TREATMENT OF INDIVIDUALS WITH ADDICTIVE AND CO-OCCURRING DISORDERS: HOW TO ACHIEVE LONG-TERM BEHAVIOR CHANGE

Donald Meichenbaum, Ph.D.
Research Director of the Melissa Institute for Violence Prevention, Miami

www.melissainstitute.org
roadmaptoresilience.wordpress.com

Email address: dhmeich@aol.com

See Don Meichenbaum's Book "Treating Individuals With Addictive Disorders: A Strengths-based Workbook for Patients and Clinicians" Routledge Publishers

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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 Chandler Dobbs Professor, Emory University, Atlanta, Georgia Editor, Clinical Psychological Science

Scott O. Lilienfeld, Ph.D.
Samuel Chandler Dobbs Professor
Emory University, Atlanta

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.*

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CHALLENGES WHEN TREATING INDIVIDUALS WITH ADDICTIVE DISORDERS

1. Most individuals with addictive disorders do NOT seek help, nor acknowledge the need to change their behavior. There are a variety of reasons (see below) for this resistant behavior. Moreover, if they do enter treatment, there is a high drop out rate. For example, in studies of telehealth treatment of patients with addictive disorders, one -third dropped out of treatment in the first month.

2. In addition to the presence of any addictive behavior such as an Alcohol Use Disorder (AUD) there is a high incidence of co-occurring psychiatric and medical health problems. They are also likely to be at risk for a variety of social interpersonal, vocational, legal, financial problems. For some individuals with chronic addictive behaviors their lives are "chaotic."

3. There may be a high incidence, or propensity for violent behavior toward oneself in terms of suicidal ideation and suicidal behavior and violence toward others in the form of family violence.

4. Addicted individuals such as those with AUD often have a history of either distal victimization in the form of having experienced multiple Adverse Childhood Experiences (ACEs), or recent traumatic experiences or loses, or BOTH. This may result in their receiving a diagnosis of PTSD, Complex PTSD, Prolong and Complicated Grief and Traumatic Bereavement.

5. Addicted individuals often have misconceptions about the impact of various substance abuses and about the nature and effectiveness of treatment. They may experience a variety of barriers in accessing help, especially if they have had a past history of treatment failures. Treatment services may also provide barriers that derive from their absence of offering culturally, developmental and gender-sensitive interventions. There is a need to "meet patients where they are at."

6. Addicted individuals who have substance abuse problems may use poly-substances and be willing to consider cutting back on some substances, but not on others substances.

7. Addicted individuals may live in a "high-risk" environment with a number of "enablers" co-dependent family members or friends who put the individual at risk of lapses and relapse. Some 75 % of addicted individuals will relapse no matter what substance they use.

8. Addicted individuals are often non-adherent to treatment interventions such as Medication Assisted Treatment or when performing intersession "homework" activities, or when encouraged to engage in a variety of supplemental interventions such as Mindfulness training or attending various self-help groups.

9. Finally, when it comes for therapists to choose among the various treatment alternatives that provide integrative treatment for addicted individuals who experience co-occurring disorders there is essentially "equivalence of outcomes across the various treatment options." (See discussion below)

CONSIDER WHAT ARE THE ASSESSMENT AND TREATMENT IMPLICATIONS OF THESE CHALLENGING FACTORS?

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 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.

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.

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

A variety of factors may contribute to the failure of individuals seeking treatment. These include:

a) denial that substance abuse is a "personal problem" that warrants treatment;

b) not ready to change;

c) not have insurance to cover treatment;

d) concerns that seeking treatment will result in “stigma”, especially in close rural and knit communities (A “Goldfish Effect”);

e) concerns that seeking treatment will have negative effects on one's job and family;

f) doubts whether treatment would be helpful;

g) fear of withdrawal symptoms;

h) practical barriers like no transportation or child care, not able to get to the clinic due to getting time off from work, no match in service providers to the patient's racial, ethnicity and religious background; no access to internet to do telehealth;

i) not know where and how to get treatment.

EXAMPLES OF REASONS INDIVIDUALS OFFER TO CONTINUE USING SUBSTANCES

1. Relieve my physical and emotional pain

2. Relieve my tension, relax

3. Helps me feel good, get high, be outgoing, be sexy, have fun

4. Experiment, see what it is like to use and see if I can manage it

5. Helps me sleep and control my nightmares

6. Avoid withdrawal symptoms

7. Self-medicate

8. I use sex to get my drug supply --an exchange program

(The more reasons offered to use substances and avoid seeking treatment, the poorer the prognosis and the poorer the response to treatment)

SEE THE WEBSITE FOR CRAFTS (Community Reinforcement and Family Therapy approach)

This is a non-confrontational motivational intervention that encourages individuals to enter treatment

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.
- 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 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.

IMPACT OF ADVERSE CHILDHOOD EXPERIENCES (ACE)

ACE events are common.

Number of categories of ACE Events

ACE Score	Prevalence
0	40%
1	25%
2	13%
3	7%
4+	7%

As compared to children with 0 ACE events, consider he following outcomes:

ACE 4+ - - 51% learning and behavioral problems, as compared to 3% for 0 ACE Students

ACE 4+ - - 7X more likely to have sex before age 15

ACE 4+ - - 30x more likely to attempt suicide

ACE 4+ - - 46x more likely to use drugs

ACE 4+ - - 500% increases chance of becoming alcoholic

ACE 6+ - - 4600% increased chance of intravenous drug use

ACE 6+ - - shorter life-span

Some 45 million of these early forms of sexual abuse have been filmed and placed on the Internet. These pictures are preserved digitally and can be recirculated on the Internet. Thus, the fear of further victimization does not end. There are few safeguards, and as a result contribute to ongoing further victimization.

For a discussion of the neurobiological sequelae of trauma (threat-focused) experiences see Meichenbaum's paper on the Melissa Institute Website "**The emerging neurobiology of trauma and resilience: Implications for psychotherapeutic interventions**".

Some of the major findings on the impact of victimization include:

a. Reduction in the volume and activity of the brain;

b. Affect HPA (Hypothalamic Pituitary Adrenal Axes) that contributes to hypersensitivity to cortisol and to an increased sympathetic nervous system activity;

c. Contribute to asynchrony and lateralization differences - - left hemisphere deficits; brain development is derailed;

d. "Top-down" self-regulatory deficits and increased likelihood of the amygdala "hijacking" frontal lobe executive functions;

e. Accelerated loss of neurons (premature pruning); Accelerated adolescent development in females - - earlier menarche; Hyperarousal (startle responses, hypervigilance); emotional dysregulation.

McLaughlin, in her Webinar, draws a distinction between children who are experiencing ongoing threat-based uncontrollable and unpredictable violence versus those children who experience some form of deprivation due to a variety of factors. Those children who experience threat-focused experiences evidence:

a. Fear-based learning and emotional dysregulation/reactivity
b. Attentional bias toward threat, difficulty distinguishing threat from non-threat stimuli
c. Hostile attribution bias ("on purpose" attributions)
d. Compromised Frontal lobe self-regulation functioning due to the impact of Amygdala, Hippocampus, mesolimbre processes.

In contrast, children who experience extreme forms of neglect and deprivation due to an impoverished environment, absence of caretaking as a result of having a clinically depressed mother, inadequate and inconsistent parenting, being raised in a depriving orphanage (Romanian refugee children), evidence a different form of neurological

sequelae, than those children wo were exposed to some form of ongoing interpersonal violence.

The child's developing brain "expects" certain inputs from the physical and social environment, and when it is not forthcoming, major neurobiological changes occur. These deprived children evidence:

a. synaptic pruning of neurons as a result of lack of stimulation ("premature cellular aging");
b. cortical thickness;
c. inadequate development of Prefrontal Cortex (PFC);
d. accelerated pubertal development;
e. greater likelihood of developing depression and attachment disorders.

Keep in mind that 90% of brain growth occurs by age 5.

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.

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.

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 lifestyles and managing risk relapse have been found to be most helpful for such comorbid patients.

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. One half of all suicides in the U.S. have tested positive for alcohol use and one third have tested positive for opioid use.

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.

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.

WHAT IS YOUR ADVERSE CHILDHOOD EXPERIENCES (ACE) SCORE? (See https://www.cdc.gov/brfss Behavioral Risk Factor Surveillance System)

1. ***Did you live with anyone who was depressed, mentally ill, or suicidal?***

2. ***Did you live with anyone who was a problem-drinker or alcoholic?***

3. ***Did you live with anyone who used illegal street drugs or who abused prescriptions?***

4. ***Did you live with anyone who served time in prison, jail or other correctional facility?***

5. ***Were your parents separated or divorced?***

6. ***How often did your parents or adults in your home ever slap, hit, kick, punch each other?***

7. ***How often did a parent or adult in your home physically hurt you in any way?***

8. ***How often did a parent or adult in your home ever swear at you, insult you, or put you down?***

9. ***How often did anyone at least 5 years older than you, or an adult, try to make you touch them sexually?***

10. ***How often did anyone at least 5 years older than you, or an adult, force you to have sex?***

What is your ACE score? How have you evidenced resilience, in spite of these adverse events?

COGNITIVE BEHAVIOR THERAPY (CBT) FOR INDIDIVUALS WITH ADDICTIVE DISORDERS

CBT is a focused, goal-oriented treatment approach that not only addresses the individual's addiction, but the full range of clinical needs of patients that require wrap-around services.

Effective CBT involves the following psychotherapeutic tasks:

1. The establishment, maintenance and monitoring of the THERAPEUTIC ALLIANCE (TA) on a session by session basis is the best predictor of treatment outcomes. The use of FEEDBACK INFORMED TREATMENT is designed to enhance the patient's engagement in treatment process. When CBT is conducted on a GROUP basis there is a need to obtain on a regular basis the level of GROUP COHESION which is the best predictor of treatment outcomes. (See discussion below). In addition, the CBT needs to be individualized and sensitive to cultural, ethnic, religious, developmental and gender differences.

2. CBT is a person-centered phenomenologically-oriented treatment approach that " meets patients where they are at" and that assesses the patient's implicit theories of what are the causes of his/her presenting problems and what is needed to change. CBT uses a CONSTRUCIVE NARRATIVE PERSPECTIVE recognizing that patients are " STORY TELLERS" and they are lived by the stories they tell to themselves and that they tell others and the accompanying coping behaviors that they engage in.

3. CBT uses GUIDED DISCOVERY, a probing style of questioning in order to bolster the patient's level of CURIOUSITY, as discussed below. In order to enhance the patient's treatment engagement, CBT incorporates the procedures of MOTIVATIONAL INTERVIEWING that focuses on “CHANGE TALK”, in contrast to "SUSTAIN TALK."

4. The initial assessment should focus on safety issues including potential violence toward oneself (suicidality) and violence toward others (family violence), both of which are potentially high in addicted individuals with co-occurring disorders such as depression.

5. CBT is a STRENGHTS-BASED treatment approach that highlights the patient’s RESILIENCE ("in spite of behaviors"). CBT therapists use the Art of Questioning and TIME LINES to help patients identify strengths that they have that with the help of the therapist that they will be access and employ.

6. CBT engages patients in COLLABORATIVE GOAL-SETTING that nurtures the patient's HOPE. SMART TREATMENT GOALS are established and continually revisited with patient (Specific, Measurable, Attainable. Relevant/Valued and Timely).

7. CBT employs a CASE CONCEPTUALIZATION MODEL (CCM) of developmental and current risk and protective factors that informs both assessment and treatment decision – making. A critical feature of the CCM is the value of providing the patient, significant others where indicated, and other involved health care providers with FEEDBACK that informs the treatment plan and provides a basis for ongoing progress evaluations.

8. CBT includes a PSYCHO-EDUCAIONAL component, but this NOT a "mini-lecture". The information included in this collaborative process include the following:

    a) addressing any misconceptions that the patient has about the nature of his/her presenting problems and about the mutual responsibilities about the therapy process (There is a need to assess the patient's EXPECTATIONS about treatment, readiness to change, therapy-interfering behaviors and barriers and reasons offered to NOT engage in treatment);

    b) addressing the interconnections between the patient's thoughts, beliefs, feelings that activate addictive behaviors and related mental health challenges:

    c) the distinction between habitual (System TYPE I) substance abuse thoughts and beliefs and deliberate, intentional (System TYPE II) addiction-regulation thoughts.

    d) having the patient engage in SELF-MONITORING (data collection). For example, they engage in a "VICIOUS CYCLE ", and the impact, toll and price that they and others pay.

9. CBT therapists conduct a series of assessments including a FUNCTIONAL SITUATIONAL, DEVELOPMENTAL AND BEHAVIORAL CHAIN ANALYSIS in order to help patients better appreciate the factors that contribute and support their addictive behaviors.

10. In order not to have the therapy session "drift" and to maintain a goal-oriented treatment focus, CBT follows a format which is FLEXIBLY tailored to the patient. These include :

    a) Collaborative AGENDA -SETTING with the patient or Group participants and how this relates to the treatment goals;

    b) A Mood Check and query about how things are going in the patient's life;

    c) A discussion of a BRIDGE from previous sessions and to " HOMEWORK " or intersession patient activities:

    d) Intermittent summaries ("You said so many interesting and important things, is it okay if I summarize them to make sure I am getting what you mean? ")

    e) Consideration of what the patient will work on before the next session and self-generated reasons he/she will do so. What obstacles might get in the way and how can these be anticipated and addressed should they arise?

11. CBT helps patients to use whatever coping skills they already possess and when indicated help them develop and implement by means of DELIBERATE PRACTICE a variety of intra- and interpersonal skills. These skills include:

a) emotion regulation, acceptance and distress tolerance
b) self-soothing, relaxation, mindfulness and meditation
c) urge surfing and relapse prevention
d) rethinking and problem-solving
e) interpersonal communication, anger control and conflict resolution

CBT therapists do not merely "train and hope" for transfer, but build GENERALIZTION GUIDELINES into the training program. (See description below and visit roadmaptoresilience.wordpress.com)

12. CBT incorporates a variety of supplemental interventions including:
Contingency Management / Behavior Activation/ Mindfulness Relapse Prevention/ Dialetical Behavior Therapy/ Acceptance and Commitment Therapy/ Community Reinforcement And Family Therapy

13.CBT therapists employ a variety of supplemental self -help interventions such as 12 Step AA groups, SMART RECOVERY and other groups. There is value in integrating a spiritually-oriented interventions and CBT, when indicated.

14. A major challenge is the need to provide INTEGRATIVE TREATMENT with patients with co-occurring disorders such as PTSD, Depression, and Substance abuse.

15. The need to provide an ongoing therapeutic alliance in the form of between session phone coaching, Discharge Planning, Active Aftercare and Booster sessions. EXIT INTERVIEWS should be conducted with all patients The CBT therapist helps patients develop a BALANCED LIFE.

16. CBT recognizes the need to implement programs that bolster resilience in health care workers. See the Melissa institute Website.

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)?

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. 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.

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;
(2) the absence of sexual harassment and intimidation that may occur in mixed-gender programs;
(3) 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.

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.

See SAMHSA REPORT "After incarceration: A guide to help women re-enter the community". Publication Number PEP-20-05-01-001.

TREATMENT EFFECTIVENESS STUDIES

There are substantial differences among therapists in achieving patient treatment outcomes. It matters not only what treatment is being offered but who offers it.

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 alcoholics evidence long-term success as a result of treatment. Among people who do not maintain perfect abstinence as a result of treatment, drinking is reduced by as much as 87%. The majority of patients do recover after three years of seeking treatment.

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 and http://www.dmhas.state.ct.us/recovery.html and http://www.Paths-brecovery.org and 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. Cognitive behavior therapy places primary focus on how substance abuse impacts a variety of areas related functionally to usage and relapse prevention processes (Use wrap around services where indicated).

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). (See the discussion of Medication Assisted Treatment below).

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.

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.

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

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:

a) Polysubstance abuse and their functional impact. Use a multi-gating assessment approach.

b) Comorbidity- (Leave ample time-2 weeks to several months after abstinence period).

c) Life-span development of substance abuse and psychiatric disorders

d) History of victimization and trauma exposure.

e) Social network, including family history and social supports for abstinence.

f) 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. The use of Treatment Informed Feedback (FIT) using session-by-session patient feedback is a critical feature of effective treatment outcome. The quality of the therapeutic alliance in individual therapy and the level of group cohesion in group treatment are predictors of treatment outcomes.

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 hope (Use collaborative goal-setting, Time lines, coping efforts, psychoeducation and "Clock" metaphor). Reframe symptoms as coping effects - - "stuckness" 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 <u>not</u> "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. Focus on relapse prevention from the outset and on ways to maintain sobriety that go beyond abstinence (Balanced life-style).

21. Provide Trauma-focused interventions. Include various Constructive Narrative therapies that are tailored to the patient's dominant emotional reactions (anxiety, depression, guilt, shame, grief, anger, moral injuries).

22. Involve significant others in training programs when indicated.

23. Nurture and reinforce "change talk".

24. 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

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

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

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

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

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

30. Monitor staff turnover and include "Exit" interviews for those leaving.

31. Provide "perks" and incentives for professional development.

(See the Melissa Institute Website for ways to bolster resilience in Health Care Workers).

THOUGHTS AND BELIEFS ASSOICATED WITH ADDICTIVE BEHAVIORS TYPE I SYSTEM OF THINKING

The role of storytelling: "As the adage states "Substance abuse is 10% using and 90% thinking."

The following description provides examples of how individuals who have addictive disorders engage in self-justifying sustaining self-talk and self-generating rationalizations to convince themselves to continuing using substances. These thinking and emotional processes can be summarized using the Acronym DEFENCE. (Note that in the U.S. the word DEFENSE is spelled with an S. However, in England the word DEFENCE is spelled with a C. For purposes of my description, I adopted the British spelling).

DEFENCE

D Denial processes

E Entitlement thoughts

F Fatalistic thoughts

E Evaluative thoughts about others and about oneself

N Needs-based thinking processes

C Illusions of Control

E Expectations of self-satisfying, stimulating experiences

1. First, substance abusing individuals may evidence some form of denial or reframe that they have addictive behavior problems: "I don't think I have a problem. You are overreacting."

"I don't think I have to change."

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

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

"I could use and no one would ever know."

"No one in my family was diagnosed as an alcoholic."

"I am not hurting anyone, but myself."

2. **Entitlement** thoughts which constitute permission-giving beliefs that they deserve and are entitled ("Earned the right to use"), and moreover, that they have no other options available for obtaining self-deserved pleasures:

"I deserve x."

"I cannot be happy without x."

"I have quit everything else."

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

"I am my own boss and I don't like people telling me how to live."

"It is the only way to be accepted."

"Life is boring without getting high."

3. **Fatalistic** thinking reflects individuals deep-seated feelings of helplessness, powerlessness and uselessness that sustain addictive behaviors:

"I am helpless."

"I feel trapped. This is my only escape."

"I am powerless."

"I lack willpower."

"I am at the mercy of my urges."

"I have hit bottom. What is the use of stopping? I will start again."

"Once an alcoholic, always an alcoholic."

"I am useless."

"I am a complete mess."

"Stopping won't do any good anyway."

"I am stuck in my life. I can never get out of my drug habit."

"I hate myself."

"I have always been a drunk. That is who I am."

"It is too late to change."

4. **Evaluative** thoughts about others and about oneself which reflect negative views about their relationships with significant others in their lives resulting from feeling marginalized, unsupported and vengeful. Feelings of being rejected, unappreciated and lonely can trigger addictive behaviors.

"Drinking is my way of getting back at them."

"No one really cares if I use or not."

"No one understands me. No one can help me anyway."

"You can't trust people. In order to be safe, I have to use."

"No one thinks I am worth saving and I agree."

"I am a burden on others and they would be better off without me around."

"I am too tired to continue living."

5. **Need-based** self-statements and beliefs that reflect a tyranny of "shoulds", "needs", "musts" and "cant's". Self-talk that begins with "I need, must, should X", drives the urge to use substances.

"I need x in order to unwind, avoid withdrawal symptoms, forget, survive."

"I need x in order to (get some benefits) such as be creative, attractive, sociable and sexy."

"I must use to have a good life."

"I can't survive without x."

"Without x, I can't handle, control, tolerate, cope."

"Life is unbearable, I have to escape for a while."

"I need to use x in order to avoid the pain of withdrawal symptoms, survive, fall asleep."

6. **Illusions** of **control** are held at some level that they can exert control and handle substance abuse behaviors.

"I can test myself."

"I am different from others who use."

"I know how to handle my use."

"I am more in control of myself, when I use."

"I can hold my liquor better than others."

"I will have only a couple of drinks."

"When I am ready, I will quit by myself."

7. **Expectations** of self-satisfying and stimulating experiences as a result of using substances. Such thoughts highlight the expected and perceived physiological, psychological and social benefits of using, especially with others who are also using substances.

"It just feels so good. I love the buzz and the high."

"I need a pick-me-up."

"When I use I feel alive."

"My body needs this to survive."

"If I don't use drugs, I will lose my friends"

"When I use, I have more friends and better sex."

"When I use with others, I can find customers to sell to."

"I always have a good time when I am partying with my friends."

"Nothing else in my life makes me feel so good."

"Experiment to see what it is like to use."

"To increase the effects of other drugs."

Are there any other examples you can offer of how you convince yourself to continue using? What advice would you have as to how to change these thought patterns and the accompanying addictive behaviors?

CHANGE-REALTED BELIEFS AND THOUGHTS: TYPE II SYSTEM OF THINKING RECOVERY VOICES

As Kurt Vonnegut observed in his book Mother Night "We are what we pretend to be, so we must be careful about what we pretend."

EXAMPLES OF SELF CONTROL BEHAVIORS AND BELIEFS

I can tolerate and accept discomfort and cravings

I can cope with unpleasant emotions without using X

No emotion lasts forever.

I can endure this short-term pain/discomfort for long-term gain.

If I resist long enough, the craving will go away.

I have control over my own behavior, including my need to use X.

Even if I slip, I don't have to relapse.

I have learned that I can relax with using X.

I have learned how to accept my feelings and thoughts (let them float away).

I have learned that I can question, and even challenge my beliefs and thoughts that trigger my use of X.

EXAMPLES OF BELIEFS RELATED TO ONE'S SELF-CONCEPT

When I use X, I am NOT really being myself, I am only a drunken version of myself.

I do not need X to feel good about myself.

I realize that my journey to recovery will have ups and downs that I can learn to handle them.

I am acquiring important skills that i can use to control X.

I am learning that I can solve problems without using X.

I learned how to be on the lookout for " high-risk " situations (people, places and activities).

I learned that it is okay to say " NO" and also to ask for help.

The best way to pass the test is NOT to test yourself in the first place.

TAKING CREDIT FOR CHANGING

This discomfort means that I am doing something important in moving toward a more balanced drug-free life.

Quitting X is the most loving thing I can do for my family.

I am person who can keep a commitment.

I am proud that I can now have fun (be outgoing, sexy, creative) without having to use X.

By stopping using X, I can show myself that I am stronger than X.

I have gained an understanding of how my thoughts trigger my use of X.

VISIT THE FOLLOWING WEBSITES TO LISTEN TO THE STORIES OF INDIVIDUALS ON THEIR JOURNEYS OF RECOVERY

abcnews.go.com/Health/abc-news-anchor-Elizabeth-Vargas

www.crisisnextdoor.org

www.storiesrecoveryuk/index.php

www.recoverymonth.gov/personal-stories/

www.ncadd.org/people-in-recovery/recovery-stories

www.heretohelp.bc.ca/personal-stories

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;

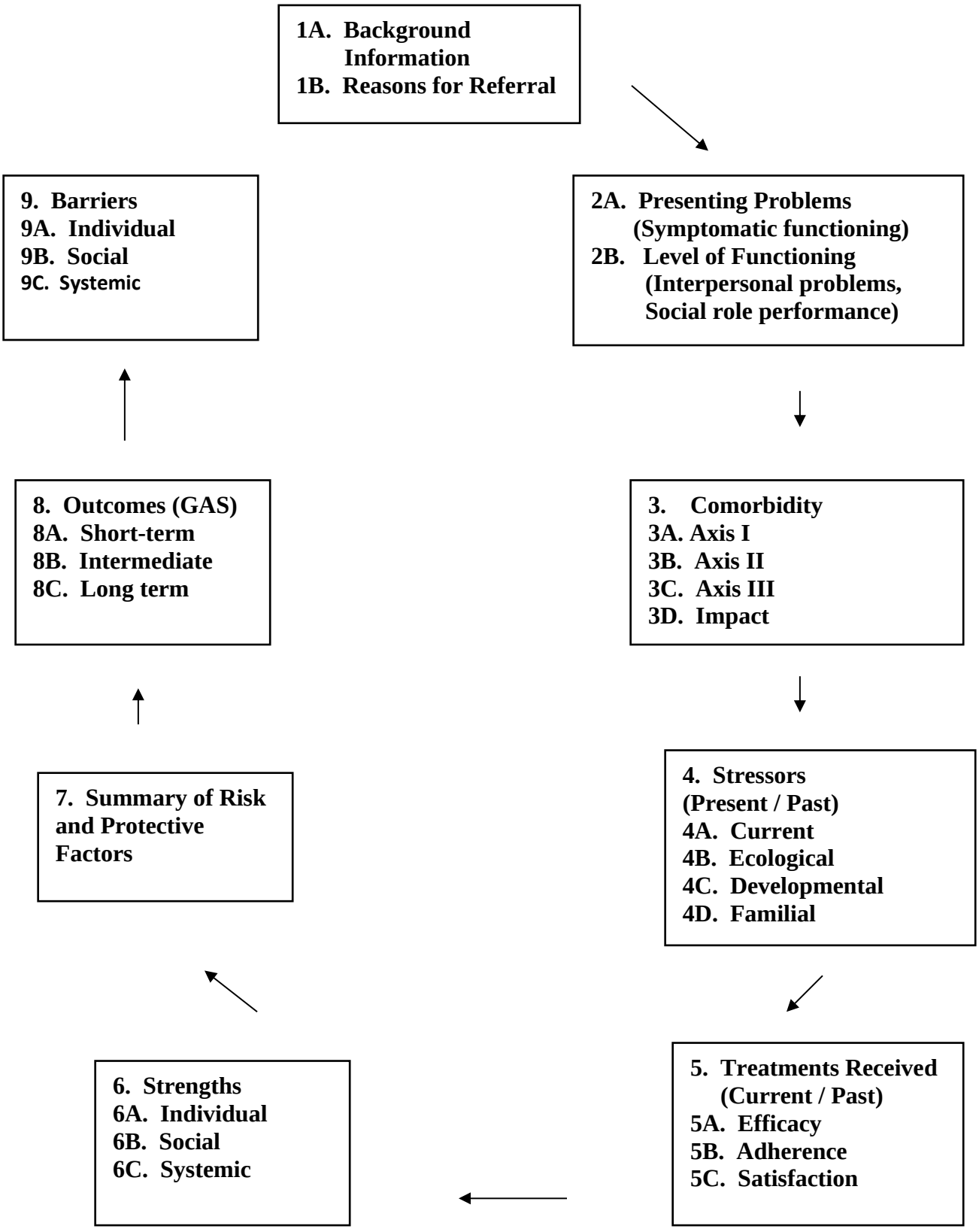
7. identify, anticipate and address potential individual, social and systemic barriers that may interfere with and undermine treatment long-term effectiveness;

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



FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see **if I understand:**

BOXES 1& 2: REFERRAL SOURCES AND PRESENTING PROBLEMS

"What brings you here...? (distress, symptoms, present and in the past)
"And is it particularly bad when..." "But it tends to improve when you..."
"And how is it affecting you (in terms of relationship, work, etc)"

BOX 3: COMORBIDITY

"In addition, you are also experiencing (struggling with)..."
"And the impact of this in terms of your day-to-day experience is..."

BOX 4: STRESSORS

"Some of the factors (stresses) that you are currently experiencing that seem to maintain your problems are...or that seem to exacerbate (make worse) are... (Current/ecological stressors)
"And it's not only now, but this has been going on for some time, as evident by..." (Developmental stressors)
"And it's not only something you have experienced, but your family members have also been experiencing (struggling with)..." "And the impact on you has been..." (Familial stressors and familial psychopathology)

BOX 5: TREATMENT RECEIVED

"For these problems the treatments that you have received were-note type, time, by whom"
"And what was most effective (worked best) was... as evident by...
"But you had difficulty following through with the treatment as evident by..." (Obtain an adherence history)
"And some of the difficulties (barriers) in following the treatment were..."
"But you were specifically satisfied with...and would recommend or consider..."

BOX 6: STRENGTHS

"But in spite of...you have been able to..."
"Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present situation are..."
"Moreover, some of the people (resources) you can call upon (access)are..." "And they can be helpful by doing..." (Social supports)
"And some of the services you can access are..." (Systemic resources)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

"Have I captured what you were saying?" (Summarize risk and protective factors)
"Of these different areas, where do you think we should begin?" (Collaborate and negotiate with the patient a treatment plan. Do not become a "surrogate frontal lobe" for the patient)

BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

"Let's consider what are your expectations about the treatment. As a result of our working together, what would you like to see change (in the short-term)?
"How are things now in your life? How would you like them to be? How can we work together to help you achieve these short-term, intermediate and long-term goals?"
"What has worked for you in the past?"
"How can our current efforts be informed by your past experience?"
"Moreover, if you achieve your goals, what would you see changed?"
"Who else would notice these changes?"

BOX 9: POSSIBLE BARRIERS

"Let me raise one last question, if I may. Can you envision, can you foresee, anything that might get in the way- any possible obstacles or barriers to your achieving your treatment goals?"
(Consider with the patient possible individual, social and systemic barriers Do not address the potential barriers until some hope and resources have been addressed and documented.)
"Let's consider how we can anticipate, plan for, and address these potential barriers."
"Let us review once again..." (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words. Involve significant others in the Case Conceptualization Model and treatment plan. Solicit their input and feedback. Reassess with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 5B, 4C, 6B, etc) Maintain progress notes and share these with the patient and with other members of the treatment team.

CASE CONCEPTUALIZATION MODEL APPLIED TO SUBSTANCE ABUSE DISORDERS

1A. **Background Information** - gender, marital status, sexual orientation, ethnicity, social and religious background, migration status, 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 Activities Daily Living (ADL's), Medical history and current medical condition, including pregnancy.

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 in treatment.

USE MOTIVATIONAL INTERVIEWING PROCEDURES AND VARIOUS PATIENT WORKSHEETS TO ENGAGE THE PATIENT

2A. **Current and Past Chief Complaints and Symptoms**

1. Conduct both situational and functional analyses 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). Information on alcohol-related screening tests can be found at *www.SAMHSA.gov.*

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. (*Use the CAGE, MAST, AUDIT, Addiction Severity Index, Drinkers' Profile assessment tools)*.

5. Obtain trauma history. 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? 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. **<u>Comorbidity</u>**

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 opioids 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. **<u>Stressors</u>**

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 and micro aggressions).

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).

ADMINISTER ACE QUESTIONNAIRE (ADVERSE CHILDHOOD EXPERIENCES QUESTIONNAIRE). It is the cumulative number of developmental stressors that is most impactful.

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

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, "islands of competence", desire to change.

6B. **Social** – Presence of social supports and network, sense of prosocial community. Intergenerational transmission of resilience-engendering beliefs and behaviors.

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 IMPROVEMENT		MODERATE IMPROVEMENT		SIGNIFICANT IMPROVEMENT
	0% change	25% change	50% change	75% change	100% 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.

ASSESSMENT QUESTIONS "THE ART OF QUESTIONING"

The use of open-ended questions, such as WHAT and HOW questions, invite the patient to actively participate in the therapeutic discourse.

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. (You can use substance abuse or drug use for the word drinking in these questions).

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?
What kind of things do you know about..... ?
Would you be interested in learning more about.....?
What are your thoughts about.....?

Help Acknowledge Concern

What worries you about your drinking?
What do you think could happen if…?
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 drinking?
How would things be better for you if.....?
What kind of things might work for you?
What might be the first steps for you to make?

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?

These 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?

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).

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.

CHANGE TALK PREDICTS TREATMENT OUTCOME

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?" Research on Motivational Interviewing highlights the types of patient's statements that reflect a readiness to change and the stability of such behavioral changes. William Miller in his recent book on ambivalence ("On second thought," Guilford Press) highlights the following examples of CHANGE TALK:

DESIRE --- "I would like to ..." / "I look forward to..."/ "I want to,,,,/ I wish ..."/

ABILITY-- "I could try to..." / "I am able to" / "I know how to..." / "I can do .. "/

REASONS--- " If I do....then ..."/ "If I do NOT do .... then...?"

NEED--- "I need to..." / "I have got to... " / "I really have to ... "/

COMMITMENT (ACTIVATING LANGUAGE) --- "I am ready to..." / "I am willing to..."/ "I plan to..." / "I intend to..." / "I have decided to..." / "I am going to " / "I promise to...."/

Research by Dunlop and Tracy (2013a, b) illustrate the role of the patient's narrative in predicting long-term behavior changes in recovering alcoholics.

> ***"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.

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?"

CHANGE TALK

As a result of participating in treatment, the clients should begin to incorporate the following "language of change" into their narrative or "stories" and learn to use these phrases in an unprompted fashion. The clients should be able to employ the terminology of relapse prevention and offer multiple examples of each of these coping actions. They should be able to operate in a consultative mode being able to explain, teach and demonstrate these activities to others, and moreover, offer self-generated reasons why doing each of these activities is important to his/her recovery. As a result of treatment, the client should be able to indicate that ***"I can now…"***

IDENTIFY TRIGGERS

Analyze "near miss" episodes, so I can learn from them
Catch myself before I fall off the wagon
Identify high-risk situations ahead of time
Increase awareness of unseen problems
Pinpoint triggers, tell tale signs, watch out for warning signs
Recognize when I am time-sliding back
See how I stir up my feelings and frequently fuel my feelings
Stay alert to my personal needs and people, places and things that put me at risk of using again
Troubleshoot events ahead of time
Turn off the CD in my head that leads to drinking (substance abuse)
Watch out for what activates my "hibernating" (dormant) beliefs that lead to my drug use

COPE MORE EFFECTIVELY

Avoid getting blind-sided
Avoid putting myself at risk
Avoid tunnel vision
Catch myself using "musts", "shoulds", "always", "never"

Change my moods without using drugs
Change who I spend time with. Increase my association with non-substance abusing buddies.
Structure my daily activities
Check my 2 X 2 Grid of the pros and cons of using and not using drugs
Check my coping cards that I keep in my wallet/purse, cell phone, iPad
Check out my beliefs
Come to grips with my emotions
Conduct a behavior chain analysis
Go for hugs, not drugs
Increase my tolerance for others
Increase ways to get positive "healthy" reinforcers or "perks" in my life
Maintain hope
Perform personal experiments
Plan ahead
Refocus on what is really important in my life
Remind myself of what "***I have***", what "***I can do***" and "***Who I am***", besides someone who has been a drug user.
Seek help when I need it
Start using my coping plans and back-up plans if I need them.
Stop being my own worse critic
Stop "catastrophizing"
Stop deluding myself
Stop giving myself a "snow job"
Stop my self-defeating behaviors
Stop putting myself down all the time
Stop sabotaging my treatment plan
Stop setting myself up for failure
Take pride in what I have accomplished
Teach (explain, demonstrate) what I have learned in treatment to others and offer reasons why I now do these things
Use my Clock Analysis (**12 o'clock- internal and external triggers; 3 o'clock – primary and secondary emotions; 6 o'clock – thinking processes and beliefs; 9 o'clock – behavior and consequences)**
Use my game plan and back up strategies to cope with my urges and cravings

The clients should be encouraged to offer **commitment statements** of specific ways (how, where, when) they will engage in each of these activities, <u>in spite of</u> barriers, pressures, obstacles to perform, and most importantly, they should be encouraged/challenged to provide the **reasons why** engaging in such behaviors are important to achieving their treatment goals.

A sign of the clients' commitment statement is the desire to which their accounts ("stories") include examples of **change talk verbs**. Consider the following list of verbs that reflect self-efficacy.

" I CAN NOW... anticipate, catch, challenge, choose, delay and distract, enable, evaluate, manage, modify, monitor, plan, question.

RE- calibrate, RE-frame, RE-focus. RE-author, RE-pair, RE-conceptualize, RE-join, RE-new, RE-apply, Re-program, Re-script

SEE the website roadmaptoresilience.wordpress.com ITEMS 62 and 65, on pages 127 and 136 for a list of examples of the LANGUAGE OF POSSIBILITIES.

TREATMENT GUIDELINES FOR ACHIEVING STABLE LASTING CHANGES

1. Establish, maintain and monitor the quality of the therapeutic alliance using session-by-session, or regular, treatment-informed feedback (FIT) in order to monitor patient progress and the "fit" with the therapist (treatment team). Visit the Website to download FIT tools. ***(See www.centerforclinicalexcellence.com and Scott Miller on Melissa Institute Website.)***

2. When conducting Group Therapy assess for the level of group cohesion and the patient perceived support.

3. Be culturally-sensitive and gender-sensitive when providing services. Conduct gender-specific treatment programs and tailor interventions to issues of sexual orientation. Individualize the treatment protocol and assign a Case Manager to each patient. The quality of the therapeutic alliance is the most important predictor of the length of the treatment participation, engagement and treatment outcomes.

4. Use Motivational Interviewing Empathy-based procedures to increase patient treatment engagement. Focus on "change talk". ***(See www.motivationalinterviewing.org and http://ctndisseminationlibrary.org.PDF/146.pdf).***

5. Nurture patient HOPE by employing collaborative goal-setting using **SMART** goals (Specific, Measurable, Attainable, Realistic Timely goals). Use the language of possibilities and becoming "solution talk". Incorporate meta-cognitive and RE verbs in social discourse.

6. Use Genograms and Time-Lines to help the patient identify "strengths" and evidence of resilience ("In spite of" behaviors). Nurture a coping resilient mindset in spite of vulnerability factors.

7. Use a Case Conceptualization Model of risk and protective factors and employ patient and significant other feedback. Assess the patient's implicit theories of his/her addictive behavior and views of the treatment plans. Consider treatment alternatives of abstinence and harm reduction interventions.

8. Employ psycho-education that informs about both "addiction traps" and the impact of substances on brain/body, as well as information about neurogenesis and neuroplasticity of the brain. ("Rewire the brain" and "History is not destiny!) Educate patients about the

difference between Type I (fast, habitual, impulsive) and Type II (slow, intentional, deliberate) thinking processes and the implications for treatment.

9. Use the CLOCK metaphor to educate the patient about the interconnections between his/her appraisal of external and internal triggers (12 o'clock); accompanying primary and secondary emotions (3 o'clock); accompanying thoughts and thinking processes (6 o'clock); and behaviors and resultant consequences (9 o'clock)?

10. Help the patient to appreciate how they inadvertently, unwillingly, and perhaps, unknowingly contribute to their present problems. How they contribute to a "vicious cycle" and focus on the mindset and constructive narrative ("stories" patents tell themselves and others and accompanying behavior).

11. Teach and strengthen emotion and self-regulation skills such as distress tolerance, managing cravings, chronic pain and learn ways to engage in positive resilient-engendering emotions and accompanying self-care, empowering activities. Implement generalization guidelines before, during and after skills training.

12. Put the patient in a consultative role using Patient Checklists and Post Treatment Recovery Checklist. Include Self-attribution training procedures ("taking credit" for behavioral changes - - "nurture ownership".)

13. Employ medication-assisted treatment (MAT), where indicated. Address issues of treatment non-adherence throughout.

14. Involve significant others, like family members whenever possible. Conduct a network analysis, as part of Relapse Prevention procedures. Provide peer support recovery specialists, if possible.

15. Incorporate Relapse Prevention procedures, conducting a trigger analysis, behavioral chain analysis, potential barrier analysis, and preparing skills training. Focus on potential therapy-interfering behaviors. Consider "unsafe for recovery" settings and plan with the patient accordingly.

16. Provide Integrative treatment to address the impact of co-occurring disorders. Use evidence-based interventions and beware of HYPE in the field.

17. Incorporate the patient's spirituality (religion, faith, participation in various forms of treatment like 12 Step AA and Smart Recovery into intervention. (See Meichenbaum "Trauma, spirituality and recovery" on the Melissa Institute Website).

18. Provide Active Aftercare and ongoing group interventions. Include follow-up assessment and Booster sessions to address any "unfinished business." Engage the patient with a community of "successful" patients. Provide access to computer-assisted resources.

19. Conduct a collaborative detailed comprehensive discharge planning, anticipate high-risk situations. View any lapses as a "learning opportunity." Help patients learn to "fail successfully."

20. Provide wrap-around services to address the multiple needs of patients such as back-to-work programs, parenting and academic skills training. Treat the "whole" person, not just addiction problems.

21. Engage other health care providers as follow-up therapeutic agents, both professional and non-professional facilitators. Use the Case Conceptualization Model and Feedback-informed Treatment, as a mode of communication.

22. Where indicated, help patients find safe drug free living circumstances (eg., Halfway housing, College safe Haven settings). Assess the "social capital" and "recovery capital" of the community to which the patient will return.

23. Obtain patient feedback ("exit" interviews) and treatment satisfaction feedback and ask for ways the treatment program can be improved. Maintain ongoing feedback with the patient. Encourage the patient to be a "collaborator."

PHASE-ORIENTED INTEGRATIVE TREATMENT APPROACH

INITIAL PHASE

1. **Develop, maintain and monitor therapeutic alliance. Use session-by-session Feedback-Informed Treatment and similar patient feedback measures.**

2. **Conduct Initial Assessment and conduct ongoing assessments**

    a. **Polysubstance abuse**

    b. **Comorbidity assessment from a life-span perspective**

    c. **Risk assessments toward self and others**

    d. **Assess for evidence of strengths and signs of resilience**

    e. **Assess from a Constructive Narrative Perspective: "Addictive and Redemptive Stories", and Reasons for noncompliance**

3. **Use Three Tile-Lines:**

    Time Line 1 - - History of Addictive and Co-occurring Disorders and Interventions

    Time Line 2 - - "In spite of" resilient behaviors

    Time Line 3 - - Focus present and future

4. **Use Case Conceptualization Model (CCM) of Risk and Protective Factors: Have the patient fill this out. Maintain Progress notes using CCM.**

5. **Use Motivational Interviewing: Use the "Art of Questioning."**

6. **Engage in Collaborative Goal-setting. Establish SMART goals (Specific, Measurable, Attainable, Relevant, Timely). ("As yet", "So far").**

7. **Conduct Psychoeducation**

    a. **Discuss the impact of the use of substances: "Addictive Trap"**

    b. **Discuss the role of resilience - - "plasticity": Use language of possibility ("As yet", "So far") and RE Active Verbs.**

c. Use CLOCK Metaphor and distinguish between Type I and Type II thinking process.

i. 12 o'clock - - external and internal triggers

ii. 3 o'clock - - primary and secondary emotions

iii. 6 o'clock - - automatic thoughts, thinking style, schemas and beliefs

iv. 9 o'clock - - behaviors and resultant consequences

These contribute to a "Vicious Cycle." Question "Toll, Impact, Price" patient and others pay. Consider ways to "Break the Cycle."

d. Discuss ways in which PTSD and Substance Abuse go hand-in-hand ala Najavits.

8. Address ways Psychoeducation and Collaborative Goal-setting can be conducted on a <u>Group</u> basis: Use CLOCK metaphor and "Conversation Starters."

9. Engage the patient in Self-monitoring: Contribute to skills training.

PHASE II- SKILLS BUILDING AND CONSOLIDATION

1. Help the patient develop Intra-and Interpersonal Skills and ways to bolster resilience.

a. Emotion self-regulation skills and "build and broaden" positive emotions.
b. Identify Triggers and develop urge-surfing skills.
c. Mindfulness and relaxation training.
d. Interpersonal communication skills and social network associations.
e. Refusal skills training
f. Ways to bolster resilience
(see www.roadmaptoresilience.com)

2. Incorporate Generalization Guidelines: Do <u>not</u> "train and hope" for transfer and maintenance.

3. Engage significant others, where indicated (e.g., Couples, Family and Peers involvement).

4. Discuss Role of 12 Step AA programs (See Checklist) and other possible programs such as SMART Recovery and Community-based supports.

5. Integrate spiritually and religiously-based interventions, where indicated.

6. **Integrate skills and Treatment of Co-occurring Disorders such as PTSD.**

    a. **Cloitre - - STAIR-MPE**
    b. **Ford - - TARGET**
    c. **Najavits - - SEEKING-SAFETY**

    Use various exposure-based interventions, Cognitive restructuring, Restorative Retelling (Gestalt "Empty Chair" Procedures).

7. **Help patients develop SOBRIETY SCRIPTS and accompanying coping skills.**

PHASE III - - STEPS TOWARD DEVELOPING "LASTING CHANGES"

1. **Conduct Relapse Prevention Training**

2. **Engage the patient in Self-attributional training ("Taking Credit").**
    a. **Use Patient Checklist**
    b. **Use Active Verbs that reflect meta-cognitive abilities.**
    c. **Put the patient in a "consultative" role: (Describe, Demonstrate, Teach, Own skills and express commitment and enumerate <u>Reasons</u> why and when and where to use coping skills. How to anticipate "high-risk" situations ("triggers"), game plan and back-up plan.)**

3. **Have patient Revisit his/her Case Conceptualization and "retell" story.**

4. **Have patient complete Patient Satisfaction Measures and solicit suggestions for improvement of treatment.**

PHASE IV - - ACTIVE FOLLOW-UP PROCEDURES

1. **Build in active follow-up Booster Sessions.**

2. **Focus on transition skills such as job skills and role responsibilities.**

3. **Help the patient reclaim a life worth living, and engage in meaning-making skills ("Making amends"; forgiveness skills toward self and others; altruistic behaviors ("Give to Get"), and the like.**

4. **Engage in Active Case Management.**

MEDICATION-ASSISTED TREATMENT (MAT): PHARMACOTHERAPY FOR ADDICTIVE DISORDERS

There is much controversy over the use of medication-assisted treatment, especially for those who experience opioid addiction. A survey of some 3000 residential treatment programs indicates that only 49% use any medication-assisted intervention. This is in part due to a commitment to a total abstinence based treatment on the part of the treatment staff and the patents' beliefs that such treatment is "merely replacing one addiction with another". The accompanying belief is that this will lead to a wholly pharmaceutical solution to addiction.

Where indicated, the use of medication-assisted treatment requires a three-phased psychoeducational approach with patients.

Phase I. - - A collaborative non-judgemental, supportive discussion with the patient and significant-others (family members) about:

a) their implicit notions or theories about the causes of their addiction and what is needed to change;
b) their history of treatment in terms of efficacy, adherence and satisfaction;
c) their present motivation and willingness to engage in treatment? (Use Motivational Interviewing and Collaborative goal-setting procedures).

Phase II. If M.A.T. is to be considered then use the analogy of **Diabetes** to convey the need to combine glucose monitoring procedures with the use of the drug Insulin to treat Type I and Type II diabetes. Underscore that medication-assisted treatment needs to be supplemented with psycho-education behavioral interventions (diet, exercise, life-style changes, foot care, and other procedures) in order to be effective. Addictive disorders, like diabetes, require a complex, interactive treatment approach to achieve "lasting" changes.

Phase III. Educate the patient and family members about the various pharmaceutical treatments and the potential benefits. Address issues of treatment nonadherence and how the medications will be integrated with evidence-based trauma-informed interventions.

M.A. T. treatment for opioid dependence include Buprenorphine, also known as Suboxone (a partial agonist) often combined with Naloxone, and with an injectable naltrexone also known by the brand name Vivitrol (an antagonist). It blocks the brain's opioid receptors preventing a high in patients who try to use opioids while on it. Vivitrol requires a 10 to 14 day abstinent period from opioid use before it can be administered. Methadone, also an agonist, has also been found to be as equally effective as Buprenorphine. These drugs work by easing withdrawal symptoms relative to placebo treatment.

Treatment must last, on average for at least 3 months to produce stable behavior change.

Some hospitals are administering opioid treatment in ER. They provide buprenorphine around the clock to people. A single ER visit can provide 24 to 48 hours of withdrawal suppression, as well as suppress cravings. Addicts report that even such brief respite can nurture hope. "It shows that there is a pathway back to feeling normal." Such ER interventions need to

be followed with Addiction Treatment Services. There is a need to highlight that smoking can hinder recovery.

Unfortunately, such Medication-assisted Treatment is underutilized. "The good news is that with abstinence from substances, the brain heals and it can look normal again." Lisa Najavits (National Institute of Drug Abuse, 2014, Drugs, brain and behavior. www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery)

When discussing with patients about MAT convey what happens to the brain with recovery (Abstinence). There are changes in the communication system, as well as changes in the structure and function of the brain. Remind them of the concept of "neurogenesis" and "neuroplasticity". With recovery and abstinence, there is :

a) an increase in neurometabolites;

b) an increase in regional brain volume;

c) an increase in hippocampial volume resulting in improved short-term memory and visual long-term memory;

d) improved cognitive functioning and IQ improvement, contributing to better social relationships

ESSENTIAL SKILLS TO ESTABLISH, MAINTAIN AND MONITOR THERAPEUTIC ALLIANCE

1. The therapist should meet patients where they are at. Query about their implicit theories of what is causing their presenting problems and what is needed to change their behaviors?

"I am curious to learn what you think is causing your problems with X and what you think it will take to change?"

"I want to understand what you think about yourself and about your life?"

"Are there any aspects of your behavior or your life situation that you would like to change?

"How did you choose these?"

2 The therapist should use GUIDED DISCOVERY which involves asking probing questions of patient's that causes them to reflect, question and develop a "curious mindset." The therapist models a style of questioning that helps patients to appreciate the interconnections between external and internal triggers and their feelings, thoughts and beliefs and their addictive behaviors,

3. The therapist needs to engage in rapport-building with a positive, accepting, non-judgmental, genuine, caring, trust-engendering relationship. The therapist needs to use accurate empathy and elicit patient feedback on a session-by-session basis.

4. The therapist needs to maintain an ACTIVE AFTERCARE program, including Booster sessions.

EXAMPLES OF THERAPIST'S SOCIAL DISCOURSE

"My job is help you better understand and define your problems that bring you here and help you find and employ solutions that work for you."

"Can we begin by our getting to know each other? Is that okay? Please take a few moments to tell me about yourself, your family? How would you describe yourself? How would someone who knows you well describe you?"

"I would like to know what you hope /think will happen in our sessions? "

"I notice that you have a tattoo. Can you tell me the story behind your tattoo? "

"Have you ever sought help / treatment like you are now?"

"Was the treatment helpful, in what ways?" "Did you have difficulty following through? "

" How often have you tried to make such changes in the past? "

"Let us put aside for the moment your problems with addiction and think about some other possible treatment goals that you can work on? What would you like to see changed in your life?

"What are your goals for therapy?" "If we are successful in helping you reach your treatment goals, what would you see change?" "What would someone who knows you well notice change in your behavior? "

"On a Scale from 1 to 10, how ready are you willing to work on achieving your treatment goals of X?" "Would you be willing to....?" "How likely are you to...? On the same Scale from 1 to 10, how much confidence do you have that you could X?"

"What is going through your mind right now that is contributing to your feelings of X?"

"How likely are you to succeed in reaching your treatment goals? " What might get in the way or be a barrier to achieving your goals? How can you anticipate ahead of time and address these potential barriers to change?"

"What would be the PROS and CONS of changing? What are the possible consequences of NOT changing your behavior?"

"Do you mind if I ask ...?" "What do you mean when you say X?"

"Am I correct in assuming.... ?" "I would like to better understand your thoughts /beliefs about ... "

"I want to answer any questions you may have."

“Am I missing anything?”

TREATMENT GOAL -SETTING

A critical therapeutic task is establishing SMART treatment goals with patients, namely, Specific, Measurable, Attainable, Relevant/Valued and Timely goals that nurture HOPE in BOTH patients and therapists.

These well defined treatment goals should be COLLABORATIVELY established, as well as the pathways to achieve these goals. The patient's treatment goals should be revisited regularly throughout the course of treatment.

The treatment should goals should go BEYOND a consideration of the patient's addictive behaviors and focus on how to establish and maintain a BALANCED LIFE. The treatment goals should focus on how to achieve POSITIVE goals and NOT on the elimination of negative behaviors.

Any failures should be viewed as "learning opportunities."

ILLUSTRATIVE PATIENT TREATMENT GOALS "I want to...."

Cope with urges and cravings

Learn to identify triggers for my substance use

Understand what beliefs I hold that fire up my need to use

Manage my thoughts and feelings

EDIT my thoughts and NOT have to say every thought I have

Live a BALANCED LIFE

POSSTBLE THERAPIST'S RESPONSES TO THE PATIENT'S CONSIDERATION OF VARIOUS TREATMENT GOALS

"Are you saying that you are willing to do X?"

"What are the potential benefits (payoffs) for making these changes?"

"What will you do if your X was not available? "

"What else can you do to get the same result instead of using/doing X?"

"What are your thoughts and feelings about working on these behavior changes? "

"Are you saying that you can become your own therapist? "

PSYCHO-EDUCATION

Psychoeducation is NOT a mini-lecture, but occurs on an ongoing basis over the course of therapy and may take a variety of formats including the Art of questioning, Patient self-monitoring exercises, filing out Patient Checklists. performing personal exercises, correcting any misconceptions JUMP-STARTER QUOTATIONS in group therapy sessions, listening to U TUBE LINKS of Recovery Voices.

The content of the psychoeducation is designed to provide the basis for the interventions and help patients better understand what processes drive their addictive behaviors.

This psycho-education includes information about:

a) the nature and mutual responsibilities about therapy for both the patient and therapist. Issues about confidentiality, safety issues, ongoing assessment procedures

b) ways to have patients self-assess substance abuse behavior (provide Website addresses) (SEE the Website roadmaptoresilience.wordpress.com ITEM 5 on Pages 34 to 37)

c) a consideration of the interconnections between the patient's feelings, thoughts/beliefs, behaviors and reactions of others (SEE the use of a CLOCK Metaphor and the BEHAVIOR CHAIN ANALYSIS in the Handout). Educate about drinking and substance abuse behavior. For example, what constitutes binge and controlled drinking? Encourage the patient to visit Website that provide a Self-assessment of one's dinking behavior.

d) the distinction between FAST TYPE I System of thinking processes AND DELIBERATE SLOW TYPE II System thinking processes. (SEE the discussion of Substance Abuse thought processes DEFENCE and Self-control thinking processes.)

TYPE I THINKING PROCEESSES are fast. automatic, spontaneous, impulsive, habitual, effortless, knee-jerk reactions, often emotionally-driven "EMOTIONS OF THE LOWER BRAIN STEM (Amygdala, Hippocampus) CAN HIJACK THE FRONTAL LOBE EXECUTIVE TYPE II PROCESSES "

TYPE II THINKING PROCESSES are slow, deliberate, intentional, effortful, methodical, planful, conscious. mindful of potential consequences

e) Psycho-education also includes a consideration of the evidence of the patients' strengths, evidence of resilience and "islands of competence" that they bring to therapy that can be accessed. Namely, a consideration of their "in spite of behaviors", "the rest of their story" (SEE the use of the THREE TIME LINES).

SKILLS GROUP TRAINING PROGRAMS

See roadmaptoresilience.wordpress.com
(Physical, Interpersonal, Emotional, Cognitive, Behavioral, Spiritual domains)

Emotion regulation and distress tolerance skills
Urge surfing skills
Use of acceptance skills, Mindfulness and Relaxation training
Ways to bolster positive emotions (Gratitude, forgiveness, compassion, humor and meaning-making activities)

Problem solving and values clarification (Goal setting)
Rethinking skills
Assertive communication skills
Activity planning including exercise (yoga, meditation, and the like)

Relapse prevention skills
Avoiding enablers and engaging social supports of behavioral change ("Give to get")
Use of one's faith and religious beliefs and activities

Wellness and Wrap around skills (Activities of Daily Living, Fulfilling various roles and Quality of life indicators)

REPORT CARD ON HOW WELL YOUR TRAINING PROGRAM FOSTERS GENERALIZATION AND MAINTAINANCE OF THESE SKILLS ACTVITIES

(How many of these 20 activities do you include when you do training with clients, no matter what skills you are training? Do NOT "Train and Hope" for transfer)

In order to foster transfer at the OUTSET OF TRAINING my intervention program:

1. Uses collaborative goal-setting and discusses with clients their treatment goals and how learning and deliberately practicing these skills will help them achieve their treatment objectives.

2. Elicits from clients self-generated reasons and value statements about why it is important to work on their treatment goals. ("How will the quality of their lives be different?") Convey an EXPECTANT ATTITUDE that the clients have the ability within themselves to use these skills. Highlight times in the past where they have evidenced such abilities and survival skills.

3. Use open-ended Socratic discovery-oriented questioning. See if you can have the clients come up with what skills might be helpful. (You are at your therapeutic best, when YOUR clients are one step ahead of you, offering the suggestions that you would otherwise be offering. Be inductive, rather than deductive. DO NOT BE A SURROGATE FRONTAL LOBE FOR YOUR CLIENTS).

4. Solicits the clients' public commitment, and if indicated, use behavioral contracts.

5. Anticipates and addresses any possible barriers that might undermine the implementation of the skills.

6. Chooses the skills to be trained carefully, and ensures that the training setting is as similar as possible to the real life application settings.

In order to foster transfer DURING THE TRAINING my intervention:

7. Keeps the training regimen as simple as possible--Use Acronyms and reminders

8. Uses performance-based individualized training so the length and frequency of the training session are determined by some performance criteria. Not everyone will receive the same designated number of sessions. Teach to the point of mastery.

9. Accesses the clients' prior knowledge and competence in performing the skills that are to be taught.

10. Train at the META-COGNITIVE level using active transitive verbs and the like. Such Executive Frontal lobe verbs will help clients learn to "notice, catch, interrupt, plan, use back-up plans and the like. "Teach clients how to use the SNAP (STOP NOW AND PLAN) behavioral scripts and routines on themselves and with others.

11. When they are with others who are in "high risk" provocative situations clients can learn to use BYSTANDER INTERVENTION procedures to help defuse the situation.

12. Uses a variety of cognitive behavioral instructional strategies like advanced organizers and informed instruction in order for the clients to know what skills are going to be the focus of the training ahead of time.

Other Cognitive behavioral interventions to be included in training are self-instructional training, cognitive modeling, client think aloud, coping models as evident in Recovery Voices Websites, YOU Tube videos, and scaffolding procedures. Nurture a RESILIENT MINDSET and encourage clients to become "courageous explorers and curious emotional detectives."

13. Involve significant others as part of training, whenever possible, such as a family or group members.

14. Include relapse prevention procedures in planning to address possible "high risk" situations and potential barriers to DELIBERATE PRATICE. Discuss how your clients can obtain FEEDBACK and COACHING from other group or family members, or from a Sponsor, as in AA groups.

15. If possible, conduct training across settings, using multiple trainers, and environmental supports. When the skills work, ensure that the clients "take credit" for the change (Self-attributional training). The clients need to see the connections between their efforts and the resultant outcomes.

16. Provide between session coaching via Internet or by some other means.

In order to foster transfer at the CONCLUSION of training.

17. Challenge clients to take ownership of the skills that they have Deliberately Practiced by putting them in a reflective CONSULTATIVE MODE. Have them fill out Client Checklists indicating what they took away from the training and what and how they intend to use these skills. Most importantly, have them offer the REASONS why they will use these skills .and how they can anticipate and plan for any potential obstacles or barriers to their skills implementation. Have them look upon any failures or setbacks as "learning opportunities."

18. Have the clients share what they have learned with significant others and even engage in teaching these skills to others. For example, visit the Website SMART RECOVERY TOOL KIT and see the SARS (Smart Recovery Activities Scales) that Meichenbaum and Myers created to increase the likelihood that Substance abuse participants would use the skills that are being taught.

19. Provide Active Aftercare and booster sessions where possible. Maintain some form of contact with the clients, leaving the door open and convey your sense of caring. REMEMBER THAT THE QUALITY OF THE THERAPEUTIC ALLIANCE IS WHAT MAKES THE SKILLS TRAINING PROGRAMS WORK. Include Feedback Informed Feedback (FIT Scales) on a session-by-session basis throughout the training.

20. Conduct a Graduation Ceremony and have the clients take away something from the training that indicates their participation and accomplishments.

THE USE OF GROUP THERAPY

TAKE AWAYS

1. Group therapy has been found to be as effective as individual therapy for a variety of psychiatric disorders including Alcohol Use Disorders (See list of references).

2. The level of group cohesion is the best predictor of treatment outcomes when conducting group therapy (Burlingame & McLendin, 2018).

3. There is a need to conduct session by session patient feedback in order to monitor the quality of the group members' therapeutic alliance with both the group leaders and fellow group members (See discussion below on Patient Feedback Informed Treatment).

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4 There is value in conducting gender -specific group treatment (See discussion in the Handout).

5. There is value in providing group participants with preliminary introduction sessions prior to their entry to the group sessions. Highlight group rules, need for confidentiality and assess for the patient's expectations and use this as an opportunity to conduct screening.

6. The use of psychoeducational procedures such as the use of the CLOCK Metaphor is a means of nurturing a sense of shared group experiences and group coherence. (See below for a discussion)

TYPES OF GROUP THERAPIES

1. Process-oriented groups (See Yalom & Leszcz, 2005)

2. Skills-oriented training group (See Velasquez, et al, 2016)

3. Supportive Psychoeducational groups (See CRAFTS Website)

4. Self-help groups (See the Appendix for Checklist for 12 Step AA groups)

5. Telehealth groups

6. Therapeutic activity groups (Exercise, Wilderness, Yoga, Mindfulness, Scrapbooking, Music, Dance)

LOGISTICAL FEATURES OF CONDUCTING GROUP THERAPIES: DECISIONS TO BE MADE

1. Closed versus open-ended groups (Can patients join once the group has started?)

2. Heterogeneity composition of the group by Gender, Addiction disorders, Integrated disorders such as PTSD and Substance Abuse disorders. (Consider Exclusion criteria such as suicidality and the threat of aggressive violent behaviors).

3. Size of the group and the number of sessions (Suggestion of 5 to 9 attendees and 12 to 19 sessions).

4. Group leaders (More than one leader and gender of the group leaders?)

5. Use of JUMP START Conversation Quotes. (See below for a list of potential Quotes)

SOLICIT PATIENT FEEDBACK ON A SESSION By SESSION BASIS (See Miller et al and Burlingame on ways to assess the level group cohesion). Consider the following questions:

1. "I felt I could trust the other members during today's session."

2. "I feel supported and valued by the group members."

3. "The group leader is warm and friendly toward me."

4. "The other group members and I agree about the things I will need to work on in the group therapy."

5. "The members of the group are distant and withdrawn from each other." (SCORED NEGATIVE)

6. "There is friction and anger between group members." (SCORED NEGATIVE).

7. "Did you experience any problems or tension, any misunderstanding, conflict in your relationships with your fellow group members or with your therapist?"

8. "To what extent did you feel holding back or avoiding something? "

9. "Were these issues addressed in this session? "

SEE THE FOLLOWING INDIVIDUAL THERAPY AND GROUP RATING SCALES USED ON A SESSION BY SESSION BASIS

FEEDBACK-INFORMED TREATMENT (FIT) SCALES

"Completing this scale is a bit like taking your temperature. In a minute or less, we can get an idea about how you think things are with you and your life. Just as your temperature tells us something about how much distress your body is in, so do the scores on this scale. And like your temperature, this scale will let us know how things have been with you during the past week up through today, - not tomorrow or in a month. Right now we are trying to understand how we can help you which is more difficult if we don't have a good idea of how you are doing to begin with. Can you help us out? (Bertolino, 2017, p. 197).

OUTCOME RATING SCALE

This Scale should be administered at the beginning of each session.

Looking back over the last week including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels

INDIVIDUALLY
(Personal well-being)

INTERPERSONALLY
(Family, close relationships)

SOCIALLY
(Work, School, Friendships)

OVERALL
(General sense of well-being)

SESSION RATING SCALE

Please rate today's session by placing a hash mark on the line nearest to the description that fits your experience.

RELATIONSHIP:

I did not feel heard, understood and respected ---------- I feel heard, understood and respected

GOALS AND TOPICS:

We did not work on or talked about what I wanted to work on and talk about ---------- We worked on and talked about what I wanted to work on and talk about

APPROACH or METHOD:

The therapist's approach is not a good fit for me ---------- The therapist's approach is a is a good fit for me

OVERALL:

There was something missing in this session today ---------- Overall, today's session was right for me

For additional ways to solicit client feedback visit the following websites

www.centerforclinicalexcellence.com (Feedback informed Treatment Scott Miller)

www.OQ45measures.com

https://www.prof/horvath.com/Downloads Working Alliance Inventory

Or you can ask the client such questions as, ***"Is there anything, I the therapist, did or did not do, or said or did not say, that you found particularly helpful or unhelpful?"***

Group Session Rating Scale (GSRS)

Name _____ Age (Yrs):____
ID# _____ Gender_____
Session # ____ Date: _____

Please rate today's group by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel understood, respected, and/or accepted by the leader and/or the group. I----------I I felt understood, respected, and accepted by the leade and the group.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I----------I We worked on and talked about what I wanted to work on anc talk about.

Approach or Method

The leader and/or the group's approach is a not a good fit for me. I----------I The leader and group's approach is a good fit for me.

Overall

There was something missing in group today—I did not feel like a part of the group. I----------I Overall, today's group was right for me—I fel like a part of the group

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https://scott-d-miller-ph-d.myshopify.com/collections/performance-metrics/products/performance-metrics-licenses-for-the-ors-and-srs

FEEDBACK INFORMED QUESTIONS

What are your thoughts about the ideas/skills that we have been working on today?

How might these ideas/skills be helpful for you?

What will you take away from today's session that you can use right away?

In what situations/circumstances will you be able to use (deliberately practice) these skills?

How will you be able to tell if using these skills are being helpful?

What will others notice change in your behavior if you use these skills?

What might get in the way of you using these ideas and skills? How can you anticipate and address these potential obstacles/ barriers?

To what extent was our discussion today what you wanted to work on?

Is there anything I said or did, OR anything that I failed to say or do that you found particularly helpful or unhelpful?

Overall, how do you feel about today's session in moving you closer to your treatment goals of X? (BE SPECIFIC)

What will you take away from today's session that you can use right away?

USE CLOCK METAPHOR

12 o'clock - - external and internal triggers
3 o'clock - - primary and secondary emotions
6 o'clock - - automatic thoughts, thinking processes such as ruminating, schemas and beliefs
9 o'clock - - behaviors and resultant consequences

1. 12 O'CLOCK Both the external and internal triggers may vary greatly from patient to patient and change over time. Various triggers activate the patient's thoughts and feelings that contribute to addictive behaviors.

EXAMPLES OF TRIGGERS

a) interpersonal conflict
b) others using or encouraging use
c) negative emotional states such as anxiety, fear, depression, grief, anger, loneliness
d) positive events such as celebrations, achievements, and the like

Patients can learn that some of these triggers are avoidable, while other triggers are not avoidable.

2. The therapist presents the triggers to patients for their acknowledgement and embellishment. Follows this with questions about the patient's feelings that he/she experienced before, during or after the specific triggering event? It is useful to help patients view their feelings as a set of COMMODITIES that one does something with. For example, the patient indicate that he/she "stuffs their feelings", " drink their feelings away.", "act out."

3. If that is what he/she does with such emotions, ask, "what is the impact, toll, price he/she and others pay, as a result? If the client answers, "I do not know", then the therapist should say "I do not know either, how can we go about finding out? Moreover, how will finding out help you achieve your treatment goals of X (be specific)?"

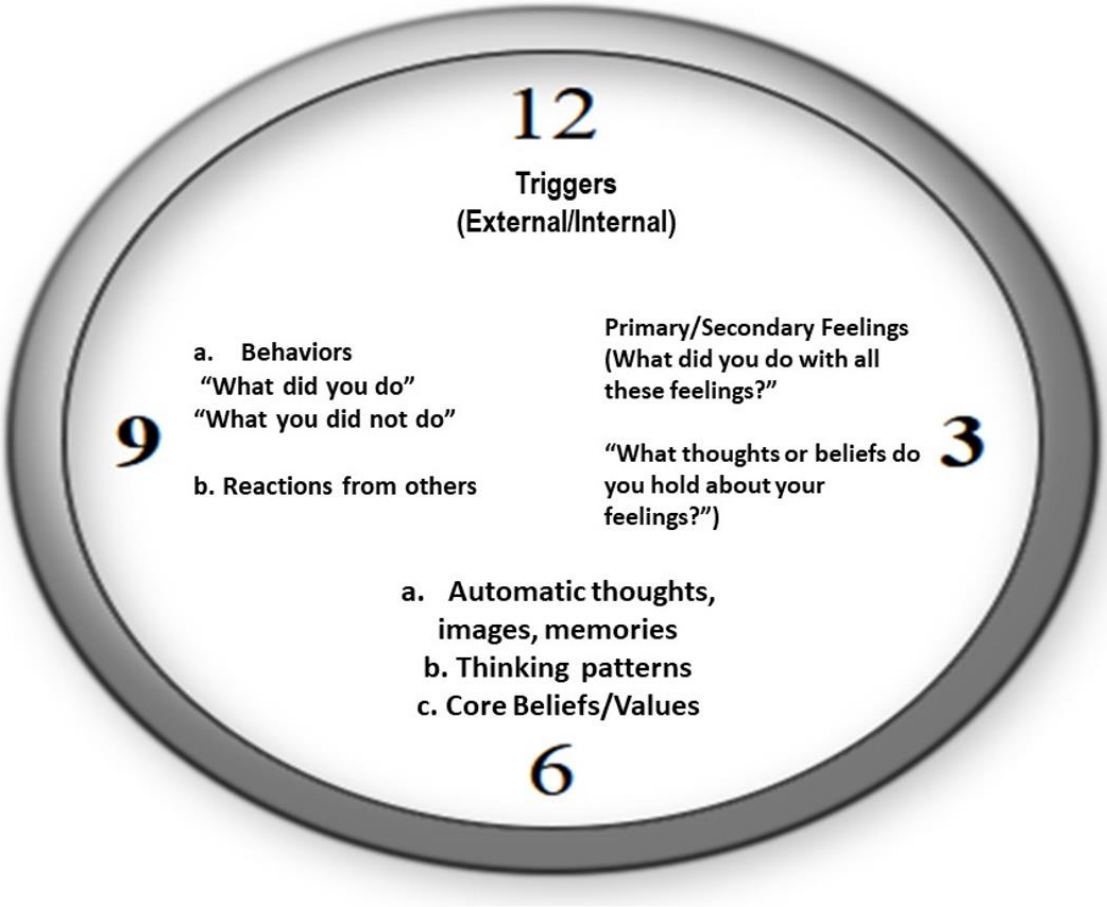
4. In order to help patients better appreciate the interconnections between their feelings, thoughts and behaviors, the therapist can place his/her hand at the 9 O' Clock position and move it slowly toward the 3 O' Clock position and say, without finishing the sentence,

" It looks like a VICIOUS .....

Permit the patient to finish the sentence by saying ...." CYCLE or CIRLCE."

In collaboration with the patient, the therapist can explore how such a "VICIOUS CYCLE" develops and the impact that it has?

5. Explore alternative more adaptive ways "to break the cycle".


12
Triggers
(External/Internal)
9
a. Behaviors
"What did you do"
"What you did not do"
b. Reactions from others
Primary/Secondary Feelings
(What did you do with all these feelings?"
"What thoughts or beliefs do you hold about your feelings?")
3
a. Automatic thoughts, images, memories
b. Thinking patterns
c. Core Beliefs/Values
6

GROUP APPLICATION OF A "CLOCK" METAPHOR AS A PSYCHOEDUCATIONAL TOOL

The objective is to have the group of participants appreciate how their feelings, thoughts, behaviors and reactions of others are interconnected. Moreover, from the group members consider what and how they share these common processes and the implications for change. Group cohesion is the best predictor of treatment outcomes. The therapist should use a Socratic discovery-oriented approach when asking these questions.

The CLOCK metaphor has the following features:

12 O'clock refers to both External and Internal Triggers

3 O'clock refers to Primary and Secondary Feelings

6 O'clock refers to the Thinking Processes (Automatic thoughts and images, Habitual Thinking patterns, Beliefs and developmental schemas)

9 O'clock refers to specific behaviors and reactions of others

Using this framework, the therapist can ask each of the various group members about their 12 O'clock trigger ("What were the triggers that set them off?" "What got each of them going?" "What increased their levels of stress?")

The therapist can have the group members explore what, if anything, these various triggers have in COMMON across the various group members?

The therapist can then ask the group members to discuss how did they FEEL in this situation or when this happened? Most important, the therapist can ask each member, "What, if anything, did they do with their feelings?")

In short, the therapist is helping the group member's view their feelings as a COMMODITY that they do something with. The therapist can then ask the group the following questions:

("If they do this with their feelings, then What is the IMPACT, What is the TOLL, What is the PRICE that they and others PAY? Is this what they want to have happen?")

If the members say, "I do NOT know", then the therapist can say, "I do NOT know either and how can WE go about finding out and how will finding out be helpful in your achieving your treatment/training goals?")

The therapist can now move onto the 6 O'clock mode and have the group members consider what thoughts preceded, accompanied and followed the particular stressful incident and what is common and shared by the group members?)

Finally, the therapist can have the group members to share what they DID in this situation and how did OTHERS respond and, in turn, how did they respond? Once again, the therapist can have group members discuss what is similar and different on how they each behaved and how others reacted?

At this point, the therapists can say, " It sounds to me that this is just a VICIOUS .....without finishing the sentence, and let the group members complete the sentence with the words VICIOUS .... CYCLE or CIRCLE.

Once again, if they are caught up in this "VICICOUS CYCLE ", as they each describe it, then What is the IMPACT, What is the TOLL, What is the PRICE they and others PAY?

The therapist can help the group members gain insight (increased awareness) of how they inadvertently, unwittingly and, perhaps unknowingly, behave in ways that exacerbate their stress levels?

This will provide the basis to help the group members explore ways to BREAK THEIR VICIOUS CYLCES.

Moreover, the therapist can ask, "How are they presently each going about breaking this CYCLE and if they are doing so in this manner, then what is the IMPACT, what is the TOLL, what is the PRICE they and others are paying?

The goal of this line of questioning is to have group members learn better, more adaptive and effective ways to BREAK THEIR CYCLES and how can group members help each other be of assistance (Use of BYSTANDER INTERVENTION)?

The therapist now helps group members learn how to use a variety of EXECUTIVE FRONTAL LOBE META-COGNITIVE VERBS (identify triggers, anticipate high risk situations ahead of time, notice, catch, interrupt, use their plans and their back up plans, learn from any failures or setbacks, take credit for behavioral changes they were able to perform).

Group members may require deliberate practice of intra- and interpersonal skills training (See the description of Stress inoculation on the Melissa Institute Website, especially look at the Generalization Guidelines on ways to increase the likelihood that group members will indeed use any of these skills.)

Finally, have group members can share what they did with the group and the therapist " WHAT THEY DID THEY EACH DO THAT WORKED?" Have them tell their story using the CLOCK metaphor and how they were able to create a VIRTUOUS CYCLE or CIRCLE.

What does this say about them as a person and their ability to cope with stressors in their lives?

APPLICATION OF THE CONCEPT OF GROUP THERAPY WHILE CONDUCTING INDIVIDUAL THERAPY

The therapist can invoke the presence of significant others from the patient's life by asking,
" What did you find attractive in PERSON X that brought you both together?
" What do you think PERSON X saw in you that was attractive, what evidence of resilience did he/she see in you? Are those attributes still present?"

In short, the therapist can call upon the absent other as a source of culling strengths (BOX 6 material) of the patient.

STARTER QUOTATIONS FOR GROUP DISCUSSION

These quotations fall into three categories:

1. Behavior change processes
2. Ways to redirect one's story-telling narrative
3. Ways to engage in meaning-making activities

You can present the group with a couple of quotes and ask them to choose which one they want to discuss? Ask how they chose this particular quote and how will the discussion help each of them work on their treatment goals? The group members should be invited to bring to future sessions their own quotes for the group to discuss.

FOCUS ON BEHAVIOR CHANGE --- HAVE PARTICIPANTS GIVE EXAMPLES

"There is no situation so bad, that by your efforts, you can make the situation much worse."

" Saying NO to someone else is like saying YES to yourself."

" I can change my relationships with my feelings, thoughts and urges."

" As long as you keep secrets and suppress feelings you are vulnerable."

" No emotion is built to last forever."

" Learn to fail successfully."

"If you have skeletons in your closet, you had best teach them to dance."

"You have to give to get."

"Feelings listened to and understood rewires your brain."

"Tell me who you hang around with and I can tell who you are."

WAYS TO REDIRECT ONE'S STORY-TELLING OR NARRATIVE

" We are all natural story tellers. The stories we tell others and that we tell ourselves influence the lives we live."

"Our life is what our thoughts make of it."

"People are disturbed NOT by things, but the views they take of them."

"Alcoholism is 10% drinking and 90% thinking."

"Change talk is the best predictor of recovery."

"I now tell forward-looking stories about myself."

"To write and share my story is a sign that I am on the way of achieving my treatment goals."

"I write to define myself--an act of self -correction--a part of the process of becoming."

WAYS TO ENGAGE IN MEANING -MAKING ACTIVITIES

"One's history is NOT one's destiny."

"I learned to let the past be the past."

"It is what happened to you, NOT what is wrong with you, that is the critical question, and moreover, what you can do NOW to change?"

"I learned that recovery is made possible by shifting focus from the past to what gives life meaning and purpose NOW."

"People who have a WHY to live for, can endure almost any HOW."

"The forces of fate that bear down on people and threaten to break them, also has the capacity to enable them."

"The world breaks everyone and afterward many become stronger at the broken places."

"History, despite its wrenching pain cannot be unlived, but with courage it does not have to be lived again."

"The pessimistic sailor complains about the wind, the optimistic sailor expects the wind to change, the realistic optimistic sailor adjusts the sail."

"How would your life if you were.....? "

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APPENDIX A
TYPES OF WORKSHEETS USED WITH SUBSTANCE ABUSE PATIENTS

(*See Melissa Institute, 2020; SAMHSA TIPS- - ww.keys.samhsa.gov and T. Gorski www.cenaps.com and www.wpic.pitt.edu/accp/finds/locus.html)*

RELAPSE WARNING SIGNS WORKSHEET
- **High-Risk Situations Worksheet**
- **Lapse and Relapse Worksheet**
- **Relapse Chain Worksheet: Use "Clock" Analysis**

RECOVERY NETWORK WORKSHEET
- **Ways To Increase My Interactions With People Who Will Support My Abstinence**

POSSIBLE TRIGGERS: DRINKING AND SUBSTANCE ABUSE WORKSHEET

MY GOAL SHEET

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

POST TREATMENT RECOVERY SCALE

AA BEHAVIORS AND BELIEFS

CONSUMER GUIDLEINES FOR CHOOSING A RESIDENTIAL TREATMENT CENTER (RTC)

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)*

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, Emotional
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

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?

a) **Include reminders ("If…then" statements; "Whenever" statements)**
b) **Conduct a cost-benefit analysis (pros-cons, short-term, long-term benefits)**
c) **Share my plans with supporting others**
d) **Make commitment statements**
e) **Take credit for my efforts**
f) **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: _____.

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

___ 11. 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"

___ 12. 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.

___ 13. 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.

___ 14. 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.

___ 15. I write about my feelings, thoughts and stressors, tying them to action plans for recovery.

___ 16. 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.

___ 17. 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

___ 18. 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.

___ 19. I use strategies to manage the physical triggers that affect my substance use, such as hunger, thirst, sleepiness, fatigue, stress, and pain.

___ 20. I follow a schedule which helps make life feel both more manageable and pleasurable.

___ 21. I get enough sleep, exercise, and good nutrition.

___ 22. 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.)

___ 23. I take medications that have been prescribed by my doctor and engage in alternative therapies that are helpful.

___ 24. 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

___ 25. I can label (name and tame) my intense feelings. I recognize the differences between my emotions and my thoughts and behaviors.

___ 26. 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."*

___ 27. 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.

___ 28. I share my feelings with supportive others who do not judge, nor criticize me.

___ 29. 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

___ 30. 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.

___ 31. I pause to think before I act on my thoughts and feelings, thus leading to better outcomes. I take a "time out" when needed.

___ 32. I can change my beliefs that contribute to my substance use, particularly the "should", "musts", "wants", and preoccupation with "perfection".

___ 33. I use my CHANGE TALK to "notice", "catch", "interrupt", "anticipate", "plan for", "set positive social goals", and "tell/show others what I have learned".

___ 34. 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."*

___ 35. 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.

___ 36. 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.

___ 37. I use my problem-solving skills and practice planning as a way to attain my short, mid, and long-term goals.

___ 38. 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

___ 39. 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.

___ 40. I increase my sober support network of family, friends, co-workers, and others.

___ 41. 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.

___ 42. I seek information and help by connecting to others via the internet (chat rooms, blogs, recovery websites, etc.), books about recovery, and inspiring movies.

___ 43. I see my therapist, addiction counsellor, minister, or other helpful professionals.

___ 44. I have a "sober mentor" or Twelve-step sponsor.

___ 45. I am learning compassion and forgiveness of self and others. I am letting old resentments go.

___ 46. I keep a Gratitude List and actively thank people in my life.

___ 47. I remember that *"Being humble is not thinking less of yourself, but thinking of yourself less."*

___ 48. I make a GIFT of what I have learned to others and share my "story" of recovery.

___ 49. I spend time in altruistic activities, knowing that generosity is for both the receiver and the giver.

I Cultivate Hope and a Future Outlook

___ 50. I socialize with people who give me hope and encouragement.

___ 51. 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.

___ 52. 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.

___ 53. I take full responsibility for my recovery by taking charge of my life. I remind myself to "take one day at a time".

___ 54. 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.

___ 55. I use Future Imagery Procedures, mentally rehearsing how I can achieve my treatment goals.

___ 56. I use my spirituality or religion to guide me.

___ 57. I recognize that I am on a *journey*, but that I am not alone in creating a *life that is worth living*.

___ 58. 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.

___ 59. 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.

___ 60. 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.

_____

_____

_____

AA BEHAVIORS AND BELIEFS

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

_____ 1. Attend AA meetings (Beginner's meeting, Big Book meetings, 12 Step meetings). How often per week? _____

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

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

_____ 4. In AA there are many helpful tools such as meetings, 12 Steps, 12 Traditions, Slogans, the Big Book, learning from "Old Timers", being part of the 12 Step Fellowship, Having a sponsor, Being a sponsor. The parts of the AA program that helps me the most are: _____
_____

_____5. I work my program. I work toward progress, not toward perfection.

_____ 6. Be open, honest and helpful to others. As the saying goes, "***To keep it, you have to give it away***". This is all about helping others by speaking and sharing at meetings, lend a listening ear. "***Our spirit slowly starts coming back to life by dealing with honesty and tearing down barriers".*** **(H.O.W. Honest, Open and Willing)**

_____ 7. Tell my story of "What it was like to be dependent on alcohol, what happened and what it feels like now". The story I most want to talk about is about my recovery, namely, my pursuit of happiness, enjoyment, contentment and "how comfortable I am in my own skin". I have a story to share of how I got to this point.

_____8. I am not into producing a drunk-a-log, rather we talk about solutions. The more we focus on the problem, the bigger the problem becomes. The more we focus on the solution, the solutions get bigger. I call upon my "**Magic Magnifying Mind**" when it comes to solutions.

_____ 9. Surrender to a Higher Power (namely, a Spiritual Force, God, the power of my Group and the support of my sponsor.) I use prayer and meditation to improve my conscious contact with God. Thus, I can regain control and have a spiritual awakening. I recognize that the Higher Power I choose may be different than the Power others choose.

_____ 10. Get a sponsor, a home group, get involved and begin working the Steps with the guidance of my Sponsor. My sponsor helped explain the 12 Traditions, Slogans and was there when I needed him/her.

_____ 11. Remember that one of the best tools to cope is the telephone. Call or text my sponsor or friend in the program to help me deal with my cravings and difficult times.

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

_____ 13. Increase my awareness and watch out for triggers. (Social pressure, interpersonal conflict, strong emotions such as anger, resentment, depression, loneliness, boredom).

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

_____ 15. Look at my beliefs (e.g., a sense of entitlement, viewing people as doing things to me "on purpose") and see how these beliefs can contribute to my addictive behavior. Remember DEFENCE thinking processes.

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

_____ 17. Learned to listen and then listen to learn.

_____ 18. Put my experiences into words and share my thoughts and feelings with my sponsor and with trusting others. As a result, I am building self-confidence and developing social bonding skills.

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

_____ 20. Use my coping behaviors to manage threats to my self-esteem (pride, "ego"). Remember it will take time to learn to use my coping skills. Have faith "***Faith can help move mountains, but you better bring along a shovel. You have to do the work".***

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

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

_____ 23. Before I take a drink (use substances), I can look at where my drinking has led me in the past and where it will lead me in the future. Never forget how far you have come.

_____ 24. Think through the drink. Consider the consequences of my drinking. I follow the AA slogan Think…Think…Think.

_____ 25. Hang around with sober non-drinking buddies and family members. Firmly connect with a sober support network, especially at the beginning of the recovery journey. Stay around positive people, places and things to improve my safety. Right Fellowship.

_____ 26. Do a Moral Inventory on a regular basis. I check to see if I am treating people with kindness and respect and make sure that any defects that I have do not rear their head.

_____ 27. Make amends. Make a list of all the people that I have had a negative impact as a result of my drinking or drug use and begin making amends. I remember that a person does not have to accept my apology, but I have to give one in order to clear up some of the "wreckage of the past".

_____ 28. Make a Gratitude List and follow through in showing my appreciation. I remember that the word "gratitude" is an Action Verb, where I have to show (demonstrate) positive behaviors and positive attitudes. I am developing the ability to practice acceptance of myself and others.

_____ 29. Recognize signs of change and rehabilitation and "take credit" for this change. Use my "change talk" of "notice, catch, interrupt, game plan, backup plan, safety plan". Recognize the benefits of the changes I have made. Continue my healing journey.

_____ 30. I recognize that the only requirement for AA membership is a desire to stop drinking. Embrace a life of responsibility, forgiveness and patience.

_____ 31. My detailed safety plan includes: Being aware of what are my triggers; Knowing the "warning signs"; Having the telephone number of my sponsor on hand who I can call; Avoiding high-risk people, places and activities; Be watchful of "enablers" - - individuals who inadvertently may contribute to a relapse; Sharing my Safety Plan with others; Making commitment statements, not only to others, but also to myself.

_____ 32. Keep coming back. Be there for the new folks coming through the door. By helping others, we are helped ourselves.

_____ 33. Share my journey of recovery with others. Make a "gift" of my experiences with others. I can sponsor others.

_____ 34. I will commit to becoming more involved in AA 12 Step program to see where it leads me and join with others. I will share my successes, struggle and growth with my AA group members, my Sponsor and my friends and family who support my recovery journey.

AA BELIEFS

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

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

I <u>NOW</u> BELIEVE THAT

<u>Thinking</u> <u>Behaviors</u>

_____ 35. Addiction is 90% thinking and 10 % drinking. ***"Twisted thinking is something I have to avoid". "You can get mentally drunk, before you become physically drunk"***. (Some say, 99% thinking and 1% drinking).

_____ 36. I can look at and begin to change my beliefs that contribute to my drinking (for example, my sense of entitlement and the "shoulds", "musts", and "wants" in my life).

_____ 37. I believe that we can learn to put alcoholism "to sleep", but we can wake it up if I stop my AA participation.

_____ 38. I can be "right-sized" - - not have to be too perfect, nor "better than". Comfortable with myself. Make positive changes to make life more comfortable for myself and for my loved ones.

_____ 39. Sobriety is not just "stopping drinking"; sobriety is peace of mind, contentment and happiness which comes from dealing with the wreckage of the past.

_____ 40. I can recognize that urges are common during recovery and that lapses are part of a chronic condition of addiction.

_____ 41. I can tie my drinking to the trouble in my life and see the beliefs that support my addictive behaviors.

_____ 42. To be humble is <u>not</u> to think less often of yourself, but to think of yourself less, and as a result have more of yourself to give to others.

_____ 43. I can recall my sponsor telling me, "If you want what we have, do what we do". This stays with me.

I NOW BELIEVE THAT

Coping Behaviors

_____ 44. As the saying goes, "If you do the same thing over and over it will lead to the same results. If you want something different, then you have to begin to do something different".

_____ 45. Alcoholic Anonymous may not open the gates of heaven, but it can surely open the gates of Hell and let you out.

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

_____ 47. I believe that alcoholism is a "disease", AA was the doctor and my working the program was my medicine.

_____ 48. I can remind myself to "take one day at a time". "Easy does it!", "One moment at a time", "Yesterday is gone; tomorrow is not here yet; yet, all we have is today". Yesterday is history, tomorrow is a mystery, and today is a gift and that is why we call it the "Present".

_____ 49. I can remember that "This too shall pass". Recovery requires patience.

_____ 50. I can tell myself that having short-comings is a sign of being human. I can understand my vulnerabilities. I can forgive myself.

_____ 51. I can take responsibility for what I do. I ask myself what are my values, what are my treatment goals? I clutch my AA coin or AA pin, and this is a physical reminder to keep on keeping on.

_____ 52. I can consider my options. The program works if I work it, so if I work it, I am worth it. Sobriety gives me options.

I NOW BELIEVE THAT

Nurturing Hope

_____ 53. I can have HOPE. I can use the phrases "So far" and "As yet". I can also incorporate my change talk phrases like "Instead" and I can give multiple examples of how I can use RE verbs.

_____ 54. Change is possible: I do not have to continue as before. I can practice my AA principles and change will occur.

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

_____ 56. Accept life on life's terms by self-examining and confessing short-comings and embracing humility.

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

_____ 58. I can identify signs of <u>resilience</u>. I can give several examples of each of the following

I have _____

I can _____

I am _____

_____ 59. Other beliefs I learned include _____
_____

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:

a) the quality of the therapeutic alliance that is established and maintained between clients and treatment staff;

b) the degree of client engagement and active participation in treatment;

c) the client's perception of improvement in training;

d) 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;

e) 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?

a) Is your staff trained and certified in using Motivational Interviewing procedures?

b) 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).

(5) 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.

(6) 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?

(7) How do you intend to obtain long-term data from clients and from significant others? I would appreciate any reports on your treatment efficacy.

(8) 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?

(9) 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.

"TO DO" LIST

1. Describe the characteristics of "expertise" and the role of deliberate practice. How to spot HYPE in the field of psychotherapy? What are the implications for improving expertise in psychotherapists?

2. Describe in lay terms what "expert" psychotherapists do to achieve positive treatment outcomes. Enumerate the "core tasks" of psychotherapy highlighting the relative contributions of the therapeutic alliance versus specific treatment (acronymn-based) interventions.

3. Use the **Case Conceptualization Model** (CCM) of the Boxes

    a) Attend a Case Conference and use the CCM as a template to follow the group discussion. ***(Do the participants make reference to Box 6 "In spite of", or evidence of strengths, or signs of patient resilience?)***

    b) Keep Progress Notes of your sessions, noting each of your therapist activities in terms of the Box Numbers (e.g., 2A, 5B, 6B, 9C, etc.)

    c) Provide the patient (and significant others, where indicated) with feedback using the CCM. Relate each proposed treatment option to specific information derived from the CCM. Be sure to ask the patient about his/her implicit theories ("notions") about what caused, or what contributes to his/her difficulties and challenges, and moreover, what would it take to change or improve?

    d) Fill out a Report format using the CCM.

    e) Have the patient fill out, or provide a self-report, using the CCM format.

4. Use the "art of questioning", focusing on "What" and "How" questions.

    a) Use Socratic discovery-oriented questions. (Columbo" like befuddlement, bemusement). Pluck and reflect key patient phrases, metaphors, and the like. Use such reflective statements as:

        "Are you saying to me and to yourself X?"
        "Correct me if I am wrong?"
        "See if I have picked up on what you said?"
        "Let me know if I am close to understanding how you felt when X occurred?"

    b) Ask "***In spite of***" questions, followed by "***How***" and "***What***" questions

c) Provide Intermittent Summaries by saying, "***On the one hand***" (summarize information gleaned from Boxes 1 to 5), but "***On the other hand***" (summarize information gleaned from Box 6, consisting of "In spite of" strengths).

d) Explore how the patient made certain decisions by asking "How" questions.

"How did you come to the decision to …('Choose that tattoo on your arm?'; 'Choose that profession, or that major in school?'; 'Come into treatment, now?' etc.)?

"Walk me through the steps by which you chose X?"

"I want to walk in your shoes, and see the world through your eyes."

"Are you saying that there is a <u>part of you</u> that can X, but there is <u>another part of you</u> that can Y? If that is the case, what does this mean about you as a person?

5. Establish, maintain and monitor the quality of the therapeutic alliance on a Session-by-Session basis.

a) Ask the patient at the end each session:

"Is there anything I said, or failed to say; anything I did or failed to do, that you found particularly helpful, or unhelpful?"

b) Visit the following Websites to download forms that provide Feedback Informed Treatments.

www.centerforclinicalexcellence.com
www.OQ45measures.com

Use Session-by-Session Rating Scales and Outcome Measures.

6. Reframe any patient therapy-interfering behaviors as a "sign" of his/her buying into the treatment. Use "***Woo, what a relief***!" as a response. Use paradoxical responses such as:

"***Hold onto your anger. If you were not at times angry given what you have been through, I would be deeply concerned. Your anger shows you are still in touch with your feelings. It shows that there is a difference between the way things are right now and how you would like them to be."***

"Your persistent grief reflects how special your relationship was with your husband."

In other words, any presenting problem, or potentially therapy-interfering behaviors, can

be reframed as the patient buying into treatment. GO PUBLIC THE DATA of the patient's behavior that gives the therapist the hunch that the patient is engaging in what has been called " ruptures" in the therapeutic relationship. The therapist can say to the patient. "I noticed something and I wonder f you noticed it as well?" The therapist can explore this behavior with the patient and address it collaboratively.

REMEMBER THAT COGNITIVE BEHAVIOR THERAPISTS DO <u>NOT</u> BECOME DEPRESSED!

7. Conduct **Collaborative Goal Setting** that nurtures hope. Help patients establish **SMART** goals (Specific, Measurable, Achievable, Relevant/Valued and Time-limited).

    a) Use **Goal Attainment Scaling Procedures**. Collaboratively enumerate three target patient behaviors and identify what improvement would look like at 0% - 50% - 100%.
    b) Use My Goal Sheet

8. Ensure that the Therapeutic Alliance is culturally sensitive. Fill out the Cultural-sensitivity Self-report Scale and discuss this with a colleague. Check out the “cultural fit” with your patient.

9. Conduct a “Risk” assessment of patient’s suicidal behavior, and violence toward others. (See Meichenbaum’s paper “30 years of working with suicidal patients: Lessons learned on the Melissa Institute Website www.melissainstitute.org) and David Jobes CAMS Measure (Collaborative Assessment and Management of Suicidality).

10. Employ **Motivational Interviewing** procedures.

11. Use Time Lines in order to highlight the patient’s “strengths” and evidence of resilience.

    Timeline 1 - - track down from birth to the present time, noting the variety of lifetime stressful life events and any forms of interventions or treatments the patient received.

    Timeline 2 - - track any signs of resilience or strengths (“In spite of”- - Box 6 behaviors). Note that this Timeline information may go back in time to previous generations/forefathers where they evidence “intergenerational transmission” of resilient behaviors, all the way up to the present.

    Timeline 3 - - begin with the present and extend into the future, as to how the patient would like to change - - being “practically optimistic.” The therapist can say the following:

    “Let me explain what I do for a living. It is not that complicated. I am a

psychotherapist. What I would like to do is work with you to find out how things are right now in your life, and how you would like them to be?"

"Second, I would like to find out what you have tried in the past to achieve your goals and desired changes? What has worked? What has <u>not</u> worked, as evident by …? What if anything, got in the way of your achieving your goals?"

"Third, if we worked together, and I hope we can, how would we know if you were making progress? What would other people notice changed in you? How would achieving your goals of X, and your bringing about such behavior changes, make you feel? What would this mean about you as a person?

Finally, one last question if I may ask you? Can you foresee, envision, anything that might get in the way of your achieving your treatment goals of X? How can you learn to anticipate and address such obstacles, should they arise?

12. Conduct psycho-education

    a) Educate the patient about the nature of the treatment and the joint responsibilities of the patient and psychotherapist.
    b) Help the patient better understand the nature of his/her condition. For example, why does PTSD and substance go hand-in-hand? Or, the role of medication, if being prescribed? Or, the impact of chronic cumulative stress and victimization?
    c) Educate the patient about the benefits of "positive emotions" and resilient-engendering behaviors on the patient's brain and relationships. Discuss in lay terms the concept of "neuroplasticity". Discuss the distinction between Type I and Type ii thinking processes.

13. Use the **CLOCK METAPHOR** to educate the patient about the interconnection between Appraisal processes of external and internal events; (**12 o'clock**), Accompanying primary and secondary emotions (**3 o'clock**); Cognitive processes - - automatic thoughts and images, thinking processes, developmental schemas/beliefs (**6 o'clock**); and behaviors and reactions they elicit (9 **o'clock**).

Treat the patient's emotions (3 o'clock), as a "commodity" or "product" that the patient does something with.

> ***"What is anything, do you do with all of your feelings?"***
>
> ***"If in fact, you do that, what if anything is the impact, the toll, the price you and others pay?"***
>
> ***"Is that the way you want things to be? If not, what can you do about it?"***

If the patient says he/she does not know, the therapist can reply, ***"I don't know either, how can we go about finding out?"***

Using the CLOCK metaphor, beginning at 9 o'clock ask about the "**Vicious cycle**" and explore how the patient inadvertently, unwittingly, and perhaps even unknowingly produces the very reactions that he/she complains about. Ask about the "impact, toll, price you and others pay" questions. Follow this up with questions about "***How the patient presently breaks the vicious cycle?***"

"How else can the patient more adaptively break the vicious cycle?

Use a "stuckness" metaphor of the patient using "old habits" and overlearned ways to "break the vicious cycle". For example, how the patient uses substances avoidance, acting out behaviors, etc. as a way to "break their vicious cycle."

14. Also, use the CLOCK metaphor to have the patient "take credit" for positive changes he/she has achieved, in the form of a "**Virtuous Cycle**".

> ***"You did what X? How did you accomplish that? Are you telling me, saying to yourself that you were able to do X, in spite of Y? (9 o'clock) How did that make you feel? (3 o'clock). And you had the thought that Z (6 o'clock), and you can even be on the lookout for more opportunities to do X? (12 o'clock). Are you saying that this is a "Virtuous Cycle." What does this mean about you as a person?"***

15. Have the patient Self-monitor behavior. See the script of how to have the patient engage in self-monitoring ("homework") activities.

16. Evaluate any training program you employ such as emotional regulation, mindfulness training, cognitive restructuring, problem-solving, interpersonal skills training in terms of how effectively you incorporate the **guidelines to achieve generalization and "lasting changes".** Have the patient fill out the Recovery Strategies Checklist and offer self-

generated reasons, self -efficacy ratings and consider ways to anticipate and address potential barriers.

Do not "train and hope" for transfer and maintenance. Consider what you should do before, during and at the end of training (e.g. putting the patient in a consultative role - - able to describe, teach and own the skill set. (See Generalization Guidelines and the Consumer's Guide to evaluate training programs).

17. Describe what you are doing to include an **active aftercare program**. For example, providing Booster sessions, maintaining ongoing patient contact, involving significant others, maintaining internet or telephone contact, helping the patient hook up with support groups such as 12 Step programs (Include the 12 Step AA Recovery Checklist, have the patient visit the Smart Recovery Website - - see Meichenbaum and Meyers Checklist on the Smart Recovery Website).

18. Build in **Self-attributional training** and **Relapse Prevention Procedures**.

19. Use a **Patient Checklist** and various **Recovery Checklists** such as for handling Prolong and Complicated Grief, Abstinence, developed by Meichenbaum.

20. Describe in lay terms, what distinguishes the 75% of individuals who evidence Resilience in the aftermath of traumatic and victimizing experiences **VERSUS** the 25% who evidence PTSD, Complex PTSD, and accompanying co-occurring chronic psychiatric disorders and persistent adjustment challenges. Explain the implications for conducting psychotherapy, incorporating a Constructive Narrative Perspective. ***("We are all 'homo narrans' or story-tellers"***).

21. Describe specific ways you can help bolster your patient's resilience in six domains (physical, interpersonal, emotional, cognitive, behavioral and spiritual). (See ***www.roadmaptoresilience.org***).

22. Describe how you can integrate spirituality and psychotherapy by systematically assessing for the patient's spirituality and religious beliefs and then tailoring your treatment approach accordingly. (See Meichenbaum's paper, "Trauma, spirituality and recovery" on the Melissa Institute Website).

23. How can you alter your psychotherapeutic intervention if your patient's dominant emotional reactions to traumatic events are:
    a) fear-based anxiety avoidant reactions - - use of exposure-based interventions ala Foa-Ruthbaum

b) guilt-based reactions following the work of Kubany

c) shame-based reactions using imagery focused interventions ala the work by Smucker and Dancu

d) grief-oriented interventions - - see Meichenbaum's manual on the Melissa Institute Website

e) anger-directed interventions ala work by Novaco and Chemtob

f) moral injuries ala the work of Litz and Steenkamp, Adaptive Disclosure

24. Provide a detailed outline of how you would conduct exposure-based interventions terms of the pre-treatment psycho-education, imaginal and in vivo exposure.

25. Describe how you could conduct the **Gestalt Empty-chair** procedure with patients who experience Prolong and Complicated Grief and Moral Injuries.

26. How can you provide integrative treatments, as compared to sequential or parallel treatments with patients who experience co-occurring disorders such as PTSD and Substance Abuse, or Complex PTSD and Borderline Personality Disorders. (See work by Najavits, Ford, Cloitre, Meuser, Meichenbaum).

27. How can you bolster patient's resilience and conduct Trauma-focused Cognitive behavioral interventions with children (TF-CBT), adolescents and the elderly?

28. You have been asked to recommend a Residential Treatment Center for a patient. What specific issues will you consider when making your recommendations. (See the Consumer Guidelines Checklist). See the following Websites.

    www.nctsnet,org
    www.musc.edu/tfcbt
    www.attc.usc.edu
    www.melissainstitute.org

    See papers by Meichenbaum on the Melissa Institute Website on ways to bolster resilience in children, victims of human trafficking (adolescents), LGBTQ youth and the elderly, as well as Returning Service Members.

29. Discuss how to bolster resilience in health care providers and psychotherapists. (See paper by Meichenbaum on the Melissa Institute Website on "Individual, Social and Organizational Ways to Bolster Resilience in Psychotherapists".

30. Consider all the reasons you will <u>not</u> do anything recommended on this "TO DO" list.