**ACHIEVING LASTING TREATMENT CHANGES FOR CLIENTS WITH ADDICTIVE AND CO-OCCURING DISORDERS (SESSION ONE)**

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

**BIOGRAPHICAL SKETCH**

Donald Meichenbaum, Ph. D, is Distinguished Professor Emeritus, from the University of Waterloo, Ontario from which he took early retirement 25 years ago.  Since then he has been the Research Director of the Melissa Institute for Violence Prevention and the Treatment of Victims of Violence in Miami. (Please visit [www.melssainstitute.org](http://www.melssainstitute.org/)). Dr. Meichenbaum is one of the founders of Cognitive behavior therapy and in a survey of clinicians, he was voted "one of the ten most influential psychotherapists of the 20th century." He has received a Lifetime Achievement Award from the Clinical Division of the American Psychological Association. He was the Honorary President of the Canadian Psychological Association. He has presented in all of the Canadian Provinces, in all 50 U.S. states, and internationally. He has published extensively and has authored several books including Roadmap to resilience that he has made available as  a website for FREE (Please visit  [roadmaptoresilience.wordpress.com](http://roadmaptoresilience.wordpress.com/)). His most recent article " How to spot HYPE in the field of psychotherapy " was chosen the best article in the filed of psychotherapy. His latest book "Treating individuals with addiction disorders: A strengths-based workbook for patients and clinicians" is being published by Routledge Press.    He celebrated his 80th birthday publishing "The evolution of cognitive behavior therapy: A personal and professional journey with Don Meichenbaum" (Routledge Press).

**WHY YOU SHOULD ATTEND DON MEICHENBAUM'S WORKSHOP**

 "I'm writing to express my deep appreciation for your work, style, and influence, I have all of your books and frequently cite your articles. I am a sponge when it comes to your interventions and overall approach to therapy.

Please let me tell you how I have made a gift of your work to others. I own a large private practice. I have 90 therapists and interns working with me and we see thousands of clients every year. After I attended your workshop, I was so motivated that I decided to implement your model into the daily work we do with clients. I have been teaching your philosophy, using your handouts and books. I changed the way we keep our progress notes to reflect your Case Conceptualization Model and now require every therapist to complete a Case Conceptualization form for each case.

As a therapist, I want to comment on how much I appreciate the ease of using the online version of your Roadmap to resilience book (roadmaptoresilience.wordpress.com).   It's so user friendly.  I am able to go to the fitness areas and ask what area my patient might like to discuss.  Equally, it is possible to go to the Appendices and take a look at the checklists or the topics and move forward from there.  It is really brilliantly done.  My client has said that he really likes working with Roadmap to Resilience and after having the opportunity to explore the online book in greater depth I'm certain I will use it with other clients.

It is a very generous gift for you to have shared your book in this way at this time.  I thank you very much.

(NOTE: The FREE Roadmap to resilience website in the first month has had 15,000 visitors from 103 countries worldwide).

**TREATING INDIVIDUALS WITH ADDICTIVE DISORDERS:**

**A STRENGTHS -BASED WORKBOOK FOR PATIENTS**

**AND CLINICIANS (Routledge, Taylor and Francis Press, 2020)**

**Don Meichenbaum is not only one of the foremost psychotherapy scholars of our lifetimes; in keeping with his book’s theme, he is an excellent "story-teller." This Patient Workbook provides a wealth of practical, user-friendly, and evidence-informed coping tools that addicted individuals can use in their journey of recovery. Meichenbaum’s workbook is a refreshing new approach to treating addiction, and an antidote to the ever-present hype in the addiction field.  Highly recommended!**

**Scott O. Lilienfeld, Ph.D.**, **Samuel Candler Dobbs Professor**, **Emory University, Atlanta, Georgia** **Editor, Clinical Psychological Science**

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**This is a valuable workbook that provides concrete explanations and recommendations for people who struggle with addictive behaviors. Dr. Meichenbaum has vast experience in field of mental health and is considered a world-renowned expert. He certainly understands that the skills needed for overcoming addictions go well beyond “Just say no.” He focuses on cognitive, behavioral, interpersonal, general coping, and life skills in accessible, conversational ways – and his vivid case examples (“Recovery Voices”) are particularly helpful. I highly recommend this workbook to anyone seeking relief from addictive behaviors, as well as those professionals who help people with addictions.**

**Bruce Liese, Ph.D., A.B.P.P., Clinical Director, Corrin Logan Center for Addiction Research And Treatment; Professor of Family Medicine and Psychiatry, University of Kansas, Kansas City**

**This book offers an excellent combination of hope and inspiration, useful factual information, and actual skill instruction and the language needed to achieve and maintain recovery. There is also valuable attention to managing interpersonal problems and to the use of cultural strengths and spiritual-religious resources. I expect that both therapists and their clients/patients will want to have a copy for their frequent reference. Strongly recommended!**

 **Michael F. Hoyt, Ph.D., author of *Brief Therapy and Beyond*; editor of *Therapist Stories of Inspiration, Passion, and Renewal*; and co-editor of *Single-Session Therapy by Walk-In or Appointment*.**

**TOPICS TO BE PRESENTED**

**By Way of Introduction: Bio and Resources**

**Overview of the New Treatment Book: Reviews**

**A Constructive Narrative Perspective of an “Addictive Mindset”: DEFENCE Thinking Pattern**

**Integrative Treatment of Patients With Co-occurring Psychiatric and Substance Abuse Disorders**

 **The Nature of the Challenge: Comorbidity, Cultural and Gender**

**Differences, Treatment Effectiveness**

**Examples of Integrative Treatment Programs: Treatment Implications**

**Consumer Guidelines for choosing A Residential Treatment Center**

**A Case Conceptualization Model: Assessment and Treatment Decision-Making Tool**

 **Illustrative Assessment Questions**

 **Patient Worksheets**

 **Summary of Addictive Mindset**

 **Post-treatment Recovery Strategies**

**A CONSTRUCTIVE NARRATIVE PERSPECTIVE (CNP) OF ADDICTIVE BEHAVIORS: AN “ADDICTIVE MINDSET”**

 **The role of story-telling “As the adage states - - substance abuse is 10% using and**

**90% thinking”**

1. Thinking processes that contribute to and sustain usage: Self-justifying and self-convincing statements and emotionally-charged auto-biographical reasoning processes.

Acronym Summary: **DEFENCES**

**D** - - Denial - - Individuals deny that they have an addiction problem and reframe their

 substance abuse behavior.

 **E** - - Self- Evaluative Thoughts - - Individual’s self-talk reflects low self-esteem, low

 self-worth that contribute to low self-control and absence of self-efficacy.

 **F** - - Fatalistic Thinking - - Individuals self-generative narrative reflects deep-seated

 feelings of helplessness, powerlessness and uselessness that sustain

 addictive behaviors.

 **E - -** Evaluative Thoughts About Others - - individuals hold negative views about their

 relationships with significant others in their lives such as feeling

 marginalized, vengeful, and unsupportive that sustains addictive

 behaviors (“***rejected, isolated, lonely***”).

 **N** - - Needs-based Beliefs - - Individual’s autobiographical reasoning reflects a “tyranny”

 of “shoulds”, “needs”, “musts” and “cant’s”. Self-talk that begins with

 “I need/can’t/must/should X”, drives the use of addictive behaviors.

 Most importantly, continued use is needed in order to avoid withdrawal

 symptoms and negative reactions.

 **C** - - Illusions of Control - - Individuals are able, at some level, to convince themselves

 that they can exert control and handle their substance-abuse behaviors.

 Such “illusions” of control help sustain usage.

 **E** - - Entitlement Thoughts - - Individuals hold a variety of permission-giving beliefs that

 they deserve and are entitled (“earned the right to use”), and they have

 few other options for obtaining well-deserved pleasures.

**S** - - Substance-related Stimulating and Satisfying Thoughts - - Individuals engage in

 self-talk that highlights the short-term perceived physiological benefits

 (“high, buzz sensations”) that sustains addictive behaviors. These

 thoughts convey the “tunnel vision” that results from substance abuse

 and that reflects a strong desire to avoid the “negative effects” of

 withdrawal and abstinence. A form of self-medication.

1. Thinking processes that are predictive of abstinence. What particular features of the patient’s “story telling”, or autobiographical reasoning, are predictive of who will maintain abstinence and evidence “lasting changes?”

These questions were addressed in a set of studies by Dunlop and Tracy (2013 a,b). They asked abstinent alcoholics to answer the following questions:

***“Please think about the last time you drank alcohol and felt bad about yourself as a result. This might be a time when you slipped from your sobriety. Please describe in as much detail as possible what happened, how it made you feel, and what you did in response to this event?” (Dunlop & Tracey, 2013a, p. 58).***

***“What was the last time you were tempted to use and did not give into (resisted) the temptation? How did you handle this situation?” (Dunlop & Tracey, 2013b)***

They found that how alcoholics answered these questions was predictive of their long-term abstinence. The “stories” about their last drink and resisting temptations by abstinent alcoholics that reflected autobiographical reasoning processes denoting self-change and self-stability were more likely to maintain abstinence, as well as accompanying higher levels of self-esteem, pride and mental health.

**CHANGE TALK PREDICTS TREATMENT OUTCOME**

These self-redemptive narratives and “sobriety scripts” convey a set of controllability attributions and reflect a renewed motivation and a recovery trajectory. Their answers include efforts to achieve self-improvement. Their accounts include benefit-finding and benefit-remembering positive experiences. Those alcoholics who remained abstinent were more likely to use casual transitive verbs that reflect some effort to exert controls such as “notice, catch, game plan.” For example:

 ***“I can see what I did was wrong the last time and I can learn from it.”***

 ***“My obsession with using lifted and I feel relieved.”***

 ***“I have resisted my cravings before and I can do it again.”***

 ***“My cravings in the past have passed and these will too.”***

 ***“Having a craving is not a commandment to use.”***

In summary, humans are natural “story tellers.” They construct stories to justify and explain their behavior of substance abuse. Stories bring a sense of comprehension and coherence to the events around them. They live the stories they tell. In turn, their behavior and resultant consequences influence the stories they tell. This bidirectional process can lead to an “addiction trap.” How can therapists help patients become aware of this process and learn how to break this “addiction trap?”

**A CASE CONCEPTUALIATION MODEL: ASSESSMENT AND TREATMENT**

**DECISION-MAKING TOOL**

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**A CASE CONCEPTUALIZATION MODEL (CCM)**

 A well-formulated CCM should:

1. identify developmental, precipitating and maintaining factors that contribute to maladaptive, mental health and substance-abusing behaviors and adjustment difficulties and that reduce the quality of life;

2.  provide direction to both assessment and treatment decision-making;

3. provide information about developmental, familial, contextual risk and protective factors;

4 highlight cultural, racial, religious and gender-specific risk and protective factors;

5. identify individual, social and cultural strengths that can be incorporated into treatment decision-making;

6. provide a means to collaboratively establish the short-term, intermediate and long-term goals and the means by which to achieve them;

7. identify, anticipate and address potential individual, social and systemic barriers that may interfere with and undermine treatment long-term effectiveness;

8. provide a means to assess on a session-by-session basis the patient's progress and the quality of the therapeutic alliance on a regular basis;

9.  consider how each of these treatment objectives need to be altered in a culturally, racially and gender sensitive fashion;

10.engender and bolster a high empathy therapeutic alliance, and one that nurtures hope in both the patient and the treatment team.

**GENERIC CASE CONCEPTUALIZATION MODEL**

**1A. Background**

 **Information**

**1B. Reasons for Referral**

**2A. Presenting Problems**

 **(Symptomatic functioning)**

**2B. Level of Functioning**

 **(Interpersonal problems,**

 **Social role performance)**

**9. Barriers**

**9A. Individual**

**9B. Social**

**9C. Systemic**

**8. Outcomes (GAS)**

**8A. Short-term**

**8B. Intermediate**

**8C. Long term**

**3. Comorbidity**

**3A. Axis I**

**3B. Axis II**

**3C. Axis III**

**3D. Impact**

**4. Stressors
(Present / Past)**

**4A. Current**

**4B. Ecological**

**4C. Developmental**

**4D. Familial**

**7. Summary of Risk and Protective Factors**

**5. Treatments Received**

 **(Current / Past)**

**5A. Efficacy**

**5B. Adherence**

**5C. Satisfaction**

**6. Strengths**

**6A. Individual**

**6B. Social**

**6C. Systemic**

**FEEDBACK SHEET ON CASE CONCEPTUALIZATION**

Let me see **if I understand:**

**BOXES 1& 2: REFERRAL SOURCES AND BOX 7: SUMMARY OF RISK AND**

 **PRESENTING PROBLEMS PROTECTIVE FACTORS**

**“What brings you here...? (distress, symptoms, “Have I captured what you were saying?”**

 **present and in the past) (Summarize risk and protective factors)**

**“And is it particularly bad when...” “But it tends “Of these different areas, where do you think we**

 **to improve when you...” should begin?” (Collaborate and negotiate with**

**“And how is it affecting you (in terms of the patient a treatment plan. Do not become a**

 **relationship, work, etc)” “surrogate frontal lobe” for the patient)**

**BOX 3: COMORBIDITY BOX 8: OUTCOMES (GOAL ATTAINMENT**

 **SCALING PROCEDURES)**

**“In addition, you are also experiencing (struggling**

 **with)...” “Let's consider what are your expectations about the**

**“And the impact of this in terms of your day-to-day treatment. As a result of our working together,**

 **experience is...” what would you like to see change (in the short-**

 **term)?**

**BOX 4: STRESSORS “How are things now in your life? How would you**

 **like them to be? How can we work together to**

**“Some of the factors (stresses) that you are currently help you achieve these short-term, intermediate**

 **experiencing that seem to maintain your problems and long-term goals?”**

 **are...or that seem to exacerbate (make worse) “What has worked for you in the past?”**

 **are... (Current/ecological stressors) “How can our current efforts be informed by your**

**“And it's not only now, but this has been going on for past experience?”**

 **some time, as evident by...” (Developmental “Moreover, if you achieve your goals, what would**

 **stressors) you see changed?”**

**“And it's not only something you have experienced, “Who else would notice these changes?”**

 **but your family members have also been**

 **experiencing (struggling with)...” “And the BOX 9: POSSIBLE BARRIERS**

 **impact on you has been...” (Familial stressors**

 **and familial psychopathology) “Let me raise one last question, if I may. Can you**

 **envision, can you foresee, anything that might**

**BOX 5: TREATMENT RECEIVED get in the way- any possible obstacles or**

 **barriers to your achieving your treatment**

**“For these problems the treatments that you have goals?”**

 **received were-note type, time, by whom” (Consider with the patient possible individual, social**

 **“And what was most effective (worked best) was... and systemic barriers Do not address the**

 **as evident by... potential barriers until some hope and resources**

**“But you had difficulty following through with the have been addressed and documented.)**

 **treatment as evident by...” (Obtain an “Let's consider how we can anticipate, plan for, and**

 **adherence history) address these potential barriers.”**

**“And some of the difficulties (barriers) in following “Let us review once again...” (Go back over the**

 **the treatment were...” Case Conceptualization and have the patient put**

**“But you were specifically satisfied with...and would the treatment plan in his/her own words.**

 **recommend or consider...” Involve significant others in the Case**

 **Conceptualization Model and treatment**

**BOX 6: STRENGTHS plan. Solicit their input and feedback.**

 **Reassess with the patient the treatment plan**

**“But in spite of...you have been able to...” throughout treatment. Keep track of your**

**“Some of the strengths (signs of resilience) that you treatment interventions using the coded**

 **have evidenced or that you bring to the present activities (2A, 3B, 5B, 4C, 6B, etc) Maintain**

 **situation are...” progress notes and share these with the patient**

**“Moreover, some of the people (resources) you can and with other members of the treatment team.**

 **call upon (access)are...” “And they can be**

 **helpful by doing...” (Social supports)**

**“And some of the services you can access are...”**

 **(Systemic resources)**

**CASE CONCEPTUALIZATION MODEL APPLIED TO SUBSTANCE ABUSE DISORDERS**

1A. **Background Information** - gender, marital status, sexual orientation, ethnicity, social and religious background, migration, highest level of education, current and past employment history, current source of income, current and family constellations, current living arrangements, life-style, criminal history and cohabitating with substance abusing partner./ social activities, current ADL’s, Medical history and current medical condition, including pregnancy. USE CHECKLIST ADMISSION FORM.

1B. **Reason for Referral** - self-referred “sees a problem”; referred by family member; mandated treatment. How did the patient arrive at the treatment center.

Record the level of insight, judgement, ability and willingness to engage treatment staff.

USE MOTIVATIONAL INTERVIEWING PROCEDURES AND VARIOUS SELF-REPORT RATING SCALES

2A. Current and Past Chief Complaints and Symptoms

 1. Conduct both situational and functional analysis of substance abuse and related

 problems.

 2. Conduct a time-line of sequence of disorders.

 3. Obtain a substance use history (Onset, polysubstance use, involvement peer group and

 family, heavy and binge drinking, means of obtaining money to support drug habits

 abstinent days).

 4. Assess current and past use - - frequency, severity, abstinent days, incapacity (for

 example, perceived need to cut down on use; being annoyed by others for criticizing

 substance first thing in morning; and perceived risk associated with illicit drug use). Also

 assess for alcohol-related problems and lifestyle associated with substance use.

 5. Obtain trauma history (e.g. See Resnick et al. 1993). Note nature, duration, frequency,

 intensity, presence of psychological trauma, perceived threats, relationship to

 perpetrator(s). Assess social supports and treatments provided before and after trauma.

 Assess for current PTSD risk of revictimization-risk-taking behaviors and safety issues.

 6. Consider the functional role of substance abuse. Is substance abuse related to social, self-

 enhancement and/or coping motives (See Kustache et al. 2005). Was substance use a

 form of “self-medication”, to reduce inhibitions, join social groups, drinking to get drunk

 (“See if I can hold it better than others”), as an exchange for sex, as a means to lose

 weight? The total number of reasons has been found to be associated with higher levels

 of alcohol use.

 7. Assess for personality correlates. See Conrad & Stewart (2005) for a discussion of

 personality-matched dual-focused interventions based on the patient’s Sensation Seeking

 (SS), Anxiety Sensitivity (AS), Hopelessness (H) and Impulsivity (I). Some suggestion

 that female SUD patients with different personality styles have specific drug preferences:

 SS = alcohol dependence; AS = anxiolytic substances; H = opioids; I = cocaine (Conrad

 et al., 2000). Also, assess for impulsive and reckless (high-risk) behaviors (unprotected

 sex, speeding, self-injurious behaviors).

 8. Be sure to assess for “strengths”. (Box 6)

Note that specific substance abuse may correspond to a specific trauma-related symptom profile. Alcohol-dependent individuals tend to report more trauma-related arousal symptoms than do cocaine dependent individuals, raising the possibility of a connection between the type of substance and the symptom profile.

2B. **Functional Impact** – Quality of life indicators

Can use a variety of PTSD and SUDS assessment tools (see Meichenbaum’s Clinical Handbook for Treating Adults with PTSD for a list) to understand how substance abuse and trauma contributed to each other and to current level of functioning. Also see SAMHSA 2005, TIP 42). The therapist can ask the client:

 **On a 10 point scale, where 1 is the worst problem ever and 10 is no**

 **problem at all indicate:**

 **where were you a year ago...where are you now...and where do you**

 **expect to be in 6 months from now?**

 **How do you see yourself accomplishing these changes?**

3. **Comorbidity**

3A. **Evidence of Comorbidity** – Obtain **Timeline** of birth to present time of stressor, comorbid disorders and treatments. In addition to PTSD and SUDS consider Axis I, II, III disorders (Victims of trauma often report numerous physical health problems (**3B and 3C**). Comment on the impact

Access for physical complaints, especially pain symptoms and the use of opiods and other pain medication and other forms of treatment. Assess for other major emotional issues such as Prolong and complicated grief and Traumatic bereavement, guilt, shame, anger, PTSD  and moral injuries.

4. **Stressors**

4A. **Current** - financial, legal, medical, familial, relationship distress, domestic violence, “daily hassles”, job-related.

4B. **Ecological** - environmental stressors; (culture-at-large has a blaming victim attitude, acculturative stressors, “secondary victimization” experiences in terms of medical and legal systems; living in poverty; experience discrimination).

4C. **Developmental** - history of substance abuse and history of victimization, history of psychopathology, history of aggressive and violent behavior. Adolescents who start drinking before age 15 are five times more likely to report alcohol dependence or abuse alcohol in adulthood than individuals who first used alcohol at age 21 or older. 16% of those who began using alcohol before age 14 are classified with alcohol abuse and dependence. The rate is 4% for those who began drinking alcohol between ages 18 and 20. (***See www.oas.samhsa.gov***)

4D. **Familial** – history of familial psychopathology, familial history of substance abuse, intergenerational victimization. Children of addicted parents are 4 times more likely to be sexually abused and are at higher risk for foster care, depression, anxiety, somatic ailments, academic difficulties and psychiatric hospitalization. Biological studies indicate that children of alcoholics respond differently to alcohol ingestion than children of nonalcoholics (e.g., have increased feelings of pleasure, elation and relaxation, and decreased feelings of intoxication, and experience exaggerated levels of serotonin when ingesting alcohol- SAMHSA, 2005). Children of alcoholics have more psychosocial problems than do children of non-substance dependent parents. (e.g., increased somatic complaints, anxiety, depression, conduct disorder, alcoholic, lower academic achievement and lower verbal ability). Moreover, the parents of these children are reluctant to allow them to engage in any type of mental health treatment. Interventions with parents of alcoholic children have found more favourable impact on preadolescent children (ages 6-12 years) than adolescent children (ages 13-16) (Fals-Stewart et. al., 2005; Johnson & Leff, 1999; Windle & Searles, 1990).

5. **Treatments** (Current and Past)

 5A. All Forms of Treatments Received and Evidence of Efficacy: Include traditional

 healing practices and interventions for family members.

 5B. Treatment Non-adherence

 5C. Treatment Satisfaction

 ADMINISTER ACE QUESTIONNAIRE (ADVERSE CHILDHOOD EXPERIENCES

 QUESTIONNAIRE). It is the cumulative number of developmental stressors that is most

 impactful.

6. “**Strengths**” – Signs of Resilience (Obtain Timeline 2 of “in spite of” experiences)

 6A. Individual – Personal strengths and abilities, beliefs, ethnic and cultural pride,

 spirituality, optimism, desire to change.

 6B. **Social** – Presence of social supports and network, sense of prosocial community.

 6C. **Systemic** – Culturally-sensitive services available, continuity of care, case management

 and follow through services.

8. **Collaborative Goal-setting** (Use Goal – Attainment Scaling Procedures). (Obtain

 Timeline 3 beginning Now and extending into future).

 8A. Short-term goals

 8B. Intermediate goals

 8C. Long-term goals

 USE GOAL-ATTAINMENT SCALING (GAS) PROCEDURES

 Collaborative goal-setting is used to determine how the patient, significant others and the

 treatment team can identify specific behaviorally proscriptive short-term, intermediate and

 long-term treatment goals. What are the specific agreed-upon signs of improvement that can

 be worked on and expected? For each target behavior, help the patient describe what specific

 changes would look like?  If the patient was very successful as a result of treatment, what

 would change in that target behavior look like? If he/she was only moderately successful what

 would that look like? If little or no change occurred what would that look like? These

 behaviorally specific goals should be stated in POSITIVE  terms, as behaviors designed to

 increase, NOT stated in NEGATIVE terms designed to be reduced or stopped.

 GOAL ATTAINMENT SCALING (GAS) asks the patient to identify Three Target

 behaviors, each developed collaboratively with the patient in specifying  what Minimal,

 Moderate and Significant Improvement would look like and how progress is to be evaluated.

 The therapist should work with the patient to indicate exactly what each level of behavioral

 improvement would look like.

                           SPECIFIC WAYS MY 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

9. **Potential Barriers**

 9A. Individual – belief systems such as a fatalistic worldview, mismatch between the

 patient’s and the theoretical orientation of the treatment approach; neuropsychological

 impairment, level of psychopathology, reluctance to participate in treatment, nonadherence

 history, relapse history, avoidance behaviors.

 9B. Social – exposed to high risk environment. Significant others undermine and may

 sabotage treatment program, exposure to peer pressure and familial influences (codependent

 partners)

 9C. Systemic – Barriers to access to treatment services (transportation, child care, waiting

 list, lack of insurance, geographic isolation). Ethnic mismatch between the patient and the

 therapist results in higher dropout rates.

**TREATMENT OF PATIENTS WITH COMORBID PSYCHIATRIC and SUBSTANCE ABUSE DISORDERS**

**ASSESSMENT QUESTIONS “THE ART OF QUESTIONING”**

The following illustrative list of questions are designed to help determine the patient’s reasons for seeking treatment, areas of concern that the patient and significant others have about the patient and the role that substance abuse plays.

**Help Recognize the Problems**

 ***What difficulties have you had regarding drinking?***

 ***How has drinking stopped you from doing what you want?***

 ***In what ways have other people been harmed by your drinking?***

**Help Acknowledge Concern**

 ***What worries you about your drinking?***

 ***What do you think could happen to you?***

 ***In what ways does this concern you? Your family?***

**Help Generate Intention To Change**

 ***What reasons do you see for making a change?***

 ***If you succeed and it all works out, what will be different?***

 ***What things make you think you should keep on dri***

**Help Develop Optimism**

 ***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?***

 ***How did you accomplish this goal?***

This question 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 that while you are sleeping tonight and the entire house is quiet,***

 ***a miracle happens. The problems that brought you here are solved. Because***

 ***you are sleeping, however, you didn’t know that the miracle has happened.***

 ***When you wake up tomorrow morning, what will be different that will tell***

 ***you a miracle has happened, and that the problems that brought you here have***

 ***been solved?”***

**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:***

***How things are in your life right now and how you would like them to be?***

***What have you tried in the past to bring about such change?***

***What has worked and what has not worked, so we can both be better informed?***

***Worked, as evident by? What were you most satisfied with that you could try again?***

***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?***

***How would that make you feel? What conclusions or lessons would you draw as a result of such changes?***

***Permit me to ask, one last question. Can you foresee, envision what might get in the way of your bringing about such change?***

***Is there some way that you can learn to anticipate and plan for such possible barriers or potential obstacles***

**TYPES OF WORKSHEETS USED WITH SUBSTANCE ABUSE PATIENTS**

 **(*See Daley & Marlatt, 2006a,b; McCrady & Epstein 2009a,b; Meichenbaum 2009;***

 ***Project Match, 1998 and SAMHSA TIPS- -*** [***www.keys.samhsa.gov***](http://www.keys.samhsa.gov/) ***and T. Gorski***

[***www.cenaps.com***](http://www.cenaps.com/) ***and www.wpic.pitt.edu/accp/finds/locus.html)***

**POSSIBLE TRIGGERS: DRINKING AND OTHER SUBSTANCE USE**

 **Substance Abuse Triggers That Lead to Urges and Cravings**

**RECOVERY NETWORK WORKSHEET**

 **Ways To Increase My Interactions With People Who Will Support My Abstinence**

**RELAPSE WARNING SIGNS WORKSHEET**

 **High-Risk Situations Worksheet**

 **Lapse and Relapse Worksheet**

 **Relapse Chain Worksheet: Use “Clock” Analysis**

**PATIENT CHECKLIST: WHAT I HAVE LEARNED AND WILL CONTINUE**

**POSSIBLE TRIGGERS: DRINKING AND OTHER SUBSTANCE USE**

**Drinking Location/Settings**

**Drinking Times**

**Drinking Companions**

**Drinking Activities**

 **(What are you doing when drinking?)**

**Drinking Urges**

 **(What sets you off?)**

**Nature of Difficulties That Trigger Drinking**

 **Financial**

 **Social/Interpersonal**

 **Emotional/Psychological**

 **Family**

**RECOVERY NETWORK WORKSHEET**

***Identify People, Groups, Organizations that you believe can be helpful in your recovery, and the potential benefits of obtaining their assistance.***

**People/Groups/Organizations Potential Benefits**

**What Potential Barriers Might Get in the Way of Your Accessing Their Help**

**Potential Barriers How To Overcome These Barriers ACTION PLAN**

**Repair Sobriety Supportive Relationships**

**Who are the people I have harmed by my addiction? (Make a list)**

**What did I do to hurt them?**

**What can I say and do to acknowledge/convey this hurt?**

**What can I do to repair the damage?**

**How can I make amends?**

**How can I prepare for possible rejection**

**LAPSE AND RELAPSE WORKSHEET**

**Describe Main Reasons for Lapse**

**Describe Triggers (External/Internal - - feelings and thoughts)**

**Do a Relapse Chain Analysis of Sequence that led to lapse. *(Use Clock Analysis)***

**RELAPSE CHAIN WORKSHEET**

 **Use “Clock” Analysis**

 **12 o’clock**

 **Triggers**

 **(External/Internal)**

**9 o’clock 3 o’clock**

**a. Behaviors Primary/Secondary**

 **“What did you do” Feelings**

**“What you did not do” (What did you do with all these feelings?”**

**b. Reactions from “What thoughts or beliefs do you**

 **others hold about your feelings?”)**

 **6 o’clock**

 **a. Automatic thoughts,**

 **images, memories**

 **b. Thinking patterns**

 **c. Core Beliefs/Values**

**MY GOAL SHEET**

**A Goal is something I want to get or something I want to have happen and I am willing to work for it.**

My goal is:

The change(s) I want to make are:

The most important reasons for changing are:

The steps I plan to take are/or the advice I would give someone else to achieve this goal is:

How can I get started? What small changes can I make to begin with?

The ways other people can help me are:

Person: Possible ways they can help:

I will know if my plan is working if:

Who else would notice the change? What would he/she observe?

Some things that could interfere with my plan and some possible solutions are:

If my plan does not work, I will: ***(“I will be on the lookout for…”; “Whenever I see…I will do…”: “I will tell myself…”)***

What else do I have to do to increase the likelihood of achieving my goals?

1. Include reminders (“If…then” statements; “Whenever” statements)
2. Conduct a cost-benefit analysis (pros-cons, short-term, long-term benefits)
3. Share my plans with supporting others
4. Make commitment statements
5. Take credit for my efforts
6. Reinforce myself

**PATIENT CHECKLIST: WHAT I HAVE LEARNED AND WILL CONTINUE TO USE**

**As a result of participating in treatment, I have learned to do the following activities/skills: (Please give examples of each and then indicate the reasons why doing each activity is important and how it will help you achieve your goals). How confident are you, from 0% confidence to 100% confidence, that you can implement each of these activities? What barriers are you likely to encounter and how can you address these as they arise?**

\_\_\_\_1. Be on the lookout for triggers and setting events (people, places and things) such as the

 use of drugs or having urges/cravings that set me off. Bring these triggers into my

 awareness. (Give examples of such triggers).

\_\_\_\_2. Notice warning signs of when I am getting upset. (For example, “I am becoming upset,

 angry, depressed, anxious, bored”), as evident by ...

\_\_\_\_ 3. Conduct my “Clock Analysis in order to see the connections between my feelings,

 thoughts and behaviors.

 12 o’clock - - external and internal triggers

 3 o’clock - - primary and secondary emotions and urges and cravings

 6 o’clock - - automatic thoughts/images, thinking patterns underlying beliefs

 9 o’clock - - behavioral acts (what I do) and how others respond

\_\_\_\_ 4. Take action to break my “Vicious Cycle” (Use my Clock analysis)

\_\_\_\_ 5. Monitor my moods and accompanying thoughts. Keep my journal and check it regularly.

 Modify my beliefs that fuel my craving and behavior. Look at my Coping Flashcards as

 reminders of what I have to do differently.

\_\_\_\_ 6. Reduce risk factors and make sure I spend my time in “safe” places with “safe” people.

 Work to keep myself out of trouble and away from temptations. Safeguard my

 environment so it is “unfriendly to trouble”.

\_\_\_\_ 7. Remind myself why it is important to stay “safe” and free of trouble. Think about the

 consequences to me and others for my actions. Conduct a cost-benefit analysis of pros

 and cons, short-term and long-term (2x2 analysis). “Think through the drink” and

 consider consequences for myself and those I care for.

\_\_\_\_ 8. Take responsibility for the choices I make. Recognize that the responsibility to change is

 clearly mine.

\_\_\_\_ 9. Be able to “notice”, “catch”, “interrupt”, “anticipate/plan for”, “set positive/prosocial

 goals”, “reward myself”, “tell others/show others what I have learned”, and “take credit

 for changes I have made”.

\_\_\_\_ 10. Ask for help from “safe people” (family, friends, training team members) who will help

 me achieve my treatment goals. Make “healthy decisions” and develop meaningful

 relationships.

\_\_\_\_ 11. Develop and expand AA sober support network. Socialize with recovery people.

\_\_\_\_ 12. Learn how to have fun without substance abuse. Pursue hobbies, volunteer.

\_\_\_\_ 13. Give up resentments and choose to forgive others, as well as myself.

\_\_\_\_ 14. Implement my Safety Plan which includes the following specific steps (spell these out).

\_\_\_\_ 15. Anticipate the possible barriers and potential obstacles that might get in the way of

 doing my Safety Plan. Have a Game Plan in place to address each of these potential

 barriers/obstacles.

\_\_\_\_ 16. Create an “If...then” and “Whenever ...if” backup Safety Plan.

\_\_\_\_ 17. Use my Coping Cards as reminders to “jump start” my healthy thinking and Safety

 Plans.

\_\_\_\_ 18. Avoid high-risk situations and activities (people, places and things).

\_\_\_\_ 19. Challenge, test out and change my thoughts and thinking processes. Change what I tell

 myself and change my “internal debate”.

\_\_\_\_ 20. Catch myself when I am being demanding and impatient with others. Lengthen my fuse

 and learn how to “think before I act”. Increase my frustration tolerance. Reduce my

 “musts” and “shoulds”.

\_\_\_\_ 21. Accept my feelings and thoughts and learn how to “ride out” my cravings and the urge

 to hurt others or to hurt myself. Like an “ocean wave”, peak and then gradually come

 down.

\_\_\_\_ 22. Use my problem-solving skills. View perceived provocations, threats and

 disappointments as “problems-to-be-solved”, rather than as interpersonal insults and

 personal failures. Use my Goal-Plan-Do-Check protocol.

\_\_\_\_ 23. Use my self-soothing techniques so I won’t hurt others or won’t hurt myself. (Use my

 relaxation, mindfulness and distraction coping skills).

\_\_\_\_ 24. Look for the “Middle Road” and use my “I statements”, Negotiation Skills, and

 Cognitive Skills. For example, I can ask myself:

 ***“What is the data and evidence to support my belief that ...?”***

 ***“Are there any other explanations for what happened?”***

 ***“What does it mean if indeed...?”***

 ***“Can I ask myself the question that my trainer/counsellor would be discussing?”***

 ***“What are my goals in the situation and what are all the ways to achieve***

 ***them?”***

 ***“Which alternatives are likely to keep me out of trouble?”***

 ***“Write this all down in my journal”***

\_\_\_\_ 25. Remind myself of the reasons to do all of these activities and visit my “Hope Kit”.

 Remind myself of my “strengths” and “signs of resilience” and “survivor skills” that

 I have used in the past. Listen to the audiotape of my training sessions as a reminder.

\_\_\_\_ 26. Use my Future Imagery Procedures. Mentally rehearse how I can handle high-risk

 situations and ways to achieve my goals beforehand.

\_\_\_\_ 27. Cope with any lapses that may occur and view them as "learning opportunities". These

 are “wake-up” calls to use my coping skills. They should awaken my curiosity so I can

 play detective/scientist and use my problem-solving skills. Use my Clock analysis to

 figure out what went wrong. (Give examples).

\_\_\_\_ 28. Plan for future high-risk situations and possible reoccurrences so I am not “blindsided”

 down the road. Have an Action Plan for each high-risk situation.

\_\_\_\_ 29. Make a “gift” of what I have learned and share it with others.

\_\_\_\_ 30. Take pride in what I have been able to achieve, “in spite of” possible temptations,

 social pressure, conflict with others and upsetting feelings (boredom, loneliness,

 humiliation, guilt, shame, anger). Take credit for changes I am bringing about. Build

 my self-confidence.

\_\_\_\_ 31. Recognize that I am on a “journey”, but not alone in creating a “Life that is worth

 Living”. Structure my daily activities with meaningful activities. Live up to my

 behavioral contract that I made with others and with myself. Remember that being a

 “person” is keeping your word and being a model for others. Maintain hope and

 demonstrate the “courage to change” and create a “positive lifestyle”. I have learned

 ***“to keep on keeping on.”***

\_\_\_\_ 32. These are some things I learned from my treatment that I can use. In addition, I can also

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

\_\_\_\_ 33. Treatment tips that I would be willing to try: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**"MINDSET" of ADDICTED INDIVIDUALS: THE STORIES THEY TELL THEMSELVES AND OTHERS**

                                                      Donald Meichenbaum

 As the adage goes: "Alcoholism (and other forms of addictions) is 90 % thinking and 10% drinking."

Consider the MINDSET of individuals who have Substance Abuse Disorders and how such thinking processes play a key part in contributing to their use. These thought patterns can be summarized by the mnemonic =0 A

                                                              DEFENCE

D--DENIAL

E--Self- EVALUATIVE Thoughts

F-- FATALISTIC Thoughts

E--EVALUATIVE Thoughts about OTHERS

N-- NEEDS-based beliefs

C-- Illusions about CONTROL

E--ENTITLEMENT feelings and beliefs

Let's consider examples of each form of "story-telling" and self-generated narratives.

1. D-- DENIAL

Drinking (substance abuse) is a problem for some people , but not for me.

I am different form other people who use.

I can hold my X

I am not an addict, I am a social drinker.

No one will find out if I use.

I know I should stop, but I don't want to ( or need to).

2. E--Self-EVALUATIVE Thoughts

I hate myself

I'm inept (a failure, unloveable, boring, depressed , too anxious , damaged goods . broken, soiled. victimized).

I messed up my whole life.

I am my own worst enemy (critic, inner persecutor) .

I berate myself. I loathe myself.

3. F-- FATALISTIC Thinking

I am HELPLESS.

I feel trapped, defeated

I need to punish myself. I have no other choice.

I do not deserve to be happy given what I did. I am so guilty and ashamed.

Nothing is going right in my life, I might as well use.

If I need help, then that means.....

The losses are too great.

I am POWERLESS to stop.

I lack the will power, incapable of resisting. Too much work.

Drinking (substance abuse ) has hijacked my life.

I am at the mercy of my urges.

I will never be able to stop.

I am at the end of my rope.

My life is a revolving door of treatment failures.

My cravings are too strong; they make me use.

Nobody can help. There is no point in trying.

I am USELESS.

Stopping won't do any good anyway.

I have blown it so many times, I might as well go all the way this time.

Once an alcoholic, always and alcoholic.

I worked so hard to stop and look what happened. I only got into more trouble.

I am stuck and I cannot get on with life.

I will never get out of this "vicious cycle".

4. E--EVALUATIVE Thoughts of OTHERS

This is my way of getting even (taking revenge).

My use will make her feel guilty (ashamed) for my fall.

I feel isolated (alienated, marginalized, rejected, abandoned, betrayed, manipulated, overwhelmed , taken for granted).

No one really cares if I use or not.

No one understands me.

People are untrustworthy. In order to be safe I have to use.

People who are against drugs, don't really understand.

Only drug users will understand this and can be of help.

Only people who have been through what I have been through will understand my use.

I know you mean well, but you cannot be of help.

5. N--NEEDS-based Beliefs

I NEED X in order to (reduce, avoid, escape  an aversive state) such as take away the pain, drown my sorrows, unwind, self-medicate, take a time out, escape my bad thoughts . forget, survive).

I NEED X in order to (acquire some benefits) such as be creative, sexy, attractive, sociable.

If I use X, then I will be able to improve my mood, boost my morale, endure life, take the edge off.

Without X, I can't handle Y, tolerate, control, stand , cope .

Without X, I will mess up, be overwhelmed be impotent.

Without X, my life is unbearable.

6. C--Illusions of CONTROL

I can test myself.

I can use just one more time. I am in control.

I am different from others who use.

I can stop anytime I want. I can control my use when I want to.

I can keep it limited this time.

I know how to handle my use.

As long as I am careful, using won't be an issue.

I am more in control when I use.

7. E--ENTITLEMENT Thoughts: Permission-giving beliefs

I deserve X.

I cannot be happy without X.

It feels so good.

I need a pick me up.

Getting high is the only thing I have to look forward to.

It will be good to party tonight.

I will be able to be with all of my buddies. What will they think of me if I do not use. It is only way to be accepted, being part of the group. It is the only form of pleasure and freedom I have.

I do not like being told what to do and not do by others. I am my own boss.

**POST-TREATMENT RECOVERY STRATEGIES**

**Don Meichenbaum, Ph.D. and Julie Myers, Psy.D.**

The first months after substance abuse treatment can present challenges for the newly recovered. There are new tasks to face, new ways of relating to others, and often continued cravings for substances. But it is also a time of new awakenings, renewed purpose and hope, and learning new ways to cope with the challenges. In some respects, this period is like going on a “journey”, with multiples routes and various rates of recovery, with no one right way to cope or path to take and no one right amount of time to recovery.

People deal with these challenges in different ways. In the list below, you will find recovery strategies that others, like yourself, have used in their personal journey of recovery. This list is not meant to be a measure of how much you have recovered, but rather to reinforce the strategies you currently use and to help you discover new ways to move forward on your personal journey of sobriety.

We suggest that you look through the list and put a checkmark by the strategies that you have tried and find helpful. Then, choose some new items you would like to try, and if you find them helpful, add them to your toolbox of recovery strategies. If there are things you have found helpful that are not on this list, add them to the end of the list to share them with others!

We hope that reviewing this list will be a valuable opportunity to expand your repertoire of recovery activities and reinforce the ones you currently use. We thank you for taking the time to complete this checklist, and we wish you continued progress in your recovery.

**MY RECOVERY STRATEGIES**

**I Can Reduce the Risk Factors That Lead to Relapse**

1. I recognize that substance use is driven by habits, external triggers and internal/emotional states, so I make a list of these and actively avoid those that might trigger relapse.
2. I avoid high-risk situations that could lead to relapse. I limit contact with people, places and things that trigger urges, for example drinking/drugging-buddies, bars, and drug/alcohol paraphernalia.
3. When I cannot avoid high-risk situations, I can have a plan in place of how I will deal with them, such as limiting time spent in the situation, having a trusted friend with me, etc. I anticipate barriers that might get in the way of my carrying out my Action and Safety Plans.
4. I eliminate easy access to substances, such as deleting my drinking/drugging contacts on my phone and computer, removing all drugs/alcohol from my environment, etc.
5. I abstain from using all mind-altering substance, because I know that if I use these substances, I am at higher risk for relapse of my drug of choice.
6. I recognize that the “Seemingly Irrelevant Decisions” I might make can be the first step toward relapse. For example, agreeing to meet an old friend in a bar.
7. I limit interpersonal conflicts and strong emotional response, and I set boundaries with those who cause me stress or are unsupportive.
8. I practice my refusal skills to respond to the social pressures to use substances.
9. I engage in healthy, sober activities that are incompatible with using drugs or alcohol.
10. I keep recovery in the forefront of my mind to avoid complacency, and I try to engage in a positive “recovery activity” every day.

**I Address My Urges**

1. I recognize my warning signs of relapse and have a Safety/Action Plan in place to counter them. I stop the “vicious cycle” before it begins so I don’t get “blind-sided”
2. I have a list of urge-controlling techniques and refer to the list often. When I learn a new tool or strategy, I add it to my list.
3. I rate my craving intensity on a 1-10 scale and then watch the intensity rise and fall without judgment, like riding a wave. Or I allow the thought to just pass, without giving it power or too much attention since a thought is just a thought and doesn’t have to be cranked-up into an urge.
4. I track my urges in a journal to help identify their cause and remember how I handled the urge. I ask myself “What is triggering my craving?” I see these as problems-to-be solved, rather than as a command to use. I play “detective” and can have a compassionate curiosity and figure out what led to the relapse.
5. I write about my feelings, thoughts and stressors, tying them to action plans for recovery.
6. I know that I don’t have to give into immediate gratification, and I have other ways to feel good, indulge myself, or celebrate. I *deserve* sobriety.
7. I remind myself that I often used alcohol/drugs to avoid bad feelings, tough situations or withdrawal symptoms, and that I now have better ways to handle these without using.

**I Take Care of Myself Physically**

1. I try to lead a balanced life, with time for both work and play. I engage in leisure and social activities, learn new skills, spend time outdoor, help others, and engage in meaningful activities.
2. I use strategies to manage the physical triggers that affect my substance use, such as hunger, thirst, sleepiness, fatigue, stress, and pain.
3. I follow a schedule which helps make life feel both more manageable and pleasurable.
4. I get enough sleep, exercise, and good nutrition.
5. I eliminate or limit substances that affect my physical state. (Those who give up tobacco are shown to have better recovery progress. Caffeine can cause anxiety, which triggers use.)
6. I take medications that have been prescribed by my doctor and engage in alternative therapies that are helpful.
7. I recognize the physical signs of stress and have relaxation tools to manage them, such as slow breathing, muscle relaxation, mindfulness activities, meditation, exercise, music, etc.

**I Manage My Emotions**

1. I can label (name and tame) my intense feelings. I recognize the differences between my emotions and my thoughts and behaviors.
2. I can tolerate and accept uncomfortable emotions, recognizing them as normal feelings that will pass. ***“****My negative feelings have gone away before. These too shall pass.”*
3. I manage emotional triggers that lead to my substance use, rather than reacting to them. I use coping statements, positive self-talk, relaxation techniques, acceptance, spirituality, recite the Serenity Prayer, or other self-soothing tools.
4. I share my feelings with supportive others who do not judge, nor criticize me.
5. I recognize that the way I react to others affects how they react to me. My past may drive my reactions, but I am not a destined by my past. I am assertive but not reactive.

**I Examine My Thoughts**

1. I analyze the pros and cons of my using, and I know that the benefits of not using far outweigh the benefits of using, for myself and others, both in the short and long-term. I can remind myself of the consequences
2. I pause to think before I act on my thoughts and feelings, thus leading to better outcomes. I take a “time out”when needed.
3. I can change my beliefs that contribute to my substance use, particularly the “should”, “musts”, “wants”, and preoccupation with “perfection”.
4. I use my CHANGE TALK to “notice”, “catch”, “interrupt”, “anticipate”, “plan for”, “set positive social goals”, and “tell/show others what I have learned”,
5. I use my Coping Cards to jump start my healthy thinking. For example, *“It is normal for my body to crave alcohol/drugs since I used to use, but I can choose to resist my cravings.”*
6. I recognize my automatic negative thoughts and challenge, test out and change these thoughts, avoiding “Thinking Traps”. I change my negative “Internal Dialogue” and the negative words I use for myself. I am less self-critical, use positive self-statements, and view perceived threats, provocations, losses and disappointments as “problems-to-be-solved”, rather than as insults and personal failures.
7. I “talk back” to the emotional part of my brain by engaging the “thinking” part of my brain. I can make better decisions when I do not let my emotions hijack my thinking.
8. I use my problem-solving skills and practice planning as a way to attain my short, mid, and long-term goals.
9. I recognize that lapses may be part of the recovery process and that a mistake or slip, should it occur, is a learning opportunity and it doesn’t mean I’m a failure. Instead, I accept the natural consequences of the slip and do not let a lapse become a relapse*.*

**I Reach Out to Others**

1. I create a list of people whom I can reach out to for encouragement when I am at risk of using. When I need help, I recognize who to turn to in order to get the kind of help I need: Emotional Support, Advice and Practical Support.
2. I increase my sober support network of family, friends, co-workers, and others.
3. I participate in self-help groups by attending AA meetings, NA meetings, SMART Recovery, Women for Sobriety, Secular Organizations for Sobriety, or other self-help groups
4. I seek information and help by connecting to others via the internet (chat rooms, blogs, recovery websites, etc.), books about recovery, and inspiring movies.
5. I see my therapist, addiction counsellor, minister, or other helpful professionals.
6. I have a “sober mentor” or Twelve-step sponsor.
7. I am learning compassion and forgiveness of self and others. I am letting old resentments go.
8. I keep a Gratitude List and actively thank people in my life.
9. I remember that *“Being humble is not thinking less of yourself, but thinking of yourself less.”*
10. I make a GIFT of what I have learned to others and share my “story” of recovery.
11. I spend time in altruistic activities, knowing that generosity is for both the receiver and the giver.

**I Cultivate Hope and a Future Outlook**

1. I socialize with people who give me hope and encouragement
2. I acknowledge the positive things I have gained by being sober, and I remind myself of how far I have come. I have faith in the future and remind myself that with sustained abstinence my brain will recover and my thinking processes will improve*.*
3. I take “credit” for the changes I have made, taking time and pause and honor my accomplishments. I recognize the personal strengths I have that are needed to sustain my recovery.
4. I take full responsibility for my recovery by taking charge of my life. I remind myself to “take one day at a time”
5. I know that I am of value, and I stop thoughts of helplessness, hopelessness, or low self-worth. I have found new direction and purpose in my life.
6. I use Future Imagery Procedures, mentally rehearsing how I can achieve my treatment goals.
7. I use my spirituality or religion to guide me.
8. I recognize that I am on a *journey*, but that I am not alone in creating a *life that is worth living*.
9. I remember that being a “responsible person” means keeping my commitments and being a model for others so that they too may have hope for the future.
10. I maintain hope and demonstrate the courage to change. I learned to *“keep on keeping on.”*If one method doesn’t work, try something else. The important thing is to keep working on my Recovery Plan.
11. Other coping strategies and activities I have used. Please list what else you have done so that we can share them with others. THANK YOU.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**INTEGRATIVE TREATMENT OF PATIENTS WITH CO-OCCURRING PSYCHIATRIC AND UBSTANCE ABUSE DISORDERS**

**Donald Meichenbaum, Ph.D.**

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**SUMMARY OF RESEARCH FINDINGS**

**(*These findings have been gleaned from the following references, Berglund et al., 2003; Brady et al., 2009; Dutra et al. 2003; Hien, 2009; Imel et al., 2008; Lambert, 2010; Mee-Lee et al., 2010; Miller et al., 2005; Najavits, 2003; Ouimette & Brown, 2003; Wampold et al., 1997).***

**EPIDEMIOLOGICAL FINDINGS**

The lifetime prevalence of drug dependence in the U.S. is 9% in males and 6% in females.

10% of Americans buys and drinks more than half of the alcoholic beverages

The American Psychiatric Association DSM-IV estimates that 5% of the adult population in the U.S. experiences alcohol dependence during any calendar year and 15% of the U.S. population will experience alcohol dependence sometime in their life.

It is estimated that 22 million people ages 12 and older in the U.S. need treatment for illicit drug or alcohol use.

Alcoholism is associated with more than 100,000 deaths per year in the U.S.

Substance Abuse Disorders (SUDs) cost various government agencies approximately $470 Billion dollars a year.

Substance abuse has been reported to be the nation’s number one health problem.

Individuals with addictive disorders represent a **heterogeneous** population with different etiologies and diverse developmental pathways.

20% of individuals with substance abuse problems abstain on their own without professional treatment.

80% of incidents of family violence are associated with alcohol abuse.

For individuals with co-occurring psychiatric and SUDs, the mental health disorders usually precedes SUDs about 90% of the time with a median onset age of the psychiatric disorder at age 11. The SUDs usually develops 5 to 10 years after the psychiatric disorder (median age 21).

The highest comorbidity of addictive disorders and severe mental illness is among young males, single, less educated and who have a family history of substance abuse.

About one third of persons with mental disorders have experienced a substance abuse disorder during the past 6 months.

Among persons with an alcohol disorder, the odds that they will abuse another substance are 7.1 times greater than those who do not have an alcohol disorder. A person who abuses multiple drugs has a more difficult time stopping drinking and they have a higher risk of relapse after treatment. There is a need to assess for and treat polysubstance use.

**EVIDENCE OF COMORBID PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS (SUDs)**

**PTSD and SUDs**

* PTSD and SUDs are frequent concurrent conditions.
* A majority of patients (80% - 95%) seeking treatment for SUDs report having experienced intense trauma
* Approximately 50% of women and 20% of men in chemical dependency recovery programs report having been victims of childhood sexual abuse. Approximately 60% of women and 80% of men in such treatment programs report being victims of childhood physical abuse and neglect. Childhood sexual abuse doubles the number of alcohol abuse symptoms in adulthood.
* PTSD is three times more common amongst alcohol and drug dependent individuals than it is in the general population. Men with PTSD are five times more likely to have SUDs than men without PTSD.
* Among patients seeking treatment for SUDs, the rate of PTSD ranges from 20% - 35%, with a higher co-occurrence in women (30% - 59%) than in men (11% - 38%). Concurrent PTSD and SUDs is approximately two times more common in women than in men. However, in a community sample, the rate of substance abuse is higher for men than women.
* Research indicates that trauma victims report greater involvement and higher expected future involvement for engaging in substance abuse than do nonvictims. This finding is consistent across different types of violence (e.g., sexual abuse, physical abuse, combat exposure) and in particular, for those who have experienced multiple victimization incidents.
* SUDs patients with PTSD show a more severe substance abuse dependence profile and they tend to use drugs to reduce the impact of negative affect and hyperarousal symptoms (exaggerated startle responses, nightmares).
* Intrusive symptoms at pretreatment are most predictive of relapse.
* People with PTSD and SUDs tend to abuse “hard drugs” (cocaine and opiates), prescription medications, marijuana, as well as alcohol.
* Among persons with an alcohol disorder, the odds that they will abuse other substances are 7.1 times greater than for those who do not have an alcohol disorder. A person who abuses multiple drugs has a more difficult time stopping drinking and they have a higher risk of relapse after treatment. There is a need to assess and treat polydrug usage.
* Research indicates different developmental pathways by gender. The primary PTSD groups (where PTSD develops first) are more likely to have experienced childhood sexual assault, whereas the primary substance abuse groups (SUDs first) are more likely to have witnessed a trauma or to have experienced a physical assault. The SUDs first group may have experienced trauma in the context of obtaining and using drugs such as cocaine.
* People with PTSD and SUDs are more likely to have other severe DSM-1V disorders, experience interpersonal medical and legal problems, marital and social conflicts, domestic violence, assault charges, suicide attempts, maltreatment of their children, custody battles, homelessness and HIV risk. They are more likely to be unemployed, financially challenged, socially isolated, devoid of purposeful activities and lack family support.
* There is a need to allow a sufficient wait time (2 weeks to several months) for the patient to be substance free before other psychiatric disorders can be diagnosed.
* Patients with comorbid disorders of PTSD and SUDs have more severe levels of psychopathology, with greater symptomatology for each disorder, more life stressors (e.g., more medical problems, higher unemployment, higher arrest-records); higher health care utilization; less effective coping strategies; and poorer response to treatment then do patients with either PTSD or SUD alone. They are also more likely to experience additional comorbid affective disorders (panic attacks, major depressive disorders), personality disorders, and a record of antisocial and violent behaviors.
* There tends to be a family history of trauma exposure and SUDs.
* Large scale trauma events like natural disasters are associated with increased substance abuse.
* Certain subgroups are especially prone to have high rates of PTSD and SUDs including veterans, the homeless, prisoners, rescue workers, prostitutes and victims of domestic violence.

**EXAMPLES of OTHER FORMS of COMORBID PSYCHIATRIC and SUBSTANCE ABUSE DISORDERS**

**Severely Mentally Ill Patients**

Among schizophrenic some 47% have co-occurring SUDs, which is 4 times more likely than the general population.

Bipolar patients have a 61% co-occurrence of SUDs, which is 5 times more likely than the general population.

90% of both Schizophrenics and Bipolar patients reported at least one traumatic event and 43% met this diagnostic criteria for PTSD. But only 2% had this PTSD diagnosis noted in their medical charts (Mueser et al. 2003).

**MAJOR DEPRESSIVE DISORDERS (MDD) and SUDs**

Comorbidity for MDD and SUDs range from 20%-35%. Depression in both before and after alcoholism treatment is associated with poorer treatment outcome. Patients with clinical levels of depression 3 months post treatment is associated with a 5 times risk of relapse.

Situations that involve negative affect are the most common types of situations reported by substance abusers as preceding their lapses to substance abuse.

Treatment procedures that focus on such areas as mood monitoring, activity planning for pleasurable activities, constructive problem-solving thinking, social skills training, modifying life styles and managing risk relapse have been found to be most helpful for such comorbid patients (Conrad & Stewart, 2005).

Alcohol is associated with 25% to 50% of suicides. Between 5% and 27% of all deaths of people who abuse alcohol are caused by suicide, compared to 1% in the general population.

The lifetime suicide risk among alcoholics has been estimated to be 60 to 120 times higher than the non-psychiatric population. The risk is particularly increased when heavy drinking is accompanied by comorbid depression, serious medical illness, living alone and interpersonal loss and conflict.

**ANXIETY DISORDERS**

Alcoholism with comorbid anxiety disorders experience more severe alcohol withdrawal and increased tendency to relapse. Alcohol withdrawal can mimic symptoms of panic and generalized anxiety. Persons with comorbid anxiety and alcoholism often manifest additional comorbid disorders of affective disorders. Comorbidity between alcoholism and social phobia is 20% and untreatable social phobia may interfere with treatment compliance.

**LIFE-SPAN DEVELOPMENTAL PERSPECTIVE**

Children with Conduct Disorders have the highest ODDS RATIO (OR) of developing SUDs. (OR=21). Alcoholism is 21 times more likely to occur among individuals with a history of antisocial behavior disorder than without such a developmental disorder. In comparison consider the OR of developmental Bipolar Disorder and SUDs is 5 (the next highest).

Substance abuse increases substantially between ages 11 and 15 years of age.

**GENDER DIFFERENCES and SUBSTANCE ABUSE DISORDERS-SUDs**

Females with SUDs differ significantly from their male counterparts in terms of risk factors, developmental history of trauma experiences, the nature of their presenting problems, the pattern of comorbid disorders, motivation for treatment, and reasons for relapse. Over their lifetime women are less likely to seek treatment. Women with SUDs are more likely than men to seek care in non-alcoholic specific settings, especially from mental health service agencies.

Women with SUDs are more likely to present with major depression than their male counterparts. SUDs, mood and anxiety disorders frequently co-occur in women than in men.

Women with comorbid depression and SUDs have a shorter trajectory between years of regular use, problem use and seeking treatment- - a phenomenon called “telescoping”.

Women’s alcohol problems are related to attempts to cope with depression, and related symptoms of PTSD (a “self-medication” model); whereas male drinking is more motivated by peer pressure and by desires to enhance positive moods.

Females are more susceptible than men to the immediate effects of alcohol intoxication and they are more likely to suffer the adverse health consequences of prolonged substance abuse.

The co-occurrence of SUDs and Personality Disorders such as Borderline Personality Disorder is common. Women with such co-occurring disorders have a more severe clinical profile than those with either disorder alone.

There is a high rate of co-occurring SUDs and Eating Disorders (ED) among treatment seeking women. Roughly 50% of individuals with ED are also abusing drugs and/or alcohol which is more than 5X the abuse rates seen in the general population. 30-40% of women with SUD report a history of an ED which has a high rate of suicide. There is a need to explore the interconnectedness or linkage between such comorbid disorders. Does the ED trigger substance abuse? Do they occur concurrently? Do they function in service of each other (e.g., amphetamine abuse in service to ED)? (CASA, 2003).

The rate of SUDs and PTSD in females is 2 to 3X higher than men with SUDs. For women, the most common trauma experience derives from a history of repetitive childhood sexual and/or physical assaults that may be accompanied by multiple accumulative other stressors such as neglect, exposure to domestic violence, and an “invalidating” social environment. For men, PTSD tends to stem from combat or crime trauma.

Women are more likely to have experienced a traumatic stressful event prior to the development of SUDs; whereas for men their trauma experience is more likely to follow the SUDs.

Overall, some 20-65% of individuals in treatment for SUDs report assault histories. Men with PTSD are 5X as likely to have a drug abuse or dependence disorder when compared with men without PTSD. Women with PTSD are 1.4 times as likely to develop SUDs as women without PTSD.

Thus, there is a need to assess for early trauma history, even in those patients who do not evidence PTSD. For example, see the Early Trauma Inventory (Bremner et al., 2000) and Childhood Trauma Questionnaire (Bernstein et al., 2003).

Exposure to traumatic stressors and the accompanying psychological sequelae on the hypothalamic-pituitary-adrenal axis (HPA), which increases cortisol and other stress-related hormones can increase drug cravings (Sinha, 2001). Substance abuse may act as a means of self-medication lessening the effects of hyperarousal and numbing symptoms.

Women who have been traumatized have a more rapid onset of substance abuse than women who have not been traumatized. They also have an increase of PTSD symptoms with initial abstinence and they are more vulnerable to relapse.

A major source of victimization for women is Childhood Sexual Abuse (CSA). In the U.S., CSA is 3 to 5X greater in females, compared to males. CSA in adulthood is associated with depression, eating disorders and SUDs. Clinical studies have found high rates of CSA (20-80%) among women seeking treatment for SUDs. Individuals with CSA are less responsive to treatment and need targeted treatment for CSA.

There is a high rate of revictimization among individuals with CSA histories, including intimate partner violence, stranger rape, and physical assaults in adulthood. Helping such patients protect themselves against future trauma is a critical feature of treatment.

The results of the National Comorbidity study found that approximately 80% of women with PTSD have at least one other psychiatric diagnosis, and some had two or more additional diagnoses.

Individuals with comorbid SUDs and PTSD typically have a more severe clinical profile than those with only one disorder. They tend to abuse more severe substances (e.g. cocaine), have high rates of psychiatric comorbidy including depression, and have poorer treatment outcomes. A series of additional problems are often common, including problems related to interpersonal deficits, physical health issues, difficulties coping with parental responsibilities, homelessness, HIV/sexually-transmitted infections, risk behaviors, suicidality, and intimate partner violence (Courtois and Ford, 2009; Hien, 2009).

**GENDER-SPECIFIC TREATMENTS**

Greenfield and Pirard (2009) summarize the beneficial features of gender-specific treatment for women with comorbid psychiatric and substance abuse disorders. They include:

1. the women’s positive engagement and responsiveness to individual psychotherapy

and to women’s focused supportive groups;

1. the absence of sexual harassment and intimidation that may occur in mixed-gender programs;
2. the mixed-gender treatment programs were judged as not being as conducive to

open consideration of women’s needs and issues and experiences such as victimization

(rapes, childhood sexual abuse), child care, financial concerns, relationship issues,

women’s societal roles and interpersonal violence. Women are more likely to have

partners who use drugs or alcohol and they have fewer friends than their male

counterparts. There is a need to address repairing relationship with children and family members.

Gender-specific treatment for women may be organized as either female-only programs or female-only interventions within mixed gender programs. Women with comorbid disorders, especially if the women are pregnant have specific needs such as prenatal and post partum considerations, as well as baby services, client advocacy issues, financial issues assistance with housing, and the like. The treatment program may also include peer support groups, on-site 12-step meetings, social outings and specialized counselling for such issues as eating disorders, risk of revictimization (Safety First issues), and specialized referral services. Treatment-programs should consider policies and services allowing children to accompany their mothers to treatment.

Motivational Interventions procedures can be tailored in gender-specific ways as in the case of substance abusing pregnant mothers (Grella, 2009).

 In spite of these potential advantages, Greenfield and Pirard (2009, p. 295) conclude:

 ***“Based on the available literature, the effort of gender-sensitive***

 ***programs and services for women in treatment outcomes remains***

 ***unclear.”***

 While the research yields mixed results (Ashley et al., 2003), recent clinical trials of Women’s Recovery Groups (WRG) by Greenfield and her colleagues (2007) have yielded encouraging beneficial results of gender-specific interventions.

 Finally, the research on matching the gender of the psychotherapist and the patient have reported mixed results, as well.

**TREATMENT EFFECTIVENESS STUDIES**

Less than 10% of individuals with Substance Abuse Disorders (SUDs) seek professional help. 90% of individuals who have suffered a negative consequence from alcohol abuse do not seek treatment. It is only after they have experienced multiple negative consequences that they seek help.

The majority of those who receive professional help do not complete treatment.

Many of those who complete treatment do not fare well, with more than 50% remaining problematic or use drugs within 6 months.

Relapse rates across chemical addictions (heroin, cocaine, nicotine, alcohol) and across various treatment models are **fairly uniform** and **discouraging –around 75%.** The likelihood of life-long abstinence is low.

Among alcoholics who have been treated

* 1/2 will be abstinent at 3 months
* 1/3 will be abstinent at 6 months
* 1/8 will be abstinent at 12 months

- 1/10 will be abstinent at 18 months

Approximately 90% of treated alcoholics will have at least one drink within 3 months of abstinence treatment. 45%-50% will return to pre-treatment drinking levels within a year.

Overall, about 20% to 30% of alcoholic patients evidence long-term success with treatments.

70% of those who relapse will do so during the first 3 months after discharge. Nearly all who relapse do so before 6 months expires. The first 90 days post treatment is the most vulnerable period for relapse across various substances of abuse (heroin, smoking, alcohol).

An emergent view of SUDs is that it should be considered a “chronic disorder” that requires a “Recovery-oriented System of Care”. There is a shift from acute intervention models to models of sustained recovery support. ***(See*** [***www.glattc.org***](http://www.glattc.org) ***and*** [***http://www.dmhas.state.ct.us/recovery.html***](http://www.dmhas.state.ct.us/recovery.html) ***and*** [***http://www.Paths-brecovery.org***](http://www.Paths-brecovery.org) ***and*** [***http://www.facesandvoicesofrecovery.org***](http://www.facesandvoicesofrecovery.org) ***and http://www.bhrm.org/bhrmpsummary.pdf).***

Major reviews by Berglund et al. (2003) and by Imel et al. (2000) of a wide variety of psychologically-based interventions (e.g., 12 Step Facilitation, Alcoholic Anonymous, Motivational Enhancement Therapy, Cognitive behavior self-control training, Relapse prevention training, Aversion Therapy and Psychodynamic Therapy) were found to be equivalent, “***There was no difference in outcome obtained among competing treatment approaches”*** (Mee-Lee et al., 2010, p. 399).

An intensive inpatient treatment program is no more effective than less intensive treatment in outpatient settings.

Studies that have compared differing lengths of treatment for alcohol use have not found differential positive effects for longer lengths of treatment. Increasing the length and intensity of treatment may be more important in treating patients with more severe dependence and co-occurring psychiatric problems.

Low intensity interventions that focus on assessment, feedback and recommendation to reduce heavy drinking can be effective.

Cognitive behavioral treatment (CBT) has been found to be more effective as one component of intensive treatment programs than as stand alone interventions. CBT places primary focus on alcohol consumption per se, but on life areas related functionally to drinking and relapse.

Meta-analytical studies of other skills-oriented treatment programs indicate positive results for a variety of interventions including Community Reinforcement Treatment Approach; Behavioral Social Skills Training; Motivational Enhancement Therapy; Brief Motivational Interventions; Behavioral Monitor Therapy and Behavioral Self-control Training.

What does not work include Educational Films and Lectures; Confrontational Interventions; General Alcoholism Counselling; Insight Based Psychotherapy.

There is also evidence supporting the use of severe pharmacological therapies including Disulfiram (Antabuse), Naltraxone (ReVia) and Acamprosate (Campral).

Treatment of additional presenting problems leads to more positive treatment outcomes than attention to the substance abuse disorder alone.

Over 50% of those who enter treatment will drop out within the first month. Those who drop out of treatment have worse outcomes. For example, only 54% of subjects completed treatment in PROJECT MATCH and only 27% completed treatment in another major community study conducted by Morgenstern et al. (2001).

Among those seeking help and who drop out of treatment, some 20% will abstain without professional help and an additional 20% will moderate their drinking.

Mandated treatment, or those patients who are perceived as merely “putting in their time”, benefit from treatment just as much as those who voluntarily seek treatment. There are few treatment outcome differences between individuals who were or were not mandated into treatment with regard to program compliance and treatment outcomes, regardless of gender or ethnicity.

Self-help Therapy such as AA has been found to be more effective and less expensive than traditional therapy led by professionals (Groh et al. 2008; Timko et al. 2006).

Individuals who have the poorest social support network, namely, significant others who support drinking, had the best outcome in AA. Social support by AA members, as opposed to non-AA members, had the greatest impact. (Tonigan et al. 1996; Winzeberg & Humphreys, 1999)

Twelve step facilitation procedures are needed to address the high dropout rate.

**EXAMPLES OF INTEGRATIVE TREATMENT PROGRAMS**

 Integrated treatments emphasize the links between trauma exposure and addictions. A prominent example of such an Integrative treatment approach has been offered by Marsha Linehan (1993) in the form of Dialetical Behavior Therapy. Dialetical Behavior Therapy outlines a treatment hierarchy that addresses the patient’s:

1. life-threatening behaviors;
2. treatment-interfering behaviors (A Barriers analysis);
3. quality-of-life interfering behaviors (multiple complex problems).

 The DBT treatment combines individual, group skills training, telephone coaching and therapist consultation teams. The skills training focuses on mindfulness, distress tolerance, emotional regulation, urge surfing, relapse prevention and interpersonal effectiveness. This is combined with an Active Outreach component. There is encouraging data for the relative efficacy of the DBT treatment approach with comorbid Personality Disorder (PD) and substance abuse (SUDs) patients (Linehan & Dimeff, 1997; Linehan et al. 1999; McMain et al. 2007; Verheul et al. 2003).

 Other integrative treatment approaches that have been used with comorbid patients include:

Addiction and Trauma Recovery Integrated Miller and Guidry, 2001

Model (ATRIUM)

Concurrent Treatment of PTSD and Cocaine Brady et al, 2001

Dependency (CTPSD)

Substance Dependency-PTSD Therapy Triffleman et al., 1999

(SDTP)

Seeking Safety (SS) Najavits, 2002, 2003, 2006

TRANSEND Donovan et al., 2001

Trauma Recovery and Empowerment Fallot & Harris, 2002

(TREM)

Dual-Focused Schema Therapy Ball, 1998; Ball et al., 2005

(DFST)

Trauma-focused, patient-centered, Ford et al., (2009)

Emotional self-regulation: Trauma-

Adaptive Recovery Education and

Therapy (TARGET)

Skills Training in Affective and Cloitre et al., 2009

Interpersonal Regulation with

Motified Prolonged Exposure

STAIR-MPE

Cognitive Behavior Therapy Beck et al., 1999; Coffee et al., (CBT) 2003; Conrad & Stewert, 2005;

 Hepner et al., 2007; Marlatt & Witkiewitz, 2005; Mueses et al., 2003; Otto et al., 2005; Reilly & Shopshire, 2002; Riggs & Foa, 2003;

 Ruzek et al., 1998

**STUDIES of PREDICTORS and MECHANISMS of BEHAVIOR CHANGE**

Research findings have indicated that a variety of process variables are most predictive of treatment outcome. These variables include:

1. The quality of the therapeutic relationship;
2. The degree of client engagement and active participation in the therapy process;
3. The clients subjective experience of improvement early in treatment, especially tied to outcome-driven timely feedback;
4. The length of treatment and aftercare attendance;
5. The presence of social supports for abstinence and their involvement during the treatment program;
6. The use of Motivational Intervention procedures that evoke Change Talk.
7. The patients’ “faith” (belief) in the program and his/her perception that the staff care about their progress and treatment outcome.

There is a stronger relationship between nonspecific aspects of treatment and outcome than between so-called “active ingredients” (specific techniques and theories) and outcome.

The quality of the therapeutic relationship, especially that experienced early in treatment is predictive of patient engagement and treatment outcome. It has been estimated that between 50% and 60% of the variance in outcome is attributable to quality of the alliance between the client and the therapist. The therapeutic relationship contributes 5 to 10 times more to outcome than does the specific treatment model or the treatment approach that is used (Mee-Lee, 2010).

The patient’s rating of the therapeutic relationship is a significant predictor of participation, and drinking behavior both during treatment and at follow-up.

An effective Therapeutic Alliance (TA) contains the following essential ingredients:

1. shared treatment goals between the patient and the therapist
2. consensus on the means, methods or tasks of treatment
3. an emotional bond
4. an alignment between the patients’ frame of reference or theory of their

presenting conditions and their behavior change and the theory

underlying the treatment intervention program.

Another significant predictor of treatment outcome is the patient’s subjective experience of improvement early in treatment. In some studies, the absence of improvement by the third session was predictive of drop out and poor treatment outcomes. As Mee-Lee et al., (2010 p. 401) highlight:

 ***“The best way to improve retention and outcome is to attend to the***

 ***client’s experience of progress and the therapeutic relationship***

 ***early in treatment. Use of Real-time monitoring of results allow for rapid***

 ***and responsive modifications in the treatment plan and content”***

What the patient brings to the therapy and what happens outside of treatment are also significant influences in treatment outcome.

**TREATMENT IMPLICATIONS of RESEARCH FINDINGS**

 ***According to the Institute of Medicine, there is a lag of 17 years between the publication of health care research results and the impact in the delivery of***

 ***the treatment.***

**Consideration of Research Findings in Terms of**

 **Assessment Issues**

 **Therapeutic Issues**

 **Therapeutic Alliance and Engagement Procedures**

 **Treatment Features**

 **Staff Training**

**I. ASSESSMENT ISSUES**

1. Assessment should be comprehensive, ongoing and provide clients with feedback. Assessment and treatment are highly interconnected and include outcome-driven data that can be regularly given to both patients and therapists in order to flexibly alter the treatment program.

2. Assessment and Treatment should include the patient’s:

1. Polysubstance abuse and their functional impact. Use a multi-gating assessment approach.
2. Comorbidity- (Leave ample time-2 weeks to several months after abstinence period).
3. Life-span development of substance abuse and psychiatric disorders
4. History of victimization and trauma exposure.
5. Social network, including family history and social supports for abstinence.
6. Risk assessment toward self and others.

3. Assessment should include the measurement of the client’s strengths, signs of resilience, not only of the individual, but also family and cultural group (“survival skills”).

4. Assessment should include Adherence History and potential Barriers (Individual, Social and Organizational) encountered and those likely to occur in the future.

5. Assessment should include the patient’s theory of his/her distress (presenting problems) and theory of behavior change and potential alignment with the treatment philosophy.

6. Assessment information should be incorporated into a Case Conceptualization Model (CCM) that informs treatment decision-making and where feedback is given to the patient.

7. Assessment should include both treatment outcome and follow up measurement and process measures (patient engagement and patient satisfaction measures).

8. Assessment should include staff behaviors such as degree of cultural sensitivity/competence; ability to develop and maintain therapeutic alliance; use of spirituality-based interventions and the degree of Vicarious Traumatization and Burnout.

9. Assessment of the Treatment milieu (ala R. Moos type measures)

**II. THERAPEUTIC ALLIANCE and ENGAGEMENT STRATEGIES**

10. Focus on Therapeutic Alliance (TA) factors from the outset and monitor TA, and work on TA impasse/strains/ruptures

11. Use Motivational Interviewing and Related Procedures to nurture Active Client treatment participation.

12. Measure TA on a regular basis, including group cohesion and related measures.

13. Conduct Adherence History and anticipate future possible adherence issues (Barrier-based interventions).

14. Foster collaboration and nurture hype (Use collaborative goal-setting, Time lines, coping efforts, psychoeducation and “Clock” metaphor). Reframe symptoms as coping effects - - “stuckiness” issue.

15. Ensure that the patient perceives therapeutic benefits early on in treatment (e.g., reduction in symptom distress).

**III TREATMENT FEATURES**

16. Individualize the treatment program and provide integrated treatment that is gender and culturally-sensitive.

17. Use ancillary and adjunctive services to treat other life problems (homelessness, legal problems, health problems) and focus on the maintenance of treatment effects.

18. Implement generalization guidelines. Do not “Train and hope” for transfer.

19. Training should focus on intra- and interpersonal skills (emotion regulation, distress tolerance, risk-reduction behaviors, problem-solving) and interpersonal skills (communication, and assertiveness skills) and well-being training. Build on strengths such as spirituality.

20. When training coping skills build in generalization guidelines. Do not just “train and hope” for transfer and maintenance of treatment effects

21. Focus on relapse prevention from the outset and on ways to maintain sobriety that go beyond abstinence (Balanced life-style).

22. Provide Trauma-focused interventions.

23. Involve significant others in training programs.

24. Nurture and reinforce “change talk”.

25. Have an active aftercare system that builds on the long-term patient’s Recovery Plan. Build in ways to monitor progress and outcome.

**IV. STAFF TRAINING**

26. Ensure that the entire staff have a common language system and share a common treatment philosophy.

27. Ensure that the staff communicates regularly about specific cases.

28. Ensure that the staff receive ongoing supervision and professional feedback and training.

29. Systematically assess the needs, perceptions and well-being of stuff in terms of vicarious traumatization (VT), burnout and perceived benefits of their job.

30. Consider ways to employ individual, collegial and organizational interventions to improve staff well-being.

31. Monitor staff turnover and include “Exit” interviews for those leaving.

32. Provide “perks” and incentives for professional development.

**PROGRAM DEVELOPMENT BASED on RESEARCH FINDINGS AND**

**TREATMENT IMPLICATIONS**

**Task 1**. Develop a week long schedule from 7 o’clock in the morning until 10 pm. at night. How should

 patients spend their time over a seven day period?

**Task 2**. Develop a “game plan” of what are the steps a new patient should follow- - namely,

 Orientation, Assessment and Feedback, Involvement of significant others, Collaborative

 goal-setting, Motivational interviewing, and the like.

**Task 3.** Outline an Assessment Strategy for Intake, Ongoing Processes and Outcome measures.

 Integrate this information into a Case Conceptualization Model that informs treatment

 decision-making.

**Task 4**. Develop an integrative psychotherapeutic plan outlining session-by-session material and skills

 to be addressed and ways to increase the likelihood of generalization and maintenance of

 treatment effects.

**CONSUMER’S GUIDELINES FOR CHOOSING A RESIDENTIAL TREATMENT**

**CENTER (RTC)**

**Donald Meichenbaum Ph.D.**

 I have often been asked by relatives, friends and colleagues, “How can I best choose a RTC for my loved one?” This article provides Guidelines that I encourage them to follow. Imagine what the impact would be if Directors of all TRCs would have to address these questions on a regular basis or post their answers to such Frequently Asked Questions (FAQs) on their Website?

To: Director of Treatment

From: A Concerned Parent (Spouse, Client, Employer, Referring Agency)

 I am considering your Treatment Center for my family member. Before I decide on a placement, I would greatly appreciate your providing me with answers to the following questions so I can make an informed decision.

 I gather that critical reviews of the treatment research literature indicate that the following factors have been found to be key predictors of outcome for clients with psychiatric and substance abuse disorders. They include:

1. the quality of the therapeutic alliance that is established and maintained between clients and treatment staff;
2. the degree of client engagement and active participation in treatment;
3. the client’s perception of improvement in training;
4. the inclusion of an active aftercare program that involves significant others (family members), supportive non-substance abusing peers and the development of a long-term Recovery Program;
5. the flexible implementation of a treatment package that incorporates regular feedback from outcome-driven results.

 I would like to learn how your Treatment Center incorporates each of these treatment features. More specifically in terms of **Therapeutic Alliance**.

1. How does your treatment program develop and monitor a therapeutic alliance with clients? How does your staff handle possible impasses or strains that may arise over the course of treatment?
2. What specific client feedback measures about the quality of the therapeutic alliance does your staff regularly employ? For example, what specific Helping-alliance scales, client engagement/participation measures do you regularly obtain?
3. Since continuity of care is so important, please share your staff turnover data and what you have done to address this issue?
4. Since client engagement and active participation are critical to treatment outcome, what specific engagement strategies does your treatment center employ?
5. Is your staff trained and certified in using Motivational

Interviewing procedures?

1. How does your staff engage clients in collaborative goal-setting

and in developing a long-term Recovery Plan? (Could you please

send me a copy of the Resident Handbook and of the Goal Sheets

and Recovery Plan forms that clients are asked to fill out).

1. What is your Treatment Center’s policy for involving family members (significant others) from the outset and keeping them informed throughout treatment? ) Policy toward visiting, phone call consultations, family therapy and the like).

 In terms of **Assessment Issues**, I would appreciate your addressing the following questions.

1. How effective has your Treatment Program been in helping clients become abstinent, or at least reducing their substance intake, and in developing a better quality of life? Please share what long-term outcome data you have collected (beyond testimonials). How do you go about collecting such follow up data on a regular basis?
2. How do you intend to obtain long-term data from clients and from significant others. I would appreciate any reports on your treatment efficacy.
3. I gather that the best assessment data in helping clients is to use ongoing outcome-driven feedback that is given to both clients and therapists in real-time. In this way both clients and therapists can adapt the treatment program in a flexible individualized fashion in order to reach agreed upon treatment goals. How does your treatment staff obtain such outcome-driven data and employ it in treatment? What specific assessment measures do your therapists employ and how is this information shared with all staff and the clients?
4. How does your treatment team assess for the presence and history of polysubstance use, comorbid disorders, risk to self and others? How is this information incorporated into an integrated Case Conceptualization Model that informs treatment decision-making?

(10) How does your treatment staff assess for the “rest of the story”, namely, the client’s

 strengths, evidence of resilience, values, interests, talents, and how are these incorporated

 into the treatment plan? How does your staff explicitly nurture hope in clients, significant

 others, and staff?

(11) How does your staff employ a life-span perspective and assess for early victimization and

 trauma exposure? If such developmental events are identified, how do you incorporate this

 into the client’s treatment program? What specific trauma-focused interventions do you

 use and how do you integrate them with the treatment of substance abuse?

In terms of **treatment issues** I would appreciate your addressing the following questions.

 (12) What is the weekly treatment schedule? Please indicate how each of these various activities

 have some evidence-based or empirical support for clients with comorbid disorders? How

 will engaging in these activities help with long-term recovery? Any evidence for this?

 (13) How does your staff provide integrative (as compared to sequential or parallel) treatment

 approaches for clients with dual diagnosis? Has your treatment team adapted and been

 trained in any specific evidence-based integrative treatment procedures? Which programs?

 (14) How do you ensure that your treatment staff communicate regularly and convey a similar

 treatment message to clients and significant others?

 (15) Most importantly, when your treatment staff train clients on a variety of intrapersonal and

 interpersonal coping skills, how do you ensure that the staff has incorporated generalization

 guidelines designed to improve the likelihood of transfer and maintenance of the treatment

 effects? In short, what explicitly does your staff do besides “train and hope” for

 generalization and maintenance of treatment effects?

 (16) What specific coping skills does your treatment team teach? How do you go about deciding

 which skills should be taught and nurtured (“tailored”) with which clients?

 (17) When psychotherapies are provided, either individual, group or family, what specific

 approaches are used? Is this left up to the individual psychotherapist or is there one general

 psychotherapy approach at your Treatment Center? What is the psychotherapeutic approach

 and how do you evaluate its effectiveness?

 (18) Given the high incidence of lapses and relapses, how does your treatment team incorporate

 relapse prevention training? How do you work with clients to develop and maintain a life

 of sobriety, a balanced life-style and a high quality of life that is drug free?

 (19) How are your various treatment interventions culturally and gender sensitive? How do you

 incorporate the client’s cultural background, rituals and values into treatment? Do you

 conduct any gender-specific treatment programs? Please describe them.

 (20) How do you incorporate spiritually-based interventions, such as 12 Step AA programs into

 your treatment program? How do you explicitly facilitate such AA programs in order to

 increase the likelihood that client’s will continue his or her participation, once he/she leaves

 the Treatment Center? Are such AA meetings on campus or off campus? How do you

 monitor the quality of these meetings? What percentage of the week’s activities are devoted

 to AA meetings?

 (21) How do you incorporate psychotropic medications as part of your treatment program? How

 do you go about educating clients about their medication, systematically assess for possible

 side-effects and efficacy, and ensure that the client “takes credit” (makes self-attributions)

 about what the medication has allowed him/her to achieve in terms of their treatment goals?

 Since I raised the issue of medication, what is your Treatment Center’s policy about

 smoking and how do you handle clients who feel addicted to cigarettes?

 (22) How does your treatment program conduct an assertive after-care program with follow up,

 as well as contact with recovery programs in the client’s natural environment? What

 specifically, do you do in the form of follow-up contracts, assessments and ongoing

 contacts? Moreover, are there any additional charges for such aftercare activities, or is this

 service included in the initial treatment fees?

 (23) How do you explicitly address the needs of your staff at the individual, collegial and

 organizational levels in order to avoid burnout, vicarious traumatization and to ensure their

 professional development?

 I realize that this is a long list of comprehensive questions, but I am sure you will understand my desire to make the best, most informed decision concerning our loved one. If you were in my shoes, I am certain you would want to thoughtfully address each of these areas of therapeutic alliance, assessment procedures, treatment effectiveness, and various features of the treatment program in order to make an informed decision.

 Thank you for your careful consideration of each of these questions, and I look forward to meeting you and discussing a possible placement at your setting.