

CHAPTER 1 | Scope of the Problem

Addiction is a major public health problem that is associated with substantial adverse consequences for families, communities, health care access and provision, and addicted individuals themselves. According to the American Society of Addiction Medicine (ASAM), *addiction* is defined as “a primary, chronic disease of brain reward, motivation, memory, and related circuitry” and “is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response” (n.d.).

There are many notable features of this definition. First, by referring to an addiction as a “chronic disease,” this definition points to the lifelong struggle that many individuals with addictions endure. Second, by referring to “brain reward, motivation, memory, and related circuitry,” this definition implies that addiction has a significant neurobiological component. Third, by referring to an array of consequences of addiction, this definition acknowledges that addiction is associated with significant individual and relational impairment and distress.

Notice, however, that this definition does not reference any particular type of addictive behavior. This reflects contemporary conceptualizations of addiction, which suggest that addictive behavior characterizes much more than the misuse of alcohol and drugs (Freimuth, 2005; J. E. Grant, Brewer, & Potenza, 2006). The current diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000), includes misuse of alcohol, illicit drugs, prescription drugs, nicotine, and caffeine in the broad category of substance-related disorders.

The DSM-IV-TR recognizes two kinds of substance misuse: (1) abuse and (2) dependence. *Abuse* is characterized by a problematic pattern of substance use that is associated with life interference within a 12-month period. Examples of life interference include a failure to perform expected duties at work or at home, using the substance in potentially dangerous situations (e.g., drinking and driving), legal consequences of substance use, and interpersonal strife resulting from the substance use. *Dependence* is also characterized by a problematic pattern of substance use that is associated with life interference within a 12-month period. However, in most instances, the consequences of dependence are even more severe and persistent than those associated with abuse. These consequences can include tolerance, withdrawal, unsuccessful attempts at decreasing use, and the devotion of a significant amount of time to substance use at the expense of other important occupational, social, or recreational activities. Many experts refer to *substance use disorders* as those that involve either the abuse or dependence of alcohol or drugs.

These diagnostic criteria are likely to change with the publication of DSM-5 (American Psychiatric Association, 2010). However, a new set of criteria will not change the fact that a significant number of people will be addicted to alcohol, drugs, and other behaviors, such as gambling and compulsive sexual behavior, and that these people are in serious need of effective treatment. Research sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA; 2011) indicates that rates of alcohol and drug dependence have been relatively stable across the first decade of the 21st century. This finding suggests that treatment programs and public health initiatives have not been successful in decreasing the rates of the addictions that have received the most attention in clinical settings and in the research literature.

This volume describes a treatment for addictions that recognizes many of the key components of addictive behavior described thus far. The cognitive therapy addictions group (CTAG) is a group treatment approach that has its basis in cognitive behavioral therapy (CBT), an active, semi-structured approach to treatment that focuses on the establishment of healthy patterns of thinking and behavior. CTAGs welcome members who are at any point in their journey of recovering from addiction, recognizing that addiction is a chronic problem and that people who have struggled with addiction are prone to relapse. The model underlying the CTAG recognizes that there are biological substrates that increase some people's vulnerability to addiction and that biological changes result from chronic engagement in addictive behavior. CTAGs directly address the myriad adverse consequences of addictive behavior to the individual and family and provide group members with tangible cognitive and behavioral strategies to manage these consequences. Finally, CTAGs are open to people with a wide range of

addictions—not only alcohol and drug use—in light of the fact that many of the same cognitive and behavioral processes are at work in addiction despite the diversity of addictive behaviors (cf. Flores, 2007).

PREVALENCE AND COST OF ADDICTIONS

It is no secret that addictions cause great disturbance in today's society. We frequently watch the evening news, read the newspaper, or peruse an Internet news site and hear of tragedies caused by people who drive while intoxicated, or of the staggering costs to society caused by alcohol and drug abuse, or of alarming new trends in Internet use or pornography viewing. In this section, we provide information on the prevalence and consequences of many addictive behaviors so that readers can understand the grave need for effective treatments and provide psychoeducation to their patients and their patients' families.

Alcohol, Drug, and Tobacco Misuse

By far, the most research and clinical attention has been devoted to alcohol, drug, and tobacco misuse, as these addictions have been recognized by health professionals and researchers alike as significant public health problems for many years. Part of the reason why alcohol, drug, and tobacco misuse is such a problem is that these behaviors are commonly accepted in today's society. Results from the 2010 National Survey on Drug Use and Health (SAMHSA, 2011) revealed that heavy drinking, defined as binge drinking on at least 5 days of the past 30 days, was reported by 6.7%, or 16.9 million people in the United States ages 12 or older. Illicit drug use, consisting of the use of drugs such as marijuana, hashish, cocaine (including crack), heroin, hallucinogens, inhalants, and prescription drugs for nonmedical reasons, has risen to its highest level in 8 years. Specifically, 22.6 million people, or 8.9% of the U.S. population ages 12 or older, said they had used illicit drugs in the month prior to the survey. Tobacco use was reported by 69.9 million Americans ages 12 or older, or 27.4% of the population in that age range. In fact, according to a survey by the World Health Organization (WHO), the United States led the 16 other nations surveyed, spanning North and South America, Europe, Asia, Africa, and Australia, in lifetime use of cocaine, cannabis, and tobacco (Degenhardt et al., 2008). Clearly, use of alcohol, drugs, and tobacco is a part of American culture for a substantial minority of people.

The number of Americans who meet criteria for a substance use disorder is equally as alarming. According to results from the National Epidemiologic Survey on Alcohol and Related Conditions (Stinson et al., 2005), in

2001–2002, 7.4% of adults in the United States ages 18 or older met criteria for a current alcohol use disorder (i.e., abuse or dependence), 0.9% for a current drug use disorder, and 1.1% for a current co-occurring alcohol and drug use disorder. In other words, over 9% of American adults met diagnostic criteria for a current alcohol or drug use disorder. These rates more than triple when one considers the percentage of the population who has met criteria for one of these conditions at some point in their lives (Hasin, Stinson, Ogburn, & Grant, 2007). SAMHSA's National Survey on Drug Use and Health (2011) includes individuals ages 12 and older, and results indicate that 8.7% of American adolescents and adults meet criteria for a substance use disorder. Similarly, epidemiological research suggests that about 25% of Americans have been dependent on nicotine at some point in their lives (Breslau, Johnson, Hiripi, & Kessler, 2001; Hughes, Helzer, & Lindberg, 2006), with 15% meeting criteria for current nicotine dependence (Hughes et al., 2006).

The consequences of substance use disorders are staggering. According to the WHO, alcohol abuse is the third leading risk factor for early death and disabilities around the world. In 2004, an estimated 2.5 million people died of alcohol-related causes, including 320,000 people between ages 15 and 29 (WHO, 2010). Tobacco use is responsible for 1 in 10 adult deaths, killing more than 5 million people per year worldwide. In fact, there are approximately 1 billion smokers across the globe, and more than half of them will die prematurely of tobacco-related causes (WHO, 2011). In the United States, drug-related deaths have increased from 6.8 deaths per 100,000 in 1999 to 12.6 deaths per 100,000 in 2007. These numbers highlight a pressing need to continue developing effective prevention and intervention strategies in order to save lives.

Substance use disorders can cause health problems on multiple levels. Health problems might arise from the physiological effects of the substance (e.g., alcohol cirrhosis), from the effects of the practice of using the substance (e.g., nonsterile injections), from the behaviors in which people engage while under the influence (e.g., drinking and driving), from the consequences of the lifestyle associated with heavy substance use, or from the neglect of existing health problems (Des Jarlais, 1995; Islam, Day, & Conigrave, 2010). Despite their need for health care interventions, substance users often do not have access to health care or choose not to use it, resulting in a precarious situation in which they ultimately present for emergency treatment with acute conditions, which is of great cost to the health care system (Islam et al., 2010). In 2008, there were approximately 2 million visits to the emergency rooms in American hospitals for drug abuse/misuse—about half of those involved the use of illicit drugs, and the other half involved the nonmedical use of pharmaceuticals (SAMHSA,

2010). Moreover, substance use disorders often co-occur with psychiatric disorders, such as depression and anxiety (e.g., Hasin et al., 2007), which means that there is the potential for mental health to be affected just as much as physical health.

The resulting economic cost of substance use disorders illustrates just how great a toll on society these addictions are taking. In 2002, the economic cost of drug abuse in the United States was estimated at \$180.9 billion (Office of National Drug Control Policy, 2004), which includes the resources needed to address health and crime consequences and the loss of productivity due to disability, premature death, and inability to work. In addition, it has been estimated that cigarette smoking was associated with \$193 billion in health-related costs each year from 2000 to 2004, including lost productivity and direct medical costs (Centers for Disease Control and Prevention, 2008). These numbers indicate that substance use disorders affect all of us, even if we do not know a single individual who is struggling with the effects of a substance use disorder. Moreover, these numbers say nothing about the distress that substance use disorders cause to marriages, families, and other close relationships (Friedmann, Hendrickson, Gerstein, & Zhang, 2004).

Other Addictions

Only now are researchers beginning to study the prevalence and consequences of non-substance-related addictions, including (but not limited to) those in the realms of gambling, Internet, sex, and overeating (cf. J. E. Grant et al., 2006). There are no large national and international epidemiological studies, save for those that have assessed pathological gambling, that can provide the type of definitive information about these addictions that we presented in the previous section on alcohol, drug, and tobacco misuse. Nevertheless, we are starting to see that nonsubstance use addictions can be just as debilitating as substance use disorders, and in the remainder of this section, we cite the available research that is beginning to identify the prevalence and consequences of these other addictions.

Although gambling addiction has received significant attention from the research literature in the past two decades, the need to address this addictive behavior has been known at least since the late 1950s, when the first Gamblers Anonymous meeting was held (Gamblers Anonymous International Service Office, n.d.). Gambling is another potentially addictive behavior that is commonly accepted in American society. Epidemiological research indicates that over 75% of Americans report that they have gambled at least once in their lives, that over 50% of Americans report that they have gambled more than 10 times, that over 25% of Americans report

that they have gambled over 100 times, and that over 10% of Americans report that they have gambled over 1,000 times (Kessler et al., 2008). The lifetime prevalence of pathological gambling, defined in a similar manner as DSM-IV-TR substance abuse and dependence, ranges from 0.6% (Kessler et al., 2008) to 1.6% (Shaffer, Hall, & Vander Bilt, 1999), although results from smaller studies raise the possibility that, in some areas of the world, the prevalence is up to 7% (Ladouceur & Walker, 1996). Pathological gambling is associated with many financial, relational, and legal consequences, including high rates of bankruptcy, divorce, and incarceration (J. E. Grant & Potenza, 2007). Like the other addictive behaviors, it is associated with high rates of comorbidity with psychiatric disorders (J. E. Grant & Potenza, 2007), which raises the possibility that gambling addiction puts people at risk for adverse mental health consequences.

In contrast to gambling, the Internet is a relatively recent phenomenon that has assumed an increasing amount of importance over the past 20 years. Although the Internet is a crucial tool for obtaining necessary information to conduct research in our professional and personal lives, it also offers a number of social and recreational outlets (e.g., gaming, social chat rooms, dating sites) that have the potential to consume a great deal of time. Up to 6% of the population reports an Internet addiction (Young, 2007). Internet addiction might not necessarily be associated with the health and mortality consequences that are associated with substance use disorders. However, research shows that it is strongly associated with social isolation and marital discord, as Internet relationships can replace “real-life” intimacy with other partners, and many people with an Internet addiction hide their behavior and lie to others about it (Brenner, 1997; Morahan-Martin & Schumacher, 1999; Young, 1998). Moreover, research shows that Internet addiction is similar to substance use disorders in that it is often used as a tool to escape life problems (Young, 2007).

Of course, a large subset of problem online behavior is Internet sex addiction, which includes visiting adult websites to view pornographic material and participating in adult chat rooms, among other activities (Young, 2008). Sex addiction (sometimes referred to as hypersexuality) that occurs primarily online, however, may represent only about one-quarter of all compulsive sexual behavior (Cooper, Delmonico, & Burg, 2000). Other manifestations of hypersexuality include compulsive masturbation, promiscuity, excessive viewing of pornographic magazines and movies, frequent attendance at strip clubs, and telephone sex (Kafka, 2007). Although it has been difficult to measure the prevalence of sex addictions, it is clear that pornography is an enormous industry in the United States (Weinberg, Williams, Kleiner, & Irizarry, 2010). In addition, compulsive sexual behavior is associated with significant relationship distress, although relationship

problems are often perceived as more distressing to the partner than to the addicted individual him- or herself (Cooper, Scherer, Boies, & Gordon, 1999). When hypersexual behavior extends beyond the online community, there is an increased risk of unprotected sex (Muench et al., 2007), which, in turn, is associated with the spread of sexually transmitted diseases (Kalichman, Cherry, Cain, Pope, & Kalichman, 2005) and unintended pregnancies (McBride, Reece, & Sanders, 2008).

Finally, many experts consider overeating to be an addictive behavior. Currently, people regarded as having binge eating disorder are diagnosed with eating disorder not otherwise specified. The lifetime prevalence of binge eating disorder is estimated to be 2.8% (Hudson, Hiripi, Pope, & Kessler, 2007), and one study found that 92% of a sample of patients with binge eating disorder would meet criteria for a substance use disorder if the substance in question were binge eating, with some of these patients describing themselves as “food addicts” and “compulsive overeaters” (Cassin & von Ranson, 2007). Binge eating disorder is associated with substantial health risks, although evidence is currently mixed as to whether or not these health risks are solely attributable to the increased rates of obesity found among those with binge eating disorder (Striegel-Moore & Franko, 2008). Thus, it is important to keep in mind that, although there is a strong association between binge eating disorder and obesity, they are not one and the same, and it is likely that people with binge-eating disorder form a subset of obese individuals who are characterized by a hypersensitivity to the pleasure associated with eating and a predisposition to engage in addictive behavior (Davis et al., 2009). Research also shows that individuals with binge eating disorder suffer from psychosocial consequences, including comorbid psychiatric disorders and impaired social adjustment (Wilfley, Wilson, & Agras, 2003). Overeating is an addiction with unique properties, because unlike substance use addictions, abstinence is not an option. Instead, these patients need to acquire skills to regulate their food intake (Collins, 2005).

THE NEED FOR EFFECTIVE TREATMENT

To this point in the chapter, we have illustrated that addictions affect a substantial percentage of the population and that they are associated with severe health, economic, and interpersonal consequences. There exist many treatment options for people who struggle with addictions, including inpatient treatment facilities, day treatment and partial hospitalization programs, outpatient treatment programs, and self-help groups (e.g., Alcoholics Anonymous [AA]). Unfortunately, research suggests that only a small percentage of people with these addictions get the treatment they need.

For example, in the National Survey on Drug Use and Health (SAMHSA, 2011), it was determined that only approximately 11% of those who needed treatment for alcohol or drug misuse actually received treatment in a specialty facility. In the National Epidemiologic Survey on Alcohol and Related Conditions (Stinson et al., 2005), only 6.1% with an alcohol use disorder, 15.6% with a drug use disorder, and 21.8% with a co-occurring alcohol and drug use disorder sought treatment. When people with a substance use disorder enter into treatment, between one-third and two-thirds drop out prior to treatment completion (Dutra et al., 2008; Malat et al., 2008; Tzilos, Rhodes, Ledgerwood, & Greenwald, 2009). It is likely that a combination of factors accounts for these unfortunate facts; however, these statistics also suggest that addiction treatments need to be acceptable and tolerable for the people who are encouraged to seek them.

Another factor that makes the need for effective treatment all the more pressing is that relapse is extremely common among patients who struggle with addictive disorders (Marlatt & Witkiewitz, 2005; Polivy & Herman, 2002). In fact, many experts consider relapse as something to be expected (Dunn, 2000), such that returning to old behaviors is part of the natural cycle of change (DiClemente & Prochaska, 1998). For example, in a 10-year follow-up study of people with substance use disorders, of those who had achieved remission, approximately one-third relapsed in the first year, and approximately two-thirds relapsed at some point in the follow-up period (Xie, McHugo, Fox, & Drake, 2005). Other studies have reported alcohol and drug relapse rates of up to 90% in the first year (e.g., Hunt, Barnett, & Branch, 1971). Similarly, Cohen et al. (1989) found that only 13–14% of smokers were abstinent 6–12 months after their attempt to quit, and Brown (1989) reported that only 7% of gamblers were abstinent 2 years after their attempt to quit. High relapse rates are also the norm in the treatment of overeating and obesity (Collins, 2005) and relapse is similarly a part of the typical progression of sex addiction (Young, 2008). Thus, for treatments to be effective, they must account for the very high rates of relapse in addicted populations, and clinicians who administer them must directly address this issue with patients.

COGNITIVE THERAPY OF ADDICTIVE BEHAVIOR

We propose that cognitive therapy has the potential to be an effective treatment for the wide range of addictive disorders. According to A. T. Beck, Wright, Newman, and Liese (1993), there are a number of features of cognitive therapy that make it a good match for use with this population. First, patients gain perspective that their addictive behavior is the primary

pathway by which they experience pleasure and/or get relief from distress. They acquire the understanding that unhelpful beliefs fuel addictive behavior, and they begin to modify these beliefs, as well as the belief that their addiction is due to circumstances outside of their control. Developing this understanding in the context of a collaborative therapeutic relationship gives patients a sound rationale for the treatment and empowers them to make decisions on the basis of this model, which may be more attractive to some patients with addictions than treatment approaches in which they are told what to do in an authoritative manner. In addition, cognitive therapy provides specific strategies for managing cravings, which strengthens a patient's "internal controls" and has the potential to decrease the likelihood of relapse. Finally, cognitive therapy also helps patients to combat negative emotional experiences like depression, anxiety, anger, guilt, and loneliness, which can serve as triggers for relapse (cf. Monti et al., 2002).

Cognitive therapy, often referred to as cognitive behavioral therapy (CBT), for addictions has been studied extensively in the research literature. As we evaluate this research literature, we use the terms *cognitive therapy* and *CBT* interchangeably, according to the terms most often used by the investigators who conducted the research. These terms also encompass many specific protocols developed on the basis of cognitive and behavioral principles, including Marlatt and his colleagues' Relapse Prevention approach (Marlatt & Donovan, 2005; Marlatt & Witkiewitz, 2005), L. C. Sobell and Sobell's Guided Self-Change approach (2011), and Monti and his colleagues' Coping Skills Training and Cue Exposure Treatment approaches (2002). The majority of the research we review in this section pertains to CBT for alcohol and drug use disorders, but we briefly reference the efficacy of CBT approaches to the treatment of other addictive disorders.

In general, comprehensive meta-analytic studies confirm that CBT is efficacious in treating alcohol and drug use disorders, as these patients exhibit significant reductions in alcohol and drug use posttreatment, and these reductions are greater than those achieved by physician advice and psychoeducational groups (Irvin, Bowers, Dunn, & Wong, 1999; Miller et al., 1995; Miller & Wilbourne, 2002). Moreover, there is evidence that improvement from participation in CBT can be maintained at least a year after treatment has ended, and, in some cases, that patients experience further improvement (Epstein, Hawkins, Covi, Umbricht, & Preston, 2003; Carroll et al., 1994, 2000). CBT for the treatment of alcohol and drug misuse is also efficacious in reducing co-occurring emotional distress (e.g., depression, anxiety) and improving coping (Hides et al., 2010). Similarly, it has been used effectively in treating cigarette smokers who are trying to quit (e.g., Marks & Sykes, 2002) and may be particularly efficacious for

smokers who are vulnerable to depression (Kapson & Haaga, 2010). Both group and individual CBT protocols have been evaluated in the empirical literature, and data suggest that both approaches are efficacious (Rotgers & Nguyen, 2006).

Despite these positive findings, it is important to acknowledge that there are other efficacious treatments for substance use disorders. In fact, many studies have reported that other treatments, such as programs that facilitate engagement in 12-step programs, motivational interviewing, supportive-expressive therapy, and interactional group therapies, are equally as efficacious in achieving a decrease in substance use (e.g., Project MATCH Research Group, 1997; Kadden, Litt, Cooney, Kabela, & Getter, 2001; Woody, Luborsky, McLellan, & O'Brien, 1990). Further complicating matters is that research on the mechanism of action in CBT suggests that improvement in CBT does not necessarily occur through the acquisition of strategies that are emphasized and practiced (Morgenstern & Longabaugh, 2000), and that patients who participate in treatments that are not focused on the acquisition of cognitive and behavioral strategies exhibit significant improvement in the use of these skills posttreatment (Litt, Kadden, Cooney, & Kabela, 2003). Experts have speculated that important factors in explaining the efficacy of treatments for substance use disorders include the administration of the treatment by clinicians who have a great deal of experience with this population (Crits-Christoph et al., 1999) and the capitalization on patients' motivation and increased self-efficacy (Litt et al., 2003).

The treatment outcome literature is much less developed for addictions other than substance use disorders. However, data from existing studies show great promise in CBT for the treatment of these addictions. For example, CBT for gambling has been modeled after CBT for substance use disorders, with the idea that people who have gambling addictions make incorrect assumptions about probability, skill, and luck, and that CBT can help them acquire skills to modify these assumptions (Shaffer & LaPlante, 2005). Controlled studies have found that CBT for gambling is associated with significant reductions in gambling behavior and a desire to gamble, as well as an increase in perceived control, relative to waiting list control conditions (e.g., Sylvain, Ladouceur, & Boisvert, 1997; Ladouceur et al., 2001). CBT has been described as the "gold standard" treatment for conditions that overlap with some of the addictions considered in this chapter, such as obesity (Collins, 2005) and illegal sexual behavior (Wheeler, George, & Stoner, 2005), as well as Internet addiction (Young, 2007).

In sum, cognitive therapy is one of many efficacious treatments for substance use disorders, and it is currently regarded as the psychotherapy of choice for non-substance use addictions. Although research conducted to date raises the possibility that it does not exert its action in the manner that is intended, the facts that (1) it significantly reduces alcohol, drug, and

smoking use, relative to no treatment and nonspecific treatments; and (2) it has been shown to be efficacious hundreds of times in the general psychotherapy literature (see Butler, Chapman, Forman, & Beck, 2006) suggest that it can play a role in addressing the grave need for effective treatment of people with addictions. Because results from some studies raise the possibility that addictions treatments are most effective when they are administered by professionals who have a great deal of experience with the population, and when they capitalize on patients' motivation for change and self-efficacy, it is logical that attention to these treatment characteristics would be important to consider in cognitive therapy.

The treatment described in this volume—the CTAG—indeed embraces these features. Although CTAGs can be implemented in any treatment setting (e.g., outpatient psychiatry clinics, private practices), they were designed to be compatible with interventions offered in addiction specialty programs, where treating professionals have rich clinical experience in working with this population. In addition, CTAGs welcome members at various stages of change, which means that some members are highly motivated to reduce their addictive behavior, whereas others may be ambivalent. These individual differences are respected, and strategies to enhance motivation are integrated into the group's work. It is usually the case that some group members have attended sessions for some time, whereas other group members have attended only a few sessions. This mixture of clientele allows seasoned group members to model the effective application of cognitive and behavioral coping strategies, which in turn has the potential to increase group members' confidence that these strategies do indeed work and that they can indeed apply them to their lives.

There are four additional characteristics of CTAGs that we believe make them an especially attractive treatment option for use with patients with addictions. As we discuss in Part II, the treatment is flexible. Although facilitators adhere to a general session structure format, there is no prescribed curriculum. There is nothing that *must* be done in a group member's Session 1, Session 2, and so on. Rather, facilitators educate about and model the cognitive behavioral approach to managing addictions while simultaneously responding to the needs of group members at the time of any one session. In other words, there is a cognitive therapy framework that guides each session, but the content and work of each session is guided by the concerns of the group members and the collaborative decision making between the group members and the facilitators. This flexible structure allows for a guiding framework on which facilitators can rely in helping group members to leave with something more than they had at the beginning of the session, but also for attention to be given to issues and crises that the facilitators could not have anticipated when they prepared for the session (which frequently happens).

A second characteristic that makes the CTAG an attractive option for use with patients with addictions is that it welcomes members with any type of addiction—alcohol use, drug use, tobacco use, gambling, Internet use, sex, overeating, and so on. This heterogeneity reflects the heterogeneity of the clientele in many treatment programs, making it practical to implement the CTAG continuously in these settings, rather than requiring a lengthy wait to accumulate a number of new patients who all have the same addiction to begin a group. Moreover, this heterogeneity illustrates the commonality among patients with addictions in terms of the cognitive and behavioral factors that maintain addictive behaviors, which are the very same factors that will be the targets of treatment. As a result, group members will see that addictions affect people from many different socioeconomic and cultural backgrounds, and they will benefit from multiple points of view and wisdom that they might not have otherwise considered (Bieling, McCabe, & Antony, 2006).

A third characteristic that makes the CTAG an attractive option for use with patients with addictions is the fact that it is an open group, which means that group members are not bound to attend a specific number of sessions, that they attend or do not attend as they please, and that new members are continually being integrated into the group. This structure has the potential to be particularly relevant for addiction specialty programs, which often see a large rate of turnover and dropout (McCarty et al., 2007). Thus, new members can join the group as there is space, which increases the likelihood that patients in need will receive treatment at the time when they need it the most, as well as the likelihood that there will be a large enough quorum on any given day to conduct meaningful group psychotherapy. This structure also has the potential to be especially tolerable to patients with addictions who are still in the process of making a commitment to change and may hesitate to commit to a prescribed course of treatment.

Because the CTAG is an open group, by definition, it is also ongoing. Many experts in the field of addictions state unequivocally that longer involvement in treatment is associated with better outcome (e.g., Flores, 2007; Rotgers & Nguyen, 2006), although we recognize that many patients with addictions, particularly those with alcohol dependence, achieve significant gains in time-limited treatments with as few as four to eight sessions (Monti et al., 2001; Rohsenow et al., 2001; L. C. Sobell, Sobell, & Agrawal, 2009). It also is quite common for patients with addictions to attend treatment sporadically, “recycling” through periods of abstinence or controlled use and periods of heavy use (Norcross, Krebs, & Prochaska, 2011). An ongoing group provides these patients with the opportunity to revisit and practice the skills they had acquired in the past in order to continue to work to overcome their addiction. Of course, we recognize that

time-limited groups, rather than open groups, have the potential to be most compatible with some patients' insurance plans in this age of managed care (cf. L. C. Sobell & Sobell, 2011). However, the CTAG is designed in such a way so that group members who attend only a limited number of sessions are expected to take away many tangible strategies for managing their addictive behavior and, at the same time, so that group members who are able to attend a larger number of sessions can capitalize on their time in treatment by gaining extensive practice with the strategies and developing a sense of self-efficacy as they model the application of these strategies to others in the group.

Finally, a fourth characteristic that makes the CTAG an attractive option for use with patients with addictions is the group format itself. Interactions with people who are struggling with related problems allow for the emergence of curative factors that can come only from group, rather than individual, psychotherapy (Flores, 2007; L. C. Sobell & Sobell, 2011; see Chapter 3 for more discussion of these factors). Moreover, group formats offer up to 50% greater efficiency relative to individual psychotherapy (Morrison, 2001; L. C. Sobell et al., 2009), which allows treatment facilities to serve a large number of patients.

ORIENTATION TO THIS VOLUME

The remainder of this volume describes the theoretical basis for the treatment and the treatment's components and strategies. This volume is divided into three parts. Part I provides background information that is necessary to understand the context and rationale for CTAG components. This chapter presented information on the scope of the problem—the prevalence and consequences of addictions—as well as a brief overview of research that has evaluated the efficacy and effectiveness of cognitive behavioral approaches to treating addictions. Chapter 2 describes our comprehensive cognitive model of addiction so that readers can gain an understanding of the theoretical basis of the treatment and the manner in which intervention logically follows. Chapter 3 describes theory related to the implementation of group psychotherapy and motivation for change in order to give context for the CTAG that extends beyond scholarly work on cognitive behavioral theory, which is crucial in mobilizing group process and support and in enhancing group members' commitment to treatment. Chapter 4 provides a brief overview of the CTAG. Chapter 5 describes case conceptualization, or the manner in which the theory described in Chapters 2 and 3 can be used to understand the clinical presentations of individual group members, as well as the group as a whole. Part II provides a detailed description of the CTAG session components that were introduced in Chapter 4, including

introductions (Chapter 6), evaluation of thoughts and beliefs (Chapter 7), development of coping skills (Chapter 8), and homework and closure (Chapter 9). Part III includes a concluding chapter that organizes the treatment strategies according to the comprehensive cognitive model of addiction, provides suggestions for handling challenging group members from a cognitive behavioral framework, and illustrates the ending of treatment for group members who have achieved their goals.

A few notes about the terminology that we use in this volume are in order. The reader will see that we often refer to group members as “engaging in addictive behavior.” Although this phrase is, admittedly, awkward, we use it in this volume to be as inclusive as possible in representing the array of addictive behaviors reported by group members (e.g., “using” applies mainly to group members who have substance use disorders and does not apply as readily to those with many non-substance use addictions). We also refer to both *patients* and *group members* throughout the volume. We generally use the term “patients” to refer to people with addictions who seek treatment in general, and the term “group members” to people with addictions who participate in the CTAG. However, the terms can be used interchangeably, as the material we describe with reference to “patients” applies to CTAG members, and we would expect that the observations we have about “group members” would apply to patients in general who might choose to participate in the CTAG. At times, we refer to a patient with an addiction as “he” or “she” but the reader can assume that the information is relevant to people of both genders. Finally, we make numerous references to “slips,” “lapses,” and “relapse.” *Slips* and *lapses* are terms that can be used interchangeably, and they refer to a single instance in which a person engages in addictive behavior after being previously abstinent, or a single instance in which a person engages excessively in addictive behavior after a period of controlled, nonharmful use. *Relapse* refers to multiple instances in which a person engages in addictive behavior after being previously abstinent, or multiple instances in which a person engages excessively in addictive behavioral after a period of controlled, nonharmful use. Often, relapse signals a return to the previous problematic pattern of behavior (Marlatt & Witkiewitz, 2005).

Throughout the volume, we follow five group members who are at various stages of change and who struggle with different types of addictions. These “case descriptions” represent a composite of characteristics that we have seen in group members whom we have treated with the CTAG. The following is a brief biography of each of these five group members.

“Dave” is a 29-year-old single Caucasian male who joined the CTAG 6 weeks earlier for polysubstance dependence, which includes heavy use of marijuana and alcohol and occasional use of crack cocaine. He

recently received his second driving-under-the-influence (DUI) arrest and spent time in jail; as a result, he was ordered to enroll in the group by his probation officer. Currently, he works at an auto parts store, although he has held a number of jobs over the past 2 years and has often been fired due to being under the influence of substances at work or missing work due to being hung over. Dave lives with his girlfriend, and the two of them have an “on again, off again” relationship characterized by arguing, blaming, and occasionally, physical violence. He often goes on binges, in which he stays with his buddies for days on end. Dave expresses ambivalence, at best, about curbing his substance use; although he sees that many of his friends are “growing up” and assuming more responsibility in life, he also views substance use as an escape from his stressful home life and as a way to relive his younger years. Most of the time, Dave is defensive about his substance use, and he is often skeptical about the topics discussed in group, claiming that they do not apply to his particular situation.

“Michael” is a 45-year-old married male of mixed African American and Korean heritage who joined the CTAG 8 months earlier for a sex addiction. Michael had 10 affairs with women during the time in which he was dating the woman who later became his wife and early in his marriage. He also had many additional “inappropriate” relationships with women characterized by heavy flirting, emotional intimacy, exchange of inappropriate messages (i.e., “sexting”), and occasional kissing. Immediately prior to joining the group, his wife discovered that he had been carrying on an inappropriate relationship with a coworker despite repeated promises that he would remain faithful. Michael is an attorney at a prominent firm in town, and at times he has risked his professional reputation by viewing pornography on the Internet while at work, or by engaging in inappropriate sexual behavior with female clients. Michael has two children, ages 4 and 6, and prior to joining the group, he had often missed their evening activities in order to go to strip clubs with his male colleagues, view pornography on his computer at home, or go to happy hour with female clients or colleagues. His wife has given him an ultimatum that he must stop this behavior, or she will divorce him and seek custody of the children. Michael has been abstinent from extramarital sexual and emotionally intimate behavior with other women for the past 6 months, although he continues to feel sexual tension with female coworkers whom he finds attractive or with whom he had “flirted” in the past.

“Ellen,” a 61-year-old divorced Caucasian female, joined the CTAG 6 months earlier for compulsive overeating. She currently weighs 300 pounds; she joined the group at the recommendation of her doctor, who encouraged her to lose over 100 pounds. Ellen is struggling with generalizing the cognitive and behavioral strategies learned in group

to her daily life. She is unemployed and receiving disability, she lives alone, and she rarely sees her adult children. She states that she is very lonely and that she has little meaning in her life. Ellen also meets criteria for major depressive disorder, and she complains of little motivation and energy to implement a structured diet and exercise routine. She finds that she overeats in the evening, when she ruminates over the fact that she lives alone and begins to view herself as worthless. She often becomes tearful in group when she admits her lack of progress to the other members.

“Allison” is a married 50-year-old Native American female who joined the CTAG a week earlier to address her nicotine addiction. Allison has smoked since age 11, and nearly all of her family members and friends also smoke. Recently, Allison has had trouble catching her breath after excessive coughing fits, and her doctor informed her that she must give up smoking in order to prevent further deterioration of her lungs. She asked her husband and her mother-in-law (who lives with her) to give up smoking with her because she became concerned with their health, and she also believed it would be easier to give up smoking if there were no cigarettes in her household. Unfortunately, her husband and mother-in-law refused to do so, and Allison constantly feels urges to smoke when she is home. She has tried nicotine gum and the patch, but she does not believe that either method has been helpful. Allison described increasing tension with her husband and mother-in-law because of this issue.

“Brian” is a 34-year-old Caucasian male who has attended the CTAG sporadically for over 2 years to address a gambling addiction. Brian had enjoyed going to the riverboat casinos to “blow off steam” ever since he turned 21 and was legally allowed to gamble, stating that he thrived on the “high” of “winning big.” At age 30, his grandmother died, and he received an inheritance. Although he and his new wife had agreed to invest the money from the inheritance into their retirement, his gambling increased substantially, with the idea that he could increase the size of their newfound sum of money if he could hit the “jackpot.” Eventually, Brian lost much more than he won, and he dwindled away the inheritance. Currently, Brian is separated from his wife and is struggling to make ends meet financially. His behavioral pattern is that he goes many months without gambling, but when he comes into money, he often goes to the casino and loses it. He and his wife are currently in couple’s therapy in an attempt to decide whether they can repair their relationship. Brian was raised in an upper-middle-class family where achievement and success were emphasized, which contributes to the belief that he is a “loser” because of his current situation. Like Ellen, Brian meets criteria for major depressive disorder.

SUMMARY

Addictions take an enormous toll on the people who engage in addictive behavior, their families, and society as a whole. Although much funding, time, and effort have been devoted to developing efficacious treatments for addictions, the fact remains that the majority of patients who undergo treatment for addictions will relapse. Thus, scholars and clinicians must continue to develop and refine addiction treatment approaches so that they target the core factors that maintain addictive behaviors, are tolerable to patients with addictions, and address high rates of relapse. The CTAG is an outgrowth of cognitive therapy for addictions (A. T. Beck et al., 1993) that was developed to take into account these and other factors and to be administered in a flexible manner in an array of clinical settings. Though it has not yet been evaluated in a large randomized controlled trial, we view it as an *evidence-informed treatment* because its theory, structure, and strategy are firmly grounded in findings from the empirical literature (Maude-Griffin, Hohenstein, Humfleet, Reilly, Tusel, et al., 1998). This volume describes the theoretical underpinnings of the CTAG as well as the implementation of its components.