

Chapter 4:

Ingredients of the Integrated Treatment Approach

OVERVIEW

The integrated approach to treating SUDs is a model we have evolved over many years of working with patients in institutional settings and in our office practices. Regrettably, and despite the fact that studies on the treatment of SUDs have demonstrated convincingly that no one method of treatment is better than all others, the addiction field continues to be split into opposing factions, each claiming superiority of their own approach. Our clinical experiences have taught us to steer clear of dogmatic approaches claiming to be the single best method for treating SUDs. We are by no means the first to acknowledge or write about the importance of a more flexible, integrated approach (e.g., (Kaufman, 1994; Margolis & Zweben, 1998; Shaffer & Gambino, 1990), but the addiction treatment system in some parts of the country has been slow to move beyond rigid adherence to the disease model and reliance on harsh confrontational tactics. Although in recent years motivational and other individualized client-centered approaches have been incorporated increasingly into addiction treatment programs in both public and private sectors, a welcomed change indeed, many individuals who make contact with traditional treatment programs still encounter a confrontation-of-denial “one size fits all” approach.

The integrated approach neither requires nor recommends adherence to one theoretical model or method of treatment. To the contrary, this approach is nondogmatic and encourages clinicians to exercise creativity, flexibility, and reasonableness in treating SUDs as they would in addressing other types of mental health problems. The approach is integrated in the sense that it blends together many seemingly disparate and competing treatment approaches including: addiction counseling, supportive psychotherapy, cognitive-behavioral therapy, Rogerian client-centered therapy, psychodynamic insight-oriented therapy, motivation-enhancement therapy, harm reduction therapy, 12-step facilitation therapy, interpersonal therapy, patient education, and pharmacotherapy- all of which are brought together to meet the individual and changing needs of patients at different stages of treatment.

We view abstinence as the preferred treatment goal, especially for patients whose pattern of substance use provides clear evidence of impaired control and puts them at significant risk of suffering severe consequences if use continues. Nonetheless, we do not mandate abstinence or make it a precondition for patients to receive our help. And we do not convey disappointment or disapproval to those who do not choose abstinence as their goal. Developing individualized treatment goals as part of engaging patients “where they are” is an essential aspect of the integrated approach, as discussed more fully in Chapter 9.

In this chapter, we discuss certain ingredients and distinguishing features of the integrated approach: (a) the centrality of the therapeutic relationship; (a) application of the stages of change model to enhance patient-treatment matching (b) application of motivational interviewing techniques to engage patients and enhance readiness for change; (c) dividing treatment into successive stages focusing on specific tasks and goals; (d) using the self-medication hypothesis to understand and address certain psychodynamic aspects of the addiction; (e) using aspects of

the disease model to justify a request for total abstinence; (f) using on-site urine drug testing as a clinical tool to support and reinforce behavior change; (g) facilitating patient engagement in self-help programs; (i) avoiding certain therapeutic traps and dilemmas.

Centrality of the Therapeutic Relationship

A central feature of the integrated approach that permeates all aspects of treatment is its emphasis on developing and maintaining a therapeutic relationship between patient and therapist. Of particular value in this regard are motivation-enhancement techniques (described below) that are designed to facilitate patient engagement and enhance readiness for change. Regardless of what particular issues or tasks are being addressed during a given phase of treatment, the therapist's style, stance, and overall attitude toward the patient are often the most critical determinants of treatment engagement, retention, and outcome. Unfailing respect for the patient's autonomy and freedom of choice is essential. The therapist must maintain vigilant self-awareness especially with regard to controlling behaviors and other countertransference reactions that can alienate patients and lead them to drop out of treatment. Aggressive confrontation and not giving patients the benefit of the doubt, the mainstay of traditional addiction counseling, are seen as counterproductive and antithetical to the integrated approach. It is essential for therapists to maintain unfailing respect for the patient's autonomy, sensitivities, defenses, and personal strengths. And clinicians must remain ever-mindful of the power of the therapeutic relationship to engender both benefit and harm. The therapeutic relationship is by far the most important ingredient of the integrated approach and, as in all other forms of good psychotherapy, it is the primary vehicle for facilitating positive change.

Phases of Treatment

Treatment within the integrated model is divided into different phases, each focusing on a specific set of tasks and goals. There are no rigid or clear cut dividing lines between the different phases as they often blend gradually and sometimes imperceptibly from one to the next. Also, all patients do not necessarily progress in linear or stepwise fashion through the different phases. Patients can and do enter treatment at different phases, progress through them at different rates, and move back and forth between phases or straddle more than one phase at a given point in time.

Assessment. The primary tasks of this phase are to engage the patient in a therapeutic relationship and to perform a multidimensional assessment of the patient's substance use and related problems. This is often the most critical phase because it sets the tone for just about everything that follows and has a profound impact on whether or not the patient becomes engaged in the therapeutic process or drops out. Effecting a positive outcome rests heavily on creating a safe environment in which patients feel they can be open, honest, and forthcoming with you about details of their substance use and related difficulties without fear of being judged or rejected. The assessment explores in detail the nature and extent of the patient's past and present substance use, negative consequences associated with use, its functional role and

significance in the person's life including how it may continue to serve some positive function, and the patient's motivation and readiness for change. Techniques for conducting a multidimensional assessment of substance use are discussed in Chapter 7.

Individualized Goal Setting and Treatment Planning. Completing the multidimensional assessment paves the way for establishing individualized treatment goals and collaboratively developing a treatment plan with your patients to help them work toward achieving those goals. An essential ingredient of this process is to match treatment interventions to the patient's level of motivation and stage of readiness for change. The stage-of-change (SOC) model informs and guides the process of finding the "best fit" between where the patient is and what the therapist should be doing to engender positive change at each stage of the process (Connors, Donovan, & DiClemente, 2001; DiClemente, 2003; Prochaska, DiClemente, & Norcross, 1992).

Taking Action. This phase focuses on helping patients change their substance use behavior and achieve their initial treatment goals of reducing or stopping their alcohol and drug use. While this phase focuses primarily on changing substance use behavior, other presenting problems and ongoing issues also are addressed.

Preventing Relapse. This phase concentrates primarily on doing what is necessary to maintain and solidify positive gains and prevent relapse to the former pattern of substance use. The development of relapse prevention strategies emanates from recognition that the types of clinical interventions needed to initiate changes in substance use behavior differ from those needed to maintain these changes and prevent relapse over the longer term (Marlatt, 1985; Marlatt & Gordon, 1985). A wide variety of relapse prevention strategies are discussed in Chapter 10.

Psychotherapy in Ongoing and Later-Stage Recovery. This is not a specific treatment phase, but a thread that runs throughout the treatment, with the focus and timing of psychotherapeutic interventions being based on individual needs. The types of issues that need to be addressed at any given point in therapy are difficult to specify in advance for all patients because of wide variation among individuals with SUDs with regard to how and why they present for treatment, and the complex psychological and sociological context within which alcohol and drug problems are often embedded. For example, some patients who present with alcohol and drug problems want to focus immediately on some of the psychological issues (e.g., poor self-esteem, relationship conflicts and failures, etc.) that they feel are connected to their ongoing substance use, whereas other patients want to focus only on changing their substance use behavior whether or not they are aware of other psychological factors that may be present.

THE STAGES OF CHANGE MODEL

Coming to grips with a serious problem and taking the necessary steps to resolve it is a process, not an instantaneous event. Recent research shows that people progress through a series of different stages along the way toward overcoming problem behaviors such as alcohol and drug abuse and that for treatment to be effective it must be carefully matched to which stage of the process the person happens to be in. The SOC model (Prochaska & DiClemente, 1986) describes not only the stages of change that individuals move through as they attempt to modify or

overcome problem behaviors such as substance abuse, but also the types of interventions most likely to be effective within each stage and to promote movement onto the next stage. The five stages of change in this model are: precontemplation, contemplation, preparation, action, and maintenance.

The Five Stages of Change

Pre-Contemplation is the stage in which the problem is evident to others, but not to individuals with the problem. Patients in this stage are generally unaware or under-aware of their problem and do not understand why others are so worried about it. The stronger they are confronted or badgered about the problem the more likely they are to dig in their heels and argue that the problem either does not exist or is not serious enough to warrant doing anything about it. For example, since those in the precontemplation stage are generally unaware that the behavior in question is a “problem” or that it may be contributing to other problems, they invest no energy into thinking about or attempting to change. Patients in precontemplation do not ordinarily seek treatment unless propelled to do so by negative consequences such as an arrest, DWI, or the threat of losing a marriage or other valued relationship. Although these individuals may enter treatment convinced that their only problem was getting caught, this situation presents an opportunity to try to increase their awareness and hopefully their motivation to change.

In the contemplation stage, individuals begin to experience ambivalence or conflict about the behavior which is now perceived as possibly a problem, but they take no action since it is not yet entirely clear to them that the problem is serious enough to warrant doing anything about it. The contemplator may vacillate back and forth about whether or not to do something about the problem, reflecting the ambivalence and motivational conflicts that characterize this stage. Individuals in this stage vacillate between the difficulties of living with the problem and the challenges created by the prospect of making changes. An individual with a serious alcohol problem may, for example, dread trying to participate in the same social activities with heavy drinking friends without drinking himself, but fear the decline in health warned by his physician if his drinking continues. At this point, the option of disengaging from his social network is not perceived to be a viable option. People can remain in Contemplation for very long periods of time, or return to it on the heels of relapse after periods of extended abstinence.

In the preparation stage, the balance tips in favor of change and the person decides to take some type of Action, but has not yet decided what method to employ or exactly how to go about making these changes. Also, they have not yet committed themselves to specific goals or to a truly effective course of action (such as getting outside help) although they intend to do so in the near future. They may experiment with reducing the number of drinks they have in a given day or the number of days per week they use cocaine, but are not quite ready to stop completely. In typically human fashion, most people in this stage hope to find the fastest, easiest, and most painless way to accomplish the desired change and may feel frustrated and discouraged when faced with the reality that no such method exists. This is essentially a warm-up stage; behavior changes are in the making, but the person has not yet reached the point of taking definitive action.

The action stage begins when the person has committed to specific goals, chosen a definitive method for achieving those goals, and has begun in earnest to do something about the problem behavior. People in this stage make significant changes to reach a clearly defined goal such as

abstinence or a significant reduction in use. They make committed efforts to change and take effective goal-oriented action, either on their own or with professional assistance. For example, actively working toward a goal of reducing alcohol consumption by 50 percent within two weeks, achieving 30 days of total abstinence, attending a few AA meetings, and/or seeking professional help from a therapist or program, are indicative of individuals in the Action stage. In this stage, the person typically takes definitive action to break the habitual pattern of alcohol and drug use, including changing daily routines and avoiding people, places, and things associated with prior use. This is visible to others and often elicits considerable support. This period may also include managing physiological withdrawal. Although people can and do navigate this stage successfully without professional intervention, there is much that a knowledgeable therapist can do to facilitate and guide this process, including teaching early recovery skills based on cognitive-behavioral therapy techniques.

In the maintenance stage the primary goal is relapse prevention; i.e., to maintain progress and prevent backsliding or relapse. An addictive behavior is often easier to stop initially than to stay stopped over the long term. The types of behaviors necessary to initiate change are different from those needed to maintain it, and so the maintenance stage is one of solidification, in which the patient makes more extensive changes and learns new coping patterns for emotions and relationships. A wide variety of relapse prevention techniques are useful in this stage to help patients maintain abstinence.

Relapse in the SOC model is defined not only as returning to the former pattern of alcohol and drug use, but more broadly as regression (i.e., movement backward) from any given stage of change to an earlier one. For example, when a vacillating patient in the contemplation stage encounters aggressive confrontation from a counselor who sees the patient as “resistant” and “unmotivated”, the patient may regress (i.e., relapse) back to the precontemplation stage since this negative feedback diminishes rather than enhances the person’s motivation and readiness for change. Sometimes relapse is a byproduct of success when the patient feels dramatically better after a sustained period of abstinence and begins to believe that occasional or controlled use is possible again without losing other gains. It can also occur when a patient loses respect for the power of relapse triggers, such as certain situations and activities where alcohol and drugs may be present. For example, a patient may continue to attend sporting events with friends who drink as part of the ritual. The patient may manage to remain abstinent for a period of time, but is likely to relapse at some point in the face of repeated exposure to these triggers. The patient may reject self-help participation and succeed for a while, but eventually conclude this type of recovery support network is indeed essential to maintain progress. Relapse is common and offers the opportunity for new and deeper learning about addiction and recovery, but the therapist must avoid sounding complacent about alcohol and drug use while working to reduce shame and promote learning from the experience. No matter how successful the patient has been, it is always possible for motivation to wane. Patients then cycle back through earlier stages of change and lose their foothold in the recovery process. Although some patients show linear progress in recovery without relapse, it is more realistic to expect some backsliding, even if the treatment is clearly effective in producing positive change.

Clinical Value of the Stages of Change Model

The clinical value of the SOC model is the framework it provides for matching treatment interventions to the particular stage of the change process that the patient happens to be in. Treatment techniques that work well with patients in one particular stage might be ineffective, countertherapeutic, or seriously backfire with those in another stage. Knowing which stage the patient is in provides important clues about what will work and what will not. A patient and therapist working at different stages (a therapeutic mismatch or misalliance) is one of the most common sources of patient resistance and premature dropout from treatment. Interventions mismatched to the patient's stage of readiness for change are likely to be unhelpful and may even be harmful.

For example, when a therapist insists on immediate action such as stopping all substance use and going to AA meetings with a patient who is in the precontemplation stage, the patient is likely to experience the therapist as insensitive and controlling, like a parent pressuring for change when the person is not yet convinced that change is really needed. Similarly, patients who believe that developing social supports and taking other concrete measures will make it easier for them to give up alcohol and are likely to resist spending time talking with a therapist about their self-esteem problems or childhood (Connors, Donovan, & DiClemente, 2001). A common mismatch occurs when patients in the Contemplation stage collide with therapists or treatment programs that expect them to be in the Action stage. This mismatch is likely to result in failure to engage the patient in treatment. The therapist or program expects the patient to comply with requests for immediate behavior change such as stopping all substance use without further delay while the patient is not at all convinced that this type of action is really necessary. The more the clinician insists on change, the more reluctant and resistant the patient becomes. These types of mismatches can and often do degenerate into no-win power struggles. The therapist increasingly confronts the patient's "denial" while the patient digs in his/her heels insisting that no such problem exists. Typically, this misalliance and impasse are blamed on the patient as the clinician concludes that the patient was "resistant", "in denial", and "just not ready to change" in the first place.

Certain types of treatment interventions are best suited for patients in each of the five different stages of change and choosing interventions properly matched to the patient's stage of change is among the therapist's most important tasks in the integrated approach. For example, motivational interviewing and other engagement strategies that start "where the patient is" are most appropriate for patients in the early stages of Precontemplation and Contemplation. Interventions such as discussing various treatment options and negotiating a treatment plan are most appropriate for patients in the Preparation stage. Specific behavior change strategies for establishing abstinence or curtailing use are best suited for those in the Action Stage whereas relapse prevention strategies are most appropriate for those in the Maintenance stage.

MOTIVATIONAL INTERVIEWING TECHNIQUES

In recent years, a significant advance in the adaptation of psychotherapeutic approaches to treating SUDs has been the development of motivational interviewing techniques (Miller and Rollnick, 1991). These techniques have provided a new way to conceptualize and deal more effectively with the problems of patient resistance and poor motivation. Within the framework of the stages-of-change model, motivational interviewing techniques combine Rogerian principles of patient-centered therapy with a variety of cognitive-behavioral interventions designed to

reduce patient resistance and enhance motivation and readiness to change.. This approach has helped to focus long-overdue attention on the need for effective strategies to deal with ambivalent, resistant patients who are in the early stages of change (i.e., precontemplation, contemplation, and preparation). Motivational interviewing represents a major departure from the standard confrontational approach which has dominated the addiction treatment field for several decades (see Miller and Rollnick, 1991, pgs 52-54 for detailed comparison of motivational interviewing versus confrontation-of-denial approaches). Motivational interviewing is a non-coercive, non-authoritarian approach intended to help patients free up their own motivations and mobilize their internal resources so they can move forward in the process of change. It gives clinicians an effective way to reconceptualize their approach to “resistant” and “unmotivated” patients and defines the critical role of the clinician in helping patients move from one stage of change to the next.

In motivational interviewing, patients’ reluctance or inability to acknowledge having an alcohol or drug problem is seen not as resistance, denial, or lack of motivation, but rather as an outgrowth of an individual’s ambivalence and conflicted attachment to the substances. Substance abusers often want to stop using alcohol and drugs, but at the same time they do not want to or do not feel ready to stop using. Painful ambivalence, including fears about facing reality without the chemical buffer provided by alcohol and drugs, causes them to suppress and selectively ignore negative aspects of their substance use. Instead of facing reality they rationalize and minimize substance-related consequences while trying to convince themselves and others that the problem either does not exist or is just not serious to warrant concern.

The task of clinicians encountering patients embroiled in this dilemma is to help them reduce their ambivalence and tip the balance in favor of change. Motivational interviewing techniques are designed to do just that; i.e., to increase the chances that substance-abusing patients will recognize and actually do something about their alcohol and drug problem. Motivation like ambivalence is seen not as an immutable characteristic of people who have alcohol and drug problems, but as a fluctuating state of readiness or willingness to change that can be influenced by situational factors and certain types of interpersonal interactions. In the motivational interviewing approach, a therapeutic patient-centered relationship between clinician and patient is considered the primary vehicle for moving the patient along the path to positive change. Patients are given permission and expected to resist, they are encouraged to explore their ambivalence about changing and consider various options to resolve their dilemma while the clinician acts as facilitator. Patient resistance is taken not as an indicator of poor motivation but as a signal that the clinician is pressing too hard, prematurely, or in the wrong direction (i.e., out of synch with where the patient happens to be at the moment). Some of the basic principles of and techniques of motivational interviewing¹ are:

1. *Express empathy for your patient’s plight.* Look beyond their substance-using behavior and recognize the fears and difficulties involved in changing what are often long-standing and deeply ingrained patterns of living. Remain tolerant of the range of patients’ reactions to receiving objective feedback about their alcohol and drug use including anger, denial, astonishment, arrogance, shame, embarrassment, reticence, etc.
2. *Avoid arguments.* Do not argue or debate with patients about whether or not they have an alcohol and drug problem and what to do about it. Patients are not adversaries.

3. *Roll with resistance.* When patients show signs of resistance, the clinician should back off. Resistance is a sign that whatever you are trying to do is not working and it would be better to try something else. When you encounter resistance from patients avoid the temptation to regard this as a challenge to your authority or to react with frustration or annoyance. Stay in the role of compassionate clinician and expert who can advise and guide patients in making good decisions for themselves.
4. *Avoid coercive or pressuring tactics.* The responsibility for change rests solely on the patient and not on the therapist. The therapist should assume the role of change facilitator. Convey your willingness to work with substance-abusing patients in a mutually cooperative partnership to define and address the problem.
5. *Be positive, and reassuring.* Let patients know that alcohol and drug problems are not the result of character flaws or moral deficiency, but disorders that can be treated successfully.
6. *Express interest, concern, and curiosity.* Simple expressions of interest and caring by the therapist can go a long way toward creating a trusting atmosphere that encourages truthful self-revelation.
7. *Ask open-ended questions.* When interviewing patients about their alcohol and drug use it is best to ask open-ended questions rather than yes/no questions. Open-ended questions elicit relevant details rather than simple yes/no answers. For example, rather than ask “Have you ever felt that your alcohol and drug use was a problem?” which can be responded to with a simple “yes” or “no”, it would be better to ask an open-ended question such as “Tell me about your alcohol and drug use over the past year and to what extent you have ever felt it to be a problem”.
8. *“Start where the patient is” not where you want him/her to be.* Match your treatment interventions to the patient’s stage of readiness for change, as discussed earlier. Don’t jump too far ahead by pressing for changes that patients are not yet ready to make.

Miller and Rollnick (1991) have outlined eight essential building blocks of motivational strategies summarized by the mnemonic “ABCDEFGH” (pp. 20-28):

1. *Give ADVICE.* When properly timed and delivered, simple advice offered by a knowledgeable, caring professional can be motivating and empowering.
2. *Remove BARRIERS.* Patients need help in overcoming practical, emotional, and attitudinal barriers to change. This may include assisting patients with transportation or childcare problems, offering flexible appointment times, and pairing up newcomers with supportive peers who can “show them the ropes”.
3. *Provide CHOICES.* This is based on the belief that intrinsic motivation is enhanced by giving the person a voluntary choice between different courses of action without subjecting him/her to external pressure or coercion. Few people like to be told what to do and resist or recoil when presented with no choice. The patient’s personal investment in treatment is enhanced when offered a choice among a number of alternatives.
4. *Decrease DESIRABILITY.* In-depth assessment of pros versus cons of a person’s substance use may reveal a variety of unrecognized or unappreciated consequences as well as distorted notions about the presumed necessity or benefits of alcohol and drug use.

Interventions that provide objective, realistic feedback about substance-related problems and consequences can help to tip the balance in favor of change.

5. *Practice EMPATHY.* An empathic therapist style is associated with low levels of patient resistance and greater receptivity to change. This includes empathic and reflective listening as well as conveying warmth, respect, supportiveness, and active interest.
6. *Provide FEEDBACK.* An important motivational task is to provide clear feedback about a patient's situation, behavior, and consequences. Accurate knowledge of the present situation is an essential ingredient in developing motivation for change.
7. *Clarify GOALS.* An essential task is to help the patient clarify, define, and set goals that are realistic, desirable, and attainable. This involves helping patients define where they are now as compared to where they would like to be. Seeing a large gap or discrepancy between one's current status and desired goals can be motivating, but only if the person believes that the goals are actually attainable and can see a clear path for achieving them.
8. *Actively HELP.* Clinicians must be active, optimistic, involved, and empowering. Their role encompasses that of teacher, coach, guide, and supporter. Giving advice, offering recommendations, and alerting the patients to potential obstacles or pitfalls are all essential parts of the clinician's role.

CLINICAL USE OF THE DISEASE MODEL

The disease model has long been the foundation of traditional approaches to treating addiction, but it continues to be a topic of controversy and debate among mental health professionals and the public at large. Many people question the legitimacy of viewing addiction as a disease and are concerned that doing so dangerously absolves addicts and alcoholics of personal responsibility for their excessive substance use and related irresponsible behaviors. However, most concerns about the disease model stem from misinterpretations and misunderstandings based on lack of accurate information. For example, the notion of addiction as a disease does not absolve individuals of personal responsibility for their behavior, but it can reduce the paralyzing shame and guilt that impairs their ability to acknowledge and address the problem. Individuals who become addicted to alcohol and drugs are not responsible for having the disease, which can be viewed as a biochemical "brain allergy" to psychoactive substances (whether substance-induced, inherited, or both) associated with pathological thinking and behavior when these substances enter the brain of affected individuals. However, they most certainly *are* responsible for remaining abstinent and making the requisite behavioral and lifestyle changes necessary to prevent relapse. They also are fully responsible for any harm done to others while under the influence of intoxicants. Individuals who have the disease, regardless of etiology, respond differently to psychoactive substances than those who do not have the disease. Not only do they experience difficulty in controlling the quantity and frequency of their use, but they also become obsessed and preoccupied with using these substances, and continue to use them despite life-damaging consequences. It is difficult to understand the habitual, self-destructive tendency of the addicted person who resorts repeatedly to excessive alcohol and drug use even in the face of severe life-damaging consequences, as anything but pathological.

Certain tenets of the disease model have enormous therapeutic value and can be utilized for patients' benefit regardless of your theoretical orientation. You need not wholly accept or believe in all aspects of this model in order to utilize selected pieces of this approach to help your

patients deal with their alcohol and drug problems. To quote an AA slogan, when questioning the value of the program you are advised to “take what you need and leave the rest”. The model is not only an extremely useful clinical tool, guiding the clinician’s therapeutic stance on a variety of important treatment issues, but it also aids in lifting the paralyzing shame, guilt, and self-recrimination that interfere with addressing addictive disorders in constructive ways.

Among the most useful tenets of the disease model is the importance of total abstinence from all intoxicants as the most reliable way for individuals who have the disease to avoid relapse and insure the widest margin of safety. From a clinical, perspective, there are several reasons for this. First, there is the often-observed phenomenon of drug substitution in which individuals develop addictive patterns with other substances that they may or may not have abused in the past. For example, it is quite common for patients in recovery from cocaine or opioid addiction to develop problems with alcohol that sometimes progress into full-blown alcohol dependence. Especially for those with no pre-drug history of alcohol problems, resumption of normal drinking patterns seems entirely possible to them and they find it hard to justify why they have to deprive themselves of a glass or two of wine with dinner or a bottle of beer or two while watching a sporting event. Actually, it appears that some individuals can accomplish this safely, but it is impossible to predict who they are. The risks of trying this experiment with social drinking can be considerable for those with the more severe form of the disorder, and sometimes only after experiencing further alcohol-related harm do they decide that controlled or responsible drinking is for them simply not attainable.

A second reason for total abstinence is the role that other substances can and often do play in precipitating relapse to a person’s drug of choice. For example, people addicted to cocaine often have difficulty accepting the idea that alcohol or marijuana can reduce their ability to refuse offers of cocaine and may actually stimulate cravings for cocaine. Addiction specialists have long noted that resumption of cocaine use is frequently preceded by use of these other substances, particularly alcohol, and recent empirical evidence supports these clinical observations (Rawson, Obert, McCann, Smith, & Ling, 1990).

The clinical value of the disease model notwithstanding, it must be recognized that not everyone with an alcohol or drug problem has the disease of addiction and applying this model too broadly or indiscriminately can reduce its clinical utility and produce unwanted results. For example, individuals who meet DSM-IV criteria for a diagnosis of abuse but not dependence may or may not have the disease of addiction. Whether or not these individuals are merely in the early stages a disease process that is moving them from abuse toward full-blown addiction (which is impossible to predict reliably) they are not likely to see the disease model as applicable to their current pattern of substance use and attempts to force them into this mold are likely to be unproductive and diminish the therapist’s credibility. Even those who unequivocally meet criteria for a diagnosis of substance dependence often have difficulty accepting the disease model as applicable to their problem. In general, the more severe an individual’s addiction, the more likely it is to conform to the disease model.

Also, despite the clinical utility of the disease model, when patients hesitate or refuse to embrace this model unequivocally you should not construe this as evidence of resistance, denial, or unwillingness to “surrender” or use it to justify confrontational tactics. Helping patients see the potential value of the disease model in facilitating their recovery should be approached therapeutically within the framework of the stages of change model and motivational

interviewing techniques discussed earlier. Keep in mind that it is not necessary for patients to accept the disease model and the identity of “addict” or “alcoholic” in order to address their substance abuse problem and begin the recovery process in earnest.

CLINICAL VALUE OF THE SELF-MEDICATION HYPOTHESIS

The self-medication hypothesis adds a clinically valuable psychodynamic perspective and understanding to the treatment of patients with SUDs. This perspective is especially useful because it provides a basis for explaining some of the subjective and experiential aspects of the meaning and function of psychoactive substances in an individual’s life. It also helps to explain characteristics of people who come to rely on substances and provides a basis for conceptualizing substances use as serving the function of self-medication in an attempt to cope with certain types of deficits and problems (Murphy & Khantzian, 1995). Essentially, the self-medication hypothesis holds that substance-dependent individuals are predisposed to use and become dependent on psychoactive substances largely as a result of ego impairments and deficits in their sense of self. These deficits result in self-regulation disturbances in the critical areas of affect management, self-esteem maintenance, capacity for self care, and self-other relations (Dodes & Khantzian, 1991). The most frequently described function of substance use within this framework is the management of intolerable and overwhelming affects. Connections between certain affect states and the use of certain substances has been noted. For example, the use of opioids to manage anger, rage, and loneliness; the use of cocaine and other stimulants to manage depression, boredom, anhedonia, and feelings of emptiness or to instill a sense of omnipotence or grandeur; and the use of alcohol to manage anxiety, social awkwardness, and sexual inhibitions. On a more general level, psychoactive substances may be used to compensate for a defective stimulus barrier that leads to affective flooding, as a way of self-soothing that cannot be achieved by ordinary means, and as a substitute for human object relationships (Krystal, 1988). Deficits in the capacity to be aware of and appropriately label one’s internal affect states, a condition known as “alexithymia”, also has been noted a distinguishing feature of people who become addicted to mood-altering substances.

In light of these observations, an important part of ongoing psychotherapy for patients with SUDs is to help them identify, understand, and overcome their self-regulation vulnerabilities and deficits, as will be discussed in Chapter 11.

ENCOURAGING INVOLVEMENT IN SELF-HELP PROGRAMS

The self-help system is an invaluable resource to the therapist treating substance use and to those who are in recovery. It is important for you to facilitate the use of these programs without assuming they eliminate the need for you to address the substance use at all stages of the recovery process. In self help group meetings, your patient will see repeatedly that he or she is not alone in the self-destructive behaviors they view as isolating them from humankind. Confession can bring some relief from overpowering feelings of shame, particularly when others share similar experiences. Your patient will be exposed to a wide variety of role models for recovery, hear strategies for how to achieve and maintain abstinence, and have an opportunity to participate in a social structure that does not involve drinking and using.

There are a growing variety of self-help groups, but by far the most comprehensive support structure is offered in the 12-Step system. “Twelve-step programs” is the generic name for the many descendents of Alcoholics Anonymous (AA). Alcoholics Anonymous started in 1935 and over 2 million people call themselves members. The only requirement for membership is a sincere desire to stop drinking. Other variants developed around illicit drugs and grew in membership, particularly in urban communities. Narcotics Anonymous, or NA is a common choice for drug users, and includes those who use stimulant, opioids, and other substances. Although the basic steps of recovery are the same, it is important for people in the early stages to hear “their story,” and thus they may get a better start in a drug-specific meeting. As their involvement in recovery deepens, many seek out meetings in which there are participants with long-term sobriety, and these are most plentiful in AA. Gradually, there are more NA meetings with participants who have achieved many years of recovery.

Resistance to 12-step program attendance is to be expected, and should be handled as a clinical issue. You can make it clear that you will not immediately insist on meeting attendance, but the patient’s objections are a fruitful topic for ongoing exploration. The issue of attendance at self-help meetings a mirror that will reveal your patient’s conflicts about addiction and many other issues as well. The opening ritual, “I am Josie, I am an addict” is an opportunity for patients to look inside and check out their willingness to acknowledge their addiction. Patients in the early stages may detest this part of the ritual, and exploration often reveals their ambivalence about viewing themselves as addicted. On the behavioral level, you can let the patients know they can introduce themselves by name only, as a guest, or by some other designation of their choosing. However, it is important to ask them to listen to that inner voice that rebels at the phrase “I am an alcoholic/addict.” Thus you can work on the behavioral and emotional level concurrently, conveying that at some point it is important to give the self-help system a fair try.

A growing list of research studies document that those who become involved in the self help system show improvements in many domains of functioning (Ouimette, Moos, & Finney, 1998; Polcin, Prindle, & Bostrom, 2002; Tonigan, Toscove, & Miller, 1996). There are many ways of facilitating the use of these programs. “Stranger anxiety” and discomfort at being an outsider are early obstacles to participation. Connecting your patient with someone to accompany him/her to a meeting is a good way to begin. The central office (in the yellow pages of the phone book, under Alcoholics Anonymous, Narcotics Anonymous, etc) can usually help arrange this. You can also suggest they ask a recovering friend or colleague to assist. If it is impractical to arrange for someone to accompany your patient, you can nonetheless discuss how to cope with the awkwardness and provide encouragement to proceed. Eliciting the patient’s idea of what goes on in meetings and what they fear is a valuable way to correct misconceptions and explore charged issues. Give plenty of permission to be ambivalent, and stress that mixed feelings don’t mean they cannot benefit from continuing attendance. Those who object to “that religious stuff” can be encouraged to “take what you need and leave the rest,” and also be informed that many of the early participants of AA were atheists and agnostics. Social isolates can be assured that it is usually possible to regulate the distance between themselves and others, particularly if they avoid small meetings which tend to pull for everyone to participate. You can also role-play how to set boundaries if the friendliness of meeting participants is experienced as too intrusive.

Sometimes patients are immovable in their resistance to 12-Step meetings but are open to other possibilities. LifeRing, Moderation Management, Women for Sobriety, and SMART Recovery are examples of alternatives with enthusiastic supporters. Information about these groups can be found on the Internet, and meeting schedules are frequently available online. The main drawback is the relative paucity of meetings, so you may need to find other ways to generate the level of support required by each particular patient.

It is important to avoid a power struggle if patients refuse self-help participation, while continuing to explore the relevant issues. Reframing to focus on the underlying principles is a productive approach. Self-help programs offer two essential ingredients that promote success: 1) a subculture that supports recovery; 2) a process for personal development that has no financial barriers. You can ask your patient to consider how to achieve those goals and track patient progress. It is necessary to maintain a long-term perspective. Many patients do well initially, and then fall into regular relapse patterns because they changed their substance use but nothing else. It is tempting but unwise to assume professional therapy will fill all the gaps and provide all the necessary learning. Social support has repeatedly been shown to be a key factor in a solid recovery, and it is important to promote the requisite life style changes in whatever ways are possible.

AVOIDING CERTAIN THERAPEUTIC TRAPS AND DILEMMAS

There are a variety of ways for therapists to become ensnared in resistance. Most patients come to us in distress, and it is easy to dwell on obvious negative consequences of alcohol and drug use as soon as the therapist spots them. The patient may acknowledge negative consequences in the course of the interview, tempting you to make recommendations immediately. Often the patient then expresses ambivalence about whether the problem is “really” that serious, or whether your unexpected recommendations are warranted. This is particularly likely to happen when the patient is seeking sought help for other issues. The patient can then perceive you as unwilling to focus on the areas of primary concern, and a power struggle then ensues. The struggle is compounded if the therapist falls into the trap of cat and mouse, in which the therapist pounces on every indication that alcohol and drugs is a problem and uses every example to “make the case.” The distinction between cat and mouse and providing feedback on negative consequences is frequently one of tone. It is important to remain forthright and utilize opportunities to explore resistance in a calm and constructive manner. You should remain aware of signs of overinvolvement within yourself, or a savior trap in which you become more invested than the patient in addressing his or her substance use.

It is desirable to monitor patient receptiveness carefully at the initial stages. Some secretly view their alcohol and drug use as a serious problem, are frightened about it, and relieved when you articulate concern. Others are only beginning to grasp the seriousness of their problem and need time to digest new information and adjust their perspective. If you can allow the patient to talk about the benefits of drinking and/or using while listening without judgment, the patient is more likely to perceive you as one who can understand the complexity and allow him to move at a manageable pace. At the same time, you should carefully note the perceived benefits of substance use or positive functions it still serves, as these will need to be addressed in the course of treatment. For example, if your patient uses alcohol to initiate communication with her

husband on difficult issues, you might acknowledge this benefit of drinking and offer to help her address these issues in other ways.

Some therapists are prone to making certain types of therapeutic errors with substance-abusing patients. When patients feel that reducing or giving up their alcohol and drug use will only make things worse, not better, some therapists may accept this view without challenge and decide that addressing the patient's problematic alcohol and drug use should wait until other problems are sufficiently resolved. But, the more knowledgeable you are about the insidious effects of different drugs, the more easily you can make the case that while substance use may bring short term relief, it can delay or undermine making other therapeutic gains. For example, it is common for patients to tout the enhanced mood they get briefly from marijuana and be unaware that regular use actually exacerbates depression (Bovasso, 2001). Similarly, alcohol elevates a person's mood for a short while before the CNS depressant effects take over. Regular drinking worsens depression over time. It is almost always possible to provide a psychological explanation for substance use, but such insights are usually more helpful once the compulsive use of alcohol and drugs is no longer clouding the clinical picture.

Although aggressive confrontation is not a recommended strategy, some therapists err in the direction of passivity. It is in the nature of serious alcohol and drug problems that the individual with the problem is often unable to acknowledge and see it clearly. This is partly based on lack of understanding about potential negative consequences of use, and partly because these consequences often develop insidiously over time in barely perceptible steps. It is your responsibility to bring these problems into focus. Waiting for the patient to bring up the problem can lead inadvertently to serious consequences and puts the therapist at risk for failure to meet the standard of professional care. It is not necessary to convince a patient that he or she is and addict alcoholic in order to recommend a change in behavior. Some therapists assume that acceptance of the label is essential, but in many cases it is a stumbling block that evokes resistance. These labels are highly stigmatized and often your patient can agree that some change needs to be made long before he or she can digest the implications of what the potential benefits of recovery might be. We will discuss how to navigate these various obstacles in chapters that follow.

FINAL COMMENT

In this chapter we have described essential ingredients of an integrated approach to treating patients with SUDs. Our treatment model embodies diversity and flexibility: differing theories are drawn upon to understand and treat patients and differing interventions are woven together as they move through different stages of recovery. Various elements are integrated in a way that allows treatment to operate on several different planes at once, moving freely among different theoretical orientations, treatment approaches, and techniques. The integrated model encourages therapists as well as patients to remain open-minded and flexible, recognizing the true complexity of SUDs and the need to become versatile in managing the broad array of issues that arise with patients who abuse alcohol and drugs. Above all, we do not take a doctrinaire approach, as we believe strongly that patients with SUDs require treatment that is individualized and able to adapt to their changing needs.

Being fundamentally pragmatic, the guiding principles of the integrated approach are:

1. Start where your patients are, not where you or others want them to be.

2. Give your patients permission to resist so you can dance, not wrestle with them
3. The first and foremost goal of treatment is not abstinence, but to engage and encourage patients so they come back
4. Establishing a solid therapeutic relationship with your patients takes precedence over everything else, except their safety.
5. Do what works and be open-minded, flexible, and humble enough to change what you are doing if it is not yielding the desired results.
6. Above all, do no harm!