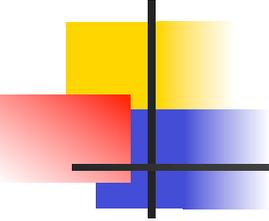


Flexible Goals & Strategies for Change: An Integrative Approach

Arnold M. Washton, Ph.D.

RECOVERY OPTIONS

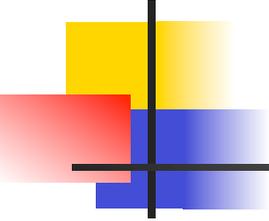
New York, NY & Princeton, NJ



Websites

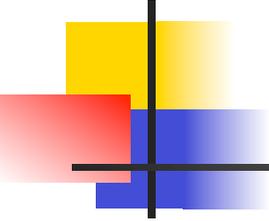
❖ www.RecoveryOptions.us

❖ www.ModerateDrinkingOptions.com



References & Recommended Reading

1. Motivational Interviewing (Miller & Rollnick)
2. Practicing Harm Reduction Psychotherapy (Denning)
3. Harm Reduction Psychotherapy (Tatarsky)
4. Working with the Problem Drinker (Berg & Miller)



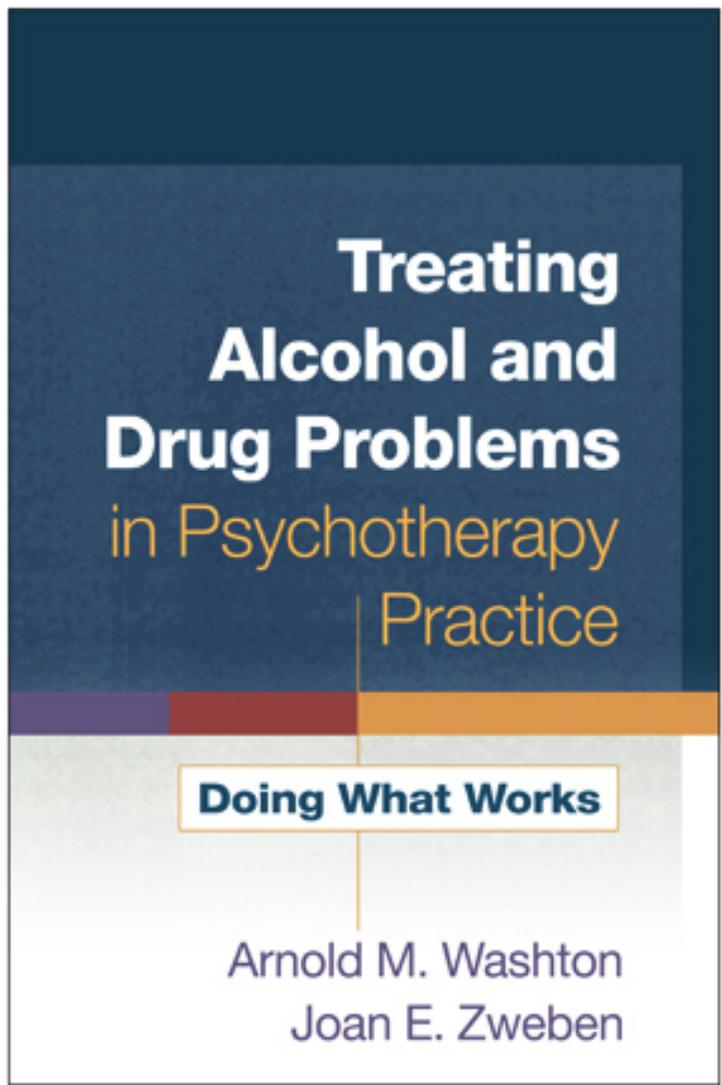
References & Recommended Reading

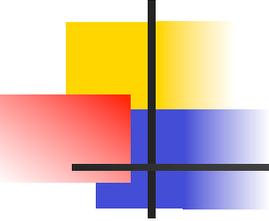
5. The Heart of Addiction (Dodes)
6. Addiction and the Vulnerable Self (Khantzian..)
7. Substance Abuse Treatment and Stages of Change (Connors et al.)
8. Rethinking Drinking
(RethinkingDrinking.niaaa.nih.gov)



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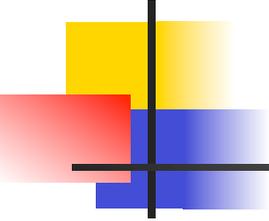
Guilford, 2006





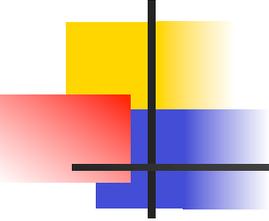
Today's Presentation

- I. Limitations of Current Treatment
- II. Principles & Elements of the Integrative Approach
- III. Assessment, Goal Setting, Specific Treatment Interventions



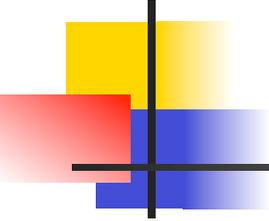
Limitations of Current System

- Countless substance users are underserved
- Majority are not in treatment
- One size does not fit all, no approach is best for everyone
- Population is highly diverse:
 - Severity of substance use & its consequences
 - Nature and severity of co-occurring disorders
 - Motivation and stage of readiness for change
 - Desired treatment goals



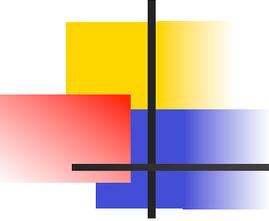
Limitations of Current System

- Many substance users:
 - Do not want to stop using
 - Do not accept lifelong abstinence as their goal
 - Do not embrace the disease model (>95% of U.S. programs)
 - Unwilling to adopt identity of “addict-alcoholic”
 - Perceive their problem as not severe enough to warrant what traditional treatment requires (they may be right)



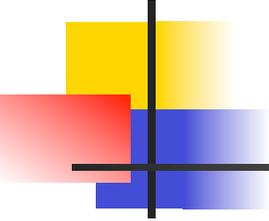
Limitations of Current System

- Mostly agency based programs
- Group therapy is primary modality, individual therapy is scarce
- Patients must fit themselves into the program rather than vice versa, especially those with emerging or early-stage problems



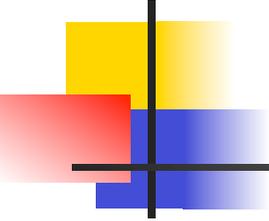
Limitations of Current System

- Current treatment more boilerplate than individualized
- Designed to treat mainly high-severity SUDs
- Not good fit clients with less severe problems (i.e., abuse) or in early stages of change
- Likely to be labeled by treatment providers as “resistant”, “unmotivated”, “in denial”



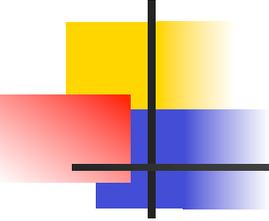
Limitations of Current System

- Not everyone with an alcohol or drug problem has the disease of addiction
- The more severe a person's alcohol/drug problem, the better it conforms to the disease model
- There are at least **four times** as many “problem drinkers” vs. alcoholics in the U.S. (NIAAA)



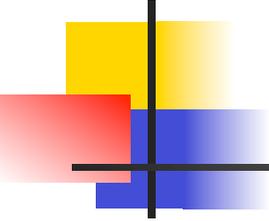
Limitations of Current System

- Providing flexible alternatives to abstinence-only disease model approaches can potentially attract many more people into treatment before they develop more serious problems
- Moderation is a realistic and achievable goal for many people with less severe drinking problems who are not alcoholics
- Many people who start with moderation, end up choosing abstinence, including people who would not have entered treatment at all



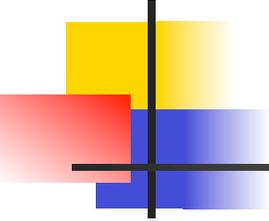
Limitations of Current Treatment System

- Many dropouts caused by aggressive confrontation-of-denial and other authoritarian tactics
- Lacking more attractive treatment alternatives, many substance users avoid getting help altogether (sometimes with dire consequences)



Limitations of Current System

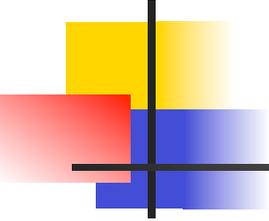
- At other end of spectrum are psychotherapists who enable substance users by failing to adequately assess and intervene
- Some join patients in seeing substance use as not the “real” problem by focusing instead on underlying emotional and psychological issues



Project MATCH

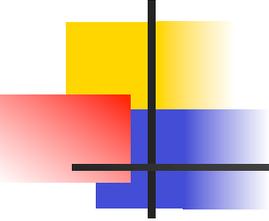
Which treatment approach is best?

- Large multi-site study funded by NIAAA
- Outpatient treatment setting
- Compared three of the most widely used treatment approaches



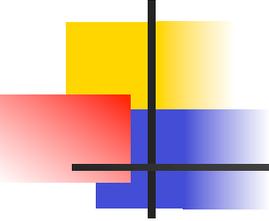
Project MATCH

- Motivation Enhancement Therapy
- Cognitive-Behavior Therapy
- 12-Step Facilitation Therapy
- Individual therapy format
- Delivered by either addiction counselors, clinical social workers, psychologists



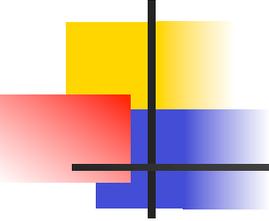
Project MATCH

- No difference between TSF, MET, CBT in retention and outcome
- No difference related to therapists recovery status or credential/degree level
- Significant differences based on therapists' clinical style & stance toward patients
- Therapists with a more empathic and engaging rather than confrontational style produced the best outcomes!



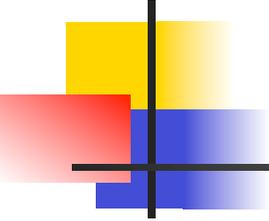
Conclusions

The clinician's therapeutic style, stance, and attitude toward the substance-using client is more important in determining treatment engagement, retention, and outcome than the clinician's treatment philosophy, degree level, or personal experience with addiction and recovery.



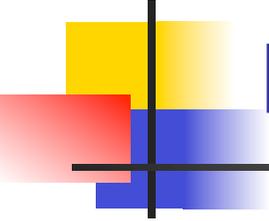
Amazing!

It has taken over 30 years of clinical research and hundreds of millions of dollars to find out that substance abuse treatment actually works better when clinicians are NICE to the patients !!



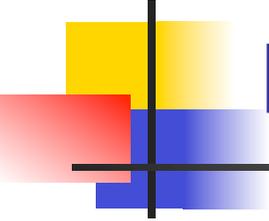
Bill W. (1955).....

"Real tolerance of other people's shortcomings and respect for their opinions are attitudes that make us more useful to others. **Never talk down to an alcoholic** ! He must decide for himself whether he wants to go on. He should not be pushed or prodded. If he thinks he can get sober in some other way, encourage him to follow his own conscience. **We have no monopoly.** We merely have an approach that worked with us. "



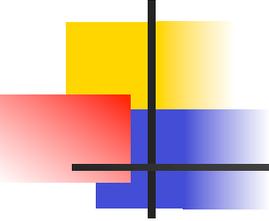
Principles of Integrative Approach

- Non-dogmatic, client-centered, atheoretical approach
- Avoids adherence to any single treatment orientation or philosophy in favor of doing “what works”
- Utilizes a toolbox of different treatment models, approaches, strategies, and interventions some of which may seem incompatible
- Do “what works”
- Above all, do no harm!



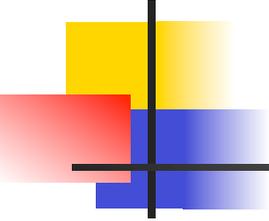
Principles of an Integrative Approach

- Brings the basic tenets of psychotherapy into the treatment of SUDs
- Puts primary emphasis on the therapeutic relationship
- First and foremost goal is to engage patients “where they are”



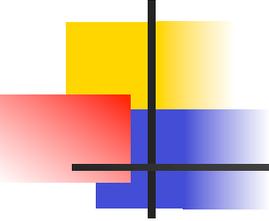
Principles of an Integrative Approach

- Consumer friendly, low-threshold entry to treatment
- Empowering, motivating, non-authoritarian
- Matched to problem severity and patient's motivation/readiness for change



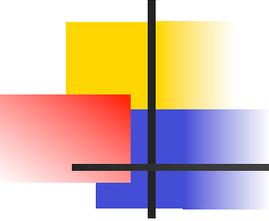
Principles of an Integrative Approach

- Designed to approach patients “where they are” rather than where the treatment provider dictates they “should be”
- Recognizes the therapeutic relationship and engagement/retention as keys to treatment success
- Respects the client’s concerns and definition of the problem as a legitimate starting point for treatment



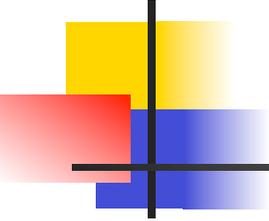
Principles of an Integrative Approach

- Comprehensive and able to address the substance use behavior itself, co-occurring disorders, and related emotional/psychological issues with appropriate emphasis and timing
- Recognizes a CONTINUUM of SUDs, not only Abuse and Dependence, and a continuum of negative consequences
- Recognizes patients' autonomy and freedom to choose their own treatment goals, regardless of what the clinician might think is best



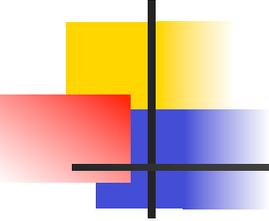
Principles of an Integrative Approach

- SUDs are complex behaviors with complex etiologies
- Multiple, interacting, often unknown causes
- Abstinence provides the greatest margin of safety, but any steps taken to reduce substance-related harm are steps in the right direction
- Goals must be client-driven, not diagnosis-driven



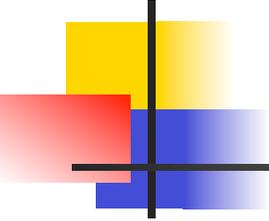
Principles of an Integrative Approach

- Treatment more likely to succeed when patients choose and are personally invested in goals and methods to achieve those goals
- Does not require patients to see themselves as “addicts-alcoholics” or accept their problem as a “disease” in order to make meaningful, lasting change



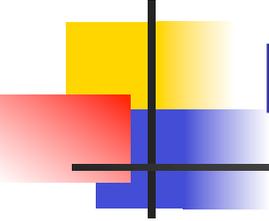
Principles of an Integrative Approach

- Encourages clinicians to be aware of and appropriately manage negative countertransference reactions (e.g., anger, sarcasm, rejection) toward patients who do not comply with recommendations, continue to use, etc.



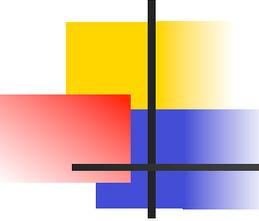
Principles of an Integrative Approach

- Clinicians should not hesitate to inform patients of the risks of continued substance use, the potential value of abstinence, and what type of treatment might be best (including inpatient care, if needed)
- Recognizes that clinicians differ in willingness to treat patients who continue to engage in highly destructive patterns of substance use



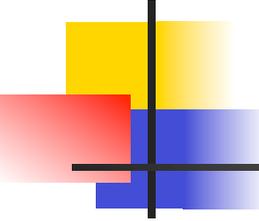
Principles of an Integrative Approach

- Appreciation for **PSYCHOLOGICAL** factors intertwined with addiction
- Addiction does not develop in a vacuum
- People rarely (if ever) become addicted during a time in their life when they are feeling reasonably happy and self satisfied
- Addiction flourishes when people are exposed to chronic inescapable stress that exceeds their coping abilities and they feel powerless to do anything about it



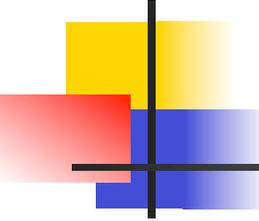
Principles of an Integrative Approach

- There is a strong connection between adverse childhood experiences (various types of physical and psychological trauma) and later development of addictive disorders
- Mood and other psychiatric disorders are neither necessary or sufficient to cause addiction.
- Alleviating psychiatric symptoms with medication does not prevent relapse to substance use
- Addiction is not in the drug. It is in the person using the drug
- The vast majority of people who use “addictive” drugs do not become addicted to them



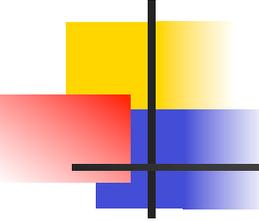
Psychological factors

- Disease model explains how chronic alcohol/drug use ultimately changes brain, behavior, and personality, but it does not explain what motivates some people to use these substances intensively and to the point of ending up with an addicted brain



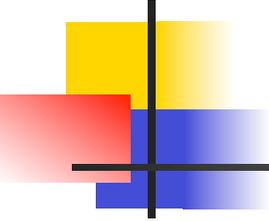
Psychological factors

- Addiction can be seen as a disorder of affect and self-esteem regulation
- Substances are used initially as an attempt to cope
- Addiction develops when chemicals are used repeatedly and habitually as coping strategies



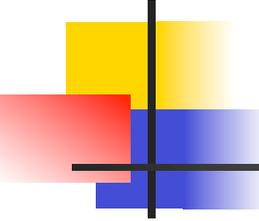
Psychological factors

- Addiction-prone people often lack the ability to reliably identify, modulate, tolerate, and appropriately utilize/express feelings
- Addiction develops only to substances that actually work to alleviate problems and/or enhance functioning
- Using substances to manage moods and internal affects is maladaptive because it disables the “signal value” of emotions
- Without emotional “radar” painful collision with reality is inevitable



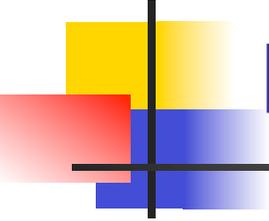
Elements of Integrative Approach

- **Stages of Change Model** to accurately match treatment interventions to the patient's stage of readiness for change
- **Motivational Interviewing** techniques to facilitate patient engagement and to enhance patient motivation and readiness for change



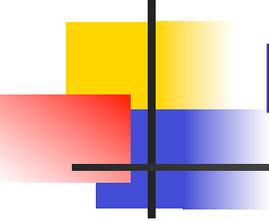
Elements of Integrative Approach

- **Cognitive-Behavioral Techniques (CBT)** to facilitate behavior change, prevent relapse, manage cravings/urges and negative emotions/moods, acquire adaptive non-chemical coping skills as alternatives to habitual self-medication with alcohol/drugs
- **DBT and ACT** to manage overwhelming and disruptive affects/moods



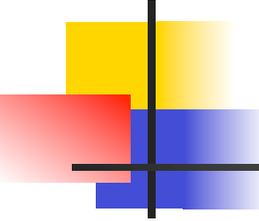
Elements of Integrative Approach

- **Pharmacotherapy** to treat co-occurring mood/anxiety disorders, facilitate relapse prevention
- **Disease Model** to reduce stigma, shame/guilt, to support need for total abstinence, provide “roadmap” for recovery, encourage AA involvement, remove serious risk



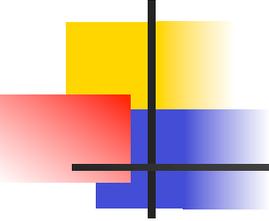
Elements of Integrative Approach

- **Harm Reduction Strategies** for initial engagement and as incremental approach for patients unwilling to embrace abstinence
- **Self-Medication Model & Modified Psychodynamic Therapy** to address “self-medication” aspects of substance use and other core psychological issues intertwined with the use



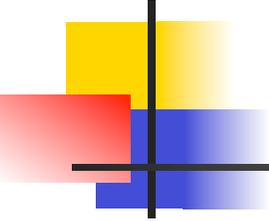
Self-Medication Model (Khantzian)

- Substance use is initially adaptive, an attempt to cope-- with stress, negative emotions, lack of assertiveness, social anxiety, etc...
- Because substances instantly reduce negative emotions and enhance functioning, they become extremely powerful and compelling reinforcers



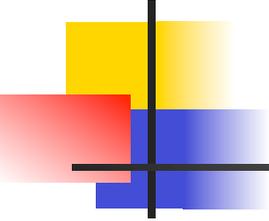
Self-Medication Model

- Addiction vulnerability stems from deficits in four core areas: affect regulation, self-care, self-esteem, and interpersonal relationships
- Feelings often are vague, ill-defined, confusing
- Feelings are poorly regulated and poorly tolerated
- Feelings are usually acted out (expressed through action), rather than worked out (processed adaptively)



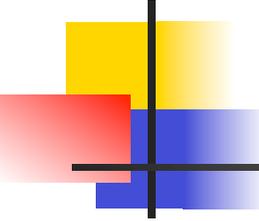
Self-Medication Model

- Some people are overwhelmed by their feelings (“affective flooding”)
- They have an inadequate stimulus barrier and deficient affect management or self-soothing abilities.
- They are likely to choose depressant drugs (e.g., alcohol, tranquilizers, opioids)



Self-Medication Model

- Other people feel too little, have an overactive stimulus barrier, are emotionally numb, lack signal anxiety, and have impaired affect recognition skills (alexithymia)
- Lack emotional “radar” which leads to maladaptive behavior (failure to recognize, attend to, and cope with real life problems)
- My gravitate toward stimulant drugs such as cocaine or methamphetamine which induce feelings of sexuality, being alive, and the illusion of being emotionally present



Stages of Change Model

- To facilitate “starting where the patient is”
- To enhance patient-treatment matching
- To prevent the misalliance of patient and clinician working in different stages of change
- Treatment programs usually expect patients to be ready for change, but many are in the early stages of acknowledging the problem, let alone committing to a definitive course of action

Readiness to Change Paradigm

Is the patient's goal to reduce or stop use?

x resistance x ambivalence x

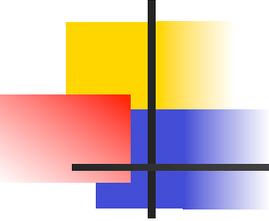
Not considering
Change
Precontemplation

Thinking
about
change
Contemplation

Ready to
Change
Preparation

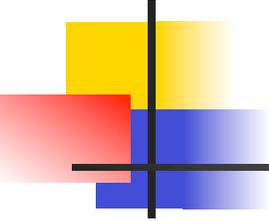
Taking
Action
Action

Maintaining
Change
Maintenance



Five Stages of Change

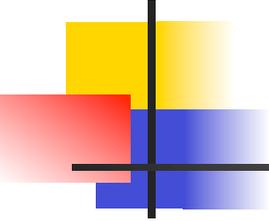
1. **Precontemplation-** Not seeing the behavior as a problem or feeling a need to change it (“in denial”)
2. **Contemplation-** Ambivalent, unsure, wavering about necessity and desirability of change
3. **Preparation-** Considering options for changing in the near future



Five Stages of Change

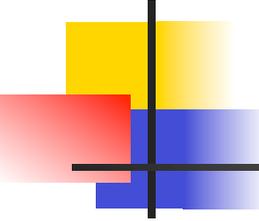
4. **Action-** Committed to a specific action plan, taking specific steps to change behavior
5. **Maintenance (relapse prevention)-** Sustaining changes, working to prevent backsliding/relapse

[In this model, RELAPSE is defined not simply in terms of substance use per se, but as any regression back to an earlier stage of change]



Assessing Readiness to Change

- Elicit the patient's view: How do you see your substance use and to what extent do *you* see it as a problem?
- What concerns *you* the *most* about your use?
- What do you see as the *positive* benefits of your substance use, how does it still *help* you?
- What do *you* see as the potential *benefits* of reducing/stopping?
- What do *you* see as the potential *drawbacks* of reducing/stopping and what obstacles that might get in the way
- How would *you* like to proceed?

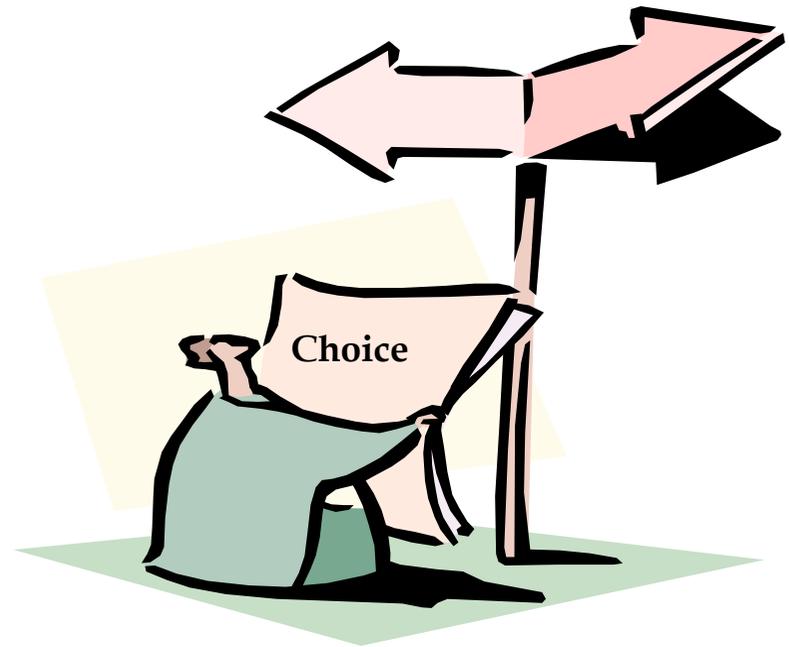


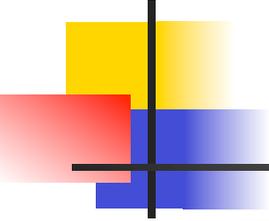
Stage-Appropriate Goals

- Precontemplation- Increase awareness, raise doubt
- Contemplation- Tip the balance toward change
- Preparation- Select the best course of action
- Action- Initiate change strategies
- Maintenance- Learn and practice relapse prevention strategies
- Relapse- Get back on track with renewed commitment to change

Motivational Strategies

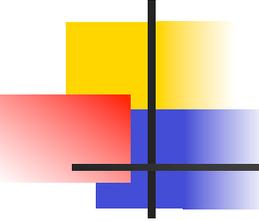
- Normalize client doubts
- Amplify ambivalence
- Avoid arguments & power struggles
- Support self-efficacy
- Roll with resistance
- Offer choices





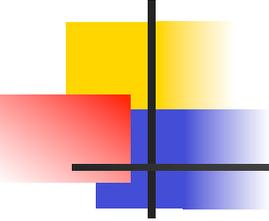
Motivational Approach

- Therapist style exerts a powerful influence on client resistance and readiness to change
- Therapist style can either provoke or diminish (side-step) “resistance”
- Argumentation, aggressive confrontation, and pressure tactics are poor methods for inducing change
- When resistance is evoked the therapist should back off and find a creative way around it



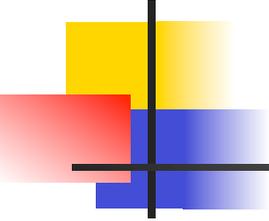
Working With AMBIVALENCE

- Unhelpful to think of clients as “poorly motivated” (engenders negative interaction)
- How you respond to ambivalence determines whether you increase or decrease the client’s readiness for change.
- Clinicians often jump too quickly and too far ahead in pressuring for change--- provokes resistance
- Problems of clients being “unmotivated” or “resistant” occur when a clinician is using strategies mismatched to the client’s stage of change



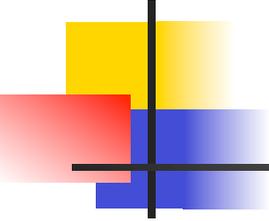
Assessment

- Beginning of treatment
- Beginning of the therapeutic relationship
- Assessment is a two-way process (YOU are being assessed too!)



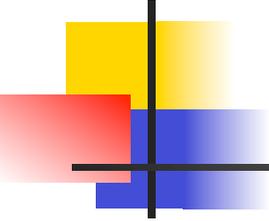
Assessment

- Why NOW? (external and internal motivators)
- Substance use profile (in-depth functional analysis)
- Other addictive/compulsive behaviors
- Co-occurring MH and other life problems
- Family history
- Previous attempts to reduce or stop with or w/o treatment



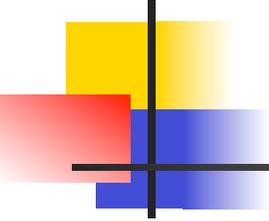
Assessment

- Personal goals
- Stage of readiness for change
- Potential obstacles to change
- Location on continuum of substance use & consequences
- Risk assessment (including need for medical and/or psychiatric intervention)



Assessment Tools

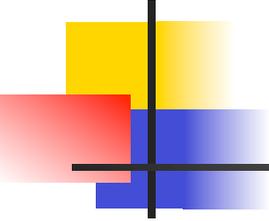
- Clinical face-to-face interview is by far most important assessment tool
- Washton New Patient Questionnaire
 - www.RecoveryOptions.us
 - www.ModerateDrinkingOptions.com
- Alcohol Use Disorders Test (AUDIT)
- www.DrinkersCheckup.com



Substance Use Profile

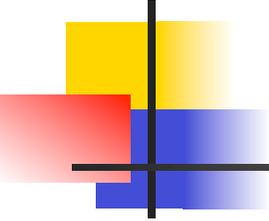
In-depth functional analysis (typology) of the nature, extent, role, aftermath, and consequences of use

- Types, amounts, frequency of substances used
- Routes of administration
- Temporal pattern (continuous, episodic, binge)
- Changes over time



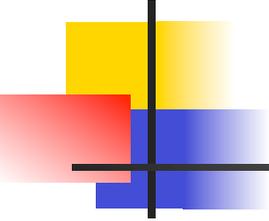
Substance Use Profile

- Environmental antecedents (external “triggers”)
- Emotional antecedents (internal “triggers”)
- Settings and circumstances of use
- Aftermath of use (physical, emotional, relational)
- Linkage between use of multiple substances
- Linkage with non-chemical compulsive behaviors (sex, gambling, spending, eating)



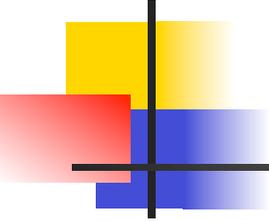
Substance Use Profile

- Perceived *positive* benefits of use
 - What first attracted you?
 - How has it helped you? (self-medication value)
 - Does it still work as well?
 - What would be the downside of not using?
- Adverse consequences
 - Physical, psychological, vocational, social, etc.



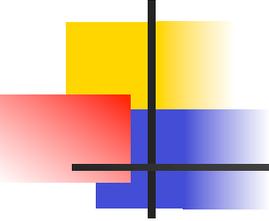
Continuum of Use

- DSM-IV lumps all SUDs into only two categories, *Abuse* and *Dependence*
- Ignores that there is a continuum of substance use and substance-related harm
- Provides no severity rating for the disorders or their consequences



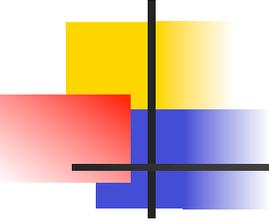
Proposed DSM-V Revisions

- Eliminates separate categories of Substance Abuse and Dependence (research studies found no sharp distinction between them)
- Replaces them within one unified category of “**Substance Use Disorder**”
- Adds a Severity Rating
 - Moderate: 2-3 criteria are met
 - Severe: 4 or more criteria are met



NIAAA Drinking Categories

- Low-risk
- At-Risk/Hazardous Drinker
- Problem Drinker- Alcohol Abuse (DSM-IV 305.0)
- Alcohol Dependence/Alcoholism (DSM-IV 303.9)



Assumptions

- Not all problem drinkers are alcoholics
- Abstinence is the safest, but not the only goal, especially for drinkers with less severe problems
- Moderation is a realistic and achievable goal for many problem drinkers who are not alcoholics
- Reducing alcohol-related harm is a desirable goal

“Standard Drink”

Each contains approximately 14g of pure ethyl alcohol



**12 ounces
BEER**

=

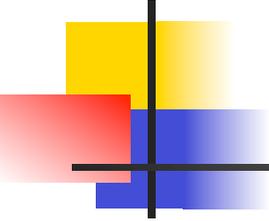


**5 ounces
WINE**

=



**1.5 ounces
LIQUOR**



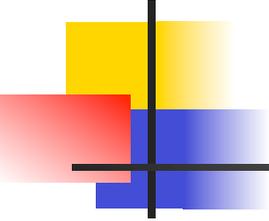
Common Drinks

- Cocktails (mixed drinks) usually contain 2-3 standard drinks depending on how they are made
- Bottle of table wine (750 ml) holds about 5 standard drinks
- “Fifth” of liquor (750 ml) contains 17 standard drinks

Champagne intoxicates more quickly!



Because carbonation accelerates absorption of alcohol into the bloodstream and brain



NIAAA “Low Risk” (Moderate) Drinking Limits

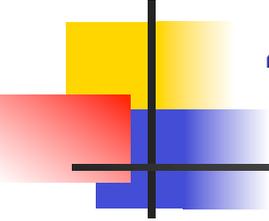
Note: These are UPPER LIMITS, not recommended levels of alcohol consumption

MEN

- No more than 14 drinks per week (2 per day)
- No more than 4 drinks on any one occasion

WOMEN & Anyone 65 or Older

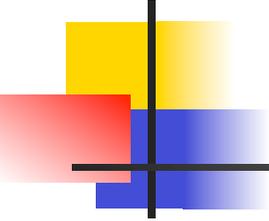
- No more than 7 drinks per week (1 per day)
- No more than 3 on any one occasion



“Low Risk” Drinking- CAVEATS

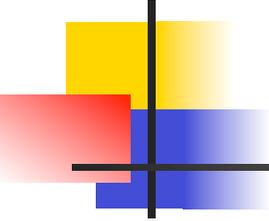
PRESUMES ABSENCE of other risk factors:

- Pregnancy or attempted pregnancy
- Medical or psychiatric conditions exacerbated by alcohol use
- Medications that interact adversely with alcohol
- Prior personal or family history of addiction
- Hypersensitivity to alcohol



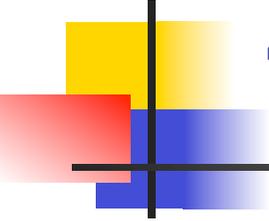
Low Risk (Moderate) Drinking

- No compulsion to drink, no adverse consequences
- Based not only the total number of drinks consumed in a given day, but also the rate of drinking so that the blood alcohol concentration (BAC) does not rise too quickly or too high (.05% or lower)
- For most people, this means drinking (sipping) no faster than one drink per half-hour (not on empty stomach)



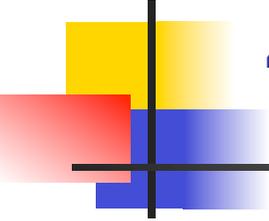
NIAAA “At Risk” Drinking

- Frequently exceeds recommended limits
- Has not yet caused serious adverse consequences, but poses risk of consequences
- Prime target for early intervention and preventive efforts



“Problem Drinking” ALCOHOL ABUSE

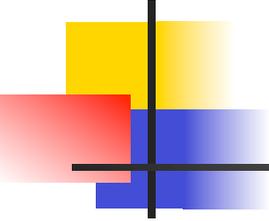
- Evidence of recurrent medical, psychiatric, interpersonal, social, or legal consequences related to alcohol use; OR
- Being under the influence of alcohol when it is clearly hazardous to do so (e.g., driving, delivering health care services, caring for small children)
- No evidence of physiological dependence
- No prior history of alcohol dependence
- No compulsion or obsession to drink



“Alcoholism” ALCOHOL DEPENDENCE

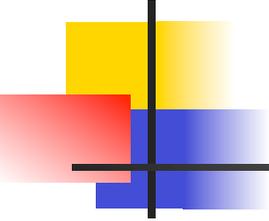
BEHAVIORAL syndrome characterized by:

- Compulsion to drink
- Preoccupation or obsession
- Impaired control (amount, frequency, stop/reduce)
- Alcohol-related medical, psychosocial, or legal consequences
- Evidence of withdrawal- not required
- Evidence of tolerance- not required



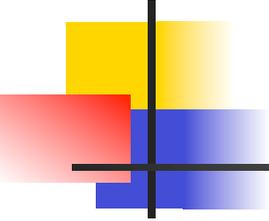
Abstinence or Moderation?

- Total abstinence is the safest, most informative course
- But only the client can choose, no matter what you think is best
- Many refuse abstinence, but willing to try moderation
- Some willing to try “experiment” with abstinence
- Your goal is to “start where the person is”
- Goals must be patient driven, not diagnosis or clinician driven !
- The first and foremost goal is to engage the patient in a therapeutic relationship



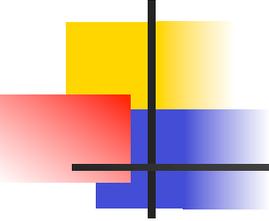
Choice of Goals

- Abstinence (temporary “experiment” or permanent)
 - Total- from all psychoactive substances
 - Partial- from substances causing the most harm
- Gradual tapering toward abstinence (“warm turkey”)
- Trial moderation- a specific plan to reduce amount and frequency of use
- Harm reduction (moderation) strategies
- No specific plan right now for behavior change, ask permission to continue the dialogue



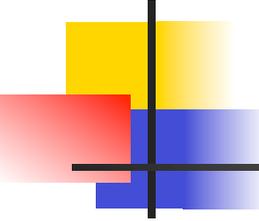
Controversy About Non-Abstinence Goals

- Dangerous enabling?
- Holds out false hopes, controlled drinking has been proven to be dangerous and ineffective
- Gives permission to engage in very risky, potentially fatal behaviors
- Denies that addiction is an incurable disease characterized by progression and permanent loss of control



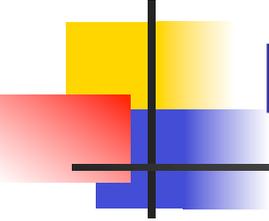
Non-Abstinence Goals: Rationale

- Although abstinence is the safest course, it is far better to engage people in a process of incremental change than to turn them away until they “hit bottom” or cause more harm to self and others
- Clinicians can encourage abstinence without making it a precondition of providing treatment
- **A professionally guided attempt at moderation is often the best way for clients to learn through their own experience whether moderation is a realistic goal.**
- Those unable to succeed at moderation often become more motivated to abstain



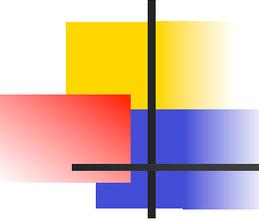
Poor Candidates for Moderation

- Heavy drinkers who are physically addicted to alcohol and/or those who have suffered serious alcohol-related problems
- Formerly dependent drinkers (i.e., alcoholics) who have been abstaining
- People with a history of dependence on other drugs



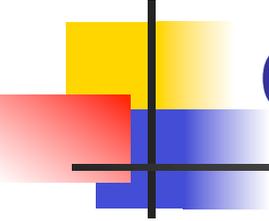
Poor Candidates for Moderation

- People who drink and drive, operate other potentially dangerous machinery, or engage in safety-sensitive tasks requiring coordination, attention, and skill
- Individuals taking medications, including over-the-counter medications, that may interact adversely with alcohol
- People who lose control of their behavior (e.g., become aggressive or violent even at moderate levels of alcohol consumption)



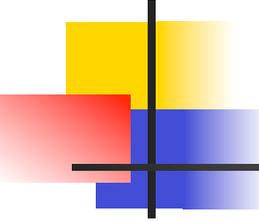
Poor Candidates for Moderation

- People who drive while intoxicated, have been arrested for driving while impaired, and/or have been in serious alcohol-related accidents
- People in recovery and others with a history of serious alcohol problems who have already been abstaining from alcohol
- Anyone with a medical or psychiatric condition that would only be made worse by drinking, even in moderation



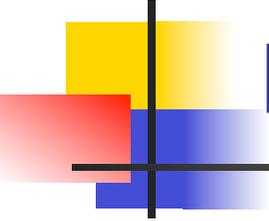
Good Prognosis Candidates

- Early stage problem drinkers (non-alcoholics)
- Believe moderation is a worthwhile and attainable goal
- Attempt at moderation not likely to threaten important relationships or job security
- Have a social network supportive of moderation
- Willing to dedicate time and effort to the process



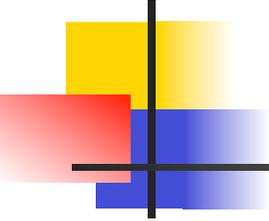
Good Prognosis Candidates

- Not in the throes of emotional turmoil, physical illness, or significant life crisis
- Drinking has been problematic for no more than the past 5 years (the shorter, the better)
- AUDIT scores below 16 (the lower, the better)
- No current abuse of other substances



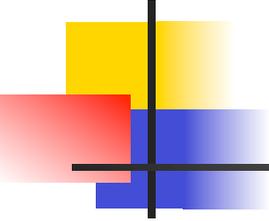
Moderate Drinking Strategies

- Establish specific drinking goals and rules
- Keeping a log of alcohol consumption
- Switch to lower-proof beverages
- Space drinks and sip more slowly
- Eat before and during drinking episodes
- Drink water or soda to dilute the effects
- Avoid drinking with heavy drinkers
- Avoid drinking when emotionally upset



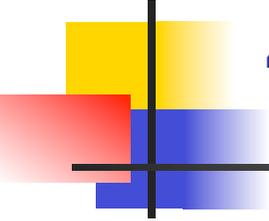
“Experiment” with Abstinence

- See things through “different set of eyes”
- Provides extremely useful clinical data
- Clarifies role of use in patient’s life
- Reveals nature and extent of reliance on chemical coping-“self medication”



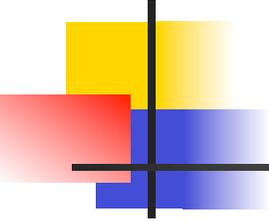
“Experiment” with Abstinence

- Reveals impact of abstinence on mood, affect, stress sensitivity, relationships, coping skills
- Identify internal/external triggers of use
- Reveals ability or inability to stop using



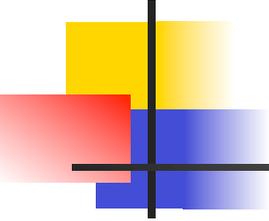
“Experiment” with Abstinence

- Can provide a clearer picture of how substances fit into clients’ lives with regard to situations, thoughts, and feelings related to the use
- Encourage clients to pay close attention to moods, thoughts, feelings, dreams, and physical sensations that both precede and follow substance use
- Careful, detailed, nonjudgmental debriefing and deconstruction of any instances of substance use or “close calls”



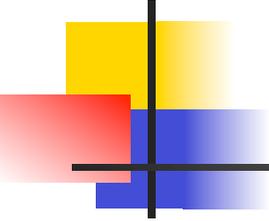
Abstinence-Focused Strategies

- Support a realistic view of change through small steps
- Create structure, support, and safety net (e.g., frequent visits, drug testing, family involvement, linkage with AA)
- Convey optimism and hope while working through initial setbacks
- Assist patient in finding new reinforcers for positive change



Abstinence-Focused Strategies

- Identifying, avoiding, and managing both internal and external triggers
- Breaking off contact with dealers and users
- Safely managing cravings and urges (“surfing”)
- Anticipating and avoiding “high risk” situations
- Developing a recovery support network
- Planning free time and avoiding boredom



Relapse Prevention Strategies

- Understanding relapse as a process activated before substance use resumes
- Managing “euphoric recall”
- Managing the desire to “test control”
- Preventing slips from escalating into full-blown relapses
- Developing a more balanced, satisfying lifestyle
- Taking medication, when indicated, to help reduce relapse potential
- Learning how to recognize and manage internal affects