Cognitive-Behavioral Therapy for Substance Use Disorder	
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GUIDELINE OVERVIEW: Cognitive behavioral therapy (CBT) is an efficient treatment that can be used as monotherapy as well as part of combination treatment. In this article there will be a review of the evidence supporting the use of CBT, clinical elements of its application, novel treatment strategies for improving treatment response, and dissemination efforts.

General Considerations	Cognitive behavioral therapy (CBT) has been shown to be effective for substance use disorders. Some of the elements of CBT includes elements such as operant learning strategies, cognitive and motivational elements, and skills building interventions. The term substance use is defined as taking any illicit psychoactive substance or improper use of any prescribed or over the counter medication. Substance use disorders are defined as substance abuse and substance dependence. Symptoms of substance abuse reflect the external consequences of problematic use such as failure to fulfill role obligations, legal problems, physically hazardous use, and interpersonal difficulty resulting from use. Symptoms of substance dependence reflect more internal consequences of use such as physical withdrawal upon discontinuation of a substance and difficulty with cutting down or controlling use of a substance. In this summary, the definition of CBT will include both behavioral and cognitive behavioral interventions.
Summary of Recommendations	**Efficacy of CBT for Substance Use Disorders (SUDs)** There are numerous studies that support the efficacy of CBT for alcohol and drug use disorders. CBT is effective for both group settings and individual treatment. Evidence also supports durability of treatment effects over time. CBT for substance use disorders includes several distinct interventions, either combined or used in isolation, many of which can be administered in both individual and group formats. The following behavioral and cognitive-behavioral interventions can be administered to individuals and groups: 1. **Motivational interventions.** Motivational Interviewing (MI) is an approach which focus is to target ambivalence toward behavior change. Treatments based on the MI model are utilized as both stand-alone interventions and in combination with other treatment strategies for SUDs. Usually, MI is offered in an individual format, and it often consists of a relatively brief treatment episode. However, greater efficacy may be achieved when a higher dose of treatment is used. 2. **Contingency Management.** Contingency management (CM) approaches are grounded in operant learning theory and involve the administration of a non-drug reinforcer (e.g., vouchers for goods) following demonstration of abstinence from substances. CM procedures may use either stable or escalating reinforcement schedules, in which reinforcer value increases as duration of abstinence increases. 3. **Relapse Prevention and Other Treatments.** This cognitive-behavioral approach to drug abuse emphasizes a functional analysis of cues for drug use and the systematic training of alternative responses to these cues. Relapse Prevention (RP) focuses on the identification and prevention of high-risk situations in which a patient may be more likely to engage in substance use. Techniques of RP include challenging the patient's expectation of perceived positive effects of use and providing psychoeducation to help the patient make a more informed choice in the threatening situation. This approach includes a range of techniques such as psychoeducation, cognitive reappraisal, skills training, and other behavioral strategies. 4. **Couples and Family Treatments.** The Community Reinforcement Approach (CRA) focuses on altering contingencies within the environment (e.g., inclusion of favorable non-alcohol related activities in the patient's daily schedule) to make sober behavior more rewarding than substance use. Another treatment which utilizes the support of a significant other is Behavioral Couples Therapy (BCT). This treatment is assumed that there is reciprocal relationship between relationship functioning and substance abuse, whereby substance use can have a detrimental effect on the relationship and this relationship distress can lead to increased substance use. Therefore, the focus of this treatment involves improving a partner's coping with substance-related situations as well as improving overall relationship functioning. Interventions commonly include psychoeducation,

	training in withdrawal of relationship contact contingent on drug use, and the application of reinforcement (e.g., enhanced recognition of positive qualities and behaviors) contingent on drug free days and including the scheduling of mutually pleasurable non-drug activities to decrease opportunities for drug use and to reward abstinence. **Clinical Elements of CBT for SUDs.** A core principle of CBT for SUDs is that substances of abuse serve as powerful reinforcers of behavior. As time goes by, reinforcing effects become associated with a wide variety of both internal and external stimuli. The core elements of CBT aim to mitigate the strongly reinforcing effects of substances of abuse by either increasing the contingency associated with non-use (e.g., vouchers for abstinence) or by building skills to facilitate reduction of use and maintenance of abstinence and facilitating opportunities for rewarding non-drug activities. **Cognitive and Motivational Strategies.** Motivational and cognitive interventions can be provided to enhance motivation for non-drug related activities, while also working to decrease cognitions that enhance the likelihood of drug use. In addition to the elements of motivational interviewing (i.e., assessment, dispassionate presentation of information, and elucidation and discussion of ambivalence about drug abstinence), broader cognitive strategies can target the cognitive distortions specific to substance abuse, including, rationalizing use, and giving up. **Skill Training.** Skills building can target interpersonal, emotion regulation, and organizational/problem-solving deficits. Interpersonal skills building exercises may target repairing relationship difficulties, increasing the ability to use social support, and effective communication. Emotion regulation skills can include distress tolerance and coping skills. Through the use of problem-solving exercises and the development of a repertoire for emotion regulation, the patient can begin to both determine and utilize non-drug use alternatives to distress. Strategies for coping with negative affect, such as using social supports, engaging in pleasurable activities, and exercise can be introduced and rehearsed in the session. Thus, concurrently increasing pleasant and goal-directed activities while reducing use can be crucial for facilitating initial and maintained abstinence.
Conclusion	CBT for substance use disorders includes a broad range of behavioral treatments including those targeting operant learning processes, motivational barriers to improvement, and traditional variety of other cognitive-behavioral interventions. Studies have shown that these interventions are effective in controlled trials and may be combined with each other or with pharmacotherapy to provide more robust outcomes. Despite this heterogeneity, core elements emerge based in a conceptual model of SUDs as disorders characterized by learning processes and driven by the strongly reinforcing effects of substances of abuse. Novel treatment strategies and combination strategies to improve rates or speed of treatment response may aid in the transportability of treatments outside of research settings.