

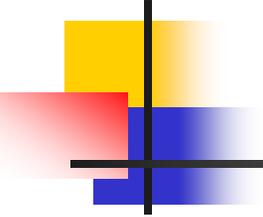
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Substance Abuse Treatment in  
Office Practice  
*Doing What Works*

Arnold M. Washton, Ph.D.

*in collaboration with*

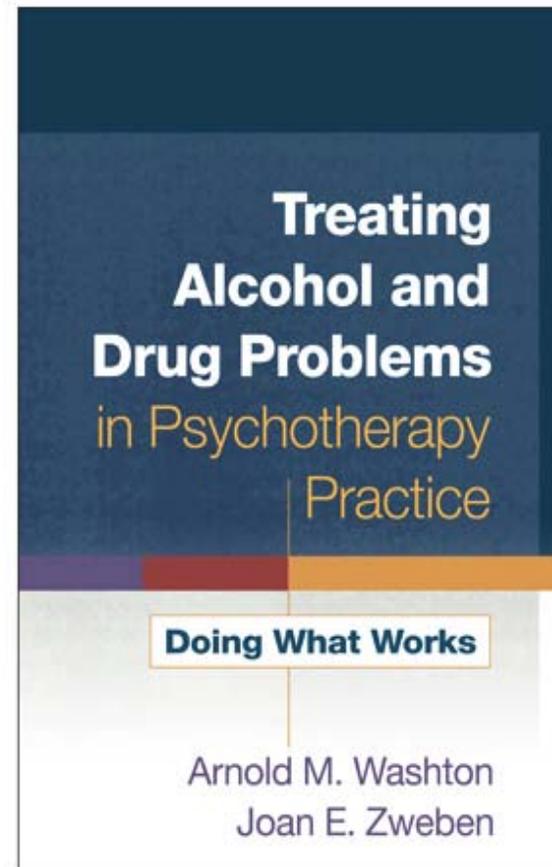
Joan E. Zweben, Ph.D.

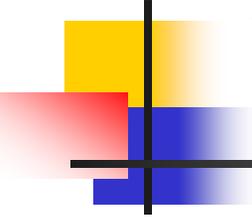


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Arnold M. Washton, Ph.D.  
Joan E. Zweben, Ph.D.

from Guilford Publications  
available Feb 2006

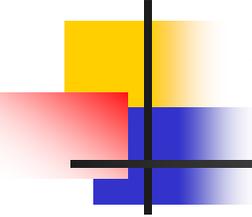




# Why Treat SUDs in Office Practice?

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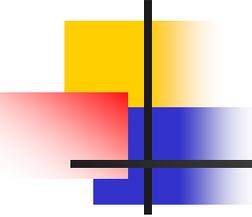
- Prevalent among psychotherapy clients
- Complicate or nullify treatment for other problems
- Fill in gaps in the addiction treatment system
- Practice expansion opportunities
- Professional gratification



# Advantages of Office-Based Treatment

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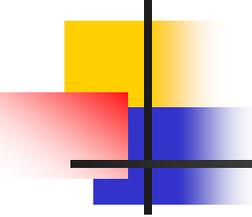
- Private, totally confidential
- Alternative to traditional treatment programs
- Lower entry threshold, less stigmatizing, less threatening
- No institutional control over treatment
- Rapid development of therapeutic alliance



# Advantages of Office-Based Treatment

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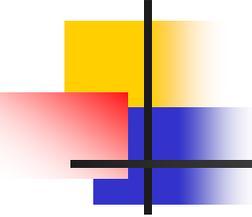
- Opportunity for early identification and intervention
- Opportunity for individual therapy & small group therapy
- Flexible, individualized approach
- Attention to individual differences rather than “one size fits all”
  - Problem severity, patient’s goals, readiness to change, phase of recovery, rate of progress, co-occurring conditions



# Limitations of Office-Based Treatment

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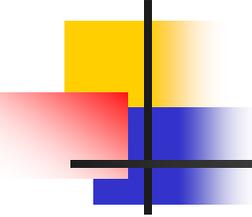
- Higher cost
- Reimbursable?
- Unregulated
- Limited intensity
- Exposure to only one clinician's philosophy and approach



# Practical Considerations

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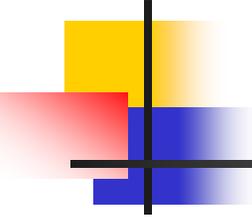
- Referral development
- Patient selection factors
- Types of services to offer
- Practice management issues
- Collaborating with other caregivers



# Referral Sources

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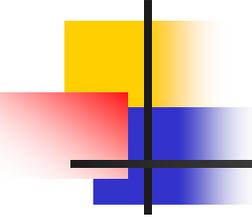
- Therapists in general practice
- Therapists who specialize in treating trauma, eating disorders, etc.
- Psychiatrists who provide medication management, but no psychotherapy
- Primary care physicians
- Physicians licensed to prescribe buprenorphine- listed on the website



# Patient selection factors

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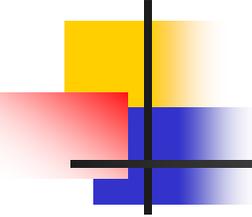
- Problem severity
- Motivation and readiness to change
- Voluntary and mandated
- Dual disorders
- Medical complications
- Insurance coverage and ability to self-pay



# Office-based treatment is especially attractive to patients who...

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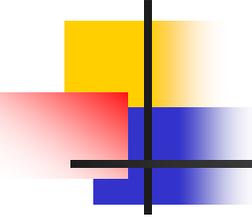
- Do not meet criteria for Abuse or Dependence
- Want alternatives to total abstinence, the disease model, 12-step programs, and “one size fits all” approach of mainstream programs
- Want personalized attention
- Want to choose their own therapist
- Want treatment delivered by a licensed MH professional
- Are executives, professionals, and others with strong confidentiality concerns



## Especially attractive to patients who...

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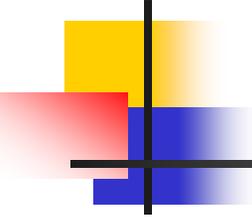
- Are in the early stages of coming to grips with an alcohol or drug problem
- Want an approach that is motivational, not confrontational
- Have maintained abstinence and want psychotherapy to address substance-related other psychological issues



## Especially attractive to patients who...

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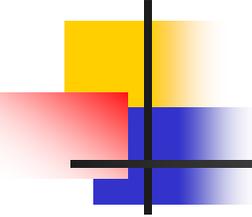
- Are currently receiving group therapy in an outpatient program and want concurrent individual therapy
- Have completed an outpatient or inpatient program and want aftercare individual and/or group therapy
- Are in AA or other self-help programs and want professional therapy to deal with issues that self-help alone cannot adequately address



# What types of services will you offer?

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- Comprehensive substance use assessment
- Brief interventions
- Individual therapy
- Group therapy- office and waiting room large enough?
- Family education and counseling
- Ongoing recovery-oriented psychotherapy
- Onsite drug testing

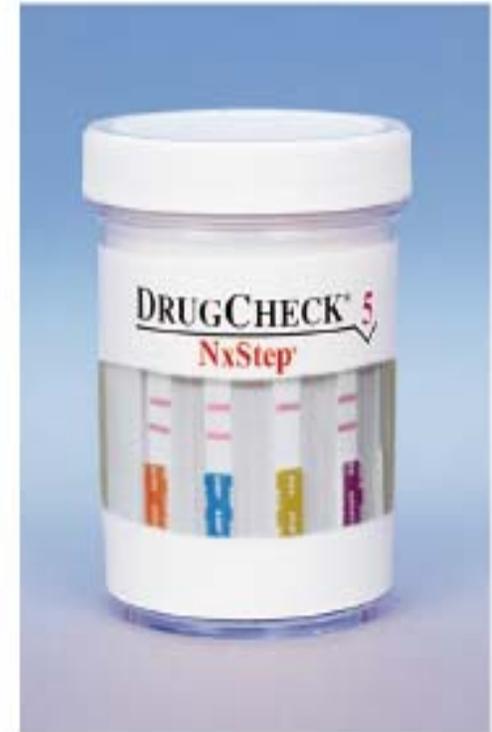
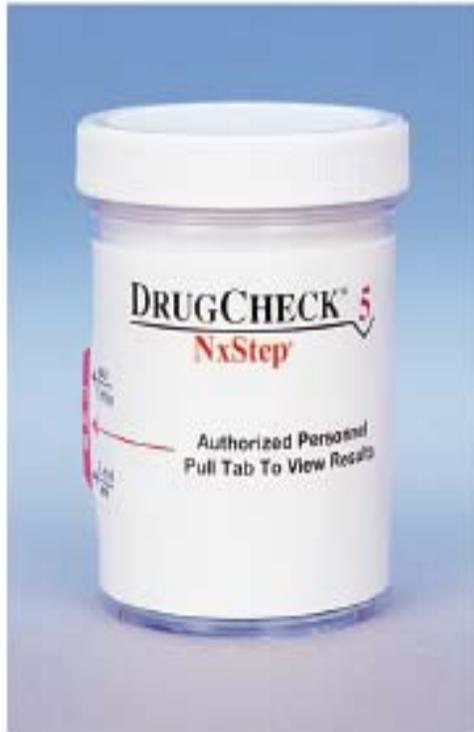


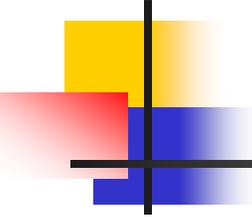
# Role of Onsite Drug Testing

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- Immediate results
- Deterrent to impulsive use
- Objective marker of progress
- Restores credibility with significant others
- Not intended to catch patients in lies
- Should not be used to impose consequences

# Onsite Urine Drug Test

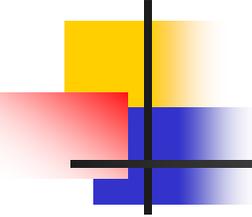




# Benefits Group Therapy

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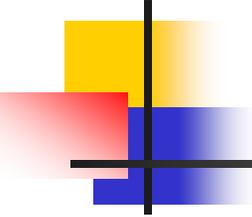
- Cost Effective
- Reduces Social Stigma
- Peer Identification, Role Modeling, Information Sharing, Social Reinforcement
- Ready-made recovery support system
- Less costly than individual therapy, can treat more patients, can generate more income



# Collaborating with other caregivers

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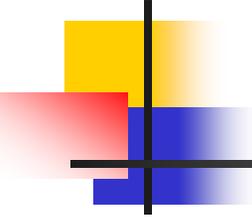
- Referral for physical examination
- Referral for physician-managed outpatient medical detoxification
- Referral to inpatient detoxification and rehab
- Interfacing with IOPs, rehabs, and other addiction treatment providers
- Interfacing with other MH practitioners



# Practice management issues

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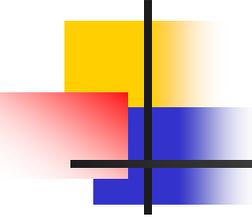
- Setting up the first appointment- ASAP, intake forms
- Written fee schedule and payment policy
- Charges for missed visits (self pay)
- Internet-based credit card payment
- Practice management software for scheduling, billing, credit card processing, and electronic patient charts (e.g., Therapist Helper, TheraManager)



# Integrative Approach

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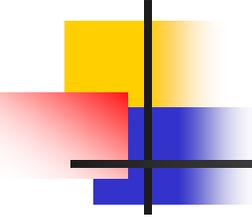
- Flexible, pragmatic, non-dogmatic
- Neither requires nor recommends adherence to one theoretical model or treatment approach
- Encourages creativity, flexibility, and open-mindedness
- Blends together many different and seemingly conflicting treatment approaches
- Priority #1: the therapeutic relationship



# Guiding principles

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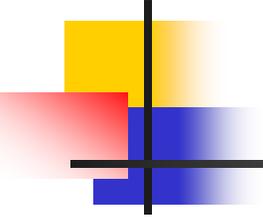
- Start “where the patient is”
- Do what works
- Above all, do no harm !



## What the research shows....

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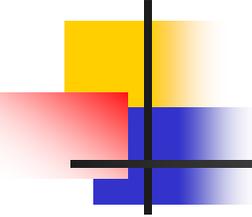
- No single treatment approach is superior to all others
- 12-step approaches are neither more or less effective than other approaches such as cognitive-behavioral, motivation-enhancement, brief therapy, or supportive therapy
- Many people overcome severe addictions without formal treatment or 12-step programs. The phenomenon of “natural” or “untreated” recovery is well-documented in people previously addicted to heroin, cocaine, alcohol, and nicotine.



## What the research shows....

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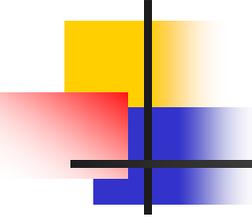
- Patient engagement and retention rates are enhanced when treatment is matched to the patient's stage of readiness for change; *i.e.* when treatment "*starts where the patient is*"
- Amazingly, it has taken over 30 years of research and hundreds of millions of dollars to find out that it's important to be nice to your patients !!



# Some Signs of Countertransference

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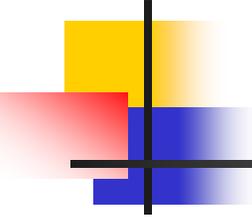
- Rejecting and controlling
- Disengaged or over-involved
- Harboring rescue fantasies
- Preoccupation, dreams, anxiety
- Feeling emotionally depleted- “burned out”
- Hoping that the patient “no shows” or drops out
- Revealing too much personal information about yourself
- Acting out your anger and frustration



## Bill W. (1955).....

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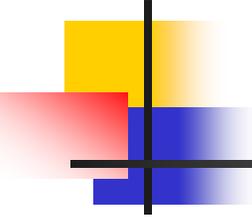
"Real tolerance of other people's shortcomings and respect for their opinions are attitudes that make us more useful to others. **Never talk down to an alcoholic !** He must decide for himself whether he wants to go on. He should not be pushed or prodded. If he thinks he can get sober in some other way,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



# Integrative Approach

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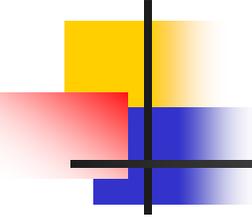
- There is a *continuum* of substance use ranging from non-problematic to extremely problematic and a continuum of substance-related consequences as well
- Substance use is initially normative or adaptive
- Progression from use to dependence is not inevitable
- Substances initially enhance functioning, reduce negative affects, promote peer identification and acceptance, and thus become potent reinforcers.



# Integrative Approach

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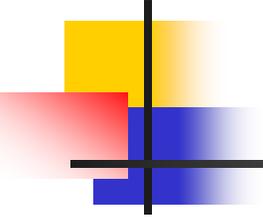
- Mix, match, and blend a wide variety of different strategies and techniques
- Respect timing: do the right thing at the right time
- Adapt treatment interventions to individual needs at each stage
- Keep the substance abuse problem in focus no matter what other issues are being addressed



# Ingredients of the Integrative Approach

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- Stages of change model
- Motivation-enhancement techniques
- Moderation and harm reduction strategies
- Disease model, abstinence-based techniques
- Self-medication, ego psychology model
- Relapse prevention techniques
- Recovery-oriented psychotherapy

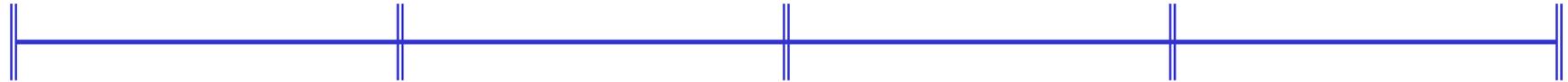


# Readiness to Change Paradigm

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

x..... resistance.....x..... ambivalence.....x



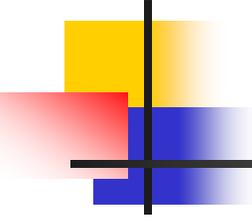
Not considering  
Change  
Precontemplation

Thinking  
about  
change  
Contemplation

Ready to  
Change  
Preparation

Taking  
Action  
Action

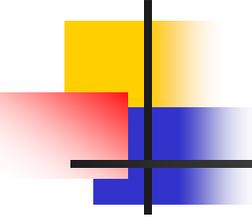
Maintaining  
Change  
Maintenance



# Stages of Change Model

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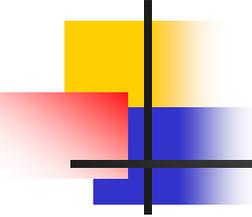
- Facilitates empathy- the ability to see patients as “stuck” in a particular stage rather than “resistant” or “unmotivated”
- Defines ambivalence about changing as normal, not pathological or part of a disease process
- Leads to better patient-treatment matching by defining the types of clinical interventions that work best with patients in each stage of change
- Provides “roadmap” and sets the tone for more positive interaction with “resistant” patients who are in the early stages of change



# Stages of Change Model

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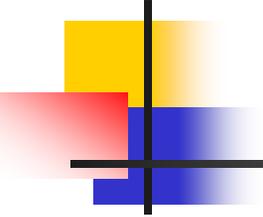
- To facilitate “starting where the patient is”
- To enhance patient-treatment matching
- To prevent the misalliance of patient and clinician working in different stages of change
- Treatment programs usually expect patients to be ready for change, but many are in the early stages of acknowledging the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



# Choice of Goals

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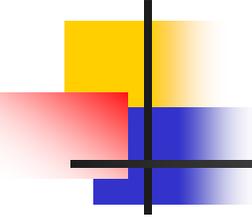
- Experiment with abstinence
  - Total- from all psychoactive substances
  - Partial- from the most problematic substances
- Gradual tapering toward abstinence (“warm turkey”)
- Trial moderation- a specific plan to reduce amount and frequency of use
- Harm reduction strategies
- No specific plan right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



# Abstinence or Moderation?

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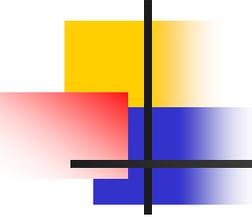
- Total abstinence is the safest, most informative course
- But only the client can choose, no matter what you think is best
- Many refuse abstinence, but willing to try moderation
- Some willing to try “experiment” with abstinence
- Your goal is to “start where the person is”
- Goals must be patient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



# Reasons for Total Abstinence

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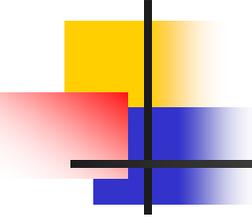
- All psychoactive substances alter brain function and behavior
- Cannot accurately assess functional role and significance of substance use until use has stopped for at least several weeks or months
- Use of any psychoactive drugs can erode motivation to abstain from others
- Use of any psychoactive drug can be a trigger for using other drugs
- Reduced ability to resist relapse (disinhibition)



# An “Experiment” with Abstinence

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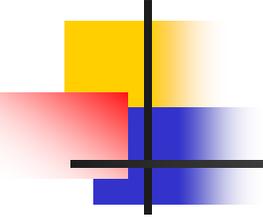
- Provides extremely useful clinical data
- Clarifies role of substance use in patient’s life
- Reveals reliance on chemical coping-“self medication”
- Chance to see things through a “different set of eyes”
- Reveals impact of abstinence on mood, affect, stress sensitivity, relationships, coping skills
- Helps identify internal and external triggers of use
- Reveals ability or inability to stop using



# Moderation Strategies

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- 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

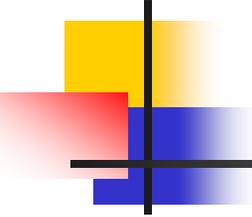


# Harm Reduction Strategies\*

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- Reducing dose and/or frequency of use
  - Reducing numbers of drugs used together
  - Changing types of drugs used
  - Changing route of drug administration
  - Changing setting and circumstances of use
  - Tapering gradually toward abstinence
  - Needle exchange
  - Opioid maintenance (methadone, buprenorphine)
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\*Denning et al., 2004.



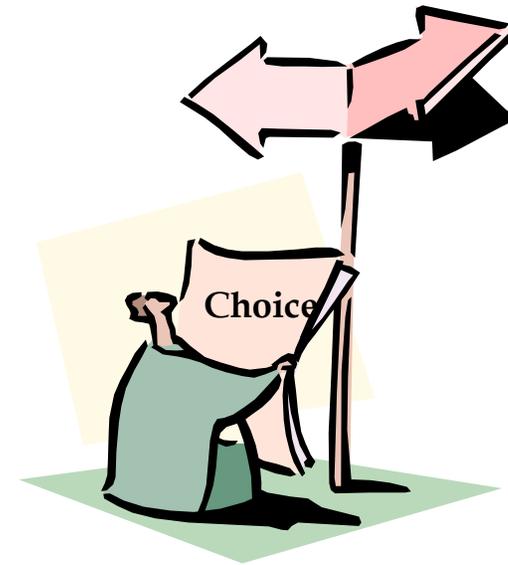
# Motivational Approach

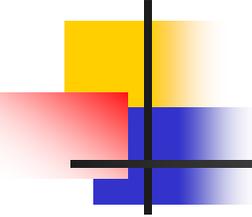
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- A style of interacting with patients that helps to move them along in the process of change
- Empathic, supportive, respectful, nonjudgmental, but directive style
- Emphasizes importance of building a strong partnership and alliance for change
- Based on Rogerian client-centered therapy techniques
- Confrontation is to be avoided in favor of techniques that foster engagement, reduce resistance, and increase motivation

# Motivational Strategies

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

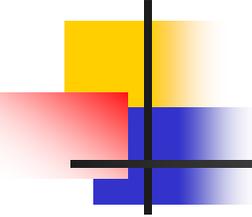




# Stage-Appropriate Goals

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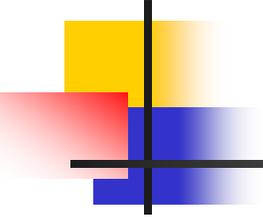
- Precontemplation- Increase awareness, raise doubt
- Contemplation- Tip the balance toward change
- Preparation- Select the best course of action
- Action- Initiate change strategies
- Maintenance- Learn relapse prevention strategies
- Relapse- Get back on track ASAP with renewed commitment to change



# Self-Medication Model

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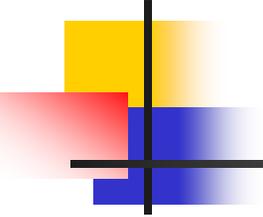
- Substance use is initially adaptive, an attempt to cope.... with stress, negative emotions, lack of assertiveness, social anxiety, etc...
- Because substances instantly reduce negative emotions and enhance functioning, they become extremely potent reinforcers



# Self-Medication Model

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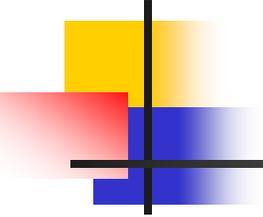
- Addiction vulnerability is due to deficits in affect regulation, self-care, self-esteem, and interpersonal relationships
- Feelings often are vague, ill-defined, confusing
- Feelings are poorly regulated and poorly tolerated
- Feelings are usually acted out (expressed through action), rather than worked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



# Self-Medication Model

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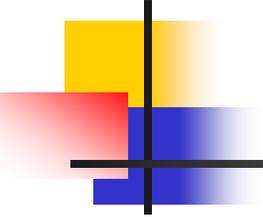
- Some people are overwhelmed by their feelings (“affective flooding”)
- They have an inadequate stimulus barrier and deficient affect management or self-soothing abilities.
- They are likely to choose depressant drugs (e.g., alcohol, tranquilizers, opioids)
- May be developmentally rooted in neglect, abuse, trauma, toxic unattuned parenting



# Self-Medication Model

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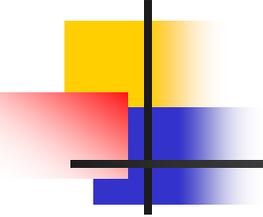
- Other people feel too little, have an overactive stimulus barrier, are emotionally numb, lack signal anxiety, and have impaired affect recognition skills (alexithymia)
- Lack emotional “radar” which leads to maladaptive behavior (failure to recognize, attend to, and cope with real life problems)
-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



# Clinical Implications of the Self-Medication Model

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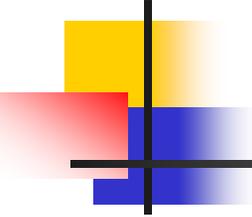
- Treatment must address the “self-medication” aspects of a person’s substance use
- Create atmosphere of behavioral and emotional safety (“holding” environment )
- Utilize cognitive-behavioral and DBT techniques to teach patients how to recognize, label, and manage internal affects and contain acting-out impulses



# Clinical Implications of the Self-Medication Model

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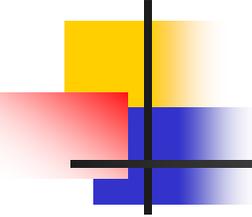
- Utilize psychotropic medication, where indicated, to cushion emotional extremes and thereby facilitate learning of affect regulation skills
- Use insight-oriented techniques, when appropriate, to address ongoing and unresolved psychodynamic issues



# Psychodynamic Issues

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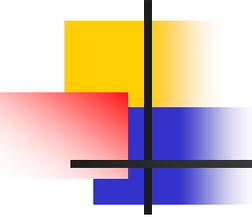
- Ongoing ambivalence about giving up alcohol/drugs
- “I’ve stopped using, but I’m still unhappy”
- Boundary issues
- Shame and guilt issues
- Assertiveness issues
- Grief issues
- Autonomy, separation-individuation issues



# Working with Patients in the Precontemplation Stage

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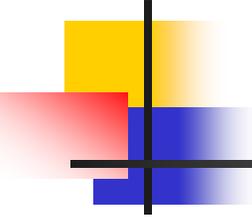
- Avoid prescribing action-oriented strategies
- Acknowledge positive benefits of alcohol/drug use
- Draw connections between substance use and presenting complaints or other problems
- Educate about some of the subtle, insidious effects of substance use on values, priorities, self-esteem, coping abilities, mood, personal growth
- Ask about the extremes- the *worst*, the *most*
- Help students assess the potential and not-so-obvious risks of continuing to use (play the tape forward, what if...)



# Working with Patients in the Precontemplation Stage

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- What would have to happen for you to decide that your use has become a problem?
- Examine discrepancies between patient's and others' perception of the substance use
- Columbo Technique: "I agree with you, I'm not at all convinced that your substance use is a problem. Maybe we should work together to take a closer look and figure it out."
- What about asking your spouse to join us at the next visit?
- Express your interest and curiosity, keep the door open, ask permission to continue the dialogue, resist your temptation to pressure for change

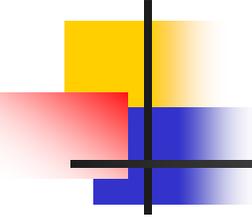


# Working with Patients in the Contemplation Stage

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**Goal: Reduce ambivalence and facilitate movement toward change**

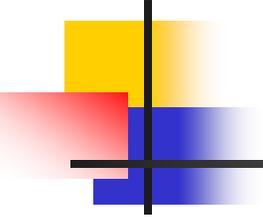
- Don't' jump ahead: If you push too hard for change, the student will retreat and defend the use
- Discuss the pros and cons of use
- Discuss fears about reducing or stopping use
- Discuss barriers to reducing or stopping use
- Ask student to consider a short-term "experiment" with abstinence or reduced use



# Working with Patients in the Contemplation Stage

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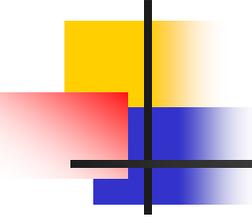
- Normalize ambivalence
- Acknowledge positive benefits of substance use
- Help to tip the balance toward change:
  - Review the “good” and “not so good” things about use
  - Review same for any prior periods of abstinence
  - Highlight discrepancies : where you are now versus where you want to be (values vs. actions)
  - Discuss expectations and anticipated difficulties with changing



## Contemplation Stage : Interventions

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- Review positive & negative aspects of use
- Review same for any prior periods of abstinence
- Highlight discrepancies and ambivalence: where you are versus where you want to be
- Propose a short-term trial of abstinence or moderation to tip the balance in favor of change
- Suggest keeping diary of use to heighten awareness

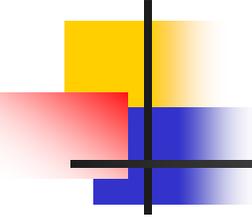


# Working with Patients in the Preparation Stage

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## GOAL: Negotiate a specific plan of action

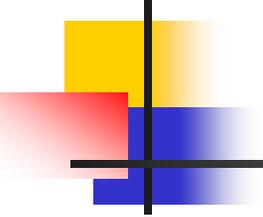
- Compliment for deciding to take action
- Define specific goals and time frame
- Know available treatment options, referral sources
- Explore what has worked/not worked in past
- Discuss menu of treatment options and offer recommendations, but respect patient's autonomy to choose what he or she feels right



# Working with Patients in the Preparation Stage

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- Compliment for deciding to take action
- Acknowledge any positive steps taken thus far
- Explore what has worked/not worked in past
- Discuss menu of treatment options, pros/cons of each, and offer your recommendations, but the student must be allowed to choose what feels right
- Take into account physical dependence and co-morbid medical/psychiatric conditions



## Working with Patients in the Preparation Stage

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- Propose an experiment with abstinence
- Discuss the practical “nuts-and-bolts” of how this would be accomplished
- Discuss potential obstacles and how to overcome them
- Consider referral for specialist consultation
- Help write out a plan and choose a start date