

# Chapter 1

## Introduction to CBT for Substance Use Problems

In this book we set out a comprehensive cognitive behavioural therapy (CBT) approach for the treatment of drug and alcohol problems. We explain how CBT makes sense of substance use problems and introduce a range of interventions for workers and therapists to use with clients to enable them to achieve control and, if appropriate, abstain from substance use altogether. We have aimed to make this book accessible not only to people who have no professional therapy training but also to health professionals and cognitive behaviour therapists wishing to develop their competencies in working with people with substance use problems. It is intended for people working in general health and mental health services as well as specialist substance misuse treatment services.

CBT is one of a number of psychosocial interventions used in the field of substance misuse and for which there is an emerging evidence base in Europe and North America. As with many evidence-based interventions, a gap remains between research findings and actual clinical practice. We hope this book provides a platform to develop the practice of CBT in the field and to address this theory/practice gap. We are advocates of CBT as a result of our clinical experience and work with multi-professional staff groups. We believe CBT has unique qualities which are of direct relevance to substance use problems and that the CBT emphasis on collaborative work and building skills is well suited to addressing the needs of clients. Our work with staff groups in both community and inpatient settings has demonstrated how CBT can provide them with a way of thinking about substance use problems instead of feeling overwhelmed and confused by them. This

understanding empowers workers to start to do things with clients as well as engage in critical discourse about the relative efficacy of different interventions. Essentially, we believe CBT helps workers to think psychologically about their clients and clinical work.

## **CBT and recovery**

One of the emerging ideas influencing service developments in mental health and substance misuse is the notion of recovery and from the outset we believe it is important to ground our vision of CBT within this broader context. The UK Drug Policy Commission Consensus Group (UK Drug Policy Commission Recovery Consensus Group, 2008) developed the following definition of recovery to clarify this concept.

The process of recovery from problematic substance use is characterised by voluntary sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.

This definition is a challenge to the structure and focus of current treatment services. We believe that CBT will be part of the solution in adopting a more recovery-focused approach. One criticism of addiction treatment is that it is primarily concerned with acute care aimed at stabilisation rather than the longer-term changes required to sustain recovery (White, 2008). White cogently argues that whilst there have been many advances in the knowledge and treatment of addictions, not least in the field of CBT, limitations remain in the efficacy of these treatments. Thus some clients, generally those whose substance use is part of a broader cluster of problems, typically relapse. This outcome has led to a call for a reorientation of treatment away from an acute care model to a recovery management model (White, 2008).

Acute care is defined in terms of crisis-intervention and symptom suppression with the aim of cure or permanent problem resolution. However, White and other commentators have noted that addiction has characteristics similar to chronic health problems (e.g. type-2 diabetes, hypertension and asthma). Whilst not all addiction problems are chronic, as some people respond to a brief period of treatment and never return to problem substance use, a number of service users, particularly those in contact with specialist treatment agencies, have a range of needs for which a chronic care model is more appropriate. A chronic care model focuses more on empowering service users to self-manage their condition and locates resources to managing well-being and sustaining recovery within social networks and the broader community. White describes this as a recovery management model which focuses on addressing the range of issues associated with substance use problems, such as educational underachievement and vocational, legal and housing difficulties, as well as co-occurring mental health problems (e.g. trauma and depression). The aim is to build 'recovery capital' to overcome social exclusion and to enable our clients to participate in society.

We believe that CBT, as described in this book, is relevant to both the acute and chronic care models as both have a part to play in enabling clients to achieve

recovery from substance misuse problems. An episode of acute care can be the trigger to initiate recovery, to help a service user to understand and gain control over his or her substance use behaviour. This would then shift into a chronic care or recovery management focus in which the service user learns to self-manage his difficulties or, as White describes it, 'focus on the lived solution'. In this context CBT involves helping clients to address obstacles in their life that stand in the way of change as well as build resources that will sustain long-term recovery from problem substance use.

We think that adopting a CBT approach within services bridges the gap between acute and chronic care models. In particular, our vision of CBT is one that is strongly grounded in an environmental context and recognises that factors outside treatment are more important for recovery maintenance. CBT enables professionals to collaborate with clients in order to help them in their recovery. Addressing both the acute and chronic aspects of substance use problems, recovery can be thought of as a two-stage process: recovery from drugs or alcohol and recovery related to wider social and personal opportunities. We call these two senses of recovery: *recovery from* and *recovery for*. Recovery from could mean abstaining from substances altogether, harm minimisation or substance stabilisation. Recovery for refers to the stage beyond substance use when clients are looking for positive things in their lives, such as social reintegration. Of course, these two elements are rarely that clear-cut, nor do they occur in such a neat, sequential manner. Indeed, the impetus or desire for a life beyond alcohol or drugs is often the initial reason for change. Sadly, such a desire or willingness to change substance-using behaviour is rarely successful on its own. Something else is needed – the skills to succeed. This is the primary focus of this book and although we mainly focus on *recovery from*, we hope that we do not lose sight of the fact that it is *recovery for* that is probably the more meaningful to both clients and staff in the long run.

As clinicians we are interested in both recovery from substance use and recovery for life more generally. Although CBT may appear to the uninitiated to be a highly technical exercise unrelated to wider social issues, it is clear that there are underlying principles at work in all good CBT interventions. We have identified four that we believe are particularly important when working with clients who have substance use difficulties. These are: increased client optimism, resilience, integration (or reintegration) and choice (ORIC). Through the considered application of CBT principles and techniques we believe clients will be more optimistic, have more resilience, be more socially included and utilise choices in their lives that enhance their sense of identity and connection with those around them. Another way of looking at this is to ask yourself what it is that is often lacking in the lives of clients with substance use difficulties. Often clients report pessimism about their ability to change, underestimate their own abilities, feel that they have very few social connections outside their using behaviour and feel trapped, as if real choice has been taken away from them. We think that a focus on optimism, resilience, integration and choice captures some of the essence of recovery and what a client needs if he is to be successful. We deal with these in more depth in Chapter 13 where we look in detail at the important issue of recovery. At this stage, when one is beginning a treatment episode with a client or reviewing where one has got, it is important that one is attentive to the development of these four areas and that they are considered as important as the particular treatment intervention itself.

## Overview of chapter 1

This chapter is divided into four key areas:

1. What is CBT?
2. What is CBT for addictions?
3. Why we use CBT in the treatment of addictions.
4. Ways of using this book.

This chapter provides a basic understanding of CBT and an orientation to the following chapters. At this stage we make a practice-based case for this therapeutic approach, highlighting both its philosophical basis and our experiences with it. Throughout this book we refer to three hypothetical clients who exemplify some of the key issues we have experienced in our clinical work. These clients are used to illustrate the general approach outlined in this book and the specific use of a range of cognitive and behavioural techniques. To illustrate the application of various techniques we introduce new information about the clients as if it has emerged through the process of clinical work as and when this is required. We introduce the first client, Paul, below, Sally in Chapter 5 and Simon in Chapter 6. By introducing Paul at this early stage we hope that you will be willing to consider your reactions to the information presented – specifically, your thoughts, emotional reactions and how these might make you respond. At this point, we envisage that this may raise more questions and answers for you; we also prompt you with specific questions to facilitate this process. However, we hope that this will create a desire to answer these questions and inspire you to read on.

### Paul

Paul is 35 years old and has recently presented to your clinic as low in mood. He has asked for a methadone prescription. At assessment you find out that he is injecting £40 of heroin daily and also injects crack cocaine with heroin when he has money available. He started smoking heroin at the age of 19 and injecting daily from the age of 22. He began smoking crack regularly five years ago. You have also gathered some information that indicates that Paul has experienced a number of traumatic life experiences and that most of his social life involves contact with other drug users. He engages in some criminal activity to fund his use.

What might be your initial feelings about Paul? Even for an experienced drugs worker this presentation might engender wariness. Thoughts that might be contributing to this are that this entrenched pattern of drug use will be hard to shift and that Paul's life experiences will not have equipped him with many resources to change. Equally, Paul's involvement in criminal activity and his social network do not inspire confidence that there is much around him to support his initial steps in seeking recovery from his drug use. If you are not working in the field of substance use, this presentation may seem very distant from what you are used to seeing in your day-to-day working life. Your concerns might centre on Paul's criminality and you may have concerns about the drugs he is using and how he uses them. It would not be unusual to draw on your own attitudes and beliefs

about drugs and the people who use them and for this to influence what you do next. Indeed, the service you work in might actively encourage passing him on to another service and terminating your work with him.

However, let us assume that you are supported to work with Paul; indeed, let us attend to the fact that Paul has voluntarily sought treatment and that this is something you wish to nurture and find out more about. You may see this as the first step towards social reintegration and that his talking to you could facilitate this process. You may recognise that, as a professional, you have access to information and resources that Paul may at some stage benefit from. You may also be interested in Paul's resourcefulness and how he has managed to get through life so far. We make these assumptions because you are reading this book, which suggests you have at least some curiosity and are seeking guidance in working with the chaos and uncertainty problem substance use can often bring. At the very least, we hope this book will inspire you to look beyond the presenting drug problem and see Paul as more than just a 'junkie'.

After Paul has been in treatment for a month, he has entered the induction phase and has attended two of the four appointments you have made with him. He is on an 80 ml daily supervised dose of methadone, which has been increasing with the aim of reducing his heroin use. Paul reports he is still spending up to £20 on heroin and £20 on crack cocaine once a week. You have successfully completed the clinic's full assessment and have got to know Paul a little better. You have begun the complex and often subtle task of engaging him in treatment. Consequently, you have begun to get to know him and have found out he does little to occupy his time and reports that he often feels bored. Paul has confided that his entire social network consists of long-term users like himself and he has found it difficult to make new, non-drug-using friends.

Through reading this book, we hope to encourage you to ask specific questions about drug and alcohol use, to seek to understand such behaviour. Let us assume that your contact with Paul has enabled you to elicit the following information. The usual pattern of his weekly use is that on the day he receives his state benefits one of his drug-using friends visits him at home and suggests that they use drugs together. Paul described what happened the last time he used drugs. His friend came round and suggested that they score, 'just for old times' sake'. Paul started to experience cravings. Although he tried to say 'no', his friend reminded him of the times when he had helped him in the past when Paul had no money and needed to score. Although part of him didn't want to use any drugs, he was worried that if he said no, this would mean he was a lousy friend. He also worried that if he said no, he would lose this friendship, would be entirely friendless and that his boredom would become unbearable. This made Paul feel low and hopeless, and his cravings intensified. So, Paul agreed to score some drugs.

Perhaps now you have some initial hypotheses about what is maintaining his drug use and how this relates to Paul's low mood. You might think that because of his drug use Paul never has any money to engage in activities that might overcome his boredom. You see how he has become so unhappy and why he feels stuck. Through reading this book we also hope to develop your ability to understand how drug problems emerge over time and the context of substance use. Perhaps you have been able to get the following information. Paul tells you that he began smoking heroin when he was 14 years old. Having been abused by his

family when he was younger, he had become withdrawn and socially isolated. You find out that using heroin helped him to cope with the emotional consequences of the abuse and also meant that he was part of a group of drug users who supported each other.

Whether you work in a specialist drug treatment service, a primary care service or service for people with common mental health problems, if you have got to this level of understanding, then you will be well on the way to engaging Paul and there is a real possibility that your relationship with him could help him. However, you may have some anxiety about what to do next and may think that you do not know how to organise the information you have gathered in any particular way. You may still feel concerned about Paul's capacity to engage in treatment and remain uncertain about his continuing a behaviour which to you (and Paul) is clearly damaging. You may even dread the next session with Paul and feel you are in the dark about what to do next.

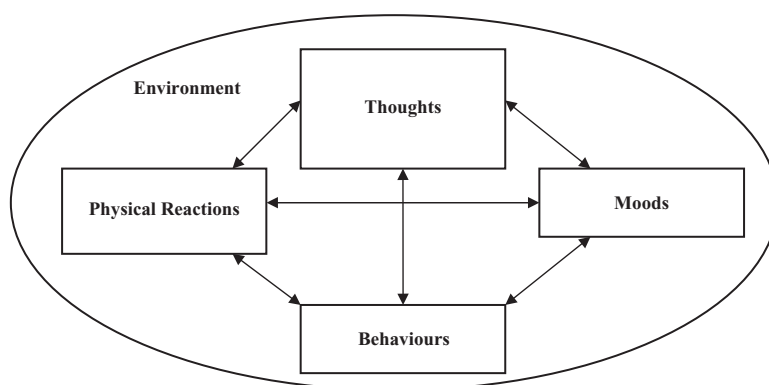
This book is written to address issues such as these, to enable you as the therapist or worker to feel better equipped to assist clients like Paul to manage their drug and alcohol use problems. Central to this is an understanding of the relationship between thoughts, feelings, behaviours and social context, which then leads to understanding the functions that drug use serves for individuals. Using this book will help you to use CBT thinking to direct an assessment, formulate a client's substance-using behaviour, plan, implement and evaluate the effectiveness of interventions with the goals of gaining control and preventing relapse. This should increase your confidence and enable you to develop an effective working relationship with clients like Paul.

## What is CBT?

CBT is now established as a major psychotherapeutic approach. It has a strong empirical basis for a range of difficulties, particularly some of the anxiety disorders and depression (Beck *et al.*, 1979). It is being adapted and utilised to treat many more problems, including addictive behaviour, for which there is an emerging evidence base (Beck *et al.*, 1993).

The central tenet of CBT is that there are thinking biases implicit in and maintaining specific problematic emotions and behaviours. By using techniques to make these thoughts explicit and assisting clients to develop alternative, more useful and realistic ones, emotions can be changed and behaviours managed or brought under control. CBT generally focuses on difficulties that are manifest in the here and now. It is an explicit collaboration between therapist and client and aims to teach clients skills to self-manage their difficulties as well as maintain improvements. Thus, CBT is defined by its empirical foundations, its explicit theory base as well as its approach to understanding individuals' difficulties.

Within this broad way of understanding human behaviour and emotions, models have been developed to guide treatment for specific disorders including addiction. Chapter 2 introduces these cognitive and behavioural addiction models. These inform the treatment for each individual through the use of formulations to conceptualise that person's specific problems. Formulations may be highly circumscribed by the model for a specific disorder, such as social anxiety (Clark &



**Figure 1.1** Padesky & Mooney's Five-part Generic Cognitive Model (© 1986 Center for Cognitive Therapy, www.padesky.com)

Wells, 1995), or may be idiosyncratic and individually tailored, but still within the broad cognitive and behavioural framework that links thoughts, emotions and behaviour within an environmental context. We take a broad approach to formulation, but one that is used to plan and evaluate interventions and may also be adapted according to how the client responds to treatment. Formulation is the central organising aspect of a CBT approach and is explained in detail in Chapter 5.

In our clinical and teaching experience we have found it helpful to use Padesky & Mooney's (1990) five-part generic cognitive model, which outlines five domains: thoughts, physical reactions, moods, behaviours and the environment (Figure 1.1). This model was devised by Padesky and Mooney as a way to explain the cognitive model in their clinical work. It is developed further in *Mind over Mood* (Greenberger & Padesky, 1995), which is an excellent general cognitive therapy resource for clients. The model is grounded on the assumption that each element is an important aspect of life experience and that all are interconnected. This means that each area affects the others and that changes in one can lead to changes in all. We use this five-part model as a formulation tool to illustrate how an individual's substance use can be understood, along with why a particular intervention is used. The model can be used to incorporate all the information utilised in the specific addictions models described in Chapter 2 and has the advantage of being easy for clients to understand and for practitioners to use.

## What is CBT for addiction?

CBT for addictive behaviour is a development within the general CBT tradition. It has given rise to a number of conceptual models and treatment manuals. Kouimtsidis *et al.* (2007) is a good example of a treatment manual based on a specific addictions model, in this case Beck *et al.*'s (1993) cognitive model of substance abuse. CBT for addiction understands substance-using behaviour within the broad framework described in the previous section and uses this understanding to inform a range of interventions. Carroll (1998) states in her cognitive and

behavioural manual designed to treat cocaine addiction that CBT attempts to help patients *recognise* the common situations in which they use cocaine, *avoid* these as appropriate and *cope* with them if necessary, as well as cope with a range of addictions-associated problems. In other words, CBT for substance use problems helps develop insight and control over addictive behaviour.

A quick note on terminology. We have already used a number of terms to describe drug and alcohol use and one of the consequences of this behaviour: addiction. There is a great deal of debate about the meaning of the term 'addiction'. It is used in academic circles as well as in everyday discourse. In acknowledgement of this broad use we have used it in the title of our book. However, as psychologists, wherever possible we seek to describe behaviour and therefore also use the term 'addictive behaviour'. To be more specific, we also use the term 'substance use problems' to indicate that the focus of this book is on the problematic use of substances, not substance use *per se*. The term 'substance use problems' includes a range of substance-related difficulties, including addiction and all the generally used diagnostic criteria for dependency and misuse. By substances we mean all psychoactive drugs, including alcohol. We also use the term 'substance misuse' in the context of describing services and with reference to the treatment field as this term is commonly used in these contexts. Other terms, such as substance abuse, are used with reference to their use in original texts. Whatever you prefer or your own service uses, always remember that it is the language the client uses that is key. Language, even when technically accurate, can alienate and confuse, and medical descriptions in particular can stand in the way of sharing intimate experiences.

As a therapist it is important to know and to be able to share with clients three particularly important assumptions underlying the CBT approach to treating substance use problems.

## 1 Addiction is a learnt behaviour

Substance dependence emerges over time with repeated use of drugs or alcohol. In this way it could be described, perhaps controversially, as a learnt behaviour. Although substance dependence is clearly complicated by biological/psychopharmacological events and social contexts it is useful to think about it in terms of the principles of learning theory.

CBT has its origins in behavioural theory and therapy. Key concepts are classical and operant conditioning. Classical conditioning describes how a stimulus produces a particular response through association. A neutral stimulus can produce a conditioned response through this learning process. This is commonly reported by substance-dependent clients. Items associated with using drugs, such as injecting equipment or foil, can trigger a desire to use. Operant conditioning describes how the consequences of a particular behaviour come to moderate the frequency of that behaviour. Behaviour can be increased through the removal of negative consequences (negative reinforcement) or by providing a reward (positive reinforcement). Behaviour can also be reduced through punishment or withdrawal of rewards (extinction). Operant conditioning is useful to understand why the euphoric or mood-altering consequences of behaviour can reinforce continued use (positive reinforcement) and why substance-dependent clients seek to avoid

withdrawal through continued substance use (negative reinforcement). The behavioural theories of classical and operant conditioning provide some explanation as to how addictive behaviour can develop and be maintained through what happens before substance-using behaviour (what the person is doing, thinking or feeling) as well as what happens after the ingestion of a substance (how the substance makes the person think, feel and behave). These concepts are explained more fully in Chapter 2. Therapies based on these ideas have also been developed to enable the addictive behaviour to be changed. The most effective of these is contingency management. Contingency management uses the principle of positive reinforcement to change substance-using behaviour by reinforcing abstinence from a specific drug. This is done through the provision of a reward that has some meaning to a client. These can be considered as motivational incentives and may be household goods, shop vouchers or prizes. Reward schedules can be constructed so that continued and sustained abstinence from a substance can be encouraged. The National Institute for Health and Clinical Excellence guideline on psychosocial interventions for drug misuse (NICE, 2007) recommends that contingency management is implemented in drug treatment services in the UK and implementation studies are currently being trialled.

Although a behavioural perspective on addiction suggests that where behaviour is learnt it can also be unlearned, it does not ignore the biological origins of addiction or the social context in which substance use develops and occurs. This understanding enables a variety of treatment goals to be negotiated with clients and worked towards in addition to total abstinence. These may include controlled use or goals informed by a harm reduction approach. These behavioural changes may be more acceptable to clients, enable early successes in treatment and may in themselves be important steps towards achieving abstinence.

## **2 Addiction emerges in an environmental context**

CBT recognises the environment and the client's experience within this context. It is suggested that the availability of substances is a key factor in determining levels of dependency within specific populations. The influence of others and learning from peers and parents can influence substance use and dependence. Environmental factors, including numerous markers of social deprivation, are strongly associated with developing substance dependency. The way clients understand their world needs to be recognised as emerging from their developmental and social context. This will help inform the interventions and enable the necessary sensitivity required to undertake CBT and develop a collaborative relationship.

## **3 Addiction is developed and maintained by particular thought patterns and processes**

Thinking processes are central to the development and maintenance of addictive behaviour as well as to the relapse process. Whilst thought patterns and processes are not always readily accessible to clients, recognising the cognitive components of addictive behaviour is essential in helping clients gain an understanding of and control over the behaviour. Cognitions related to addictive behaviour include thoughts related to outcome expectancies, often with an aspect of relief from

negative emotional states, as well as thoughts that give permission to use, such as minimising the consequences of using. These thoughts can often reinforce and maintain thinking patterns related to other psychological or psychiatric problems such as those associated with low mood or feelings of anxiety.

## Why cognitive behavioural therapy for addictive behaviour?

Cognitive and behavioural interventions have a strong evidence base for specific disorders, especially anxiety disorders and depression. However, the picture is not as clear for addictive behaviour. In Chapter 2 we introduce the principal cognitive and behavioural models that have sought to explain the development of addictive behaviour, its progression and the relapse process. However, these models have not given rise to a package of interventions that produce results above and beyond other therapeutic modalities (NICE, 2007).

Why might this be? Some reasons for this are outlined below:

1. Addiction is a profoundly complex phenomenon. The nature of addiction is contested by academics and some would question whether addiction or the other terms used (e.g. dependence) are helpful constructs to advance its understanding. Advances in brain science are unravelling the underlying biological aspects of addiction, yet any comprehensive theory must also incorporate social and psychological aspects. The cognitive therapy developments that have revolutionised the treatment of anxiety disorders are only now beginning to touch the addiction field.
2. Any search for *the* superior treatment approach in the field of addiction may be misplaced. Recent studies have indicated that different approaches tend towards similar outcomes. Project Match (Project Match Research Group, 1997) examined three interventions for alcohol dependence in a multi-site, randomised control trial. These were: motivational enhancement therapy, CBT and 12-step facilitation. Each was found to be equally effective in reducing alcohol use and few specific patient treatment matches were found. UKATT (2005), a UK alcohol treatment trial, compared motivational enhancement therapy and social network therapy and similarly found both to be as effective as treatment for alcohol misuse. These results suggest that there may be common factors to therapy that lead to change and that research may be better focused on seeking to understand common change processes rather than the relative merits of one approach over another.

If addiction is such a complex phenomenon for which definitive psychosocial treatments have yet to emerge, why might CBT still be regarded as a useful approach in this area? Some of our reasons are outlined below:

1. Paradoxically, the very complexity of addiction is a powerful reason why we advocate CBT. We need conceptual models to help us unravel the phenomenon. CBT not only provides a developmental perspective, but also grounds

this in each individual's social and environmental context, and has models to draw on that explain motivation as well as the maintenance of substance use and relapse processes. CBT encompasses a broad range of psychological approaches which are clinically useful and amenable to ongoing theory testing research.

2. CBT is useful for clients and adds value for therapists and other workers involved in care coordination and key working relationships. It consequently meets a clinical need. People need practical and pragmatic frames to understand what they do and why they do it and terminology to discuss and describe how they do it. CBT fosters a structured and collaborative approach and can inform the use of specific interventions without the need for comprehensive training. It can be adapted to a range of treatment goals, from harm reduction or controlled use to abstinence. It can also be used by more experienced therapists to develop individually tailored interventions.
3. Contingency management has been shown to be highly effective in the United States and is recommended as a key treatment intervention for stimulant drug users in the UK (NICE, 2007). Contingency management as a behavioural intervention provides motivational incentives to help reward-attaining goals such as abstinence from a specific drug. Any historical account of CBT will refer to its behavioural roots and theoretical foundations in learning theory. Thus, CBT shares a theoretical foundation with a widely validated and recommended intervention.
4. Although contingency management (CM) says nothing about internal change processes that may be occurring during a period of change, it is likely that clients are reflecting on the consequences, both positive and negative, of their behaviour. One can therefore surmise that cognitions at least mediate behaviour change. Developing cognitive interventions that maximise the changes an individual can make through a CM programme may be worthwhile. This is supported by research that shows that if the programme of motivational incentives is withdrawn, relapse rates increase (Epstein *et al.*, 2003). We argue that paying attention to the cognitive change processes is a valuable exercise and an important source of information to help individuals sustain changes made in their substance use and achieve lasting recovery.
5. Many substance-dependent clients have comorbid mental health problems, particularly depression and anxiety disorders. The Co-morbidity of Substance Misuse and Mental Illness Collaborative Study (Weaver *et al.*, 2003) found that most substance-dependent clients had a psychiatric disorder, with an affective or anxiety disorder identified in 67.6 per cent of drug clients and 80.6 per cent of alcohol clients. CBT is recommended as the treatment of choice for these problems and is explicitly recommended in the NICE guidelines (NICE, 2007). This is an important statement as, historically, substance-dependent clients have often been denied psychological treatment merely by virtue of their substance use. However, we do not yet know whether substance-dependent clients do well with generic CBT interventions or whether clinicians in generic mental health services have the capabilities, will or capacity to work with them. We argue that for these clients we are likely to need to adapt aspects of CBT for anxiety and depression treatment programmes, for example by including the substance use itself within their formulation of

their difficulties. Integrating a therapeutically congruent approach is relatively simple and this book is written with this in mind.

6. CBT can be integrated well with other approaches. Whilst CBT is explicit in its theory of distress and change, it overlaps with other approaches, at least at a basic level of intervention. Take, for example, a 12-step approach in which addiction is understood as a disease and offers a spiritual recovery programme through the 12-step fellowship. Whilst this is a fundamentally different understanding of addiction, the 12-step approach still recognises the importance of addressing negative thought patterns (also known as ‘stinking thinking’). The International Treatment Effectiveness Programme (ITEP) also integrates well with CBT (Simpson & Joe, 2004). There are specific cognitive components to some of the maps and the process of nodal link mapping that are clearly related to understanding thoughts, feelings and behaviour. Motivational interviewing is another approach that sits comfortably alongside CBT and can be effective when used as a precursor or as an adjunct to CBT (Arkowitz *et al.*, 2008), or as a fallback when treatment is not progressing.
7. CBT is often criticised for being too formulaic and insular, yet it can be used to examine process and relational issues. One of the key reasons addicted clients may be excluded from standard mental health services is that they may be deemed too chaotic to engage in therapy. It is certainly the case that some clients may miss appointments, present intoxicated or be in withdrawal and that these behaviours can interfere with other therapeutic activities. There is also a high prevalence of comorbid personality disorders. However, we argue that if therapists can step back from the issues of substance use *per se*, these issues may be more helpfully construed as therapy-interfering behaviours and dealt with accordingly. Any therapist versed in the principles and approach of CBT would be able to use CBT to address these issues with clients. Moreover, therapists can use CBT to reflect effectively on their own beliefs in working with addicted clients.
8. As indicated in the introduction, a debate currently emerging in the UK field of addictions treatment is the meaning of recovery and how services may be able to promote recovery. This represents a convergence with mental health debates and draws on definitions of recovery used in mental health. Recovery is a process resulting in a change in attitudes, values and goals to achieve meaning and maximise individual potential. Services need to support people in these individual aspirations and shift from a strict focus on managing addiction. We believe that both the collaborative process of doing CBT and its adaptability to individual goals make it relevant to the process of recovery and fits well with the longer-term recovery focus required in treatment. Indeed, whilst CBT may appear to be simply concerned with the removal of distress, whether this be anxiety, depression or substance dependence, it is just as much about living more effectively so that clients can achieve what it is they want from life.
9. Finally, we argue that there are intrinsic qualities of CBT which make it especially relevant to the treatment of addictive behaviour. Beck (1995) describes 10 principles that underlie cognitive therapy which highlight certain qualities and which are also relevant to CBT. We understand cognitive therapy to be a form of CBT, albeit with a more explicit and narrow focus on modifying

beliefs. The approach we describe in this book includes a number of elements of cognitive therapy in addition to some interventions focused directly on changing behaviour.

- a) *Cognitive therapy is based on a constantly evolving formulation of the patient and her problems in cognitive terms.* The emphasis on evolving learning and understanding within CBT is helpful with substance-using clients who may be sceptical about approaches imposed externally. Developing a shared cognitive formulation with a client sets out the therapy as a collaborative approach which respects the independence and expertise of the client. This is a very useful therapeutic stance for clients who may be ambivalent about changing their behaviour. CBT is also a flexible, individualised approach that can be adapted to a wide range of clients as well as a variety of settings (inpatient, outpatient) and formats (group, individual).
- b) *Cognitive therapy requires a sound therapeutic alliance.* Clients with substance use problems may have experienced negative interactions with professionals in the context of related health issues or in other areas of their life. Whilst this may simply reflect their difficulties and/or thinking errors, it is also possible that it genuinely reflects the negative stigma attached to addiction in wider social discourse. Clients may thus approach treatment with preconceptions about what their drug worker will think of them. Treatment itself can also be set up as an unequal power dynamic, particularly when the worker is responsible for providing a prescription of controlled drugs such as methadone or benzodiazepines. The practice of CBT can be applied to thinking about these issues, in order to identify and evaluate thoughts about the therapy, the relationship and service. By bringing these to the fore, the relationship can be enhanced in a productive way.
- c) *Cognitive therapy emphasises collaboration and active participation.* CBT is ideally suited to clients who, by the nature of their difficulties, may be ambivalent about changing their behaviour and who may have a preconceived idea about treatment involving a loss of autonomy. A cognitive perspective on managing resistance, drawing on ideas from the motivational interviewing literature, enables these issues to be brought into the body of the therapeutic approach. Focusing on building a collaborative relationship that harnesses the client's expertise, values and beliefs will always be useful and often becomes the platform on which new ways of managing addictive behaviour can be developed.
- d) *Cognitive therapy is goal-oriented and problem-focused.* In our experience many clients with substance use problems also have impaired problem-solving skills. CBT models an approach to managing life difficulties. It can also be focused on the problems that are explicit and clients bring to the sessions, in particular, the problem of continued substance use despite intentions to desist from this behaviour. CBT is also adaptable to a range of substance use goals tailored to the individual client. These goals may be understood in terms of harm reduction and controlled use, not just abstinence. Equally, CBT can focus on one or more substances when clients have a poly-drug-using profile.
- e) *Cognitive therapy initially emphasises the present.* Addicted clients are generally best served by focusing on current active use. This is often the source

of distress, particularly loss of control resulting in problems in relationships. CBT's emphasis on building control in the here and now is highly relevant to addiction. It is our experience that clients' ability to resolve past difficulties, often those associated with the development of addictive behaviour, is generally limited unless they are first able to utilise skills to manage substance use day by day, including attending sessions in a sober state. We argue that it could even be damaging to clients to focus on past issues without first giving them the skills to manage their substance use in the present.

- f) *Cognitive therapy is educative, aims to teach the patient to be her own therapist and emphasises relapse prevention.* Clients with substance use problems are often baffled by their addictive behaviour. CBT provides a framework which can lead to better understanding. This in turn becomes the basis for developing control. Central to CBT is the practice of testing new ways of thinking and being. The emphasis in therapy is what the client does outside the consulting room. Practitioners in the substance misuse field will recognise the value of this approach. It is how clients apply themselves in the real world that makes the difference in their recovery. Practitioners will also appreciate the relevance of relapse prevention. This refers to the goals of therapy as well to as a theoretical model and intervention package (discussed in Chapter 2). As a goal of therapy, relapse prevention underpins most addiction treatments, including that described in this book. The longer-term focus on managing recovery can be assisted by a set of generalisable problem-solving skills and strategies for dealing with daily hassles and setbacks.
- g) *Cognitive therapy aims to be time-limited.* Therapy needs to be focused on immediate problems from which clients are seeking relief and may be utilised in contexts where there may be only limited time to work. These settings may be determined by treatment care pathways devised to move people through the treatment system, but also be within other contexts, such as short inpatient admissions or day programmes. CBT can be targeted at these episodes of acute care, but is also relevant to developing skills for longer-term recovery management.
- h) *Cognitive therapy sessions are structured.* As indicated above, some clients with substance use problems have difficulties problem-solving and lack experience in basic self-management. The structure of CBT sessions models a way of being and thinking that can be helpful to clients outside the consulting room. The structure can also assist the process of therapy, it provides space for clients' concerns, is democratic in how time is allocated and allows the therapist to be explicit in how time can be best utilised. This is useful when trying to engage a client who is ambivalent about treatment and sensitive to the power hierarchies explicit in being, or having to be, in treatment.
- i) *Cognitive therapy teaches patients to identify, evaluate and respond to their dysfunctional thoughts and beliefs.* This is the unique defining element of CBT. The following chapters demonstrate how this can be useful in work with people with substance use problems. At this point, the relevance of this is the idea of empowering clients to be their own therapist, to take

what is learnt in therapy and apply that in their everyday lives, learning an approach to difficulties that will become an ingrained and effective way to respond to ongoing and new life problems. If one accepts that addiction is a chronic relapsing condition, then the idea of learning skills to generalise across new situations and experiences is essential to long-term recovery.

- j) *Cognitive therapy uses a variety of techniques to change thinking, mood and behaviour.* We believe you will find things in this book to help you in your work with clients with addictive behaviours. We have included a variety of techniques that can be described as behavioural and cognitive. We have also included mindfulness, which is showing promise in the treatment of depression. One strength of CBT is that it is broad-ranging, giving rise to a variety of tools and techniques. However, this may also be a weakness as it makes testing CBT in addictions settings and comparing across treatment trials problematic, as what is called CBT is quite varied. For the clinician, however, this is an opportunity as it provides great diversity in what can be drawn on in therapeutic work. We envisage this book will facilitate bringing together these ideas into a coherent form when planning and evaluating CBT with individual clients.

## Overview and ways of using this book

The aim of this book is to build competence in understanding and working with addictive behaviour. We outline a complete package of treatment from assessment to formulation and through to intervention. The book is designed to be relevant to clinicians working in different contexts, with different remits and different levels of experience in working with substance use as well as experience of using CBT. Throughout, we use the terms practitioner, clinician or therapist to encompass a wide range of roles in which therapeutic activities occur. This includes key workers, case or care coordinators working in drug and alcohol treatment services. We have set out to make this book relevant to workers with no specific therapy training but with access to appropriate supervision in which they can present and discuss the work they are doing. The approach and techniques are relevant to assist with the principal tasks of the treatment process: engaging clients, helping them to make changes in substance use and developing strategies to prevent relapse. This book can be used to identify and use specific targeted interventions as part of a care plan across the treatment journey. It can also be used by workers with CBT therapy training or a professional background to develop client-specific, formulation-based interventions. A brief overview of the chapters in this book is outlined, followed by suggestions on how you might use the book, according to your experience and knowledge of CBT.

### Chapter 2: Cognitive and motivational theories of addiction

Chapter 2 describes the theoretical background to the treatment approach described in this book. This chapter provides a conceptual framework for understanding addiction and presents a synthesis of various biological, psychological and social perspectives of addictive behaviour as well as theories of motivation, including

West's (2006) PRIME theory. We also introduce the main cognitive and behavioural models for substance-using behaviour, Marlatt & Gordon's (1985) original cognitive model of the relapse process as well as Witkiewitz & Marlatt's (2004) new dynamic model of relapse, which reflects recent findings from psychological research and attempts to accommodate the range of variables and ways in which these interact in the relapse process. We also introduce Annis & Davis's (1988b) relapse prevention model and Beck *et al.*'s (1993) cognitive therapy model of substance misuse, which also sets out a framework for understanding substance misuse from a developmental perspective. Finally, we briefly outline the evidence base for CBT with substance use problems. We envisage this chapter to be particularly relevant to those studying CBT as well as to experienced CBT practitioners interested in the conceptual and theoretical underpinnings of CBT in the area of addictive behaviour.

### **Chapter 3: Fundamentals of treatment**

In this chapter we set out the foundations of therapy on which our CBT approach should be placed. We describe the key tasks of treatment – assessment and formulation, engagement, intervention and relapse prevention – and represent these as processes which develop through therapy rather than as discrete elements that occur in sequence. We place these within the need for a positive therapeutic relationship, which may be thought of as the vehicle for the key tasks of treatment. When thinking about the therapeutic relationship we find it helpful to include two areas: (i) what we call therapist attitudes, which include how you as a worker think about your work and your clients, as well as how you might understand cultural difference and issues of diversity; and (ii) what we call therapy structure, which is the responsibilities you have as a therapist to structure the time you have with clients in a way that maximises the productivity and keeps the work on track. We believe that attention to these two aspects is essential in developing an effective therapeutic alliance. This chapter will be most relevant to workers who have not had specific therapy training and are looking for some accessible frameworks in which to develop their thinking and use of CBT interventions.

### **Chapter 4: Enhancing motivation to change**

This chapter addresses a fundamental aspect of working with addictive behaviour – namely, enhancing motivation to change. We describe how basic counselling skills can be used to help initiate a therapeutic alliance with clients. We draw on a number of ideas and techniques based on Miller & Rollnick's (2002) motivational interviewing approach and place this communication style within a CBT framework. This chapter may be of particular interest to CBT practitioners who have less experience in working with clients with substance use problems and wish to develop skills in managing ambivalence about behaviour change.

### **Chapter 5: Assessment and introducing CBT to clients**

In this chapter we introduce assessment and socialisation to the CBT approach. Assessment in CBT is a targeted activity and needs to be organised in such a

way that the necessary information is collected to develop a formulation. This activity is crucial for you as a therapist to understand your clients' substance-using behaviour. This is also the time in which you begin to socialise, or help the clients to understand their substance use from a cognitive and behavioural perspective. CBT is done *with* clients not *to* clients, so engaging them with the basic model and process needs to occur right at the start of treatment. As with Chapter 3, this chapter should be required reading for workers less familiar with CBT.

## **Chapter 6: Formulation**

This chapter sets out what we mean by formulation. This is the central organising construct that underpins CBT. It is the means by which you as a therapist organise the assessment information in a way that enables you and your clients to understand their substance-using behaviour. It then becomes the organising framework for selecting and evaluating the impact of specific interventions. This chapter is essential reading for workers less familiar with CBT.

## **Chapters 7–10: Cognitive interventions and behavioural experiments**

In these four chapters we introduce a range of interventions designed to change the thoughts and thinking patterns – or cognitions – that are maintaining substance-using behaviour. In Chapter 7 we focus specifically on these cognitions and break them down into nine categories. In Chapter 8 we look at some of the standard cognitive therapy approaches to challenging beliefs and how they may be applied to substance-using behaviour. In Chapter 9 we develop these ideas and highlight a further range of techniques and interventions. Chapter 10 is devoted to behavioural experiments. These are tasks set with clients that are designed to test specific cognitions. Done well, they can be powerful in helping clients see things differently. Behavioural experiments should not be confused with behavioural interventions (Chapter 11), which are directly focused on changing behaviour as opposed to testing cognitions. These four chapters will all be useful to experienced CBT therapists to develop their practice. For less experienced workers we recommend starting at Chapters 7 and 8 and utilising these techniques under the guidance of an appropriately qualified supervisor.

## **Chapter 11: Behavioural interventions**

In this chapter we focus on changing behaviour directly, on enabling clients to do something different. We have defined these as behavioural as opposed to cognitive interventions. This distinction is somewhat arbitrary as behaviour and cognitive changes are intrinsically linked. We introduce five interventions which are aimed at helping clients gain control over areas of their lives, including craving management and problem-solving. These interventions can be used as stand-alone, single interventions and are recommended for workers just beginning their practice.

## **Chapter 12: Working with emotions**

In this chapter we focus on a third key area of intervention: helping clients manage emotions. Emotions are often triggers to substance-using behaviour and many clients have not developed effective alternatives to managing the way they feel. In this chapter we show how the importance of emotions can be explained to clients, how the links between emotions and substance use may be understood and how they may be identified, labelled and managed. This chapter will be useful to both inexperienced workers and CBT practitioners wishing to develop their competence working with people with substance use problems.

## **Chapter 13: CBT and pathways to recovery**

In the final chapter we bring together the various elements of the CBT approach described in this book and outline how this fits with a view of the client's long-term recovery from substance use problems. We also make some suggestions for how you as a therapist might develop your CBT practice. This chapter will be of interest to all those working in the substance misuse treatment area and enable them to integrate CBT into their practice and with the broader recovery agenda.

### **Workers in the field of substance misuse with relatively little exposure to formal CBT training**

This book can be used to enhance a basic understanding of CBT and its relevance to clinical practice in drug and alcohol treatment settings. The book may be used as a resource to identify single interventions to be used in the context of key working and case coordination. Some of the ideas and language are likely to be familiar to those with some experience of working with the ITEP approach (Simpson & Joe, 2004). The visual maps to develop shared care plans and to problem-solve with clients can easily be integrated with a CBT approach and also complements some of the more cognitive-oriented aspects of ITEP.

This book may also be used to develop practice and competence in the CBT approach. For those without formal psychotherapy training, the key aspect that will be new is formulation (Chapter 6). Formulation is used to organise assessment information and to plan, evaluate and adapt interventions as required. Formulation becomes the central organising framework for work with clients. It is recommended that developing skills in using formulation be done under supervision. This may be one-to-one or in a group. Developing practice from the use of single interventions to a formulation-driven approach takes time and effort and can only occur in an organisation that supports this goal with time set aside to think reflectively about clients in a creative and constructive atmosphere. It is our experience that formulation is the key to thinking psychologically about clients and their wants, needs and aspirations.

## **CBT practitioners with limited experience in the field of substance misuse or some anxieties about working with clients with either past or present substance misuse problems**

Drug and alcohol use is hard to avoid in any health or social care setting. The new UK Improving Access to Psychological Therapies (IAPT) initiatives have and will increase the number of potential clients being screened and offered CBT and other talking therapies for depression and anxiety disorders. It is highly likely that problematic drug and alcohol use will be present in the IAPT target populations. Clients with substance use problems have not traditionally been served well by psychological therapy departments. Substance use may either be ignored or lead to clients being denied access to relevant services. Neither serves workers or their clients well.

For current CBT practitioners, or for those in training, working in primary or secondary care with adult client groups, this book aims to bridge the gap between regular practice focused on mental health problems and CBT applied to substance-using behaviour. A quick scan of the book will reveal concepts and ideas familiar to those who have had a core CBT training. The central organising principles of assessment and formulation, and the integration of these into a specific focused approach, will also be familiar. What will be new is the application of the CBT approach to substance dependence, both at a theoretical level (Chapter 2) and also in terms of interventions. Using this book to understand what material is required to develop a CBT formulation will be useful, particularly so that the function of substance use can be clearly understood and appropriately conceptualised. This may aid clearer thinking and enable a better understanding of the relationship between substance use and mental illness, for example, recognising how substance use can often be a safety behaviour. Although working with beliefs and constructing behavioural experiments will be second nature, applying these interventions to specific aspects of substance use will be new. The explicit focus on motivation in Chapter 3 is likely to be of interest as the ambivalence to changing substance use that clients may present in therapy can often be a sticking point in progress and leave the therapist feeling unskilled and demoralised. This book should enable a constructive approach to these substance use related aspects of therapy-interfering behaviour. It is hoped that this will increase competence in staff and help to reduce some of the stigma and isolation from services that this population of clients experiences.

This book describes a psychological treatment approach to substance dependence and as such does not equip workers to be fully competent in the treatment of substance dependence. This requires some understanding of the biological risks and complications associated with dependence. As a rule, any advice on changing substance use requires consulting a general practitioner or addictions specialist doctor. If a client seems particularly unwell, especially if sedated, then admission to a local accident and emergency department may be required. In the UK, for workers wishing to develop their specific knowledge in this area, there are often drug awareness courses run locally by Drug and Alcohol Action Team (DAAT) partnerships.

## **Psychologists and therapists experienced in CBT and working in the field of substance use**

This book may be useful not only as a reference point to develop practice but also to integrate different aspects of current CBT practice into a cohesive approach. Although the book is not intended to be used as a manual, it can be used as a handbook to plan individual sessions and care plans. For more experienced therapists it is likely to be used as a reference point for specific interventions. The book can also be used as a resource to develop protocol-based interventions and structured treatment programmes and groups. The book may also be an aid to the supervision of other staff without formal therapeutic qualifications.

We hope that this brief overview of what this book is about will instil some hope that you may be able to work with clients such as Paul. Some of the questions and thoughts that may now be running through your mind with regard to Paul are:

- I wonder what the function of his heroin use is?
- Given his drug using started when he was 19, I wonder what happened to him then?
- Is Paul's trauma something we could work on, or should I consult a specialist service?
- I wonder what motivated him to come into treatment now?
- I wonder which theory best explains Paul's current predicament?

Substance use problems are common in our society, yet our understanding and approaches to them are often limited. CBT has the potential to change this and we hope this book will assist this process.