Re-Envisioning Addiction Treatment: A Case Example

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We wrote an article called, "Re-envisioning Addiction Treatment: A Six-Point Plan" which will be published in 2012 in the *Alcoholism Treatment Quarterly(Volume 30, Issue 1)*. In this paper, we looked a patient's drug use Decisional Balance. Due to space limitations, we were able to explore some of the issues that emerged, but we were unable to present ways that we might conceptualize his treatment. To compensate, the clinical exploration is being continued on this website.

Looking again at the patient's Decisional Balance (see Figure 1 below), there are a number of specific strategies that the therapist might want to consider pursuing. Speaking to the hedonic aspect of drug use, the patient identifies the pleasure that he receives from drug use as a major attraction; he is also deeply concerned that he will not enjoy life as much if gives up the use of substances. Clearly, the issue of finding pleasure without the use of drugs needs to be respected. Greaves (1980) has written about the profound inability of drug-using individuals to experience normal pleasure; he felt that treatment should focus on teaching and empowering patients to gain or re-gain this ability. Working in this way would likely involve holistic somatic

experiences like yoga, dancing, acupuncture, running, sex therapy, breathing, and drumming (Winkelman, 2003). It could also involve working with the Pleasurable Activities List (Lewinsohn, Muñoz, Youngren, & Zeiss, 1992) to help the patient first identify relevant activities and then take steps to integrate and schedule them into his or her life structure. Lastly, it could involve working with such pleasure revival models as Resnick's (1997) or Hoskinson's (2010). Engaging in these kinds of exploration – both within the context of the therapy session and outside of it – could provide this patient with hope, an altered physiology, expanded perspectives, and new skills.

Clinically, there may be some resistance to trying new things. The anxieties involved could be explored, the patient could approach these activities in small steps, and/or a positive reinforcement system could be set up to help them make an initial engagement. It is also likely that some activities can be tried out or "tasted" while the person is using substances; others may require some level of abstinence before they can be engaged in safely.

In terms of not feeling "there", the therapist might want to explore this experience of "derealization" metaphorically: "What does it feel like to be unreal, to not be there, to be on the outside?" "Were there other times in your life when you felt you were not really there?" "Were there times in your life when you felt you were really here?" "What are the advantages and disadvantages, if any, of being on the outside?" "If you could speak to this experience of "derealization", what would you say?" Beyond that, the therapist might consider: (1) teaching the patient grounding techniques; (2) encouraging them to engage in a physical discipline that would move somatic experience more to the forefront; and (3) exploring the possibility of using mindfulness and chairwork dialogues so that he can both step outside of this experience and see it as part of who he is, but not all of who he is (Kellogg, 2004; Tatarsky, 2003). With the social

anxiety, systematic desensitization combined with assertiveness training could enable him lower his anxiety level and find and use his “voice” in social settings.

The “inner critic” voices can be addressed by clarifying what they are saying, creating counter-scripts, and by having both the therapist and the patient engage in dialogue with these voices or modes. Sometimes these aspects of self are actually voices of fear and sometimes they are introjections of abusive figures from the past; in either case, they will need to be worked through accordingly (Young et al., 2003). Creating a Healthy Adult mode or some kind of voice of inner affirmation that values, nurtures, and affirms the patient is essential here – especially in cases where the critical part is deeply entrenched (Chadwick, 2003; Kellogg, 2004; Rafaeli et al., 2010; Young et al., 2003).

Concomitant with this will be work on his drug use. This would involve assessing his use and jointly coming up with immediate and long-term goals and strategies to support them. This could include monitoring, safer use, moderation, or cessation. More specifically, this would include managing cravings and urges, negotiating high-risk situations, and considering necessary medications.

As the patient begins to move toward abstinence or a dramatically-altered pattern of use, it is important that the issues of grief and loss be addressed. First, an extensive dialogue could be had with the part that is connected to the drug use. As this part becomes better known and more verbal, it may become possible to more completely integrate it into the self; that is, potentially less dangerous and destructive vehicles for experiencing altered states of consciousness could be considered. Second, the patient will need to say goodbye to a life that he had lived for a long time. This may involve actually ending friendships and making radical changes in his life

structure. This grief work seems essential if the risk of relapse is to be reduced. Over the long term, therapy could include working with his identity structure to ensure that there are meaningful and reinforcing identities that can challenge and replace those based on drug use (Biernacki, 1986; Kellogg, 1993). This would also involve clarifying his value system to help provide him with a clearer and more meaningful life direction.

It is difficult to imagine how this patient, who is meeting 5 or 6 of the 7 DSM-IV-TR criteria for Substance Dependence (American Psychiatric Association, 2000), could be treated in the manner described in anything other than an addiction-informed psychotherapy setting. Splitting the treatment between two clinicians – one of whom works with the addiction and the other who works with the psychological difficulties – also seems less than optimal as the drug use is completely interwoven with the emotional and psychological issues.

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Figure 1. Drug Use Decisional Balance.

Decisional Balance	
Positives of Drug Use	*Positives of Change*
Immediate physical pleasure (10)	Feel a greater sense self-discipline (9)
Feeling more "there" (10)	Would be more productive (10)
Feels more emotion (10)	Help him be more comfortable with self (8)
Reduces social anxiety (6)	Greater confidence (6)
Shuts out inner critic voice (7)	
People will know "real" self (7)	
Mean Score = 8.33	*Mean Score = 8.25*
Negatives of Drug Use	*Negatives of Change*
Feels guilty (7)	Would not enjoy life as much (9)
Others are concerned (6)	Would be ignoring a part of himself (10)
Not as productive (10)	Breaking up with something he loves – a hard breakup (9)
Feels like it a crutch (10)	
Feels bad (7)	
Health Problems (7)	
Mean Score = 7.83	*Mean Score = 9.33*

The Decisional Balance first involves asking the patient to identify the positives and negatives of drug use and the positives and negatives of stopping or changing their use. After these forces are identified, the patient is asked to rate the power of each one, positive or negative, on a scale of 1-10. Only those items that achieve a score of 6 or higher are kept. To create a metaphorical calculus of the patient's motivation, means are formulated for each of the four boxes. The force for continued use is the Positives of Drug Use Mean plus the Negatives of Change Mean; the force for recovery or change is the Negatives of Drug Use Mean plus the Positives of Change Mean. In this example, when the ratio of forces is computed, the result is 17.66 : 16.08 – which helps to illuminate the "stuck" position of this patient.