapist and patient review skills; predict difficulties; note early warning signs of relapse; and discuss how to limit a lapse from becoming a relapse. They agree on when the patient needs to return to therapy, that is, if a lapse is imminent (instead of just after it occurs). Finally, they develop a plan for patients to continue to work on their goals, preferably with the support of friends and family.

TREATMENT PLANNING

The first step in treatment planning is to complete a thorough diagnostic assessment based on the criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000). It is essential to evaluate comorbid Axis I and Axis II disorders, as well as medical complications.

According to research (Kessler et al., 1996), many patients with substance use disorders have a co-occurring psychiatric disorder. The treatment plan should address both. For example, Kim's therapist conceptualized that she was medicating her depression with marijuana. In addition to treating her substance use, the therapist focused on the depression itself, using standard cognitive therapy strategies to reduce her depressive symptoms: activity scheduling, responding to negative cognitions (e.g., "I can't do anything right"), and problem solving (e.g., about work problems and loneliness), among others (see A. T. Beck et al., 1979; J. S. Beck, 1995). She was also referred to a psychiatrist for a medication consultation.

Kim also had an Axis II diagnosis: avoidant personality disorder with dependent and borderline features. One important implication of any personality disorder is the strong likelihood that associated dysfunctional beliefs (e.g., "I am helpless; I am bad") might arise in the therapy session itself. Her therapist planned treatment to avoid intense schema activation early in therapy that might have led to premature dropout. Adding elements from cognitive therapy for personality disorders may be helpful for Axis II issues (Beck et al., 1990; Young, 1999).

A second key step in treatment planning is to identify the patient's motivation for change. Prochaska, DiClemente, and Norcross (1992) describe five stages of change: the precontemplation stage (in which patients are only minimally, if at all, distressed about their problems and have little motivation to change), the contemplation stage (in which they have sufficient motivation to consider their problems and think about change, although not necessarily enough to take action), the preparation stage (in which they want help to make changes but may not feel they know what to do), the action stage (in which

they start to change their behavior), or the maintenance stage (in which they are motivated to continue to change).

Kim, for example, was at the contemplation stage when she entered therapy. Her therapist helped her identify the problems associated with her substance use, some of which she had avoided focusing on before therapy. Her therapist also helped her do an advantages–disadvantages analysis of marijuana use (Figure 22.6). He helped her "reframe" or find a functional response to her dysfunctional ideas of not changing. These techniques helped move Kim from the contemplation to the preparation stage. Had her therapist started with a treatment plan that emphasized immediate change of substance use behaviors, it is likely that Kim would have resisted, tried only halfheartedly, or dropped out of therapy altogether.

Part of every treatment plan involves socializing patients to the cognitive model, so that they begin to view their reactions as stemming from their (often distorted) perceptions of situations. Once her therapist taught her to ask herself what was going through her mind just before she reached for a joint, Kim could understand how her automatic thoughts influenced her emotional and behavioral reactions. Later, he taught her how to identify the more complex sequence (Figure 22.4) leading to substance use and helped her identify how she could intervene at each stage.

An essential element in treatment planning is evaluating the strength of the therapeutic alliance. Substance abuse patients often enter treatment with dysfunctional beliefs about therapy, such as the following:

"My therapist may try to force me to do things I don't like."
"This therapy may do more harm than good."
"He probably thinks he knows everything."
"She'll think I'm a failure if I use again."
"I'm better off without therapy."

The treatment plan should include the identification and testing of these dysfunctional beliefs. Otherwise, patients may drop out prematurely. A good treatment plan also specifies patients' problems (or, positively framed, their goals) and the concrete steps needed to ameliorate them. Kim and her therapist discussed her work problems. They did a combination of problem solving and correcting distortions related to work themes, such as getting to work on time, boredom on the job, fear of criticism, and relating to coworkers. Eventually she sought a new job, when it became clear that the disadvantages of the job (low pay and lack of stimulation) still outweighed the positive aspects. Her therapist encouraged her in the job search.

The work problem was one of the first problems they tackled, because Kim was motivated to work on it, it was closely connected to her marijuana use, and it seemed they might make improvements on it in a short period. Later in therapy, they addressed situations that were even more difficult: getting along with her family, meeting new friends, and developing broader interests.

Her therapist continuously assessed Kim's readiness to change her substance abuse by measuring the strength of her beliefs. At the beginning of therapy, she believed that her marijuana use might contribute to her work problems, her social isolation, and her lack of motivation. However, she also believed that nothing, including therapy, could help. After several weeks, she began to see things differently, especially when she recognized that some initial behavioral activation and responding to automatic thoughts improved her mood. Now she was ready to explore how she came to use marijuana, to start monitoring her substance use, to learn strategies to manage cravings, to avoid high-risk situations, to respond to substance-related beliefs, to join a self-help group, and to make some lifestyle changes. These strategies are described next.

Teaching Patients to Observe Substance Use Sequences

Kim's therapist used a blank version of Figure 22.4, asking Kim to fill in the boxes after thinking about a recent episode of marijuana use. For the first time, it became clear to Kim that her behavior was at least somewhat voluntary. Previously she had believed that her use was completely out of her control.

The therapist reviewed how a typical activating stimulus gave rise to negative thoughts, which led to feelings of hopelessness. They discussed how she could learn to intervene. First, she could respond to her negative thoughts to reduce her dysphoria. Even if that did not work, she could still respond to her substance-related beliefs. She could, for example, read a coping card they developed in session. Such a card might contain "what to do if I want to smoke." These coping cards are not merely affirmations but jointly composed statements that the patient endorses in session. They might include the following:

1. Go for a walk.
2. Call a friend.
3. Go out for coffee.
4. Watch a movie.
5. Read my Narcotics Anonymous book.

If Kim's automatic thoughts about substance use continued, she would have another opportunity to respond. Upon experiencing cravings, she could tell herself to ignore these sensations and distract herself. For example, she might create a coping card that said:

"If I feel cravings, *they are just cravings*. I don't have to attend to them. They'll go away. I can stand them. I've stood cravings in the past. I'll be *very* glad in a few minutes that I ignored them. When I ignore them, I get stronger!"

If she recognized her permission-giving beliefs, she could read another coping card that might say:

> "Don't reach for a joint. Wait 5 minutes. I am strong enough to wait. In the meantime, do what's on my 'to do' list."

If she found herself focusing on strategies to get substances, she could try another waiting period or do other tasks outlined in therapy. A careful analysis of the substance-taking sequence, along with potential interventions, gave Kim hope that she could conquer this problem.

Kim and her therapist developed the coping cards over several sessions. First they discussed what Kim wished she could tell herself at each stage. Before writing the cards, the therapist asked Kim how much she believed each statement. When the strength of her belief was less than 90–100%, they reworded the statement or discussed it further to increase its validity. They observed that if Kim did not believe an idea strongly in the session, it was unlikely to work in "real life"; thus, they needed more compelling beliefs.

Monitoring Progress

Progress is monitored in several ways. Most obvious is the patient's report of substance use, obtained at each session. Urine and Breathalyzer tests can also motivate a decrease in use and an increase in the validity of self-reports. When patients do use, they are encouraged to see it not as an indication of failure, but rather as an opportunity to learn from the experience and to make future abstinence more likely. A variety of self-report instruments exist for substance abuse, such as the Timeline Followback (Sobell & Sobell, 1993). For substance abuse instruments that can be downloaded directly from the Web, see the appendices at the end of this chapter. Reports from others, such as family members or probation officers, may also be particularly important for patients with low motivation or a history of lying about their use.

When a patient has a comorbid Axis I or II disorder, progress is also measured by instruments such as the Beck Depression Inventory (A. T. Beck & Steer, 1993b), the Beck Anxiety Inventory (A. T. Beck & Steer, 1993a), the Brief Symptom Inventory (Derogatis, 1992), and other instruments relevant to particular symptoms. Improvements in scores provide an opportunity to reinforce positive changes that patients have made in their thinking and behavior in the past week. Worsening scores raise a red flag, and careful questioning about recent events and perceptions often reveals agenda items to prevent the resumption of substance use in the coming week.

It is also important to monitor how patients spend their time. Kim, for example, made some changes early in therapy: less time watching television alone and fewer visits to substance-using friends. Had her therapist not been vigilant about checking weekly on these improvements, he might have missed significant backsliding many weeks later, which could have led to a relapse.

Another aspect of monitoring is assessment of old, dysfunctional beliefs versus newer, more functional ideas. At each session, the therapist assessed how much Kim believed substance-related ideas such as "I can't stand to feel bored" and "Smoking marijuana is the only way to feel better," and how much she believed the new ideas they had developed, such as "My life will improve if I don't use" and "I can feel better by answering my negative thoughts and completing my 'to do' list." This monitoring helped the therapist intervene early when Kim's dysfunctional beliefs occasionally resurfaced strongly.

Dealing with High-Risk Situations

Marlatt and Gordon (1985) observed that exposure to activating stimuli, or triggers, makes substance use more likely. In high-risk situations, activating stimuli trigger substance-related beliefs, leading to cravings. These stimuli are idiosyncratic; what triggers one patient may not trigger another.

Triggers can be internal or external. Internal cues include negative mood states such as depression, anxiety, loneliness, and boredom, or physical factors such as pain, hunger, or fatigue. Although many patients use substances to regulate negative moods, many also use substances when they already feel good, to "celebrate" or to feel great.

External cues occur outside the individual: people, places, or things related to substance use, such as relationship conflicts or seeing substance paraphernalia. In one study, Cummings, Gordon, and Marlatt (1980) found that 35% of relapses were precipitated by negative emotional states, 20% by social pressure, and 16% by interpersonal conflict.

The therapist helps patients identify the high-risk situations in which their substance-related beliefs and cravings occur. They are encouraged to avoid these situations and are taught relationship skills to handle conflict and pressure to use. For example, they might rehearse how Kim could respond when a friend offers her a drink.

Managing Cravings and Urges

Patients should learn both cognitive and behavioral techniques for managing cravings. Distraction is often helpful, and patients can devise a list of things they can easily do (e.g., exercise, read, and talk on the telephone). Thought stopping can reduce urges. Snapping a rubber band and yelling "Stop!" while envisioning a stop sign helped Kim manage her craving. Grounding is another strategy that aids distraction from cravings and intense negative emotions; one can teach mental, physical, and soothing grounding methods (see Najavits, 2002a, for a description and handouts).

The therapist can help patients identify beliefs that encourage the use of substances to deal with cravings, for example, "I can't stand the craving"; "If I have cravings, I have to give in." Socratic questioning, examining past experiences of resisting craving, reflecting on the relative difficulty versus impossibility of tolerating cravings, and other cognitive techniques can modify these dysfunctional ideas.

Case Management and Lifestyle Change

Helping patients solve their real-life problems is an essential part of cognitive therapy. Patients who abuse substances often have complex medical, legal, employment, housing, and family difficulties. Therapists should refer patients for assistance when needed. Therefore, they need to be aware of community resources and social services. Sometimes they can help identify people in patients' social network who can help them work through such practical problems.

In some cases, however, it is necessary to help patients directly in session to take steps to improve their lives. Examining employment ads in the newspaper, for example, or completing forms (e.g., for public housing) with the patient is often an important part of treatment. For examples of case management for substance abuse, including dual diagnosis, see Drake and Noordsy (1994), Najavits (2002b), and Ridgely and Willenbring (1992).

Some lifestyle change is usually necessary for substance abuse patients to eliminate substance use and to maintain progress. Often the therapist needs to help the patient repair important supportive relationships and develop new relationships with people who do not use. Many substance abusers are deficient in relationship skills and need to learn these through discussion and role plays. Patients often have dysfunctional beliefs about relationships, and modification of these beliefs is a necessary step in learning to relate well to others.

Patients sometimes need help identifying how they can build a new, nonusing network of friends. The therapist can discuss contact with nonusers in the patient's environment, as well as encourage new activities to meet new people.

Self-help groups can be a valuable adjunct to therapy—for meeting new, nonusing people, reinforcing functional beliefs, and building a healthier lifestyle. Therapists should be aware of self-help groups in their area and encourage patients to attend. AA, NA, SMART Recovery, and Moderation Management are a few examples of groups that can be of significant benefit to patients. See the appendices at the end of this chapter for websites and phone numbers. Therapists can help patients who are reluctant to attend self-help groups by eliciting their automatic thoughts and aiding them in responding to these thoughts. Problem solving may be needed to help the patient choose groups or activities, find transportation, and manage anxiety about new experiences.

Reducing Dropout

Studies have shown that approximately 30–60% of substance abuse patients drop out of therapy (Wierzbicki & Pekarik, 1993). Many factors account for this high rate, including continued substance use; legal, medical, relationship, or psychological problems; practical problems (e.g., transportation, finances); dissatisfaction with therapy; and problems with the therapeutic alliance (Liese & Beck, 1997). Early in therapy, therapist and patient should predict potential difficulties that might interfere with regular attendance in therapy and either problem-solve in advance or collaboratively develop a plan for contact (usually by phone) if the patient misses a session.

Kim's therapist, for example, helped her with problems such as changing her work schedule and transportation, which otherwise would have impeded her attendance. Both straightforward problem solving and responding to negative thinking ("I'll be too tired to come after work"; "It's not worth taking two buses") were necessary to avoid missed sessions.

To maximize regular attendance, the therapist needs to monitor the strength of the therapeutic relationship at each session. Negative changes in patients' body language, voice, and degree of openness usually signal that dysfunctional beliefs (about themselves or therapy) have been activated. A list of 50 common beliefs leading to missed sessions and dropout (Liese & Beck, 1997) is a valuable guide for therapists. Testing negative thoughts immediately can prevent a negative reaction that otherwise might have resulted in the patient missing the next session. Kim had many such cognitions, especially early in therapy: "I'm not smart enough for this therapy"; "I can't do this." A therapist who still suspects a patient may miss the next session may be able to turn the tide by phoning the patient the day before the session and demonstrating care and concern.

Formulating an accurate cognitive conceptualization of the patient from the start enables the therapist to plan interventions to avoid inadvertent activation of dysfunctional beliefs within and between sessions. Kim's therapist, for example, recognized how overwhelmed Kim became when faced with even minor challenges. She therefore took care to explain concepts simply, to limit the amount of material each session, to check her understanding frequently, and to suggest homework that she could do. Thus, she avoided undue activation of Kim's beliefs of inadequacy and helped maintain her therapy attendance.

COMPARISON WITH OTHER MODELS

It may be helpful to compare cognitive therapy for substance abuse with some other widely known approaches, specifically, motivational enhancement therapy and dialectical behavior therapy.

Motivational enhancement therapy (MET; Miller, Zweben, DiClemente, & Rychtarik, 1995) derives from several different theories, including client-centered, cognitive-behavioral, and systems theories, and the social psychology of persuasion. The treatment is guided by five principles: The therapist should express empathy, develop discrepancy between the patient's goals and current problem behavior, avoid argumentation, roll with resistance rather than opposing it directly, and support self-efficacy by emphasizing personal responsibility and the hope of change. Specific strategies include reflective listening, affirmation, open-ended questions, summarizing, and eliciting self-motivational statements (e.g., asking evocative questions, inquiring about pros and cons of behavior, and exploring goals). The therapist also addresses ambivalence that may interfere with motivation and uses assessment instruments that are presented to the patient to increase motivation for change (e.g., alcohol/drug use, functional analysis of behavior, readiness to change, life problems, and biomedical impact).

MET differs from cognitive therapy for substance abuse in several ways. First, MET is primarily designed as a process-oriented method to increase motivation. It was not designed to teach specific new skills or coping strategies (such as cognitive therapy skills of identifying dysfunctional cognitions, rehearsal of new responses to cognitions, identification of alternative coping strategies, mood monitoring, social skills training, and lifestyle changes). Second, and likely because of the difference in goals, MET is typically much shorter. For example, in Project MATCH, MET was four sessions. Indeed, MET is primarily thought of as a precursor to or combination with other therapies for substance abuse, including cognitive therapy (e.g., Barrowclough et al., 2001).

Dialectical behavior therapy (DBT) by Linehan (1993) is a CBT designed for borderline personality disorder (BPD). It comprises twice weekly group sessions and weekly individual sessions, and as-needed phone coaching. DBT teaches a variety of skills, in part inspired by Eastern philosophy, including mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, and self-management (Linehan, 1993). After positive outcomes with patients with BPD, it was adapted for substance abuse patients with BPD in the late 1990s (Dimeff, Rizvi, Brown, & Linehan, 2000; Linehan et al., 1999, 2002). The adaptation for substance abuse includes several new skills, including alternate rebellion, adaptive denial, burning bridges to drug use, and building a life worth living. DBT differs from cognitive therapy in several ways. First, cognitive therapy for substance abuse was designed for a very broad spectrum of substance abuse patients, whereas DBT focuses on patients with the dual diagnosis of BPD and substance abuse. Thus, some precepts that may be especially helpful for BPD may not apply to the typical substance abuse patient without BPD. For example, under the "four-session rule" in DBT, if a client misses four or more sessions, she loses access to the therapy. Also, a patient in DBT must agree to a lengthy course of treatment (e.g., two full rounds of the DBT skills modules, and sessions three times per week). In cognitive therapy, such imperatives are not required. Second, and again, likely due to the nature of BPD, therapists use a team or community-of-therapists approach, and therapists are asked to be available after hours for phone coaching of clients. Cognitive therapy follows more traditional therapist roles. Finally, whereas both DBT and cognitive therapy focus on teaching new coping skills, the skills themselves differ to some degree. For example, cognitive therapy focuses much more formally on changing cognitions through the use of structured tools for cognitive change such as the Dysfunctional Thoughts Record.

CONCLUSION

Cognitive therapy can be an effective treatment for substance abuse patients. It requires accurate conceptualization of the patient, a sound treatment plan based on this case formulation, a strong therapeutic relationship, and specialized interventions. Structuring the therapy session, problem solving of current difficulties, education about the sequence of substance use, planning for high-risk situations, monitoring of substance use, lifestyle change, and intensive case management are important facets of treatment.

Kim could easily have become an unemployed "revolving door" user and a burden to family, friends, and society. Cognitive therapy helped her to engage in therapy, work through dysfunctional beliefs about herself and the therapist, develop functional goals, learn new skills to solve problems, tolerate negative emotion, persist when she felt hopeless, engage in alternative behaviors when she craved substances, and develop a healthier lifestyle. Hard work by both the therapist and substance abuse patient can pay off handsomely.

APPENDIX 22.1. SUBSTANCE ABUSE RECOVERY RESOURCES*

Resource	Website	Phone
National Drug Information, Treatment and Referral Line	*www.drughelp.org*	800-662-HELP
National Clearinghouse for Alcohol and Drug Information	*www.health.org*	800-729-6686
Alcohol and Drug Healthline	*www.samsha.gov*	800-821-4357
Alcoholics Anonymous	*www.alcoholics-anonymous.org*	800-637-6237
Cocaine Anonymous	*www.ca.org*	310-559-5833
Narcotics Anonymous	*www.na.org*	818-773-9999

Resource	Website	Phone
Marijuana Anonymous	*www.marijuana-anonymous.org*	800-766-6779
Nicotine Anonymous	*www.nicotine-anonymous.org*	415-750-0328
Smart Recovery	*www.smartrecovery.org*	440-951-5357
Secular Organization for Sobriety/ Save Our Selves	*www.secularsobriety.org*	323-666-4295
Harm Reduction Coalition	*www.harmreduction.org*	510-444-6969
Moderation Management Network	*www.moderation.org*	212-871-0974
Women for Sobriety	*www.womenforsobriety.org*	215-536-8026

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APPENDIX 22.2. SUBSTANCE ABUSE ASSESSMENT RESOURCES*

Resource	Website	Phone
National Institute on Alcohol Abuse and Alcoholism	*www.niaaa.nih.gov/publications*	—
Substance Abuse and Mental Health Services Administration	*store.health.org* and *www.samsha.gov* (click "publications," then "substance abuse treatment resources")	800-729-6686
National Institute on Drug Abuse	*www.nida.nih.gov* (click "publications")	—
Free screening online for alcoholism	*www.alcoholscreening.org*	—
University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions	*casaa.unm.edu/inst/inst.html*	
To locate substance abuse home-test kits	*www.thomasregister.com* (enter "alcohol drug test" for list of companies that provide home test kits for substance abuse)	—

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