TREATMENT OPTIONS FOR ADDICTIONS AND TRAUMA IN ADOLESCENTS

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OVERVIEW

- PART 1
  - ADVERSE CHILDHOOD EXPERIENCES & ADDICTION

- PART 2
  - PSYCHOTHERAPY OPTIONS IN ADDICTIONS

- PART 3
  - PSYCHOPHARMACOLOGY OPTIONS IN ADDICTIONS
ADVERSE CHILDHOOD EXPERIENCES (ACE)

- Recurrent and severe physical abuse
- Recurrent and severe emotional abuse
- Contact sexual abuse
- Growing up with alcoholic or drug user
- Growing up with a family member in prison
- Growing up with a family member with mental illness
- Growing up seeing your mother being treated violently
- Growing up with both parents not being present
ACE SURVEY 1995-1997

- 17,500 middle class adults
- Average age 57
- Mostly college graduates and Caucasian
- Male – female 50% each
- 10-question ACE survey utilized
RESULTS

- 1 out of 14 had a score of 4 ACEs
- Higher ACE score correlated positively and significantly with higher prevalence of addictions, diseases and even death
- High ACE score also correlated with early onset of alcohol and drug use, i.e. before 14 years old (which indicates higher risk of dependence)
- Other addictions increased too: gambling, shopping, sex, gaming…
ACE and Adult Alcoholism

% Alcoholic

ACE Score

0 1 2 3 4+

- 6
- 4
- 2
- 0
ACE and Current Smoking

ACE Score:
- 0
- 1
- 2
- 3
- 4-5
- 6 or more

%
Dr. Felitti’s redefinition of addiction informed by the ACE Study:

- Addiction is the unconscious, compulsive use of psychoactive materials or agents *in an attempt to deal with a problem.*
  - “It’s hard to get enough of something that almost works.”
- Addiction is *evidence* of another problem.

What Is The Core Problem?

- Why is treatment so difficult?
- Why are long-term results so often poor?
- Is it because treating someone’s attempted solution may be threatening and cause flight from treatment?
- Are we treating the smoke, but not the fire?
Trauma-informed treatment
(SAMHSA-National Center for Trauma Informed Care)

- *Trauma-informed* care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. ...seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"

Attachment Trauma

- Children have a biological instinct to attach
- Attachment provides a secure base
- We learn how to modulate our affective states through the attachment relationship with our primary caregiver
- An impaired or absent caregiver does not provide a secure base for secure attachment to develop
- Insecure attachment patterns leave children with no skills to self-regulate
- Insecurely attached children grow up to be insecurely attached adults
Addiction as an Attachment Disorder

- Research demonstrates the prevalence of insecure attachments in adults with substance use disorders.
- “Attachment theory looks at addiction as both a consequence and a failed solution to an impaired ability to form healthy emotionally regulatory relationships…the underlying driving force behind all compulsive/addictive behavior is related to an inability to manage relationships.”
- The vulnerable individual’s attachment to chemicals serves both as an obstacle and as a substitute for interpersonal relationships.
Addiction Treatment Can be Re-Traumatizing

- Concept of powerlessness
- Absolute authority of the counselor, doctor
- Confrontation tactics
- Shaming practices
- Focus on ‘character defects’
- “Addicts can’t be trusted to tell the truth”
- Discharges for “non-compliance”
- Punishing aggression
- No choices
- Withholding medication-assisted treatment
Trauma Informed Treatment

It requires a paradigm shift away from a traditional approach to addiction treatment, toward one that seeks to reflect the principles of trauma informed care.
Punishment Safety
Distrust Trust
Confrontation Collaboration
Authoritative Choice and Treatment Empowerment
Compliance Transformation
TRAUMA-INFORMED APPROACH

According to SAMHSA: A program, organization, or system that is trauma-informed:

- *Realizes* the widespread impact of trauma and understands potential paths for recovery;
- *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively resist *re-traumatization*.

http://www.samhsa.gov/nctic/trauma-interventions
THE FIVE CORE VALUES

- Safety — is everything being done to ensure physical and emotional safety (welcoming, respectful, sufficient personal space, consistency)
- Trustworthiness — are expectations and interactions for everyone clear and consistent (boundaries, respect, non-judgmental)
- Choice — is a condition being created so individuals experience a feeling of choice and control (providing options, choices, optional program supports)
- Collaboration — is the approach one of sharing and collaboration in all interactions (learning from each other, seeking input, listening first)
- Empowerment — is there a fostering of the individual's strengths, experiences, and uniqueness for building upon (recovery, hope, skill building)
PSYCHOTHERAPY FOR TRAUMATIZED ADOLESCENTS

- SEEKING SAFETY
- RISK REDUCTION THROUGH FAMILY THERAPY (RR-TFT)
- TRAUMA-FOCUSED CBT
- TRAUMA SYSTEMS THERAPY
- CBITS: Cognitive Behavioral Interventions for Trauma in School
- SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress
SEEKING SAFETY

- Developed as a group treatment for PTSD/SUD women, but can be modified for ADOLESCENTS
- Structured with flexibility
- Educates patients about PTSD and SUD’s and their interaction
- Based on CBT models of SUDs, PTSD treatment, women’s treatment and educational research
- Goals include abstinence and decreased PTSD symptoms
- Focuses on enhancing cognitive and interpersonal coping skills, safety and self-care
- Therapist is active: teaches, supports and encourages
- Includes case management component

Najavits, 2002; www.seekingsafety.org
ADOLESCENT TRAUMA-SPECIFIC INTERVENTIONS

- Addiction and Trauma Recovery Integration Model (ATRIUM)
- Essence of Being Real
- Risking Connection
- Sanctuary Model
- Trauma Affect Regulation – Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM)
NIDA’S PRINCIPLES OF EFFECTIVE TREATMENT

1. No single treatment is appropriate for all
2. Treatment needs to be readily available
3. Effective treatment attends to the multiple needs of the individual
4. Treatment plans must be assessed and modified continually to meet changing needs
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness
6. Counseling and other behavioral therapies are critical components of effective treatment

7. Medications are an important element of treatment for many patients

8. Co-existing disorders should be treated in an integrated way

9. Medical detox is only the first stage of treatment

10. Treatment does not need to be voluntary to be effective
11. Possible drug use during treatment must be monitored continuously

12. Treatment programs should assess for HIV/AIDS, Hepatitis B & C, Tuberculosis and other infectious diseases and help clients modify at-risk behaviors

13. Recovery can be a long-term process and frequently requires multiple episodes of treatment

- NIDA (1999) *Principles of Drug Addiction Treatment*
EFFECTIVENESS of ADDICTION TREATMENT

- Goal of treatment is to return to productive functioning
- Treatment reduced drug use by 40-60%
- Treatment reduces crime by 40-60%
- Treatment increases employment prospects by 40%
- Drug treatment is as successful as treatment of diabetes, asthma, and hypertension
SMALL EFFECT SIZE of THERAPIES – WHAT CAN BE DONE?

- Fine-tuning these therapies. Why don’t they work more?
- Use more empathy? Positive correlation b/w empathy and outcome.
- Therapeutic alliance
- Commitment to therapies (both the patient and the therapist)
- Fidelity to therapies
  - Use manuals
  - Use live/videotaped supervision
COMORBIDITY

- Processing Speed
- Anxiety Disorders
- Dysgraphia
- Depression
- Learning Disabilities
- Substance Abuse
- Developmental Coordination
- Tics/TS
- Sensory
- Sleep
- Bipolar Disorder
- Enuresis
- Memory
- Speech & Language
- Working Memory
- ADHD
- OCD
- EDF

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COMORBIDITY WITH MENTAL ILLNESS

- 50 to 75% of all clients who are receiving treatment for a substance use disorder also have another diagnosable mental health disorder.

- Further, of all psychiatric clients with a mental health disorder, 25 to 50% of them also currently have or had a substance use disorder at some point in their lives.
MODELS of TREATMENT

- **Single model of care** - It was believed that once the “primary disorder” was treated effectively, the client’s substance use problem would resolve itself because drugs and/or alcohol were no longer needed to cope.

- **Sequential model of treatment** - acknowledges the presence of co-occurring disorders but treats them one at a time.

- **Parallel model of treatment** - mental health disorders are treated at the same time as co-occurring substance use disorders, only by separate treatment professionals and often at separate treatment facilities.

- **Integrated model of treatment** – an approach to treating co-occurring disorders that utilizes one team at the same facility to address all issues at the same time.
INTEGRATED MODEL

The integrated model of treatment can best be defined by following seven components:

1. Integration
2. Comprehensiveness
3. Assertiveness
4. Reduction of negative consequences
5. Long-term perspective
6. Motivation-based treatment
7. Multiple psychotherapeutic modalities
EVIDENCE BASED TREATMENTS

- Brief interventions
- Social skills training
- Motivational interviewing
- Cognitive behavioral therapy
- Community reinforcement
- Select family therapies
- Contingency management
- Select pharmacotherapies
- Matrix Model (Stimulants)
- Seeking Safety Model (Women and Trauma)
- Relapse Prevention by Marlatt
What Does Not Work?

- Confrontational approaches
- Substance abuse education alone
- Group therapy and residential treatment with some adolescent populations
- Poorly matched treatment placements, i.e. admitting a patient to a facility that s/he does not fit or need.
DISCREDITED TECHNIQUES IN ADDICTIONS

Certainly Discredited
- Electrical stimulation of the head
- Past-life therapy
- Electric shock therapy
- Psychedelic medication
- Ultra-rapid opioid detoxification under anesthesia for alcohol dependence

Neuro-Linguistic Programming
- Scared Straight
- Stimulant medications for alcohol dependence

Probably Discredited
- DARE prevention programs
- Synanon-style boot camps
- Apomorphine for alcohol dependence
- Lithium carbonate for alcohol dependence
- Electrical aversion therapy
- Beta-blocker for alcohol dependence
- Dopamine precursor for alcohol dependence
- Chlordiazepoxide for alcohol dependence
- Videotape self-confrontation
BARRIERS

 Difficult to implement
  • specialized training and supervision may be required
 Organization of care
  • inadequate access to physicians for medications
 Financing issues
  • approaches may not be reimbursed
 Perceived incompatibility with current agency values
Involvement with AA is associated with better outcomes after professional treatment.

Project Match compared Twelve-Step Facilitation Therapy (TFT) with CBT and MET.

TFT group did at least as well and did better on measures of complete abstinence.
EFFECTIVENESS of AA

- Modest correlation found between improved drinking behavior and:
  - having a sponsor
  - engaging in twelfth step work
  - leading a meeting
  - increasing participation compared to a prior involvement
Dual Recovery Groups

- Double Trouble in Recovery
- Mental Illness Anonymous
- Dual Disorders Anonymous
- Dual Recovery Anonymous
- Dual Diagnosis Anonymous
- Methadone Anonymous
CAM: COMPLEMENTARY and ALTERNATIVE MEDICINE
Body based interventions

- Yoga, Art, Music, Movement
- Drumming
- Sound Healing
- EMDR, Brain Spotting, Theatre, Psychodrama
- Sensorimotor techniques
  - SMART
  - Sensorimotor psychotherapy
  - Somatic Re-experiencing
- Neurofeedback
CAMs

- ACUPUNCTURE (TEAS: Transcutaneous Electrical Acupoint Stimulation)
- BIOFEEDBACK
- HYPNOTHERAPY
- PET THERAPY
- EXERCISE-BASED THERAPIES
- YOGA, TAI CHI
- ART-BASED THERAPIES
- NUTRITION / SUPPLEMENT THERAPIES
- HERBAL CHEMICALS: Ibogain, Kudzu, Corydalis …
- VIRTUAL-REALITY THERAPY
- MINDFULNESS-BASED THERAPIES
What is Mindfulness?

“Awareness that emerges through paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally”

(Kabat-Zinn, 1994)
MINDFULNESS-BASED RELAPSE PREVENTION (MBRP)

- Number of studies showing effectiveness in relapse prevention increasing.
- Neuro-imaging studies
- Adjunct therapy in addictions
- "Urge surfing" technique by Marlat
- Difficulties: culture-change, lack of trained people, restlessness/agitation in early recovery
- It is evidence-based in some other conditions.
FAMILY THERAPY

GENERAL APPROACH

1. Decrease family’s resistance to treatment
2. Redefine substance use as a family problem
3. Re-establish parental influence – if needed
4. Interrupt dysfunctional sequences of family behavior
5. Assess interpersonal function of drug abuse
6. Implement change strategies consistent with the family’s interpersonal functioning
7. Provide assertive training skills for the adolescent and any high-risk sibling

EVIDENCE-BASED FAMILY THERAPIES IN SUD

- Multidimensional Family Therapy (MDFT)
- Brief Strategic Family Therapy (BSFT)
- Multi-Systemic Therapy (MST)
- Functional Family therapy (FFT)
- Behavioral Family therapy (bft)
MULTISYSTEMIC THERAPY

Home-based, individualized, intensive treatment program
Integrates family therapy with direct interventions in the multiple interacting systems involving the individual, school, peers, community …
For violent and chronic patients and for complex SUDs
A caseworker is the hallmark of this approach
Effective in reducing addiction and criminal behavior
Not applicable in many settings but could be cost effective
Can be used in conjunction with drug courts and is more effective then

Henggeler et al. 1993
CONTINGENCY MANAGEMENT (CM)
Nancy Petry, PhD Addictions 2012

IT’S IN EVERY DAY LIFE….

... BUT LESS SO IN SUD TX:
- AA gives pins, certificates, makes a sponsor
- MMTP gives take home doses..
- Others: Praise, certificates…

PUNISHMENT IS MORE PREVALENT THAN REWARDS IN SUD TREATMENT:
- Confrontation, humiliation.
- Reporting to probation officer or parents.
- Discharged from programs, more frequent visits…
PRINCIPLES of CM

- FREQUENTLY MONITOR A SPECIFIC TARGET BEHAVIOR.
- PROVIDE TANGIBLE POSITIVE REINFORCEMENT EACH TIME IT OCCURS.
- WITHOLD IT IF IT DOES NOT OCCUR.
- VOUCHER and PRIZE CM VERSIONS
- BOTH EQUAL but THE LARGER THE BETTER
TYPES OF CM

- **POSITIVE REINFORCEMENT**
  - Delivery of a desired consequence on meeting a goal.
  - Example: Giving tangible goods, praise, privilege…

- **NEGATIVE REINFORCEMENT**
  - Removing of an aversive or confining circumstance on meeting a goal.
  - Ex.: Lifting grounding or early curfew, probation instead of jail time.

- **POSITIVE PUNISHMENT**
  - Delivery of a punishing consequence due to undesirable behavior.
  - Ex.: Suspension from school, grounding, losing cell phone privilege…

- **NEGATIVE PUNISHMENT**
  - Removal of a positive circumstance or condition due to undesirable bhv
  - Ex.: Removal of privileges, reducing rewards…

- **POSITIVE REINF. IS PREFERRED IN CM TX!**
- **OTHERS MAY AFFECT TX RELATION and/or ADHERANCE.**
CHALLENGES of CM

Petry, 2012

 COST
 THERAPIST FIDELITY
 ATTITUDES
  • “Drug abusers shouldn’t get special treatment.”
  • “People should want to change.”
  • “It’s like bribery.”
POSITIVES OUTWEIGH THE NEGATIVES!
  • It may tip the balance of ambivalence and keep the pt in treatment – Greatest predictor of success!
  • http://contingencymanagement.uchc.edu
RESOURCES ON CM

Contingency Management for Adolescent Substance Abuse
A Practitioner's Guide
Scott W. Henggeler
Phillippe B. Cunningham
Melisa D. Rowland
Sonja K. Schoenwald
and Associates

Contingency Management for Substance Abuse Treatment
A Guide to Implementing This Evidence-Based Practice
Nancy M. Petry
BRIEF INTERVENTIONS - THERAPIES

- COGNITIVE BEHAVIORAL TX
- STRATEGIC / INTERACTIONAL TX
- HUMANISTIC / EXISTENTIAL TX
- BRIEF PSYCHODYNAMIC TX
- SHORT-TERM FAMILY TX
- TIME-LIMITED GROUP TX
CHARACTERISTICS of BRIEF THERAPIES

- Using the FRAMES components
- Focus on intermediate goals
- Problem and/or solution focused
- They generally last 6 – 20 sessions
- When to use:
  - When there are limited sources / time
  - Less severe dependence
  - More stable patients w/ less duration of illness and better family support
FRAMES

F  FEEDBACK of personal risk / impairment
R  RESPONSIBILITY for change
A  ADVICE to change
M  MENU of alternative change options
E  EMPATHY
S  SELF-EFFICACY or optimism
COGNITIVE BEHAVIORAL THERAPY

Use CB interventions to change cognitions, which hinder cessation of drug use and to improve social skills

Relapse prevention is a major focus of CBT

Backed up by research consistently.

Contingency management, coping skills training, relapse prevention are included
ESSENTIAL and UNIQUE ELEMENTS of CBT INTERVENTIONS

- A functional analysis of substance use
- Individual training in recognizing and coping with craving, managing thoughts about substance abuse, problem solving, planning for emergencies and using refusal skills
- The identification and debriefing of past and future high risk situations
- Practice of skills within sessions
HARM REDUCTION

1. Focus is on the consequences, not on the drug use
2. Accepts alternatives to total abstinence when abstinence is not realistic
3. Uses compassionate pragmatism, not moralistic idealism
4. Easier to access, user friendly
5. For the group of patients who cannot stop with conventional methods.

Marlatt
HOW DO PEOPLE CHANGE?

- People change voluntarily only when
  - They become interested in or concerned about the need for change
  - They become convinced that the change is in their best interests or will benefit them more than cost them
  - They organize a plan of action that they are committed to implementing
  - They take the actions that are necessary to make the change and sustain the change

C. DiClemente, 2007
WHY PEOPLE DON’T CHANGE?

- Change requires the accomplishment of multiple tasks that require self-control, strength, as well as executive cognitive functioning skills, and the ability to regulate affect.
- Change also requires focus, energy and skills.
- Competing demands, contextual problems.
- Perceived ability to change.
CHANGE... IS....SLOW

PHASES OF CHANGE

Deny
Ignore
Minimize
Resist
Blame
Stress Out

Explore the Options

Make it Work
Commit to the New Reality
Consider How to Fit In

TIME
CHANGE IS HARD!

50 Reasons Not To Change

- I'm not sure my boss would like it.
- It's too expensive.
- We'll catch flak for that.
- That's someone else's responsibility.
- It won't fly.
- We've always done it this way.
- It's too political.
- We're doing OK as it is.
- We don't have the staff.
- We tried that before.
- This is just a fad.
- Maybe. Maybe not.
- We've never done that before.
- I'm not too ambitious.
- No one asked me.
- It's too complicated.
- What's in it for me?
- It's too contrary to policy.
- We have too many layers.
- There's too much red tape.
- We tried that.
- It's not my job.
- It can't be done.
- This isn't my job.
- We tried that before.
- There's not enough time.
- No se puede.
- It needs committee study.
- It needs more thought.
- Another department tried that.
- There's no clear mandate.
- They're too entrenched.
- We're waiting for guidance on that.
- It will never fly upstairs.
- We're not our problem.
- It won't work in this department.
- It's too visionary.
- I'm all for it, but . . .
- They don't really want to change.
- ¡Nunca pasará! [never will it pass!]
- ¡Es imposible! [It's impossible!]
- I don't have the authority.
- We didn't budget for it.
- It will take too long.
- It's hopeless.
- We can't take the chance.
- They won't fund it.
- It's too radical.
1. **Precontemplation**
   - **Definition:** Not yet considering change or is unwilling or unable to change.
   - **Primary Task:** Raising Awareness

2. **Contemplation**
   - **Definition:** Sees the possibility of change but is ambivalent and uncertain.
   - **Primary Task:** Resolving ambivalence/Helping to choose change

3. **Determination**
   - **Definition:** Committed to changing. Still considering what to do.
   - **Primary Task:** Help identify appropriate change strategies

4. **Action**
   - **Definition:** Taking steps toward change but hasn’t stabilized in the process.
   - **Primary Task:** Help implement change strategies and learn to eliminate potential relapses

5. **Maintenance**
   - **Definition:** Has achieved the goals and is working to maintain change.
   - **Primary Task:** Develop new skills for maintaining recovery

6. **Recurrence**
   - **Definition:** Experienced a recurrence of the symptoms.
   - **Primary Task:** Cope with consequences and determine what to do next

**Stages of Change: Primary Tasks**
Stages of Change: Intervention Matching Guide

1. Pre-contemplation
   - Offer factual information
   - Explore the meaning of events that brought the person to treatment
   - Explore results of previous efforts
   - Explore pros and cons of targeted behaviors

2. Contemplation
   - Explore the person’s sense of self-efficacy
   - Explore expectations regarding what the change will entail
   - Summarize self-motivational statements
   - Continue exploration of pros and cons

3. Determination
   - Offer a menu of options for change
   - Help identify pros and cons of various change options
   - Identify and lower barriers to change
   - Help person enlist social support
   - Encourage person to publicly announce plans to change

4. Action
   - Support a realistic view of change through small steps
   - Help identify high-risk situations and develop coping strategies
   - Assist in finding new reinforcers of positive change
   - Help access family and social support

5. Maintenance
   - Help identify and try alternative behaviors (drug-free sources of pleasure)
   - Maintain supportive contact
   - Help develop escape plan
   - Work to set new short and long term goals

6. Recurrence
   - Frame recurrence as a learning opportunity
   - Explore possible behavioral, psychological, and social antecedents
   - Help to develop alternative coping strategies
   - Explain Stages of Change & encourage person to stay in the process
   - Maintain supportive contact
MOTIVATIONAL INTERVIEWING / MOTIVATIONAL ENHANCEMENT THERAPY (MET)

- Developed by William R. Miller, 1983

- A directive, client-oriented counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.
- Change comes from resolving ambivalence.
- Change is facilitated instead by communicating in a way that elicits the person’s own reasons for and advantages of change.
THE SPIRIT of MET

1. Motivation to change is elicited from the client not imposed
2. It is the client’s task to articulate and resolve his/her ambivalence, not the clinician’s
3. Therapist’s style is generally a quiet and eliciting one, rather than persuasion, aggressive confrontation, giving advice
4. Therapeutic relationship is more like partnership or companionship than expert/recipient roles
The Framework of Motivational Interviewing

SPIRIT

- Autonomy
- Collaboration
- Evocation

Principles
- Roll with resistance
- Express empathy
- Develop discrepancy
- Support self-efficacy

Micro skills
- Open-ended questions
- Affirm
- Reflections
- Summaries (desires, ability, reason, need)

Change talk
- COMMITMENT (intention, decision)
- ACTIVATION (ready, prepared)
- TAKING STEPS

Behaviour change

Source: MINT Training, Centre for Addiction and Mental Health.
Express Empathy

- Communications that imply a superior/inferior relationship are avoided.
- The therapist’s role is a blend of supportive companion and knowledgeable consultant.
- The client’s freedom of choice and self-direction is respected.
- Persuasion is gentle, subtle, always with the assumption that change is up to the client. Miller, Chap. 5, *Handbook of Alcoholism Treatment Approaches*, 1995
Avoid Argumentation:

- If handled poorly, raising of discrepancies can create defensiveness.
- The MET style explicitly avoids direct argumentation, which tends to evoke resistance.
- No attempt is made to have the client accept or “admit” a diagnostic label.
- “The client, not the therapist voices the arguments for change.”
- “What makes you think that maybe you should do something about your drinking?”

Miller, Chap. 5, Handbook of Alcoholism Treatment Approaches, 1995
Roll with Resistance:

- MET strategies do not meet resistance head on, but rather “roll with” the momentum, with a goal of shifting client perceptions in the process.
- New ways of thinking about the problem are invited, but not imposed.
- Ambivalence is viewed as normal, not pathological, and is explored openly.
- Solutions are usually evoked from the client rather than provided by the therapist. Miller, Chap. 5, Handbook of Alcoholism Treatment Approaches, 1995
Support Self-Efficacy:

- Self-efficacy - the belief that one can perform a particular behavior or accomplish a particular task.
- The person must believe he or she can change (Rogers & Mewborn, 1976).
- Optimism can also be found in the menu of different approaches available.
- A therapist’s own optimism may also powerfully influence client motivation and outcome.
- Leake and King (1977) demonstrated experimentally that therapist expectations of good prognosis are predictive of favorable outcomes among alcoholic clients. Miller, Chap. 5, Handbook of Alcoholism Treatment Approaches, 1995
Develop Discrepancy:

- Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be.
- M.E.T. seeks to enhance and focus the client’s attention on such discrepancies.
- In certain cases (the pre-contemplator), it may be necessary to first develop such discrepancy by raising client’s awareness of the personal consequences of abuse.

Miller, Chap. 5, *Handbook of Alcoholism Treatment Approaches*, 1995
OPENING STRATEGIES

1. ASK OPEN-ENDED QUESTIONS
2. LISTEN REFLECTIVELY, EMPATHETICALLY
3. SUMMARIZE (You choose what to include)
4. AFFIRM (Reframe their weakness, appreciate their values, feelings, achievements)
5. ELICIT SELF-MOTIVATIONAL STATEMENTS:
   1. Statements of concern
   2. Problem recognition
   3. Intention to change
   4. Optimism for change
STRUCTURE of MET

1. PRE-TREATMENT ASSESSMENT
2. FIRST SESSION: Establishment of strong motivation to change. Go over personal feedback report. Send a follow up note.
3. SECOND SESSION (In 1 or 2 weeks): Obtaining commitment to change. Fill change plan worksheet
4. TWO FOLLOW UP “BOOSTER” SESSIONS (6 and 12 weeks later): Review progress, motivation and commitment
WEBSITES

- www.samsha.gov (SAMSHA)
- www.drugabuse.gov (NIDA)
- www.bhevolution.org
- www.hazelden.org
- www.naadac.org
- www.westbridge.org
PART 2 – PHARMACOLOGICAL OPTIONS IN ADDICTION PSYCHIATRY
TWO ISSUES

- MEDICATIONS FOR SUD - UNDERUSED
  - General perception: Less value in SUD.
  - Clinicians are not well-informed on this topic.
  - Many patients are not motivated to use psych medications.

- MEDICATIONS FOR SUD - UNDERSTUDIED
  - More studies in other conditions than SUDs
  - Low yield (revenue) for drug companies to conduct studies.
Medication Use in SUDs - ALL AGES

FDA-approved Medications

- **Intoxication treatment:**
  - Benzodiazepines: Flumazenil
  - Opioids: Naloxone, nalmefene

- **Detoxification:**
  - Opioids: Methadone, buprenorphine.
  - Alcohol and sedatives: Benzodiazepines, barbiturates.

- **Anti-craving / replacement / aversion:**
  - Opioids: Methadone, buprenorphine, naltrexone.
  - Alcohol: Disulfiram, naltrexone, acamprosate.
  - Nicotine: NRTs, bupropion and varenicline.
Substances for which pharmacotherapy is available

- Opioids
- Alcohol
- Benzodiazepines
- Tobacco (nicotine dependence)

Substances for which pharmacotherapy is NOT available

- Cocaine
- Methamphetamine
- Hallucinogens
- Cannabis
- Solvents/Inhalants
Thank you and Questions?