**HOW TO IMPLEMENT THE CORE TASKS OF PSYCHOTHERAPY (SESSION TWO)**

**ACHIEVING LASTING TREATMENT CHANGES FOR CLIENTS WITH ADDICTIVE AND CO-OCCURING DISORDERS**

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**See Don Meichenbaum’s recent book: “Treating Individuals With Substance Abuse Disorders: A Workbook for Patients and Clinicians” Rutledge Publishers**

**TOPICS TO BE PRESENTED**

**The Nature of the Challenge for Psychotherapist: How to Spot HYPE in the Field of Psychotherapy**

**Treatment Guidelines for Achieving “Lasting Changes”: Role of Deliberate Practice**

**Role of the Therapy Alliance and Group Cohesion: Use of Feedback Informed**

**Treatment (Session-by-Session)**

**Psycho-education: Use of a CLOCK METAPHOR and Self-monitoring**

**Procedures**

**Art of Questioning: Motivational Interviewing**

**Use of Timelines: Identify “Strengths” and Evidence of Resilience**

**Collaborative Goal-setting that Nurtures Hope SMART Goals (Specific,**

**Measureable, Attainable, Relevant, Timely)**

**Teach Intra- and Interpersonal Skills: Incorporate Generalization Guidelines and**

**Ways to Bolster Resilience**

**Emotional Coping Tool Box**

**Regulate, tolerate, accept, name and tame negative feelings**

**Increase positive emotions**

**Cognitive Coping Tool Box**

**Mentalize, Use Mindfulness, Rethinking Skills, Change talk, Language of**

**possibilities RE-verbs, Metacognitive verbs**

**Interpersonal Coping Tool Box**

**Use social support recovery network; Avoid “Enablers”, Develop and use a**

**Sobriety Script (“should” versus “wants”)**

**Involve Significant Others: Couple and Family Interventions**

**Relapse Prevention Training: Risk diary of possible triggers “Red flags,” Refusal and communication skills for high-risk situations, Self-attribution training (“Taking credit”)**

**Active Aftercare and Booster Sessions Address Needs Beyond Substance Abuse**

**Where indicated, Use Medication-assisted Treatment (MAT): Pharmacotherapy for Addictive Disorders**

**Addressing Issues of Treatment Nonadherence**

**How to Incorporate Spirituality and Psychotherapy: 12 Step AA Checklist**

**PTSD and SUD’s: Treatment implications of a history of Adverse Childhood Experiences (ACE)**

**(Controversies PTSD and resilience/ “Stat of the art” - - Acronym Therapies/ “Body keeps score - - see Resilience training can change the brain/ Constructive Narrative Interventions/ Integrated treatment approaches - - Ford, Cloitre, Najavits).**

**Prolong and Complicated Grief**

**(See Manual by Meichenbaum *www.melissainstitute.org*)**

**Depression, suicidality and SUD’s**

**(See Collaborative Assessment and Management of Suicide: Telehealth interventions by David Jobes**

**See 35 Years working with Suicidal patients: Lessons learned by Don Meichenbaum**

***www.melissainstitute.org***

**Aggression, Interpersonal Violence and SUD’s**

**TO DO list for attendees**

**THE NATURE OF THE CHALLENGE FOR PSYCHOTHERAPISTS**

**Donald Meichenbaum**

1. There has been no improvement in treatment outcomes in the field of psychotherapy over the last 30 years, as reflected by changes in Effect Sizes (ES) and by meta-analytic studies (Budd & Hughes, 2009; Hunsley & D. Guilio, 2002).
2. The dropout rate from psychotherapy averages between 20% and 47% for adult patients. The dropout rate for children and adolescents ranges from 28% to 85%.
3. Some 30% to 50% of adult patients do not benefit from psychotherapy. In the treatment of patients with Substance Abuse Disorders, the relapse rate is 75%, no matter what substance is being used.
4. The deterioration rate among adult patients in psychotherapy is 5% to 10%. Those patients who deteriorate in psychotherapy account for 60% to 70% of the total expenditure of mental health care costs.
5. Psychotherapists routinely fail to successfully identify patients who are not progressing. Such patients who are deteriorating are at most risk of dropping out and having negative treatment outcomes (Lambert, 2007; Lambert & Shimokawa, 2011).
6. Psychotherapists lack knowledge and usually do not seek treatment outcome data and as a result have a tendency to overestimate their effectiveness. There is a need to check-in with patients on a regular basis regarding the quality of the therapeutic relationship and their progress (Sperry & Carlson, 2013).
7. The Partners for change Management System which is a SAMHSA National Registry evidence-based program provides a session-by-session tool kit for obtaining real-time patient feedback. Also see Lambert’s OQ-45 measure (Duncan, 2010; Lambert 2007).
8. Psychotherapists need to focus on early changes and monitor and bolster patient progress. There is a dose-response relationship between early improvement and treatment outcome of patients who are engaged in treatment:
9. 30% of them improve by the second session;
10. 50%-60% evidence improvement by session 7;
11. 70%-75% by 6 months;
12. 85% by the end of the year.

Sudden gains in symptom reduction contributes to improved therapeutic alliance, and in turn, to a “positive spiral” of change. Early improvement and patient progress predicts positive treatment outcomes (Tang & DeRebeis, 2005).

1. With experience psychotherapists treatment effectiveness does not improve. What does change with experience is the psychotherapists’ confidence in their competence and effectiveness (Wampold, 2001).
2. For example, a study by Branson et al. (2015) provided 43 psychotherapists with 300 hours of training in CBT. They tracked outcomes in 1247 patients and found that the 300 hours of training significantly improved adherence to CBT protocols, but the extensive training did not result in better treatment outcomes, relative to untrained psychotherapists. The CBT therapists were no more effective following training than before. There was little support of a general association between CBT competence and patient outcome. Moreover, Webb et al. (2010) have reported that the psychotherapists’ strict adherence to evidence-based treatment manuals is not related to treatment outcomes. In fact, “loose compliance” that is tailored to the patients’ individual needs and preferences may be the best treatment approach (See doi.10.1016/jbrat.2015.03.002 for the Branson et al. study).
3. There is substantial variation in outcomes between providers with similar training and experience. Some psychotherapists are more “expert” in achieving better treatment outcomes and “lasting changes” in their patients.

Patients of effective psychotherapists improve at a rate of at least 50% higher and their drop-out rate is at least 50% lower than the less effective psychotherapists (Norcross, 2002; Skovholt & Jennings, 2004).

1. A variety of studies have shown that the difference in effectiveness of individual psychotherapists, within a given treatment, accounts for a larger proportion of variance than the variance accounted for between various treatments. The person and his/her clinical skills are more important than the specific treatment being implemented in contributing to treatment outcomes (Sperry & Carlson, 2013).
2. The person of the psychotherapist is more important than the psychotherapists’ theoretical orientation, years of experience, and discipline or professional affiliation (Horvath et al. 2011).
3. Over 90% of the differences in treatment outcome between more and less effective psychotherapists is attributable to differences in their ability to establish, maintain and monitor on a regular basis, the quality of the therapeutic alliance and patient progress toward achieving the collaboratively-generated treatment goals. For example, in DBT with Borderline Personality Disorder patients, those patients who perceived their therapist as both affirming and protective had longer lasting changes and were less self-injurious (Thoma et al., 2015).
4. Caution and humility is warranted even when considering the most widely endorsed evidence-based intervention of Cognitive behavior therapy (CBT). For example, consider the following findings:
5. CBT has not been found to be more effective than most other treatment approaches such as interpersonal and supportive psychotherapy. Tolin (2010) did report that CBT was more effective than psychodynamic approaches, especially for the treatment of patients with anxiety and depressive disorders.
6. However, Thoma et al. (2015) reported that the more methodically rigorous that the randomized control study of CBT with depressed patients, the poorer the treatment outcomes. Moreover, there were “allegiance” effects, with those who most advocate CBT approach, the better the outcome results. Earlier studies of CBT were more effective than more recent CBT treatment outcome studies (Thoma et al., 2015).
7. CBT has not been found to work through the proposed mechanism of change in several studies (Muse & McManus, 2013).
8. Dismantling studies do not find specific ingredients as being critical to the benefits of CBT.
9. Critical psychotherapeutic skills related to the therapeutic alliance and that are not directly related to the specific protocols contribute the largest proportion of variance in accounting for treatment outcomes (Baardseth et al., ).
10. A common finding in psychotherapy research has been the inability to detect differences when active, bona-fide psychotherapists as compared with specific treatment approaches (Wampold, 2011). Wampold argues that psychotherapy works in large part through general mechanisms of “remoralization” (ala the work of Jerome Frank), as patients develop a sense that they have value and can be effective in their lives as a result of the healing relationship with their psychotherapists (Wampold et al., 1997).
11. When comparing various Acronym-based psychotherapeutic approaches for treating patients with PTSD and Complex PTSD, there are no significant differences between the varied treatments. Whether the acronym-therapy approach is DTE, CPT, EMDR, DBT, ACT, SIT and the like, there are “no winners of the race” (Meichenbaum, 2013).
12. The psychotherapists’ effectiveness is in terms of the patient treatment outcomes tends to plateau over the course of their careers in the absence of a concerted effort to improve as a result of “deliberate practice”. (See Meichenbaum’s recent papers on “Nurturing therapeutic mastery” and “The psychotherapeutic relationships as a common factor: Implications for trauma therapy.” ***Please visit www.melissainstitute.org and on the top of the Homepage click Resources and then scroll down to Author Index. You can then scroll down to Meichenbaum to open these and related articles. Contact Don Meichenbaum at dhmeich@aol.com with your comments.***

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**CORE TASKS OFPSYCHOTHERAPY**

**Donald Meichenbaum, Ph.D.**

**Role of Case Conceptualization Model (CCM) that informs assessment and treatment decision-making (*See CCM below and the accompanying Report Format*).**

1. **Assessment Procedures.**
2. Risk factors toward self and others
3. Presence of co-occurring disorders
4. Strengths- - evidence of Resilience, “Islands of competence” and access to social resources and supports
5. **Development, maintenance and monitoring of Therapeutic Alliance - - Be culturally, developmentally and gender sensitive.**
6. Use of Motivational Interviewing practices (***See*** [***www.motivationalinterviewing.org***](http://www.motivationalinterviewing.org)**)**
7. Use guided discovery probes - - Socratic questioning procedures (***See Art of Questioning below*)**
8. Use Feedback Informed Treatment (FIT) procedures. FIT asks patients to rate on a session-by-session basis, their Progress and the Quality of the Therapeutic Alliance. Bertolino (2017), explains the FIT assessment procedure as follows: (See Bertolino, 2017 use of session-by-session patient ratings)

***“Completing this scale is a bit like taking your temperature. In a minute or less, we can get an idea about how you think things are with you and your life. Just as your temperature tells us something about how much distress your body is in, so do the scores on this scale. And like your temperature, this scale will let us know how things have been with you during the past week up through today, - not tomorrow or in a month. Right now we are trying to understand how we can help you which is more difficult if we don’t have a good idea of how you are doing to begin with. Can you help us out?”***

***(Bertolino, 2017, p. 197).***

FIT has patients fill out ORS (Outcome Rating Scale) and SRS (Session Rating Scale of the therapeutic alliances). The therapist reviews these scores with the patient “where he/she is at,” and develops a collaboration strengths-based patient-driven treatment plan (see FIT-Outcomes.com.

1. **Collaborative goal-setting - - Nurture HOPE**
2. Establish SMART goals (Specific, Measureable, Attainable, Relevant, Timely)
3. Use Goal-attainment Scaling Procedures - - “As yet”; “So far” statements
4. Focus on issues of transfer and maintenance of treatment gains across settings and over time in order to achieve “lasting changes”
5. **Conduct Psycho-Education**
6. Use CLOCK metaphor
7. **12 o’clock** - - External and internal triggers
8. **3 o’clock** - - primary and secondary emotions (Treat emotions as a “commodity” - - “What do you do with your feelings?”)
9. **6 o’clock** - - Automatic thoughts and images

* Implicit assumptions
* “If … then” Rules
* Beliefs, Developmental Schemas

1. **9 o’clock** - - Behaviors and reactions of others

Use metaphor of “vicious cycle” and ***what is the impact, toll, price you***

***and others pay?***

1. Highlight the Role of Resilience - - Build and broaden positive emotions and activities
2. Use Time Lines

Timeline 1 - - From birth to the present, enumerate stressors (experiences of trauma and exposure to violence), and interventions, if any

Timeline 2 - - “In spite of behaviors”. Evidence of strengths, signs of resilience from birth to the present. Also, include evidence of intergenerational transmission of “strengths”. What got passed on? Lessons learned.

Highlight “exceptions” - - when problems not present or less. Be solution-focused

Timeline 3 - - present and future – oriented focused. Start now and extend Timeline into the future.

1. **Teach Intra- and Interpersonal skills**
2. Focus on emotion-regulation skills and problem-solving skills.
3. Focus on interpersonal skills - - “scripted” behaviors
4. Build in generalization guidelines (Do before, during and after training - - put the patient in a Consultative Role). Use Patient Checklist.
5. **Conduct Relapse Prevention Procedures and Self-attributable training procedures (“Taking credit” statements). Use meta-cognitive and RE verbs - - “notice, catch, plan”, etc. and RE-new, RE-connect, RE-author.**
6. **Provide Integrative Treatment approaches, where indicated to address the presence of co-occurring disorders, such as Complex PTSD, depression, Substance abuse disorders. (See Alexander et al. 2013; Jaycox, 2004, 2009, Wolmer et al. 2011).**
7. **Provide Active Aftercare and Follow-through Procedures. Conduct a:**
8. Risk Analysis-triggers. Use CLOCK Metaphor
9. Use Booster Sessions
10. Use Ongoing Internet Consultations
11. Involve Significant Others in Treatment, throughout, (***See list of Websites for Family-based Interventions***)

**ART OF QUESTIONING: USE OF “WHAT” AND “HOW” QUESTIONS**

“***Let me explain what I do for a living. I work with folks like yourself and try***

***to find out how things are right now in your life and how you would like them to be”***

***“I want to find out what you have tried in the past to bring about these changes, achieve your goals? What worked, what has not work, as evident by\_\_\_\_\_? What help did you receive, if any? What did you have difficulty following through with?”***

***“If we worked together, and I hope we can, how would we know if you were making progress? What would other people notice change in your life?***

***“Permit me to ask one last question, if I may. Can you foresee, envision anything that might get in the way of your achieving your goals, changing, improving the situation? Can you think of a plan of action, where you can anticipate such possible obstacles or barriers to change? What do you think can be done?”***

**OTHER QUESTIONS**

**(*Bertolino, 2017*)**

***“How have you been doing personally?”***

***“How have things been going in your relationship? How are you getting along with your parents, friends, boss?”***

***“How are things going for you socially?”***

***“How has your life been outside of your home (in your community, school, church, work)?”***

***“Overall, how are things going in your life?”***

**GENERIC CASE CONCEPTUALIZATION MODEL**

**1A. Background Info**

**1B. Current Living**

**Conditions**

**1B. Reasons for Referral**

**2A. Presenting Problems**

**(PP)**

**2B. Comorbidity**

**2C. Level of Current Functioning**

**9. Barriers**

**9A. Individual**

**9B. Social**

**9C. Systemic**

**9B. Social**

**9C. Systemic**

**3A. History PP**

**Criminal/Substance/**

**Media Temperament**

**3B. Medical History**

**Youth/Family members**

**3C. Academic History**

**Performance/Motivation**

**/Discipline**

**3D. Peer and Sibling Influences**

**8 Outcomes**

**8A. Short-term**

**8B. Intermediate**

**8C. Long-term**

**8A. Short-term**

**8B.Intermediate**

**8C. Long term**

**7. Summary Factors**

**7A. Risk**

**7B. Protective**

**4. Stressors**

**4A. Current**

**4B. Ecological**

**4C. Developmental**

**4D. Familial**

**5. Treatments Received**

**(Current/Past)**

**5A. Efficacy**

**5B Adherence**

**5C. Satisfaction**

**6. Strengths**

**6A. Individual**

**6B. Social**

**6C. Systemic**

**COMPUTER-GENERATED REPORT BASED ON CASE CONCEPTUALIZATION MODEL (CCM)**

**(The numbers and letters in the report refer to information in the Boxes in the CCM)**

**Introduction**

This (age, gender, race) (**1A** – information) who currently lives indicate geographic area) with (**1B** – information). The housing situation (note any specific concerns about threats to safety – “**red flags**”). The date and reason for referral by …. were **1C**.

**Presenting Problems**

The **presenting problems** include **2A** (Note the source of information and if violence is indicated, the role of weapons, injuries, substance abuse and peers – violence was an isolated act or part of a peer group).

**In addition**, the youth also experiencing difficulties with (**2B** – comorbidity). These presenting and comorbid problems are having an impact on the level of functioning as evident by…

An examination of the youth’s **developmental history** reveals (review prior record and history of presenting problems and history of comorbid problems – **3A**). These behavioral problems were accompanied by (exacerbated by) – medical history (**3B**) and academic history (**3C**) and by peers and sibling influences such as (**3D**).

An examination of **current and past stressors** for both the youth and his family members reveals (**4A to 4D**). **[Note: In particular, the source of information for developmental stressors such as victimization (4C) and familial stressors (4D).]**

For these various presenting and comorbid problems and stressors, the youth and his family are currently receiving (or have received) the following treatments (cite specific interventions, by whom, when) with what effects **(5A**) (**cite source of information**. Some of the difficulties encountered with this treatment included…(cite source of information for **treatment** **nonadherence – 5B**). Based on their treatment experiences the youth and his parents were particularly satisfied with (dissatisfied with) … because … (**5C**).

**In spite of** the difficulties and the presence of … (list “risk” factors, stressors) the youth and his parents were able to achieve… (cite source for **individual and familial strengths** – **6A** and **6B**). The “strengths” that the youth and his family have going for them are… They can also access (note, **community** and **agency** resources – **6C**).

In **summary**, an examination of the “risk” factors and adversities indicate (**7A**), but a consideration of protective factors (**7B**) also reveals (Note: “challenges” and “opportunities”).

In terms of the goal attainment scale (GAS), the major three target behaviors to be addressed initially include … The agreed-upon signs of improvement negotiated with the youth and his family are … (**For each target behavior note what the specific change would look like**.)

**Specific Ways Behavior Should Change**

**Minimal Moderate Significant**

**Improvement Improvement Improvement**

**0% 25% 50% 75% 100%**

**Change Change Change Change Change**

**Target Behavior 1**

**Target Behavior 2**

**Target Behavior 3**

In collaboration with the youth and his family, the following assessments and treatment goals and plans have been established, as noted on the **Goal Attainment Scaling (GAS)** procedure. The short-term (**8A**), intermediate (**8B**), and long-term (**8C**) goals that will be worked on are … More specifically, the individualized treatment plan for the youth and his family indicates that a follow-up assessment should include … ***(What additional information is needed and how and when is it to be obtained); placement (Amount of supervision required – least to most restrictive in light of likelihood of further offences); treatment options (What should be done, by whom, when and how will generalization/transfer and evaluation be built into the treatment plan).***

In order for these changes to occur, the following **barriers** at the individual (**9A**), familial-social (**9B**) and systemic levels (**9C**) have to be addressed. (***Note, how these barriers were identified.***) The intervention plans to address these barriers include … The evidence that they have been addressed successfully include data that (***Note data like that included on GAS – 0% to 100% change***).

**TREATMENT GUIDELINES FOR ACHIEVING STABLE LASTING CHANGES**

1. Establish, maintain and monitor the quality of the therapeutic alliance using session-by-session, or regular, treatment-informed feedback (FIT) in order to monitor patient progress and the “fit” with the therapist (treatment team). Visit the Website to download FIT tools. ***(See*** [***www.centerforclinicalexcellence.com***](http://www.centerforclinicalexcellence.com) ***and Scott Miller on Melissa Institute Website.)***
2. Work to achieve and assess for treatment group cohesion and patient-to-patient support.
3. Be culturally-sensitive and gender-sensitive when providing services. Conduct gender-specific treatment programs and tailor interventions to issues of sexual orientation. Individualize the treatment protocol and assign a Case Manager to each patient. The quality of the therapeutic alliance is the most important predictor of the length of the treatment participation, engagement and treatment outcomes.
4. Use Motivational Interviewing Empathy-based procedures to increase patient treatment engagement. Focus on “change talk”. ***(See www.motivationalinterviewing.org and http://ctndisseminationlibrary.org.PDF/146.pdf).***
5. Nurture patient HOPE by employing collaborative goal-setting using **SMART** goals (Specific, Measureable, Attainable, Realistic Timely goals). Use the language of possibilities and becoming “solution talk”. Incorporate meta-cognitive and RE verbs in social discourse.
6. Use Genograms and Time-Lines to help the patient identify “strengths” and evidence of resilience (“In spite of” behaviors). Nurture a coping resilient mindset in spite of vulnerability factors.
7. Use a Case Conceptualization Model of risk and protective factors and employ patient and significant other feedback. Assess the patient’s implicit theories of his/her addictive behavior and views of the treatment plans. Consider treatment alternatives of abstinence and harm reduction interventions.
8. Employ psycho-education that informs about both “addiction traps” and the impact of substances on brain/body, as well as information about neurogenesis and neuroplasticity of the brain. (“Rewire the brain” and “History is not destiny!)
9. Use the CLOCK metaphor to educate the patient about the interconnections between his/her appraisal of external and internal triggers (12 o’clock); accompanying primary and secondary emotions ( 3 o’clock); accompanying thoughts and thinking processes (6 o’clock); and behaviors and resultant consequences (9 o’clock)?
10. Help the patient to appreciate how they inadvertently, unwillingly, and perhaps, unknowingly contribute to their present problems. How they contribute to a “vicious cycle” and focus on the mindset and constructive narrative (“stories” patents tell themselves and others and accompanying behavior).
11. Teach and strengthen emotion and self-regulation skills such as distress tolerance, managing cravings, chronic pain and learn ways to engage in positive resilient-engendering emotions and accompanying self-care, empowering activities. Implement generalization guidelines before, during and after skills training.
12. Put the patient in a consultative role using Patient Checklists and Post Treatment Recovery Checklist. Include Self-attribution training procedures (“taking credit” for behavioral changes - - “nurture ownership”.)
13. Employ medication-assisted treatment (MAT), where indicated. Address issues of treatment non-adherence throughout.
14. Involve significant others, like family members whenever possible. Conduct a network analysis, as part of Relapse Prevention procedures. Provide peer support recovery specialists, if possible.
15. Incorporate Relapse Prevention procedures, conducting a trigger analysis, behavioral chain analysis, potential barrier analysis, and preparing skills training. Focus on potential therapy-interfering behaviors. Consider “unsafe for recovery” settings and plan with the patient accordingly.
16. Provide Integrative treatment to address the impact of co-occurring disorders. Use evidence-based interventions and beware of HYPE in the field.
17. Incorporate the patient’s spirituality (religion, faith, participation in various forms of treatment like 12 Step AA and Smart Recovery into intervention. (See Meichenbaum “Trauma, spirituality and recovery” on the Melissa Institute Website).
18. Provide Active Aftercare and ongoing group interventions. Include follow-up assessment and Booster sessions to address any “unfinished business.” Engage the patient with a community of “successful” patients. Provide access to computer-assisted resources.
19. Conduct a collaborative detailed comprehensive discharge planning, anticipate high-risk situations. View any lapses as a “learning opportunity.” Help patients learn to “fail successfully.”
20. Provide wrap-around services to address the multiple needs of patients such as back-to-work programs, parenting and academic skills training. Treat the “whole” person, not just addiction problems.
21. Engage other health care providers as follow-up therapeutic agents, both professional and non-professional facilitators. Use the Case Conceptualization Model and Feedback-informed Treatment, as a mode of communication.
22. Where indicated, help patients find safe drug free living circumstances (eg., Halfway housing, College safe Haven settings). Assess the “social capital” and “recovery capital” of the community to which the patient will return.
23. Obtain patient feedback (“exit” interviews) and treatment satisfaction feedback and ask for ways the treatment program can be improved. Maintain ongoing feedback with the patient. Encourage the patient to be a “collaborator.”

**CORE COMPETENCIES FOR PSYCHOTHERAPISTS**

**Donald Meichenbaum, Ph.D.**

1. **Establish, maintain and routinely monitor the quality of the therapeutic alliance.**
2. **Actively communicate an accepting, supportive, helpful, empathetic, validating message.**
3. **Conduct a comprehensive assessment of the reasons for seeking treatment or having been mandated for treatment (e.g., presenting symptoms, current concerns, life problems). Conduct a functional, situational and developmental analysis.**
4. **Assess for the client’s and significant other’s explanatory models or implicit theories about the nature of the presenting problems and what it will take to change. (Solicit explanations about the treatment and possible barriers and provide a treatment rationale).**
5. **Be culturally sensitive, as well as gender and developmentally sensitive. (Be culturally competent).**
6. **Include assessment of risk to self and to others and risk of revictimization. Ensure client safety.**
7. **Use the “Art of Socratic Questioning” and a discovery-oriented approach. Encourage the client to tell and retell his/her story at his/her “own pace”.**
8. **Develop and use a Case Conceptualization Model and provide feedback to the client and significant others.**
9. **Engage the client in collaborative goal-setting that nurtures “hope” and adjust goals collaboratively over the course of treatment. Elicit evidence of “strengths”. Use “In spite of” statements and use Time Lines.**
10. **Use Motivational Interviewing procedures (Express Empathy, Avoid Argumentation, Develop Discrepancy, Support Self-efficacy).**
11. **Conduct ongoing psychoeducation - - Use “clock” explanation. Increase client’s self-awareness of how he/she inadvertently, unwittingly, and unknowingly produce reactions that confirm these beliefs.**
12. **Routinely solicit feedback about the therapeutic alliance and outcome from the client. Conduct feedback-informed treatment. Monitor change, lack of improvement and deterioration.**
13. **Address therapy-interfering behaviors, therapeutic impasses (“ruptures” to therapeutic alliance) and reasons for treatment nonadherence. Consider the therapists possible contribution to alliance problems.**
14. **Document, Document, Document. Maintain progress reports using the Case Conceptualization Model.**
15. **Keep the treatment focused and structured. Maintain a sense of direction (use “journey” metaphor). Use language of becoming and sense of possibilities. (Metacognitive and “RE” verbs). Be “principal-driven”, not “protocol-driven” - - be clinically flexible.**
16. **Improve credibility of the therapist by fostering client change early in treatment (e.g., symptom reduction, improve relationships).**
17. **Help the client engage in inter-session activities (Homework” assignments).**
18. **Train intra emotional self-regulation and interpersonal skills. Build in generalization guidelines. (Do not “train and hope” for transfer). Provide integrative treatments for clients with comorbid disorders.**
19. **Where indicated, incorporate spiritually-based interventions.**
20. **Provide corrective experiences within and outside of treatment. Use gradual exposure- based interventions with traumatized/victimized clients, where indicated. But be sensitive to other dominant emotional reactions including, guilt, shame, complicated grief, anger and “moral injuries” and tailor interventions accordingly.**
21. **Conduct relapse prevention and self-attribution training (“Taking credit” activities).**
22. **Help the client become his/her “own therapist”/”detective”. “Restory” one’s life.**
23. **Prepare for termination (Taking stock of changes and planning for the future).**
24. **Engage in self-care behaviors and experience vicarious resilience.**
25. **Work to enhance mastery by means of deliberate practice and self-reflection, pursuing learning opportunities.**
26. **Behave in an ethically responsible manner. (Respect boundaries and be aware of psychological treatment that cause harm.**

**Lessons to be Learned from Research on Motivational Interviewing (MI) (See www.motivationalinterviewing.org).**

***“Motivational Interviewing is a collaborative conversation style for strengthening a person’s own motivation and commitment to change and a way of eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion” (Miller & Rollnick, 2013 p. 17).***

**Guiding Principles of MI**

1. Evoke the patient’s own concerns and motivations, including consideration about changing;
2. Patient should voice arguments for changing;
3. Therapists should listen with empathic understanding and acceptance;
4. Minimize resistance. Don’t oppose it. Avoid argumentation;
5. Nurture hope and optimism. Use collaborative goal-setting of short-term, intermediate, and long-term goals. Be solution-focused that highlight strengths and resources. Highlight exceptions, “in spite of” behaviors described below in the use of Time Lines. Use phrases such as “As yet”, “So far.”
6. The responsibility for change is placed on the patient. Solicit public commitment statements.
7. Focus on “Change talk” and “Sustain talk” (**DARN**). Use active transitive metacognitive verbs (“Notice, catch, game plan, back up, plan”, etc.) and RE verbs such as REgain, REnew, REauthor, Resilient.

***Desire - - “I hope, wish”***

***Ability - - “I can, will be able to...”***

***Reasons - - “I have to because...”***

***Need - - “I need to, “I want to”, “I must”***

**SUMMARY OF MI INTERVENTIONS**

**EE - - Express Empathy**

**DD - - Develop Discrepancy**

**RR - - Role with Resistance**

**AA - - Avoid Argumentation**

**SS - - Support Self-efficacy**

**Examples of Brief MI interventions for Substance Abuse**

Bernstein et al. (2005), found an effect of brief MI on heroin use. Coffin et al., (2017), using MI, found a reduction in overdoses of opioid use. (See Coffin et al. File 1 for a 95 page detailed intake assessment Questionnaire and a description of their 45 minute REBOOT MI intervention program.

**USE MOTIVATIONAL INTERVIEWING SKILLS AND THE “ART OF QUESTIONING”: GUIDED DISCOVERY FOCUSING ON “WHAT” AND “HOW” QUESTIONS**

a). Possibility of using single session therapy

***“Many people who come here and talk about their problems find that just one time can help a lot…I’m willing to work hard today to help you get a better handle on things. Does that sound like something you’d like to do?” (Hoyt et al. 1992, p. 69).***

***“If we were only to meet once, what problem would you want to focus on solving at this point in time?”***

***“What is your hope for today’s meeting?”***

***“On a scale of 1 to 10, where is the problem now? Where would it need to be for you to decide that you did not need to continue here?”***

**Questions Derived From a Solution-focused Treatment Approach**

***“When the problem isn’t present (or isn’t so bad), what is going on differently?”***

***“When is the problem not a problem?”***

***“What do you call the problem? What name do you have for it?”***

***“When (and how) does the problem influence you and when and how do you influence it?”***

***“What is your idea or theory about what will be needed to change? How would your life be better with these changes?”***

***“What are you willing to change?”***

***“Given all that you have been through, how have you managed to cope, as well as you have?”***

***“What needs to happen today so that when you leave here you can feel that your visit was worthwhile?”***

***“If we work hard and well together, what will be the first small indication that we are going in the right direction?”***

**Additional Illustrative Questions Designed to Engage Patients in Treatment**

**Help Patients Recognize Their Problems**

* ***“What difficulties have you had regarding use of X?”***
* ***“How has using X stopped you from doing what you want?”***
* ***“In what ways have other people (family members, friends, coworkers) been harmed by your X?”***

**Help Patients Acknowledge Concerns**

* ***“What worries you most about X?”***
* ***“What do you think could happen to you if you do not change (stop using X)?”***
* ***“In what ways does this concern your family?”***
* ***“What has led you to seek help now?”***
* ***“What do you think will help?”***
* ***“How have you tried to solve the problem so far? How did that work?”***

**Help Develop Options**

* ***“What encourages you to think you can change?”***
* ***“What do you think will work for you, if you decide to change?”***
* ***“What is a positive example from your past of when you decided to do something differently? What led to that success?”***
* ***“How did you accomplish your goal?”***

These questions can help bolster hope. The clinician can also use the **MIRACLE QUESTION** derived from Solution-focused therapy. In order to help the patient imagine what life would be like if his or her problems were solved, to nurture hope of change and to highlight the potential benefits of working for change.

***“Suppose tonight, while you were sleeping, a miracle happens, and the problems that led you here were resolved? When you awaken tomorrow, how will you first notice that the miracle has happened? What will be the first sign that things are better? And then the next? And the next?”***

**Help Generate Intention To Change**

* ***“What reasons do you see for making change?”***
* ***“If you succeed in stopping using X, and it will work out, what will be different?”***
* ***“What things make you think you should keep using X?”***
* ***“How would your life be different if you made the changes you are considering?”***
* ***“What makes you think you need to change now and not at some future date?”***
* ***“If you decide to change what steps do you have to take to begin to change?”***

**Help Reinforce Commitment To Change**

Since no one can decide for you and you are in a position to choose, let me ask:

* ***“What do you think has to change?”***
* ***“What are you going to do?”***
* ***“How are you going to do it?”***
* ***“What are some benefits of making such changes?”***
* ***“How would you like things to turn out, ideally?”***
* ***“How can I help you bring about such change?”***

The clinician can then add:

***“Let me explain to you what I do for a living. I work with folks like yourself and I try to find out:***

1. ***How things are in your life right now and how you would like them to be?***
2. ***What have you tried in the past to bring about such change?***
3. ***What has worked and what has not worked, so we can both be better informed?***
4. ***Worked, as evident by? What were you most satisfied with that you could try again?***
5. ***If we work together on your areas of concern, and I hope we can, how would we know if you were making progress? What would other folks in your life notice?***
6. ***How would that make you feel? What conclusions or lessons would you draw as a result of such changes?***
7. ***Permit me to ask one last question. Can you foresee, envision what might get in the way of your bringing about such change?***
8. ***Is there some way that you can learn to anticipate and plan for such possible barriers or potential obstacles?***

***“Please notice between now and when we meet again, so that you can describe to me, when the problem isn’t so bad, what you are doing differently?***

***“Since we last spoke, what have you noticed that may be better or different? How did that happen? What did you do or not do that helped?***

**TABLE 1**

**AA BEHAVIORS**

How many of the following behaviors do you presently practice? Please put a check mark next to each behavior that you now do as a result of participating in the 12 Step AA Program. If you have participated in the 12 Step AA Program in the past, how many of these activities did you do?

\_\_\_\_\_ 1. Attend AA meetings (Beginner’s meeting, Big Book meetings, 12 Step meetings). How

often per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ 2. I still attend AA meetings even though I am in recovery.

\_\_\_\_\_ 3. Identify with presenters, but not compare myself to them. I recognize that the road one person takes to AA can be very different than another. Now, I do not feel so alone and different any more. I learn to listen for similarities than differences.

\_\_\_\_\_ 4. In AA there are many helpful tools such as meetings, 12 Steps, 12 Traditions, Slogans,

the Big Book, learning from “Old Timers”, being part of the 12 Step Fellowship,

Having a sponsor, Being a sponsor. The parts of the AA program that helps me the

most are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_5. I work my program. I work toward progress, not toward perfection.

\_\_\_\_\_ 6. Be open, honest and helpful to others. As the saying goes, “***To keep it, you have to give*** ***it away***”. This is all about helping others by speaking and sharing at meetings, lend a listening ear. “***Our spirit slowly starts coming back to life by dealing with honesty and***

***tearing down barriers”.* (H.O.W. Honest, Open and Willing)**

\_\_\_\_\_ 7. Tell my story of “What it was like to be dependent on alcohol, what happened and what

it feels like now”. The story I most want to talk about is about my recovery, namely,

my pursuit of happiness, enjoyment, contentment and “how comfortable I am in my

own skin”. I have a story to share of how I got to this point.

\_\_\_\_\_8. I am not into producing a drunk-a-log, rather we talk about solutions. The more we

focus on the problem, the bigger the problem becomes. The more we focus on the

solution, the solutions get bigger. I call upon my “**Magic Magnifying Mind**” when it

comes to solutions.

\_\_\_\_\_ 9. Surrender to a Higher Power (namely, a Spiritual Force, God, the power of my

Group and the support of my sponsor.) I use prayer and meditation to improve my

conscious contact with God. Thus, I can regain control and have a spiritual awakening.

I recognize that the Higher Power I choose may be different than the Power others

choose.

\_\_\_\_\_ 10. Get a sponsor, a home group, get involved and begin working the Steps with the

guidance of my Sponsor. My sponsor helped explain the 12 Traditions, Slogans and

was there when I needed him/her.

\_\_\_\_\_ 11. Remember that one of the best tools to cope is the telephone. Call or text my sponsor

or friend in the program to help me deal with my cravings and difficult times.

\_\_\_\_\_ 12. Call my sponsor daily, or call another AA member or a sober person on a regular

basis.

\_\_\_\_\_ 13. Increase my awareness and watch out for triggers. (Social pressure, interpersonal

conflict, strong emotions such as anger, resentment, depression, loneliness, boredom).

\_\_\_\_\_ 14. Use my self-soothing and self-regulation behaviors. Control my emotions.

\_\_\_\_\_ 15. Look at my beliefs (e.g., a sense of entitlement, viewing people as doing things to me

“on purpose”) and see how these beliefs can contribute to my addictive behavior.

Remember DEFENCE thinking processes.

\_\_\_\_\_ 16. Recognize that trust does not come overnight. It has to be earned.

\_\_\_\_\_ 17. Learned to listen and then listen to learn.

\_\_\_\_\_ 18. Put my experiences into words and share my thoughts and feelings with my sponsor

and with trusting others. As a result, I am building self-confidence and developing

social bonding skills.

\_\_\_\_\_ 19. Cut down on my self-criticism and perfectionism. I can learn to forgive myself.

\_\_\_\_\_ 20. Use my coping behaviors to manage threats to my self-esteem (pride, “ego”).

Remember it will take time to learn to use my coping skills. Have faith “***Faith can***

***help move mountains, but you better bring along a shovel. You have to do the***

***work”.***

\_\_\_\_\_ 21. I am learning to be comfortable with myself and I feel gratitude each day that I am

sober.

\_\_\_\_\_ 22. Ride out and procrastinate (delay) my cravings and desire to use substances.

\_\_\_\_\_ 23. Before I take a drink (use substances), I can look at where my drinking has led me in

the past and where it will lead me in the future. Never forget how far you have come.

\_\_\_\_\_ 24. Think through the drink. Consider the consequences of my drinking. I follow the AA

slogan Think…Think…Think.

\_\_\_\_\_ 25. Hang around with sober non-drinking buddies and family members. Firmly connect

with a sober support network, especially at the beginning of the recovery journey. Stay

around positive people, places and things to improve my safety. Right Fellowship.

\_\_\_\_\_ 26. Do a Moral Inventory on a regular basis. I check to see if I am treating people with

kindness and respect and make sure that any defects that I have do not rear their head.

\_\_\_\_\_ 27. Make amends. Make a list of all the people that I have had a negative impact as a

result of my drinking or drug use and begin making amends. I remember that a person

does not have to accept my apology, but I have to give one in order to clear up some

of the “wreckage of the past”.

\_\_\_\_\_ 28. Make a Gratitude List and follow through in showing my appreciation. I remember

that the word “gratitude” is an Action Verb, where I have to show (demonstrate)

positive behaviors and positive attitudes. I am developing the ability to practice

acceptance of myself and others.

\_\_\_\_\_ 29. Recognize signs of change and rehabilitation and “take credit” for this change. Use

my “change talk” of “notice, catch, interrupt, game plan, backup plan, safety plan”.

Recognize the benefits of the changes I have made. Continue my healing journey.

\_\_\_\_\_ 30. I recognize that the only requirement for AA membership is a desire to stop drinking.

Embrace a life of responsibility, forgiveness and patience.

\_\_\_\_\_ 31. My detailed safety plan includes: Being aware of what are my triggers; Knowing the

“warning signs”; Having the telephone number of my sponsor on hand who I can call;

Avoiding high-risk people, places and activities; Be watchful of “enablers” - -

individuals who inadvertently may contribute to a relapse; Sharing my Safety Plan

with others; Making commitment statements, not only to others, but also to myself.

\_\_\_\_\_ 32. Keep coming back. Be there for the new folks coming through the door. By helping

others, we are helped ourselves.

\_\_\_\_\_ 33. Share my journey of recovery with others. Make a “gift” of my experiences with

others. I can sponsor others.

\_\_\_\_\_ 34. I will commit to becoming more involved in AA 12 Step program to see where it leads

me and join with others. I will share my successes, struggle and growth with my AA

group members, my Sponsor and my friends and family who support my recovery

journey.

**AA BELIEFS**

***Keep in mind that AA is not a treatment, but a way of life. Abstinence is only the beginning of a life of spiritual growth and the openness to being transformed.***

Please put a check mark next to each belief or self-statement that you now hold, as a result of participating in the 12 Step AA program.

**I NOW BELIEVE THAT**

**Thinking Behaviors**

\_\_\_\_\_ 35. Addiction is 90% thinking and 10 % drinking. ***“Twisted thinking is something I***

***have to avoid”. “You can get mentally drunk, before you become physically drunk”***.

(Somesay, 99% thinking and 1% drinking).

\_\_\_\_\_ 36. I can look at and begin to change my beliefs that contribute to my drinking

(for example, my sense of entitlement and the “shoulds”, “musts”, and “wants”

in my life).

\_\_\_\_\_ 37. I believe that we can learn to put alcoholism “to sleep”, but we can wake it up if I stop

my AA participation.

\_\_\_\_\_ 38. I can be “right-sized” - - not have to be too perfect, nor “better than”. Comfortable

with myself. Make positive changes to make life more comfortable for myself and

for my loved ones.

\_\_\_\_\_ 39. Sobriety is not just “stopping drinking”; sobriety is peace of mind, contentment and

happiness which comes from dealing with the wreckage of the past.

\_\_\_\_\_ 40. I can recognize that urges are common during recovery and that lapses are part of a

chronic condition of addiction.

\_\_\_\_\_ 41. I can tie my drinking to the trouble in my life and see the beliefs that support my

addictive behaviors.

\_\_\_\_\_ 42. To be humble is not to think less often of yourself, but to think of yourself less, and as

a result have more of yourself to give to others.

\_\_\_\_\_ 43. I can recall my sponsor telling me, “If you want what we have, do what we do”.

This stays with me.

**I NOW BELIEVE THAT**

**Coping Behaviors**

\_\_\_\_\_ 44. As the saying goes, “If you do the same thing over and over it will lead to the same

results. If you want something different, then you have to begin to do something

different”.

\_\_\_\_\_ 45. Alcoholic Anonymous may not open the gates of heaven, but it can surely open the

gates of Hell and let you out.

\_\_\_\_\_ 46. The more you put into recovery, the more you will get out of it.

\_\_\_\_\_ 47. I believe that alcoholism is a “disease”, AA was the doctor and my working the

program was my medicine.

\_\_\_\_\_ 48. I can remind myself to “take one day at a time”. “Easy does it!”, “One moment at a

time”, “Yesterday is gone; tomorrow is not here yet; yet, all we have is today”.

Yesterday is history, tomorrow is a mystery, and today is a gift and that is why we call

it the “Present”.

\_\_\_\_\_ 49. I can remember that “This too shall pass”. Recovery requires patience.

\_\_\_\_\_ 50. I can tell myself that having short-comings is a sign of being human. I can understand

my vulnerabilities. I can forgive myself.

\_\_\_\_\_ 51. I can take responsibility for what I do. I ask myself what are my values, what are my

treatment goals? I clutch my AA coin or AA pin, and this is a physical reminder to

keep on keeping on.

\_\_\_\_\_ 52. I can consider my options. The program works if I work it, so if I work it, I am worth

it. Sobriety gives me options.

**I NOW BELIEVE THAT**

**Nurturing Hope**

\_\_\_\_\_ 53. I can have HOPE. I can use the phrases “So far” and “As yet”. I can also incorporate

my change talk phrases like “Instead” and I can give multiple examples of how I can

use RE verbs.

\_\_\_\_\_ 54. Change is possible: I do not have to continue as before. I can practice my AA

principles and change will occur.

\_\_\_\_\_ 55. I can clean house. Clear away wreckage of the past. Get rid of reminders and triggers.

\_\_\_\_\_ 56. Accept life on life’s terms by self-examining and confessing short-comings and

embracing humility.

\_\_\_\_\_ 57. I can see myself of value to others. Share experiences. Others can learn from me.

\_\_\_\_\_ 58. I can identify signs of resilience. I can give several examples of each of the following

I have \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I can \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ 59. Other beliefs I learned include \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**TO DO List for Attendees**

As a result of attending this Webinar, one of the clinical activities I am going to try is:

\_\_\_1. Use the Case Conceptualization Model (9 Boxes) to summarize a session and as a way to

keep progress notes.

\_\_\_2. Use a session-by-session feedback to monitor the quality of the therapeutic alliance.

\_\_\_3. Conduct a life-span analysis using Time-lines to assess for both developmental risk and

protective factors.

\_\_\_4. Use the CLOCK Analysis as part of my psycho-education in both individual, couple and

group treatment.

\_\_\_5. Engage the patient in Collaborative Goal-setting (SMART - -Specific, Measureable,

Attainable, Relevant, Timely).

\_\_\_6. Be both gender and culturally sensitive when conducting treatments.

\_\_\_7. Use the “art of questioning” (What” and “How” questions and Motivational interviewing

procedures).

\_\_\_8. When teaching skills, build in generalization guidelines.

\_\_\_9. Involve significant others in treatment.

\_\_\_10. Conduct elapse prevention and self-attribution training.

\_\_\_11. Use Patient Checklists: Put patients in a “consultative” role.

\_\_\_12. Assess for treatment adherence on a regular basis.

\_\_\_13. Assess for the role of spirituality and use the 12 Step AA Checklist, where indicated.

\_\_\_14. Provide Integrative treatment for patients with comorbid disorders.

\_\_\_15. Provide Active Aftercare addressing patient needs beyond substance abuse.

\_\_\_16. Be sensitive to HYPE in the Field of Psychotherapy.

\_\_\_17. Use the Consumer Guidelines to evaluate Residential Treatment Centers.

\_\_\_18. Share what I learned with others and engage in DELIBERATE PRACTICE of the skill I

want to master.