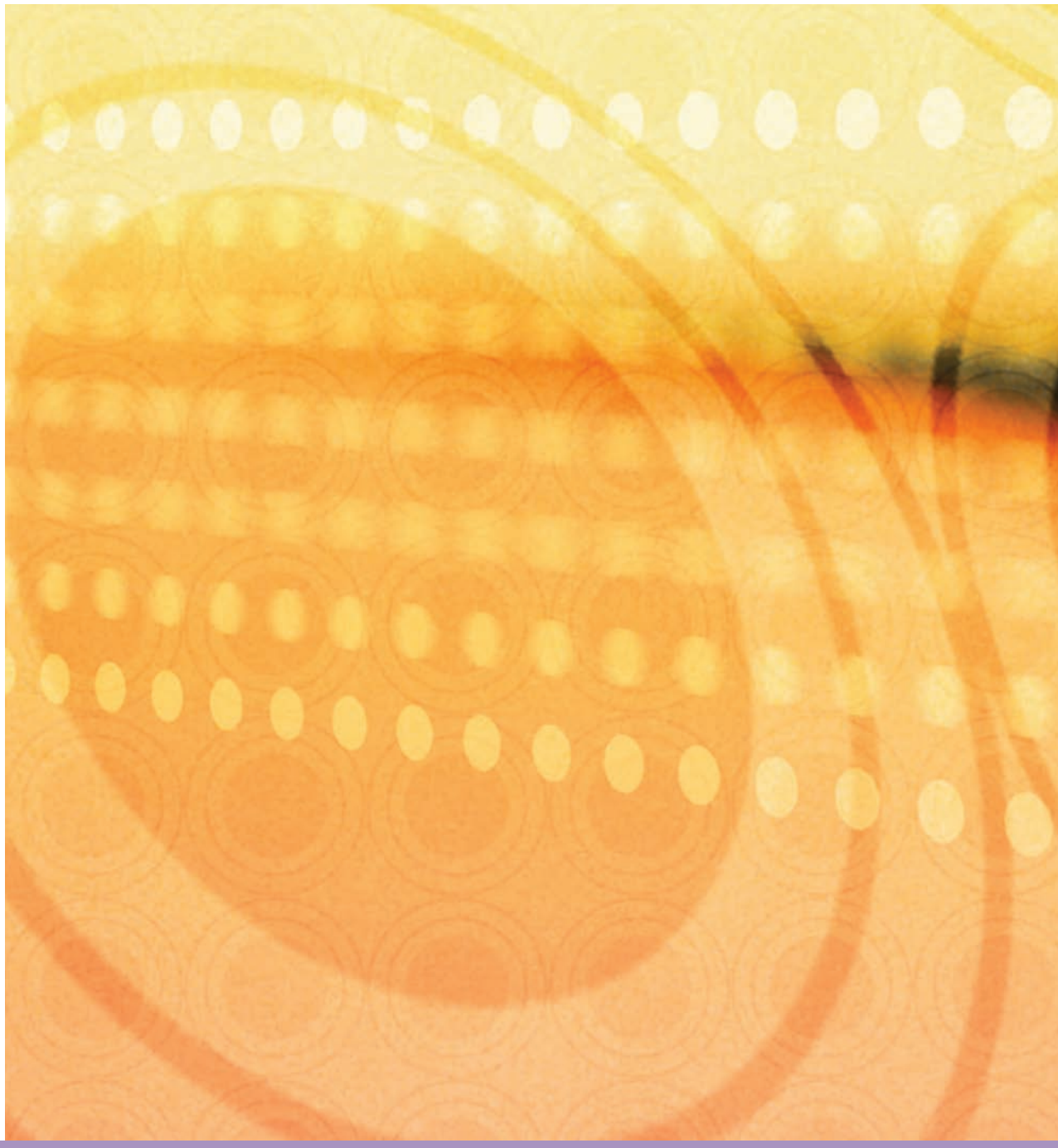
Pearson New International Edition

Foundations of Addictions Counseling

David Capuzzi, Mark D. Stauffer

Second Edition



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As noted in the previous sidebar, cognitive-behavioral (CB) theories of substance abuse and dependence typically operate according to six assumptions (Najavits, Liese, & Harned, 2005).

The six CB assumptions convey the importance of the substance abuse counselor intentionally integrating and implementing a variety of technical skills and personal qualities (e.g., empathy). For example, in order to help or teach a client in the early phase of recovery from cocaine use specific ways to manage cravings (e.g., "ride the craving wave") and urges (e.g., "surf the urge"), the substance abuse counselor should not only have knowledge of the physiological effects of cocaine use and a comprehensive understanding of the client's substance use history (by having completed a thorough case conceptualization) but should also have an appreciation for the first-hand experiences of the client struggling to stay clean. That is, by abstaining from something important to him or her (e.g., a behavior, beverage, or food item) and entering into an actual "abstinence contract" while practicing as a counselor, the substance abuse counselor (whether recovering or not from chemical addiction) can acquire greater empathy for the client's subjective experiences. Graduate students ($N = 120$) enrolled in a substance abuse counseling course offered once per academic year (Osborn & Lewis, 2004) consistently reported that experiential assignments of trying to uphold an abstinence contract for the academic semester and attending 12-step self-help groups (e.g., AA) were valuable, possibly engendering greater empathy for persons struggling with substance use. As one student in the course noted,

> ". . . we get so involved in the role of counselor that we sometimes forget the client inside us. It can become habit to separate ourselves from our clients with a sense of self-righteousness that we do not have the problems they do." (p. 49).

Yet another student reflecting on the abstinence experience stated, "I don't know how many times I have said and heard others say to smokers, 'Just quit.' Now I have a sense of why that doesn't work" (p. 50). CB practices in substance abuse counseling, therefore, may not be confined to interventions used with clients; they might also include the substance abuse counselor's own personal practices. Experiential learning, which incorporates CB assumptions and practices, might be considered an activity shared by *both* the client and counselor while engaged in counseling.

Cognitive-Behavioral Interventions That Target Triggers

Najavits et al. (2005) described specific CB interventions that address coping skills and are grouped according to five factors or types of precursors (or triggers) to addictive behaviors. Due to the multiplicity of factors that contribute to problematic substance use, interventions can and often are implemented to address more than one type of trigger. *Social interventions* include certain lifestyle changes (e.g., exercise, meditation), enhancing one's sober social support (e.g., attending AA/NA meetings), and refusal skills (i.e., practicing verbal and nonverbal communication to avoid and turn down offers to use). One client I worked with requested that the guided imagery exercises we had engaged in during our weekly sessions (I had tailored a script designed for this particular client and facilitated—verbalized—the exercise) be audio taped so that he could participate in guided imagery outside of our sessions. One day when I left the counseling facility, I could see this client sitting on a nearby park bench, eyes closed, and earphones on. I surmised he might be listening to my voice, guiding him through relaxation and a new awareness of sobriety.

Cognitive-Behavioral Interventions

- Social – lifestyle changes, social skills training, interpersonal conflict management
- Environmental – living/geographic changes, cue exposure
- Emotional – to regulate both positive and negative emotions (e.g., distress tolerance, reframing, self-soothing)
- Cognitive – to modify automatic thoughts
- Physical – to introduce distractions from triggers, urges, and cravings to use

Source: (Najavits, Liese, & Harned, 2005)

Environmental interventions include cue exposure whereby environmental triggers associated with substance use (e.g., photos or videos of drug paraphernalia or persons using substances) are repeatedly viewed while being monitored so that automatic responses (e.g., cravings, urges to use) are diminished or even extinguished. Clients can also be advised to thoroughly clean their living space, one area or one room at a time, so as to reinforce their sense of control over their own personal or local environment. This practice could also symbolize a cleansing or purging of the "toxic self."

Emotional interventions are designed to regulate both positive and negative emotions so that neither serves as a trigger for relapse. Through cognitive strategies, clients may be taught to stay with the feeling while reviewing to themselves (preferably verbalizing out loud) the list of things they have already accomplished to stay sober (e.g., "Mark, you are reMARKable for having said, 'Let's take a time-out of 5 minutes to cool down before we talk about this some more'"). This practice is similar to the distress tolerance skills (e.g., self-soothing, one thing in the moment) taught in dialectical behavior therapy (Linehan, 1993a, 1993b). In self-soothing, clients are taught to focus on one of the five senses at a time, pausing to fully attend to, experience, or soak in the natural or non-substance-induced sensation (e.g., observing the contrast of green tree leaves against a bright blue sky) in order to withstand an urge or a craving to use. In addition, certain feelings can be reframed as positive protective devices, if not acted upon in destructive ways. For example, fear and anxiety can be understood as normal responses to a brand new reality or lifestyle, and regarded as the client's attempts to protect what is now valuable (i.e., sobriety). One reframe that I often use with clients is, "the compulsivity of addiction is the persistence of recovery," meaning that they didn't necessarily have to discard all aspects of "bad behavior"; rather, they could channel or redirect their frenetic energy into a "no-holds-barred" or "pull out all the stops" approach to recovery (e.g., continuing to attend AA meetings until they found their "home" fellowship).

Cognitive interventions are specifically intended to modify automatic thoughts and drug-related beliefs, as well as conditional assumptions and core beliefs. Rather than automatically thinking that only marijuana can help them get to sleep, clients can be taught to catch themselves from lighting up (perhaps by telling themselves out loud, "Hold off!" or "Wait!") and reviewing the written plan constructed with their counselor detailing alternative preparations for sleep (e.g., listening to relaxing music while depressing a stress ball). A list of cognitive comebacks to urges or cravings can be devised so that the client has an expanding toolbox of relapse prevention strategies. Such comebacks might resemble the externalization exercise (White & Epston, 1990) used in solution-focused counseling in which the client names the problem (e.g., "restless roamer," as one heroin addict described his struggle in finding "peace" in his life), is able to regard the problem as an external entity (i.e., "I am not the problem . . . 'restless roamer' is the problem"), and through conversation is able to keep the problem at a distance so as to diffuse its

power over him. The client can be taught to confront the problem with comebacks such as, "You've led me astray!" and "I'm no longer following your twisted map!" and doing so out loud, with an amplified voice, while standing up. Using cognitive interventions, clients can also be taught to question the evidence regarding the seemingly infinite benefits of substance use, as well as the seemingly infinite detriments or negative assumptions about sobriety. Counselors can assist in stopping any circular reasoning by interjecting, "Okay, where's the evidence that this is true?" and "How do you *really* know that for sure?"

Physical interventions involve activities intended to distract the person's attention away from triggers and the consequent cravings and urges to use. Such activities include physical exercise (e.g., doing chores around the house, going for a walk), talking with someone (e.g., calling one's AA sponsor), breaking out into song, or snapping a rubber band worn on the wrist. In addition, clients can be reminded of the "insanity" of their active using days, recalling the "seemingly irrelevant decisions" made (see Marlatt & Donovan, 2005) and the negative physical consequences of their using. One I worked with, a blue-collar machinist who found his employment fulfilling because "I'm able to work on things that last," made the decision one morning to no longer drink. He said he was able to uphold this decision because "I was sick and tired of being sick and tired. I didn't want to lose this job." I recall commending this client on his decision and what I heard as his desire to work not only on large truck engines that would last, but on himself as well, so that *he* would last.

Contingency Management and Behavior Contracting

Specific CB approaches that have demonstrated efficacy in treating alcohol (Petry, Martin, Cooney, & Kranzler, 2000) and other drug dependence, namely cocaine and opioid dependence (Higgins & Silverman, 1999; Iguchi, Belding, Morral, Lamb, & Husband, 1997; Preston, Umbricht, Wong, & Epstein, 2001), have incorporated contingency management and behavior contracting (Higgins, Silverman, & Heil, 2008). These two approaches are based in part on the theory of behavioral economics, which posits that behavior is chosen because of the reward(s) it will provide, including monetary reward. Contingency management makes use of external incentives or tangible reinforcers (namely vouchers redeemable for goods and services, e.g., groceries, public transportation, movie theater tickets) contingent on the client meeting predetermined treatment goals, such as submitting drug-free urine specimens and arriving to counseling on time. Over time, clients may be awarded with an increasing number of vouchers or opportunities to win a prize (e.g., from a raffle or drawing) for not only submitting clean urine specimens, but also submitting documentation of having engaged in new and positive behaviors (e.g., going on a job interview, paying off court debts, bringing in a report card of improved school grades).

Contingency Management and Behavior Contracting

- Based on theory of behavior economics and operant conditioning
- Designed to shape and reinforce non-using behavior
- Clients and counselors agree (or contract) to participate in the systematic application of behavioral consequences
- Use of external incentives or tangible reinforcers (e.g., bus passes, vouchers redeemable for groceries or personal hygiene products), contingent upon changes in drug use and other therapeutic goals (e.g., attendance)

Source: Higgins, Silverman, & Heil, 2008.

Despite beneficial effects in research trials, it appears that contingency management practices have not been adopted by many practitioners due in part to the cost-prohibitive nature of the program. Counselors and agencies intent on offering helpful services, however, would be encouraged to pursue creative partnerships with local business representatives. These might include time-limited free access for agency clients on the local bus in exchange for free advertisement of the bus service on agency publications. In addition, as was done in Petry et al.'s (2000) study, local businesses could be approached to donate items (e.g., department store gift certificates) that would then be raffled off to clients who had upheld their contract.

Behavior contracting itself (apart from the use of vouchers) can be implemented with minimal or no cost to the counselor or agency. This practice might resemble treatment planning, but is typically not as comprehensive or expansive (i.e., the contract can focus on a specific task to accomplish in the next week) and can be done on a periodic basis. It is advised that the contracts be written (maybe even at times on a scrap piece of paper), the intended behavior clearly described, the targeted date of task completion specified, and both the incentive and the consequence for not abiding by the contract clarified. In addition, it should be signed by both the counselor and client, dated, and a copy provided to the client. Incentives for upholding the contract might include meeting with the counselor outside, on the grounds of the agency; having access to the agency's basketball court following a counseling session; an extended (by 5 minutes) smoke break during group counseling; and securing from the counselor a letter of reference for a job application. Particularly in residential treatment settings, behavior contracts are routinely used to encourage greater participation and cooperation among clients. Privileges for upholding one's contract might include telephone access to family members, being able to receive visitors on "Family Day," and being able to skip meal preparation and clean-up or other household chores for one day.

Community Reinforcement Approach

The community reinforcement approach (CRA) is a comprehensive biopsychosocial approach to the treatment of substance use disorders based on the premise that one's environment or community plays a critical role in reinforcing recovery efforts. CRA enlists community reinforcers (e.g., family, recreation, employment) to support change in an individual's substance use (Meyers, Villanueva, & Smith, 2005). Two reviews (Roozen et al., 2004; Smith, Meyers, & Miller, 2001) of studies conducted with the CRA in treating problematic alcohol and other drug use attest to its efficacy, particularly when combined with contingency management (e.g., use of vouchers as incentives).

Meyers et al. (2005) identified eight components of CRA, and although they conceded that each component is not necessarily used with every client, two are standard applications: functional analysis and treatment planning. After completing a functional analysis or thorough substance use assessment, including taking inventory of the client's external and internal motivations for substance use and its treatment, the focus of the CRA is to determine how environmental stimuli can be rearranged so that sobriety is supported and substance use is no longer tolerated or rewarded. Goals typically reflect the presence of something positive (e.g., maintaining employment, graduating from high school) rather than the absence of something negative (e.g., not drinking or drugging). Specific areas in the client's life considered in both assessment and treatment include social and recreational activities, employment, and family dynamics. Whenever possible, a significant other (e.g., life partner or spouse, girlfriend/boyfriend) is involved in treatment and regarded as an important ally in the construction and maintenance of a non-using and healthy lifestyle.

The CRA can be understood as a "package"; that is, "it contains a number of procedures that may or may not be used, depending on [the] client's specific needs" (Smith, Meyers, & Milford, 2003, p. 238). Indeed, the counselor can sift through many of the CB interventions already described in this chapter and then select those strategies that are most relevant for the client's current situation. These may include job skills training, social skills training, and couples counseling to address strains in communication. Careful attention is given to the ongoing assessment of external and internal triggers for substance use. Not only are attempts made to regulate environmental stimuli, but the counselor routinely inquires about the client's internal triggers (e.g., mood, beliefs, physical status). As a CB-oriented approach, the CRA is intended to equip the client with a variety of skills needed to not only effectively manage negative stimuli or triggers, but to also establish and maintain a lifestyle and environment that support and allow one's recovery to thrive.

A new version of CRA, Community Reinforcement and Family Training (CRAFT), is based on the principles of CRA but focuses on the environment (i.e., family members) of those persons with substance use problems who refuse to enter treatment (Meyers et al., 2005). Rather than working directly with the person with substance use problems, CRAFT enlists the assistance of a concerned significant other (CSO), such as a parent or a spouse, by training the CSO to interact with his or her loved one in new and more constructive ways. These would include not speaking with the family member when he or she is intoxicated (e.g., saying in a calm and measured voice, "I'm going to wait and talk with you about this in the morning, once you're sober") and allowing the family member to realize the natural consequences of his or her substance use (e.g., not bailing the family member out of jail). Although the goal of CRAFT is for the family member to enter treatment, it is designed to help CSOs take better care of themselves and to realize a sense of contentment on their own.

BRIEF INTERVENTIONS

Brief interventions for problematic drinking are not a homogeneous entity; rather, they are regarded as "a family of interventions varying in length, structure, targets of intervention, [and] personnel responsible for their delivery" (Heather, 1995, p. 287). However, W. R. Miller and Sanchez (1994) maintained that all brief interventions should include six elements, known by the mnemonic FRAMES. These shared elements are intended to fulfill the purposes of brief interventions, which Zweben and Fleming (1999) stated are to (a) increase one's awareness of the costs and consequences of substance use, (b) strengthen beliefs about one's ability to change (i.e., enhancing self-efficacy), (c) utilize natural helping systems to support positive change, (d) encourage the person to accept responsibility for change, and (e) promote a commitment to positive change.

FRAMES = Six Elements of Brief Interventions

- FEEDBACK of personal risk or impairment, delivered in nonjudgmental manner
- Emphasis on personal RESPONSIBILITY for change
- Providing clear ADVICE to change
- Offering MENU of alternative change options
- Therapist EMPATHY
- Facilitating client SELF-EFFICACY or optimism

Source: W. R. Miller & Sanchez, 1994.

The temporal nature of this service delivery certainly implies a shorter length of stay in treatment than what might be considered standard substance abuse counseling (i.e., detoxification followed by intensive outpatient individual and group counseling). "Brief" or "minimal" counseling can refer to one or two one-hour individual sessions, or structured and direct feedback provided in 5 to 30 minutes. Brief interventions are typically developed by specialists to be delivered by other professionals, and service settings vary from primary health care centers (e.g., hospital emergency rooms) to college campuses. Brief interventions conducted specifically with college students have included (a) an hour-long individual face-to-face motivational intervention with high-risk/binge drinkers (Borsari & Carey, 2000; Larimer et al., 2001; Marlatt et al., 1998; Murphy et al., 2001); (b) small group (e.g., fraternity house) review of assessment results (Larimer et al., 2001); (c) personalized mailed feedback of the student's reported substance use patterns (Collins, Carey, & Sliwinski, 2002; Walters, 2000; Walters, Bennett, & Miller, 2000); (d) computerized individual assessment and computer-generated feedback (Dimeff & McNeely, 2000; Neighbors, Larimer, & Lewis, 2004); and (e) combinations of these interventions.

Although believed to be underutilized by chemical dependency treatment professionals because they are thought to be reserved for those with less severe forms of substance use disorders, brief interventions should be delivered based on the recipient's stage of change (Vik, Culbertson, & Sellers, 2000) and targeted specifically to those who are relatively low on the readiness-to-change continuum (Maisto et al., 2001). Vik et al. (2000), however, noted that "Students contemplating change were the heaviest and most problematic drinkers" (p. 679). As a result, brief interventions for substance use problems should always be an option regardless of a client's level of substance dependence (Sanchez-Craig, 1990), and may be used to help prepare or cultivate one's readiness for more intensive or extensive services (W. R. Miller, 1992). Brief interventions for the substance dependent client can be ethically justified, therefore, particularly if the client would otherwise receive no help at all (Heather, 1995), including homeless adolescent substance users (Baer, Peterson, & Wells, 2004).

Studies report reduction in drinking as a result of participation in brief intervention, but no commensurate and significant reduction in *consequences* of drinking, such as missing college classes or engaging in risky sexual behaviors (Borsari & Carey, 2000; Collins et al., 2002; Murphy et al., 2001; Walters et al., 2000). Interventions should be devised, therefore, that will reduce drinking consequences, as well as consumption amounts and frequency. This may depend, among other things, on the counselor's ability to engage the student or client in a consideration of the potentially extensive and hazardous effects of one's substance use. Focused conversation on the person's use history, his or her current status and use patterns, comparisons with others in his or her peer group (e.g., age, gender, race/ethnicity), and the counselor's own informed perspective (from research findings and clinical wisdom) may at least help the client to think twice about the extent of future use.

SOLUTION-FOCUSED COUNSELING

Solution-focused counseling (SFC) was conceived and developed by de Shazer and colleagues (de Shazer, 1985, 1988; de Shazer et al., 1986; Molnar & de Shazer, 1987; O'Hanlon & Weiner-Davis, 1989) at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin, almost 40 years ago. It emerged as a form of brief or short-term psychotherapy with an emphasis on pragmatism (i.e., what works) and on mental health (rather than mental illness; Berg & S. D. Miller, 1992), thus representing an alternative to the problem-focused approaches that continue to prevail in both mental health practice and substance abuse treatment. SFC has its roots in the work of hypnotherapist Milton Erickson and family systems theory, and during its later years of development, in post-structural/post-modern or constructivist ideology (de Shazer & Berg, 1992).