What to Consider When CBT for Addictions is not Working

Bruce S. Liese, PhD, ABPP
University of Kansas Medical Center
Cofrin Logan Center for Addiction Research and Treatment
University of Kansas

1

How effective is *treatment*?

- While studies have demonstrated the efficacy of CBT for the treatment of addictions, no therapy is 100% effective
- Different 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

2

What makes CBT effective?

- People respond differently to the same therapy or therapist
- Some benefit most from a highly structured therapy
- Some benefit most from much less structured therapy
- Some benefit most from directive therapists
- Some benefit most from nondirective therapists
- Some benefit from a close therapeutic relationship, some not so much
- Some benefit most from specific techniques (e.g., thought records, advantages-disadvantages analyses, scheduling, behavioral activation, etc.)
- Implication: therapists' range is vitally important

3

What makes a clinician think therapy is not working?

Patients:
- Say they are committed to change, but continue to engage in problematic behavior – or make initial changes and then relapse
- Repeatedly describe barriers to change (e.g., "I can't…because.")
- Don't do homework they have agreed to do
- 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

4

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

5

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."

6

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."

7

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

8

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

9

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."

10

What is CBT?

- CBT is not a single approach to therapy
- More accurately, there are many 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)

11

Essential Components of CBT

- **Structure** – organization, use of time, focus, consistency
- **Collaboration** – setting goals and expectations jointly and explicitly, both in sessions and between sessions
- **Case conceptualization** – collecting and integrating all relevant information: thoughts, beliefs, behavior patterns, context, antecedents, consequences of using, readiness to change, barriers to change
- **Psychoeducation** – the transmission of salient knowledge and skills from therapist to patient, to facilitate treatment and resolve deficits
- **Specific techniques** – activities aimed at facilitating change

12

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

13

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 – Unhelpful basic beliefs and automatic thoughts
    - REBT – Cognitive distortions (should, musts, all-or-none thoughts…)
    - MBCT – Mindfulness and awareness
- *Psychoeducation* aims to provide knowledge and explain skills
- *Specific techniques* aim to practice skills

14

The process of CBT

- Often thought of as *how* change is facilitated
- Associated with *common factors* (e.g., empathy, acceptance, support, confidentiality, management of expectations, etc.)
- **Structure** involves order, organization, rules of engagement, pace, focus, etc.
- **Collaboration** involves the establishment of common goals, therapeutic alliance, rupture identification and repair
- Personal style also influential

15

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, sometimes to test hypotheses
- Agree to **homework** as needed
- **Elicit feedback** throughout
- **Facilitate closure** and plan for follow-up

16

Case conceptualization

- Collection and integration of relevant information
- Ongoing, ever-evolving process of formulating and testing hypotheses
- Requires a solid foundation of empathy
- Profoundly influenced by theoretical model (focal points), readiness to change, barriers to change, functions served by addictive behavior
- Identifies deficits, as well as targets for change
- Is the most important of the five components of therapy because management of other components depends on it

17

Case conceptualization

1. *Primary problems*: SUDs/addiction; related mental and physical health conditions, undesired thoughts, feelings, behaviors
2. *Social/environmental context*: Current living situation; close relationships; socio-cultural factors; economic circumstances; any legal or safety concerns; SDoH
3. *Distal antecedents*: Neurobiological, genetic, psychosocial, family, community, 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

18

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***: From precontemplation to maintenance for all problem areas; short-term and long-term goals for all problems – understanding that they perpetually change

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

19

Patient factors that may influence outcome

- Pressure to enter treatment
- Feelings of shame
- Tendencies to minimize addiction or lack of motivation
- Unsatisfying experiences with past professionals
- Stereotypical views of therapy and therapists
- Fear that self-disclosure will result in punishing consequences
- Resources and degree of impairment in other areas
- Reasons for using (e.g., self-medication); lack of alternatives

20

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.

21

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.

22

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.

23

Therapist and relationship factors to consider

- **<u>Therapist factors</u>**
  - Knowledge, skills
  - Flexibility (versus rigidity)
  - Temperament (e.g., warmth, authenticity, immediacy, openness…)
  - Willingness to be curious, deliberate, intentional, rigorous

- **<u>Relationship factors</u>**
  - Common goals
  - Shared expectations
  - Alliance
  - Recognition and repair of ruptures

24

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

25

Summary and conclusions

- CBT is effective, but not all CBTs are effective for all people
- The *How to do CBT* literature is massive, while the *What to do when CBT doesn't work* literature is relatively small
- Related research: common factors, therapist effects, and therapeutic ruptures, supervision
- Quite often, the purpose of supervision is to establish what to do when therapy isn't working

26

Summary and conclusions

- The question, *What to do when CBT isn't working*, is complex. The answers can only be found by focusing microscopically on multiple sub-questions, for example:
  - What cognitive, affective, behavioral, and contextual patterns surround addictive behaviors (including chronic anxiety, depression, helplessness, loneliness, restlessness, lack of personal meaning, associated relationships)?
  - What function do addictive behaviors serve (e.g., self-medication, social bonds)?
  - What are the cognitive, behavioral, affective, contextual barriers to change?
  - How is the therapist responding to these barriers?
  - How skillful, flexible, accepting, deliberate, intentional is the therapist?
  - What are the therapist's cognitive, behavioral, affective, contextual barriers?

27

Summary and conclusions

- CBT models are plentiful; some advertise themselves as third wave, but they actually all grew up together

- Like siblings, some are older and some younger – but not by much; don't be fooled by sibling rivalry; none is superior

- It's important to love them all equally because, like siblings, they all have their strengths and weaknesses; they're all loveable in their own ways

- Therapists should get to know all of them, because they all meet different needs, as a function of patients' individual differences

28

Summary and conclusions

- Therapist curiosity, determination, flexibility, and range are all essential

- Ever-evolving, accurate case conceptualizations are essential

- *Meet patients where they're at* is a nice idea, but easier said than done, especially since *where they're at* is an ever-changing condition (i.e., moving target)

- In addition to *where they're at* important questions include:
  - Where do they want to go?
  - What's keeping them from getting there?
  - When is it time to simply accept where they're at?

29