TABLE OF CONTENTS

A. **The Nature of the Challenge: Opioid Crisis**

B. **How to Achieve "Lasting Changes" In the Treatment of Opioid-abusing Patients**

1. **Lessons to be learned from research on treating individuals with other addictive disorders**
2. **Lessons to be learned from research on Motivational Interviewing (MI): Guiding Principles**
3. **Examples of Brief Motivational Interviewing Interventions**

C. **A Constructive Narrative Perspective (CNP) of Addictive Behaviors: An "Addictive Mindset"**

1. **Thinking processes that contribute to and sustain usage: DEFENCES**
2. **Thinking processes that are Predictive of Abstinence: Change Talk predicts treatment outcomes**

D. **Core Tasks of Psychotherapy**

1. **Establish, maintain and monitoring the Therapeutic Alliance**
2. **Use of Motivational Interviewing and Guided Discovery**
3. **Conduct Comprehensive Ongoing Assessments and Provide Feedback: Case Conceptualization Model (CCM)**
4. **Conduct Psycho-education over the Course of Treatment: Use CLOCK Metaphor**
5. **Engage in Collaborative Goal-setting that nurtures Hope**
6. **Help the patient develop Intra- and Interpersonal skills**
   a) **Build in Generalization Guidelines**
   b) **Bolster Resilience**
7. **Provide Integrative Treatment to Address Co-occurring Disorders**

a) Integrate Medication-based Interventions: Reasons for treatment non-adherence

8. Conduct Relapse Prevention and Self-Attributional Training

9. Use Active Case Management: Build in Follow-through Procedures

10. References

SOLUTIONS FOR CLINICIANS: HOW TO AVOID RELAPSE AND MAINTAIN POSITIVE TREATMENT EFFECTS

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A. THE NATURE OF THE CHALLENGE

According to SAMHSA (Substance Abuse and Mental Health Services Administration), some 22 million Americans age 12 or older need treatment for substance abuse.

119 million Americans, 12 and older, take prescription pain killers, tranquilizers, sedatives and stimulants like Adderall. That is nearly half of the U.S. population. With regard to the Opioid Crisis in the U.S. consider the following statistics:

- Opioid drug abuse has killed more Americans than the wars in Iraq, Afghanistan and Vietnam combined (Barbara Goldberg, Reuters, Nov. 10, 2017).
- Over 33,000 Americans have died of overdoses in the last 12 months, a 21% increase over the previous year.
- Most overdoses are caused by fentanyl which has replaced heroin as the biggest killer. The introduction of carfentanil- the elephant tranquilizer that is 10,000 times as potent as morphine has further increased overdose deaths.
- Deaths from overdoses now outnumber deaths from car accidents in the U.S..
- Opioid-related deaths among Americans 24 and under almost doubled between 2005 and 2015. Opioid emergency room visits almost doubled in this period from 52/100,000 to 97/100,000.
- Surveys of college students estimate that 7% use opioids and related drugs. The rate among college dropouts and non-college attendees is 13%.
- The sale of opioids has quadrupled between 1990 and 2010. By 2012, doctors were writing 259 million such prescriptions a year in the U.S...
- See the article by Patrick Radden Keefe on the “Empire of pain” in The New Yorker (Oct. 13, 2017) for a critical discussion of the marketing of opioids.
- Prior overdose predicts subsequent overdose and overdose deaths.

B. HOW TO ACHIEVE "LASTING CHANGES" IN THE TREATMENT OF OPIOID-ABUSING PATIENTS

1. Lessons to be learned from research on treating individuals with other addictive disorders. (*See Bemish et al., 2008; Miller & Moyers, 2014, 2017; Miller & Wilbourne, 2002; NREPP - - SAMHSA Registry of 454 Evidence-based Programs*)

http://nrepp.samhsa.gov/Allprograms.asp4 (See cbc.ca/natureofthings) (Search Wasted)

a) Equivalent treatment outcomes across treatment modalities.

- No differences in outcomes between treatment approaches compared to bona fide treatments (Intended to succeed treatment groups)

- As Miller and Moyers (2014) concluded:

> ***"Treatment outcome studies in the area of substance abuse tend to find small to no differences when specific treatment methods are compared with each other, or with treatment as usual".***

- In contrast, there are usually substantial differences among therapists in patient outcomes. Relational factors such as therapist empathy and quality of the therapeutic alliance have been found to be significant determinants of treatment outcome (Miller & Moyers, 2014).

- Studies that have compared differing lengths of treatment for alcohol use have not found differential effects for longer lengths of treatment. Low intensity interventions that focus on assessment, feedback and recommendations to reduce heavy drinking can be effective. There is value to consider the usefulness of Solution-focused Single Session Therapy.

- Longer intensive treatment may be indicated for patients with heavy dependence and co-occurring psychiatric disorders.

- No matter what the form of treatment and no matter what the substance that is being used, there is a high relapse rate (75%). Thus, the challenge is how to achieve "lasting changes".

- To further complicate treatment, over 50% of those who enter treatment will drop out within the first month. Those who drop out have the worse outcomes.

- Treatments that do not work include Educational Films and Lectures, Confrontational Interventions, General Alcohol Counseling, Insight-based Psychotherapy.

- Positive treatment outcomes have been reported for such interventions as Community Reinforcement such as CRAFT (Community Reinforcement and Family Therapy; Brief Motivational Interventions; Cognitive-behavioral Self-control Training; Mindfulness-based interventions; Acceptance and Commitment treatment approaches). Treatment successes are attributable to factors that are common to all therapies. Keep in mind that the quality of the therapeutic alliance is more important than the specific treatment approach. The longer patients stay in treatment, the better the outcome.

- Self-help approaches such as 12 Step AA have been found to be more effective than traditional therapies led by professionals.

- There is a high incidence of co-occurring disorders with substance abuse and a high incidence of a history of developmental victimization. Thus, there is a need to provide integrative treatment interventions for individuals with substance abuse disorder and psychiatric disorders.

- There is a need to recognize that substance abuse disorder is often a chronically re-occurring behavior that requires active follow-through supportive interventions.

- Pharmacological therapies can be effectively integrated with various psychosocial interventions.

- Finally, research on Feedback-Informed Treatment (FIT- Outcomes.com) indicates the value of therapists obtaining session-by-session patient feedback. Seitz and Mee-Lee (2017) describe the benefits of using FIT in an Addiction Treatment Agency. They highlight the beneficial treatment outcomes of creating a therapeutic culture that is outcome-driven and patient feedback-informed. The treatment approach "meets the patient where he/she is at" and obtains session-by-session feedback using ORS (Patient Outcome Rating Scale), SRS, (Session-by-session Rating Scale), and group SRS measures of the quality of the therapist's alliance, treatment fit, and progress in meeting individualized-tailored treatment goals. These patient feedback measures help identify patient trajectory of change and provides the therapist with "red flags" for patient dropping out of treatment. The use of actual real-time data and the accompanying reviews with patients of this feedback has contributed to significantly better lasting treatment outcomes.

Giving the patient a voice in his/her change plan results in better treatment outcomes.

"What did the patient identify as his/her treatment goals?"

"How would the patient know if he/she had achieved his/her goals?"

"How can the therapist help the patient achieve their goals?"

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

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

Guiding Principles of MI

a) Evoke the patient's own concerns and motivations, including consideration about changing;

b) Patient should voice arguments for changing;

c) Therapists should listen with empathic understanding and acceptance;

d) Minimize resistance. Don't oppose it. Avoid argumentation;

e) Nurture hope and optimism. Use collaborative goal-setting of short-term, intermediate, and long-term goals. Be solution-focused that highlight strengths and resources. Highlight exceptions, "in spite of" behaviors described below in the use of Time Lines. Use phrases such as "As yet", "So far."

f) The responsibility for change is placed on the patient. Solicit public commitment statements.

g) Focus on "Change talk" and "Sustain talk" (**DARN**). Use active transitive metacognitive verbs ("Notice, catch, game plan, back up, plan", etc.) and RE verbs such as REgain, REnew, REauthor, Resilient.

Desire - - "I hope, wish"

Ability - - "I can, will be able to..."

Reasons - - "I have to because..."

Need - - "I need to, "I want to", "I must"

SUMMARY OF MI INTERVENTIONS

EE - - Express Empathy

DD - - Develop Discrepancy

RR - - Role with Resistance

AA - - Avoid Argumentation

SS - - Support Self-efficacy

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

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

C. A CONSTRUCTIVE NARRATIVE PERSPECTIVE (CNP) OF ADDICTIVE BEHAVIORS: AN "ADDICTIVE MINDSET"

The role of story-telling "As the adage states - - substance abuse is 10% using and 90% thinking"

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

Acronym Summary: **DEFENCES**

D - - Denial - - Individuals deny that they have an addiction problem and reframe their substance abuse behavior.

E - - Self- Evaluative Thoughts - - Individual's self-talk reflects low self-esteem, low self-worth that contribute to low self-control and absence of self-efficacy.

F - - Fatalistic Thinking - - Individuals self-generative narrative reflects deep-seated feelings of helplessness, powerlessness and uselessness that sustain addictive behaviors.

E - - Evaluative Thoughts About Others - - individuals hold negative views about their relationships with significant others in their lives such as feeling marginalized, vengeful, and unsupportive that sustains addictive behaviors ("***rejected, isolated, lonely***").

N - - Needs-based Beliefs - - Individual's autobiographical reasoning reflects a "tyranny" of "shoulds", "needs", "musts" and "cant's". Self-talk that begins with "I need/can't/must/should X", drives the use of addictive behaviors. Most importantly, continued use is needed in order to avoid withdrawal symptoms and negative reactions.

C - - Illusions of Control - - Individuals are able, at some level, to convince themselves that they can exert control and handle their substance-abuse behaviors. Such "illusions" of control help sustain usage.

E - - Entitlement Thoughts - - Individuals hold a variety of permission-giving beliefs that they deserve and are entitled ("earned the right to use"), and they have few other options for obtaining well-deserved pleasures.

S - - Substance-related Stimulating and Satisfying Thoughts - - Individuals engage in self-talk that highlights the short-term perceived physiological benefits ("high, buzz sensations") that sustains addictive behaviors. These thoughts convey the "tunnel vision" that results from substance abuse and that reflects a strong desire to avoid the "negative effects" of withdrawal and abstinence. A form of self-medication.

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

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

   > ***"Please think about the last time you drank alcohol and felt bad about yourself as a result. This might be a time when you slipped from your sobriety. Please describe in as much detail as possible what happened, how it made you feel, and what you did in response to this event?" (Dunlop & Tracey, 2013a, p. 58).***
   >
   > ***"What was the last time you were tempted to use and did not give into (resisted) the temptation? How did you handle this situation?" (Dunlop & Tracey, 2013b)***

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

CHANGE TALK PREDICTS TREATMENT OUTCOME

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

"I can see what I did was wrong the last time and I can learn from it."

"My obsession with using lifted and I feel relieved."

"I have resisted my cravings before and I can do it again."

"My cravings in the past have passed and these will too."

"Having a craving is not a commandment to use."

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

D. CORE TASKS OF PSYCHOTHERAPY

1. THE CORE TASKS OF PSYCHOTHERAPY INCLUDE:

Establishing, maintaining and monitoring the quality of the therapeutic alliance which entails collaborative development of treatment goals, pathways thinking to achieve these patient goals and a positive affective bond.

a). Need to assess the patient's implicit theory of presenting problems and notions about what is needed in order to change.

b). A critical feature is the therapist's empathy which is the "ability to understand the patient's meaning and to reflect that understanding back to the patient". Be non-judgemental, compassionate, caring, emotionally attuned, and create a safe and trust-engendering therapeutic setting.

c). There is a critical need to obtain session-by-session patient feedback, and review it regularly with the patient.

d). When treatment is conducted on a group basis, then the level of group cohesion and group identification predicts treatment outcome.

e). Be culturally, racially, gender and developmentally sensitive (See Sue et al. 2007).

2. USE MOTIVATIONAL INTERVIEWING SKILLS AND THE "ART OF QUESTIONING": GUIDED DISCOVERY FOCUSING ON "WHAT" AND "HOW" QUESTIONS

a). Possibility of using single session therapy

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

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

"What is your hope for today's meeting?"

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

Questions Derived From a Solution-focused Treatment Approach

"When the problem isn't present (or isn't so bad), what is going on differently?"

"When is the problem not a problem?"

"What do you call the problem? What name do you have for it?"

"When (and how) does the problem influence you and when and how do you influence it?"

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

"What are you willing to change?"

"Given all that you have been through, how have you managed to cope, as well as you have?"

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

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

Additional Illustrative Questions Designed to Engage Patients in Treatment

Help Patients Recognize Their Problems

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

Help Patients Acknowledge Concerns

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

Help Develop Options

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

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

"Suppose tonight, while you were sleeping, a miracle happens, and the problems that led you here were resolved? When you awaken tomorrow, how

will you first notice that the miracle has happened? What will be the first sign that things are better? And then the next? And the next?"

Help Generate Intention To Change

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

Help Reinforce Commitment To Change

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

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

The clinician can then add:

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

1. ***How things are in your life right now and how you would like them to be?***
2. ***What have you tried in the past to bring about such change?***
3. ***What has worked and what has not worked, so we can both be better informed?***
4. ***Worked, as evident by? What were you most satisfied with that you could try again?***

5. ***If we work together on your areas of concern, and I hope we can, how would we know if you were making progress? What would other folks in your life notice?***

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

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

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

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

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

3. CONDUCT COMPREHENSIVE ONGOING ASSESSMENTS AND PROVIDE PATIENT FEEDBACK

a) Use a Case Conceptualization Model (CCM) of risk and protective factors that informs treatment decision making.

b) Assessment should include such patient information as:

i) History of polysubstance use – dependence on Percocet (oxycodone), Vicodin (hydrocodine), fentanyl, heroin, stimulants – Adderall, "mixologist" - - experiment mixing drugs, Opioid overdose or witness overdose in others, prior receipt of Naloxine Kit, post treatment history, trouble with the law.

See Coffin et al. (2017) File 1 for detailed Patient Questionnaire

ii) Consider where, when and how the patient obtained and used drugs. Reasons for use - - loneliness, PTSD, anxiety, depression, sensation-seeking.

iii) Consider the patient's reasons why seek help now?

Tired using/ Avoid arrest/ Choice jail or treatment/ Family and/or friend recommend treatment/ Have child-pregnant/ Feel sick need medical treatment/ Overdosed/ Witness overdose

iv) Level of patient's motivation to change ("buy in") and degree of treatment engagement

c) Assess for risk self/others; safety issues and safety plan; therapy interfering behaviors (**TIBs**); Include Quality of Life Measures.

d) Assess for strengths and resources including a network analysis. Use Genograms.

e) Use Time Lines to develop a life-span perspective of stressors, interventions and strengths.

TIMELINE 1 - - lifetime indicators of stressors and interventions

TIMELINE 2 - - evidence of "in spite of" behaviors and signs of resilience

TIMELINE 3 - - Here and now challenges and future goals (immediate, intermediate and long-term goals). Include a Values assessment.

Use Self-report Scales like Addiction Severity Index, AUDIT, and such measures as Reasons I Use Checklist; Harmful Effects Checklist; Relapse History with accompanying Lessons Learned

4. CONDUCT PSYCHO-EDUCATION OVER THE COURSE OF TREATMENT

This is not a lecture, but an interactive discussion. Can be conducted on a group basis.

a) Psychoeducation includes discussion of how the brain gets addicted; change in neurotransmitters and communication system, and how the lower brain stem – amygdala can "hijack" control from frontal lobes; increase tolerance contribute to "addiction trap". Discuss how drug use wears and tears on the body and narrows perceptual fields "myopia", and reduces behavioral inhibitions - - hyperaccessibility of beliefs and lead to "faulty" thinking; impact of vulnerability factors; and concerns about withdrawal and triggers that can contribute to lapses and relapse."

b) Address safety issue of distributing Naloxone (Narcan) that reverses opiate overdose injected or by spraying up nose.

c) Discuss the nature of "neuroplasticity" and the neurobiological and psychosocial beneficial impact of resilience-engendering behaviors and the value of building and broadening positive emotions.

d) Discuss how the body keeps score of both negative and positive behaviors and emotions ("***History is not destiny***").

e) Use "biological alarm reactions" and use of a reset metaphor.

f) Use **CLOCK** metaphor to educate about the connections of feelings, thoughts and behaviors.

i) 12 o'clock - - External and internal triggers

ii) 3 o'clock - - Primary and secondary emotions

iii) 6 o'clock - - Automatic thoughts and images; Assumptions "If…then" statements, "Thinking Traps", Belief and Developmental Schemas

iv) 9 o'clock - - Behavior and resultant consequences

v) Treat emotions (3 o'clock) as commodities. "***What did you do, if anything with your feelings of X?***"

"If you did that with your feelings of X then what is the impact, toll"; what is the price you and others pay?"

vi) Have the patient(s) appreciate how they appraise events (12 o'clock), have accompanying feelings (3 o'clock) and thoughts (6 o'clock) and behaviors (9 o'clock) can become a "vicious cycle".

g) Have the patient self-monitor and discuss ways to break the "vicious cycle"

5. ENGAGE PATIENT IN COLLABORATIVE GOAL-SETTING THAT NURTURES HOPE: SMALL WORKABLE DOABLE SMART GOALS

(Specific, Measurable, Attainable, Relevant, Time-limited)

a) Be on the lookout for Over Generalized Memories (OGM) on the part of the patient (non-specific thinking of past and future)

b) Use future-imagery procedures and help the patient develop "Sobriety Scripts"

6. HELP THE PATIENT DEVELOP INTRAPERSONAL AND INTERPERSONAL SKILLS

a) Emotion regulation skills- increase self-awareness; develop distress tolerance; self-soothing, self-acceptance skills.

b) Learn to focus attention. Use relaxation and mindfulness skills; SOS skills - - Slow down; orient; self-check).

c) Learn urge-surfing skills. Use metaphor of wave and cravings control. Trigger analysis.

d) Build and broaden positive emotions (compassion to others and self; forgiveness; gratitude; humor; awe).

e) Goal-plan-do-check). Use a 2x2 analysis (Pros-Cons and short and long term analysis).

f) Highlight possible "sabotage thinking" and "thinking traps". Use INSTEAD thinking processes and permission-giving thinking.

g) Help develop interpersonal skills of refusal skills, access prosocial abstinent supportive social network. Address developmental attachment disorder when present ("***What lingers from the victimization?" "What conclusions do you draw about yourself, others and the future as a result of experiencing X?").***

h) Build an "Islands of competence", strengths, resilience, "In spite of behaviors", "Exceptions".

(Ask "How" and "What" questions)

i) Encourage the patient to engage in meaning-making activities; Acts of kindness; Making a "gift" of one's experience - - Lessons learned. Encourage the patient to be in a consultative role teaching others.

When conducting skills raining on a group basis use Conversation Starters of quotes; Use CLOCK group procedure; Ask one thing that each patient will take away from this session (Ticket out the Door)? Request that the patient make one commitment you will complete before next meeting.

a) **DO NOT "TRAIN AND HOPE" FOR TRANSFER: BUILD IN GENERALIZATION GUIDELINES**

b) What to do before, during and after skills training in order to increase the likelihood of generalization and maintenance

(See Meichenbaum Handouts on www.melissainstitute.org)

c) Have the patient fill out Patient Checklist of skills learned; Reasons why using these skills will help the patient achieve treatment goals; possible barriers and plans and back-up plans to anticipate and address potential barriers.

d) Put patient in a Consultative Mode – "become own therapist" Lessons to make a gift; how all others.

i) Use Patient Checklist, Recovery Strategies Checklist

ii) Assess for Self-efficacy (confidence) and Reasons and Barriers Analysis

iii) Focus on developing Sobriety/Abstinence Scripts: How handle high-risk situations

7. PROVIDE INTEGRATIVE TREATMENT TO ADDRESS CO-OCCURRING PSYCHIATRIC DISORDERS WITH ADDICTIVE BEHAVIORS: ADDRESS TREATMENT OF PTSD, COMPLEX PTSD, SUDs, AND OTHER DISORDERS

a) Consider lingering impact of Adverse Childhood Experiences (ACE) or other Traumatic Victimizing Experiences

b) Attend to the stories" patients tell themselves and others.

c) When indicated, include Medication-assisted treatment to reduce cravings and to address avoidance of withdrawal symptoms (Naltrexone – Vivitrol; Buprenorphine - - Suboxone; Methadone).

Consider reasons for treatment non-adherence

a) "Doubting Thomas" - - scientist-type thinking

b) Think like an economist (pros and cons for compliance)

c) Deep-seated beliefs and developmental schemas

8. CONDUCT RELAPSE PREVENTION AND SELF-ATTRIBUTIONAL ("TAKING CREDIT") TRAINING PROCEDURES

a) Focus on triggers and sabotage thinking

b) Have patient self-monitor; keep a Risk diary; plan ahead; use mental (imagery-based) and behavioral rehearsal; create a more balanced and satisfying lifestyle with "positive addictions"; develop a new social network that supports abstinence; make a "gift" of what learned; learn to keep on keeping on.

a) Involve significant others; network building activities; use CRAFT procedures (***Community Reinforcement and Family Therapy- - see www.cadenceonline.com***)

b) Social support for college students - - The Haven at College: Recovery management (Peer meeting and support, Individual Counseling, Drug testing, Family consultation, Personal Accountability)

c) Where indicated, incorporate self-help groups; Internet Resources; 12 Step-Type Programs, and SMART Recovery.

d) Bolster Resilience – engendering behaviors in Physical, Interpersonal, Emotional, Cognitive, Behavioral and Spiritual Domains.

e) See Meichenbaum's book Roadmap to resilience

www.roadmaptoresilience.com

9. USE ACTIVE CASE MANAGEMENT; BUILD IN BOOSTER SESSIONS; FOLLOW-THROUGH PROCEDURES AND ON AN ONGOING BASIS MONITOR SUBSTANCE ABUSE

10. HELP WITH QUALITY OF LIFE ISSUES (HEALTH, EMPLOYMENT, ROLE RESPONSIBILITIES)

i) Write out and discuss a self-care plan and ways to avoid revictimization

11. OBTAIN PATIENT SATISFACTION FEEDBACK

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