Chapter 11
Stage-Based Treatment Approaches for Substance Use Disorders

11.1 Overview of Stage-Based Approaches to Treatment

Addiction to alcohol and other drugs has taken a vast toll on individuals, families, and communities across the United States for decades. Currently, the United States is experiencing a crisis in opioid addiction and overdose deaths. For instance, overdose deaths from opioid drugs, including prescription pain medications, heroin, and synthetic opioids such as fentanyl, have increased sixfold in the last 20 years and claimed almost 47,000 lives in 2018. A third of those deaths were the result of prescription opioids (CDC 2020; Wilson et al. 2020). In addition to opioids, negative consequences from the misuse of alcohol, stimulants, and cannabis continue to devastate the lives of our clients and their families.

Persons with substance use disorders (SUDs) engage in a continuous pattern of excessive alcohol and/or other drug use despite experiencing significant negative consequences in the domains of health, personal relationships, occupation, or other functional domains. Persons with SUDs continue to use substances despite these negative effects due to: (1) a loss of control over use due to physical dependency and/or strong psychological cravings and/or (2) a lack of motivation or desire to change behavior. There are several treatment approaches that are effective in treating substance use disorders (APA 2013). Unfortunately, many people with substance use disorders do not get the treatment they need (SAMHSA 2019). The decriminalizing of addiction and the dismantling of the war on drugs policy combined with an expansion of behavioral health services in the community and the integration of behavioral health practice in health, school, criminal justice, and social service settings represent an effective means to increase access to treatment. For instance, utilization of the collaborative care model that integrates behavioral health in primary care settings increases the likelihood that persons with alcohol and opioid use disorders will utilize evidence-based treatments such as brief psychotherapy and medication-assisted treatment (MAT) and will achieve abstinence within 6 months over usual care (Watkins et al. 2017).
In order for treatment to be effective, approaches should be matched to a client’s stage of change for a particular substance. According to the Transtheoretical Model of Change (TTM) (Prochaska et al. 1992), the decision to change behavior is often contingent upon a person’s motivation and readiness to change. Readiness and intention to change often move through a series of stages depending on internal and external factors such as the amount and quality of information available to the client, perceived self-efficacy of the client, external pressure to change, the perceived relative benefits and risks associated with change, and the resources available to the person that may assist change efforts, among others.

There are five general stages of change ranging from the least amount of readiness to the most amount of readiness: (1) precontemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance (Prochaska et al. 1992). Clients in precontemplation do not believe they have a problem and have no intention to change their behavior. Clients in contemplation may recognize they have a problem, but are ambivalent about whether or not they can or should change. The preparation stage of change generally describes clients who have less ambivalence about change and are preparing to change their behavior or have taken some initial steps in changing behavior such as reducing the amount and/or frequency of their use. The action stage of change refers to clients who are committed to changing their behavior and are actively engaged in treatment strategies to reduce or eliminate their use. Clients in the maintenance stage have achieved their substance use treatment goals (e.g., abstinence or reduced use) and no longer experience negative consequences related to their use for a sustained period (Prochaska et al. 1992).

Stage-based approaches to treatment coordinate and sequence treatment to match a client’s stage of change (Prochaska et al. 1992). For instance, harm reduction (HR) and brief motivational approaches to treatment are often used for persons in the precontemplation and early contemplation stages of change (e.g., clients with no or little intention to change behavior). Motivational interviewing (MI) is often most appropriate for persons in contemplation and early preparation stages of change (e.g., persons who have increasing ambivalence about change or who are moving toward making changes in their behavior). Blending motivational interviewing and cognitive behavioral approaches are often best for persons in the preparation and action stages of change (e.g., persons with less ambivalence and who are committed to making a behavioral change in the near future or those who have already begun making changes). Cognitive behavioral approaches may be best for persons in the action and maintenance stages of change (e.g., persons who are making changes to their behavior and who require relapse prevention strategies and support).

In order for treatment to be effective, providers must continually assess and recognize a person’s stage of change and align treatment interventions to match that stage. In this chapter, I will focus on the theoretical orientations, philosophies, principles, and practices of three sets of interventions: (1) harm reduction approaches for persons in the precontemplation stage; (1) motivational interviewing for clients in contemplation and preparation stages; and (3) brief cognitive behavioral treatments for clients in the action and maintenance stages of change. The principles, philosophies, theoretical orientations, and practices for each approach will be reviewed in detail and illustrated using case vignettes.
11.2 Harm Reduction Approaches

11.2.1 Overview and Definition

Harm reduction (HR) is a public health approach to high-risk behaviors. It is a form of tertiary prevention that consists of a constellation of practices and interventions designed to reduce the negative consequences that stem from harmful or high-risk health behaviors involving drug and alcohol use without directly focusing on the alcohol or drug use itself (Denis-Lalonde et al. 2019; Des Jarlais 1995; Hawk et al., 2017; Mancini et al. 2008a, b; Mancini and Linhorst 2010; Mancini and Wyrick-Waugh, 2013). Harm Reduction International (HRI) defines harm reduction as the, “policies, programmes and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights—it focuses on positive change and on working with people without judgment, coercion, discrimination, or requiring that they stop using drugs as a precondition of support.” (HRI 2020).

Harm reduction approaches are most often utilized for persons in the precontemplation and early contemplation stages of change and who currently have little or no intention or motivation to stop substance use. Harm reduction approaches can be blended with motivational approaches so that providers can prevent or reduce harm, while also helping to motivate people toward change. In contrast to medical and moralistic models of substance use, providers using harm reduction approaches take a decidedly public health approach that focuses on reducing the harmful consequences of drug use (Des Jarlais 1995). HR providers accept the person’s drug-using behaviors in a nonjudgmental manner and focus on helping them set and achieve goals (Marlatt 1996). While abstinence from substances is a goal in HR approaches, it is a goal that is placed at the far end of a spectrum of other intermediate goals designed to reduce harms associated with substance use such as overdoses, disease transmission, victimization, incarceration, poverty, homelessness, and public intoxication. HR focuses mainly on substance use, but can be used to address a variety of health issues such as obesity, smoking, sex work, and domestic violence and is a very appropriate approach for healthcare settings (Hawk et al. 2017).

11.2.2 Harm Reduction History

Resistance to harm reduction has a long history in the United States for a number of reasons. The field of substance use treatment and policy has long been dominated by moralistic views about substance use condemning intoxication and use of substances as morally reprehensible and addiction as a moral failing. Prevention and treatment programs serving persons who use substances that promote anything other than strict abstinence are often viewed as enabling or encouraging of substance use. This view has also been influenced and magnified by the stigmatization
of persons of color in the United States, and the long history of criminalization of drug use initiated and maintained by the failed “war on drug” policy in the United States which began in the 1970’s.

Harm reduction approaches came into wide prominence across the world in response to the HIV/AIDS pandemic in the early part of the 1980s. However, the resistance toward harm reduction approaches in the United States prevented the widespread use of practices such as needle and syringe exchange programs during this time, resulting in a high number of avoidable HIV transmissions. For instance, needle and syringe exchange programs were implemented in the United States and supported by funding from states and localities and the North American Syringe Exchange Network in the late 1980s almost a full decade after the start of the AIDS pandemic as a way to reduce HIV transmission among people who inject drugs (PWID). Furthermore, needle and syringe exchange programs were not permitted by federal guidelines until 2016 (Des Jarlais 2017).

Harm reduction approaches, including drug decriminalization, needle and syringe exchange programs (NSP), safe injection sites (SIS), opioid substitution therapy (OST), housing-first programs, condom distribution, and naloxone (i.e. Narcan) availability, have been shown to be cost-effective ways to save lives by reducing overdoses, increasing safety and access to health care and treatment, and reducing the spread of infectious diseases such as HIV and hepatitis C virus (HCV) (Csete et al. 2016). Given the rise in opioid deaths in the United States, these programs have never been more essential (Des Jarlais 2017).

11.2.3 Harm Reduction Principles

Harm reduction consists of a range of values that include public health, social justice, and human rights. Harm reduction requires providers to practice in a way that is nonjudgmental, evidence-based, egalitarian, pragmatic, and adaptable, and preserves clients’ self-determination and individuality. Harm reduction has been found to be wholly compatible with practice that is person-centered, trauma-informed, and recovery-oriented (Denis-Lalonde et al. 2019; Hawk et al. 2017; Mancini et al. 2008a). The harm reduction principles of humanism, individualism, autonomy, accountability, and justice make the approach inherently recovery-oriented and trauma-informed when practicing harm reduction providers prioritize humanistic care that is respectful, nonjudgmental, compassionate, and collaborative (Hawk et al. 2017). Due to the stigma that surrounds substance use and addiction, it is important for providers to avoid stereotypic language (e.g., users, offenders, addicts, junkies) and use humanizing, people-first, and recovery-oriented language when describing and working with persons who use substances. This includes referring to people as “persons with substance use disorders or addictions” or “persons who misuse substances” (Broyles et al. 2014; Sharma et al. 2017). Furthermore, providers should avoid legalistic or moralistic language to describe use such as “clean,” “dirty,” “drug-free,” or “illicit or illegal drugs.” Preferable terms include “substances,” or
saying someone is “negative” or “positive” for substance use (Broyles et al. 2014; Olsen and Sharfstein 2014). Likewise, using recovery-oriented language such as avoiding “adherent,” “resistant,” or “noncompliant,” and referring to people as “in recovery” or “currently receiving or not receiving treatment” is important. When in doubt, providers should ask people how they wish to be considered (Broyles et al. 2014).

Harm reduction providers also hold people accountable. This means that clients take responsibility for their choices and the natural consequences for their actions. Providers practicing harm reduction do not endorse or enable drug use behavior. Providers understand that clients have a right to make unhealthy choices and may suffer consequences. Providers help clients understand how their behaviors have led to negative consequences and continue to support clients despite relapses or a lack of treatment progress. Clients are not discharged or punished if they relapse or choose to not complete goals (Hawk et al. 2017; Mancini et al., 2008; Mancini and Wyrick-Waugh 2013).

The harm reduction principles of individualism and autonomy require accepting people where they are in their recovery journey and not where providers think they should be. This also makes harm reduction approaches inherently person-centered and trauma-informed since providers seek to understand the clients’ perspective, preferences, and needs and the social determinants that may be driving their substance use. Harm reduction providers offer a range of options and support clients’ self-determination through a shared decision-making orientation. Harm reduction is also a recovery-oriented approach to practice because it requires providers to respect client autonomy and choice as clients make their own informed decisions based on knowledge of the available options and their benefits and drawbacks (Denis-Lalonde et al. 2019; Hawk et al. 2017; Mancini et al. 2008a). Providers of harm reduction services hold the view that people who use substances should be free from cruelty and coercion and have adequate access to effective social and health services. All of these principles align with care that is recovery-oriented, trauma-informed, and person-centered.

The principles of pragmatism, incrementalism, and evidence require providers to collaborate with clients to set realistic goals designed to reduce the harm that clients do to themselves and society without focusing on abstinence. Client goals often involve addressing the social determinants of health around housing and resource access. Practicing from this perspective may require providers to address the internal tensions caused by their socialization around drug use and persons who use substances (Denis-Lalonde et al. 2019; Hawk et al. 2017; Mancini and Wyrick-Waugh 2013; Mancini et al. 2008a, b; Mancini and Linhorst 2010). Providers also celebrate any incremental step forward toward positive change. Recognition that change takes a long time and relapse is part of the process requires providers to plan for relapse and use it as an opportunity to learn new strategies. Harm reduction practices are also evidence-based and have been shown to be efficacious, practical, and cost-effective, making them appropriate for person-centered care. These approaches are public health-oriented and focused on preventing social, legal, and health-related harms to individuals, families, and communities (Des Jarlais 2017; Wilson et al. 2015).
11.2.4 Harm Reduction Programs

Resistance to harm reduction persists despite the clear effectiveness of the approach (Wilson et al. 2015). Several harm reduction practices have been found to be effective in reducing overdoses and disease transmission as well as improving clinical outcomes. Next, I will review several of the most widely utilized and studied practices of harm reduction.

Needle and Syringe Exchange Programs (NSP) These programs provide people who inject drugs (PWID) with clean and sterile needles and exchange used equipment with new, clean equipment to reduce needle and syringe sharing. Needle and syringe exchange programs are effective at reducing HIV, HCV, and other infections (Aspinall et al. 2014; MacArthur et al. 2014; Wodak and Cooney 2004; Wodak and Maher 2010). These programs have also been found to improve access to medical and social care, condoms, behavioral health treatment, overdose education, HIV and HCV education, counseling and testing, drug checking and education, and access to naloxone to prevent overdoses without increasing drug use or drug traffic in communities where exchange programs operate (Des Jarlais 2017; Strathdee et al. 2006).

Opioid Substitution Therapy (OST) Opioid substitution therapy uses noninjecting, long-lasting opioids such as methadone and buprenorphine as a substitute for heroin or fentanyl. Methadone and buprenorphine, while still opioids with addiction potential, are safer alternatives to heroin due to their longer half-life, more gradual onset of effect, and availability in noninjectable forms such as pills, sublingual dissolvable tablets, and transdermal patches. Pill forms of some substitution therapies can be misused by being crushed, dissolved and injected. To discourage this practice, a combination of buprenorphine and naloxone is now available (e.g., Suboxone). Naloxone is an opioid antagonist used in overdose reversal and taking it can lead to immediate withdrawal symptoms. OST can also be used by pregnant women, increasing their health and reducing harm to the fetus. OST can reduce infection-related infections and overdoses while helping people work and stay housed because the medications can help control cravings and are longer lasting, while not leading to rapid highs and withdrawal associated with heroin. In short, OST leads to more stability and has been extraordinarily effective in helping people reduce infections and live healthier lives in the community (MacArthur et al. 2012; Tsui et al. 2014; Turner et al. 2011).

Safe/Supervised Injection Sites (SIS) Supervised injection sites (SIS) are legally sanctioned, indoor spaces where people can inject drugs under medical supervision in order to discourage needle sharing, reduce overdoses, and provide a safe injection location for vulnerable people. These sites also provide people with a variety of resources and services including clean injecting equipment, medical and behavioral health care, condoms, the overdose reversal drug Naloxone, drug-checking services, education on how to reduce infections, and referrals to OST programs.
SIS have been effective in increasing access to drug treatment and primary care (Kerr et al. 2010), reducing HIV infections and needle sharing (Milloy and Wood 2009; Pinkerton 2011), and decreasing overdoses, public injecting, and dropped needles, while not being associated with increased drug trafficking, drug injecting, or crime (Potier et al. 2014; Kerr et al. 2010). A cohort study of over 800 PWID in Vancouver, Canada, found that all-cause mortality rates were significantly lower for frequent users of SIS than nonfrequent users (Kennedy et al. 2019).

**Drug Checking** Drug checking involves using testing strips to test the quality and purity of drugs to ensure drugs do not contain harmful chemicals, agents, or fentanyl, a highly potent and lethal synthetic opioid associated with increased overdose potential and deaths. These services are often available at SIS and at parties or raves where ecstasy and other drugs with high overdose or contamination potential are consumed. The recent rise of fentanyl in the United States and across the globe has led to a surge in overdose deaths, making these programs incredibly important. In a study at one supervised injection site, about 80% of drugs checked were contaminated with fentanyl. Implementation of drug checking at SIS may, therefore, also reduce the potential for overdoses in PWID (Karamouzian et al. 2018). The use of drug testing strips to identify illicit manufactured fentanyl in drugs has also shown good uptake in PWID (Krieger et al. 2018).

**Providing Noncontingent Employment and Housing Services** Programs such as *Housing First* that provide housing to people with addictions without mandating abstinence have been effective in increasing treatment engagement (Larimer et al. 2009; Tsemberis et al. 2004) and improving health for persons who are homeless with HIV/AIDS (Hawk and Davis 2012). These programs are particularly effective in persons with co-occurring serious mental illness and substance use disorders who are un-housed. This population often struggles to conform to the demands of high-threshold treatment programs that mandate abstinence as a prerequisite to services. As a result, this group tends to have high treatment dropout rates and very high rates of morbidity and early mortality (Mancini and Wyrick-Waugh, 2013). Housing First programs address social determinants of health by providing safe, secure housing and access to medical care and behavioral health treatment though case management. Housing First has been found to lead to less homelessness, greater access to treatment, and higher rates of client satisfaction (Tsemberis et al. 2004). Housing First programs are effective in helping people live longer lives that are healthier, safer, and more dignified.

### 11.2.5 Intensive Case Management

Harm reduction programs serve people’s needs without directly addressing substance use. Providing practical support and access to resources is a fundamental harm reduction approach. Intensive case management services are specifically
designed to serve populations with complex needs such as persons with co-morbid serious mental illness and substance use disorders who struggle to stay housed, employed, and healthy. Intensive case management can be provided by a single case manager or by a team of service providers. Intensive case managers provide time-unlimited, intensive, individualized wrap-around services designed to increase stability, improve health, and enhance community tenure and recovery. Intensive case management typically has a low client-to-professional ratio of around 10 to 1. Intensive case management services are comprehensive and include assessment and care planning, benefits management, housing, occupational and social rehabilitation, addiction services, psychiatric symptom management, and physical health/disease management (Salyers et al. 2013). All or most services are provided directly by members of the case management team. Intensive case management services are continuous and time-unlimited. Intensive case management has been found to reduce hospitalization, increase retention in care, and improve functioning as compared to standard care (Dieterich et al. 2017).

**Harm Reduction in Primary Care Settings** While most harm reduction programs are provided in community settings, use of harm reduction approaches have also been promoted in hospital settings as a way to engage persons who use drugs (PWUD) in treatment (Sharma et al. 2017). Several strategies have been identified that can help to increase patient access to substance use disorder treatment. One approach is using *peer providers* who have lived experience with addictions and mental health issues to engage PWUD in treatment and to include peer providers in developing humanistic and nonstigmatizing organizational policies and procedures for PWUD (Sharma et al. 2017).

Another approach is for hospitals to develop formal organizational relationships with outside addiction providers and organizations to coordinate treatment referrals and engage in consultation and cross-training of staff. For instance, hospitals could provide addiction centers with training in health screening, while addiction specialists could assist healthcare providers in a number of areas related to treating persons with opioid and other addictions. This includes training in administration and disbursement of naloxone (i.e., Narcan) for overdose reversal. Early evidence has demonstrated that providing education about overdose risk prevention and distributing naloxone to at-risk patients and their family and friends are effective in reducing opioid overdoses in the community (Adams 2018).

Providing education referral and initiating opioid substitution therapy (OST) and other medication-assisted treatments (MAT) to assist patients with withdrawal or craving management is another effective approach. Initiating buprenorphine/naloxone treatment in primary care settings such as hospital emergency departments (ED) and clinics can increase the likelihood of using medication-assisted services, reduce the likelihood of nonprescribed opioid use after discharge (Hawk and D’Onofrio 2018; D’Onofrio et al. 2015; Liebschutz et al. 2014), and can lead to increased treatment engagement (Hawk and D’Onofrio 2018; D’Onofrio et al. 2015). Providing buprenorphine in the ED has also shown significant cost-effectiveness by reducing overall healthcare utilization costs (Busch et al. 2017).
In another example, hospital staff often deny opioids to patients with opioid addiction resulting in withdrawal, unnecessary pain, and leaving the hospital against medical advice. Addiction consultants could provide guidance on how to properly prescribe opioids or nonopioid alternatives to assist with pain management while patients are in the hospital (Sharma et al. 2017). Addiction consultants can also assist hospital providers in deploying brief interventions with patients and their families. This includes how to have motivating, nonstigmatizing, educational conversations with persons with substance use disorders and their families. These conversations can include providing patients with advice about how to notice and manage cravings and withdrawal symptoms and information on safe drug use practices. These brief interventions could also include referrals to needle and syringe exchange programs, drug-checking services, self-help, behavioral health treatment programs, and services that address housing, employment, and benefits (Sharma et al. 2017).

**Case Study 11.1 Mia**

Mia is a 21-year-old, cisgendered woman. She was brought to the emergency room by the fire department after suffering an acute opioid overdose. She was injecting heroin laced with fentanyl (unknown to her) with friends when she and another friend passed out and would not wake up. The others who had not yet injected called 911.

Mia has a history of depression and PTSD. She was sexually abused as a child by her ex-stepfather. She was kicked out of her house at age 17, when she told her mother and her second stepfather that she was bisexual. She subsequently stayed at friend’s houses and shelters. She eventually dropped out of school and started working as a server in several restaurants. She made good money and was able to rent a small apartment. She started using prescription opioids when she was in high school. After she was kicked out of the house, she was exposed to other means to use opioids and quickly moved to injecting heroin. She states, “The oxy was everywhere in high school so I never thought I would inject because we would crush them and snort them. I was probably addicted then. But I got kicked out and started hanging around some people from work and they taught me how to smoke it, and then how to doing skin poppers just under the skin and then the next thing I knew I was injecting. They changed the formula of oxy so you couldn’t make it into a solution to cook or shoot so we switched to heroin. It didn’t take long. The feeling was like a warm hug that I never got from anyone. It was like nothing I ever experienced. And then I couldn’t stop myself. Every day. The withdrawals were terrible.”

Mia received a nasal injection of an opioid antagonist Narcan (naloxone) from a first responder that reversed her overdose and saved her life. While she was recovering in the hospital, the police officer who responded to the scene called a peer support worker, Jade, employed by the hospital to try to engage Mia in treatment. The peer worker, a person with lived experience of addiction and recovery, met Mia at

---

1 All names and other identifiers of this case have been changed to protect privacy and confidentiality.
her bedside. She told Mia, “You’re young, you have got your whole life ahead of you. I was in the same boat as you – I was raped, blamed for it, kicked out of my damn house by the person who raped me, got addicted, loved it at first, then I overdosed, overdosed again, tried to kill myself, and then a peer came to my bedside in this very hospital and told me I had my whole life ahead of me and asked me if I want to try to turn it around? You know what I said to her? I told her to ‘fuck off.’ So she left. And then I sat with it for a night and I called her and she came and she helped me save myself.” Jade informed Mia of some program options available and asked if she would like to enroll, get some treatment, earn her GED, and get a job or go to college.

Mia refused and said that she was OK. That she just got a bad batch. She’d be more careful. So the peer worker gave Mia her own Narcan nasal dispenser, fentanyl test kit, and taught her how to use both. She also gave her some clean syringes, her card with her phone number and told Mia to call her anytime day or night. Mia refused the Narcan and clean needles at first. The peer worker became firm: “No. You don’t know it yet – but you are going to call me and I need you to live to do that. You take these. You need to stay healthy and maybe you’ll need these to help someone else.” Mia took the items. Two weeks later her best friend overdosed and Mia was able to use the Narcan to save her. After this incident Mia called Jade and met her for coffee. Jade told Mia more about the program and how she could enroll. Jade would stand by her throughout the process.

Mia enrolled in the program. She received an opioid substitution medication (buprenorphine) that helped control her cravings and go back to work as a cashier. Mia would briefly relapse twice more that year before achieving her first 6 months of sobriety. After each relapse she and Jade would see what went wrong and develop skills to cope. They determined that boredom, seeing people she used to use with, having money, and depressed symptoms were her main triggers. They worked together to develop coping skills (e.g., craving management, refusal skills, and planning for emergencies), budgeting skills, and activity scheduling to fill her time. Mia also completed a 10-session sequence of eye movement desensitization and reprocessing (EMDR) therapy to help target her intrusive thoughts and negative self-evaluation related to her trauma. At night she studied for her GED. Mia eventually titrated off of the buprenorphine and moved to naltrexone to control her cravings. While in treatment Mia learned how to control her cravings using relaxation and distraction techniques. She received some antidepressant medication and CBT to control her depressed moods and change her negative thinking patterns. She would eventually earn her GED and is now attending college courses to earn her social work degree. She has a new girlfriend and they are considering moving in together. She is also considering being a peer support worker to help others. Jade has moved into a management position and is a supervisor for several peer workers across the city. She and Mia are still close.

**Case Analysis Questions**

- What is your case conceptualization and hypothesis of Mia?
Describe how Mia moved through the various stages of change and how the treatment approaches she experienced shifted across these different stages. Describe how Jade was able to help Mia. What strategies did she use? Why was Jade successful in engaging Mia? What harm reduction principles and practices are evident in this case? What role did harm reduction play in Mia’s eventual sobriety?

11.3 Motivational Interviewing

11.3.1 Motivational Interviewing: Philosophy, Basic Skills, and Techniques

Motivational interviewing (MI) was developed by William R. Miller and Stephen Rollnick in the 1980s. MI is a person-centered, collaborative style of practice that helps people explore their ambivalence about changing health behaviors related to alcohol and substance use, diet and exercise, using medication, and safe sexual practices (Miller and Rollnick 2013). Motivational interviewing is a “client centered, directive method, for enhancing intrinsic motivation to change by exploring and resolving ambivalence.” (Miller and Rollnick 2002; pg. 25). The basic skills of motivational interviewing can be useful in each stage of change. However, the approach is most useful in the contemplation and early preparation stages of change where ambivalence toward change is high and insight and knowledge can tip the motivational scales in the direction of change. MI approaches focus on being non-judgmental, accepting, and empathic, which can also assist in building relationships and engaging clients in the precontemplation stage of change where intention to change is low or nonexistent. Clients in precontemplation may be uninterested in change or are unconcerned about any negative effects of their behavior. Being accepting and offering some information about the potential risks of use and strategies to reduce harm in a gentle, empathic, and nonjudgmental way through reflections and open-ended questions can help people think about their use differently and diffuse conflict and defensiveness. Receptivity to this kind of approach is more likely to be higher than using confrontation which can lead the person to shut down or “dig in” to their view (Humeniuk et al. 2010b; Miller and Rollnick 2013; Prochaska et al. 1992).

The goal of MI is to invite people to consider change through a supportive relationship (Miller and Rollnick 2002). Three concepts animate the spirit of motivational interviewing approaches (Miller and Rollnick 2013). The first is collaboration. Providers work closely with clients using a warm, nonjudgmental, accepting, and empathic approach. Providers avoid confrontation, which can lead to resistance. Instead, providers create an open and warm context and seek to be in attunement with clients’ dreams, goals, and aspirations. This helps them identify discrepancies between clients’ stated goals and current behavior. Providers seek to help clients
identify and resolve ambivalence about change and help direct them toward behaviors that are best aligned with their readiness and confidence (Miller and Rollnick 2002, 2013). The second is evocation. Rather than impart unwanted advice, MI providers use reflective listening to elicit or draw out information from the client in order to help them develop an understanding of the discrepancies between their current behavior and their desires and goals for the future. MI providers strive to elicit a person’s intrinsic motivation for change and then reflect that back to the person so that they can decide whether or not to seek change. MI providers avoid preaching, ordering, persuading, praising, sympathizing, or interpreting. MI is a quiet, eliciting approach to counseling (Miller and Rollnick 2013). The third is autonomy. For MI providers, change is viewed as a natural process that is the responsibility of the client. MI providers avoid coercion or telling clients what they must or should do. Practitioners communicate to the client that the direction and amount of change is their responsibility (Miller and Rollnick 2013). These principles make motivational interviewing inherently aligned with care that is person-centered, recovery-oriented, and supportive of shared-decision-making approaches.

Motivational interviewing also has four general principles that act as a foundation to the approach. The first general principle is empathy. MI providers recognize the people are doing the best they can, given their experiences and circumstances. Therefore, the MI approach is predicated on respect, acceptance, and sensitivity. MI providers understand that change is difficult for everyone and recognize that ambivalence toward change is natural and expected. MI providers avoid judgments, labels (e.g., addict, user, alcoholic), blame, and confrontation, and instead accept clients exactly as they are, and where they are, in the change process. Providers foster this accepting environment through the use of open-ended questions and reflective listening as a means to understand and evoke client ambivalence about change and to seek out client goals, dreams, and aspirations. To put it more bluntly, no one likes to be judged or pushed around. Showing empathy and acceptance allows the client to feel comfortable and understood. This is more likely to facilitate change by giving clients a chance to see the discrepancy between their actions and their goals. The approach gives clients the space they need to consider change without feeling like they are “giving in,” reducing resistance and frustration for both the client and the provider (Miller and Rollnick 2002; Humeniuk et al. 2010b).

The second general principle is developing discrepancy. MI is a directive approach in that providers seek to help clients develop motivation toward change. This is accomplished through the development of discrepancy. Discrepancy is the gap between a person’s current behavior and their personal goals and values (Miller and Rollnick 2013). The goal of an MI provider is to help create, identify, or amplify discrepancy between the client’s present situation and where and who they want to be in the future. As discrepancy increases, the importance for change also rises. When a person sees how their current behavior interferes with their personal goals related to relationships, identity, roles, health, and success within an open and accepting environment, they will be the ones advocating for change. In order to develop discrepancy between client goals and current behavior, MI providers use a range of practices that include
open-ended questions, reflections, and strategies such as decisional balance exercises to help clients identify the pros and cons of changing and not changing behavior.

The third general principle is rolling with resistance. People naturally resist change and are ambivalent about making changes in their life. This is normal, and the MI provider accepts this as part of the change process. The goal is to invite the person to take in new information and knowledge about their substance use or other unhealthy behavior. MI providers do not argue for change. Rather, they help the client argue for change. When resistance does come, rather than fighting it, MI providers roll with resistance by reflecting the resistance back at clients by asking more open-ended questions (Miller and Rollnick, 2013; Humeniuk et al. 2010b). Signs of resistance include: (1) discounting the importance of change; (2) arguing and challenging your expertise; (3) interrupting you, talking over you, and cutting you off; (4) minimizing the problem, denying there is a problem, and blaming others; and (5) “checking out” or not paying attention. Resistance is to be expected and signals to the provider to slow down and explore (Miller and Rollnick 2002, 2013). The fourth general principle is supporting self-efficacy. Self-efficacy involves how much the person believes they have the ability and competence to be successful in a particular task or solve a problem. In order for change to proceed, providers must communicate to clients that they can change and that change is up to them. One way to communicate this is to inform the person that change can take many forms. Offering the person a menu of treatment options can help the person identify and select the best pathway for change (Miller and Rollnick 2002, 2013).

11.3.2 Motivational Interviewing Practices

By establishing and nurturing a caring and nonjudgmental relationship the provider can increase the intrinsic motivation for change by gently pointing out how the person is at odds with something they value (e.g., stability, health, employment, positive relationships). When this discrepancy has been acknowledged a person’s intrinsic motivation for change rises. In the MI tradition, change is a natural process that is most likely to occur when: (1) there is a discrepancy between the client’s current situation and how they want their life to be; (2) the importance of change is high; (3) a person understands what they have to do to change and has confidence that they can make the change; and (4) the client is ready to make the change and that change is more important than maintaining the status quo. Healthcare providers can enhance a person’s motivation for change by providing information and pointing out the discrepancy between their stated goals and their current behavior, communicating the importance of change, and providing a clear pathway for change through information and a menu of treatment options (Miller and Rollnick 2013).
11.3.2.1 Avoiding Traps

Confrontation and the use of shame, humiliation, or other punishments can act to create defensiveness in the person and can often lead to immobilization and a sense of hopelessness. It can also create anger that may cause the person to resist change. For instance, Miller and Rollnick (2002, 2013) have identified several “traps” that get in the way of increasing client’s intrinsic motivation to change. I will explore several of these traps below.

The Q & A Trap  This trap is when the provider asks a series of closed-ended questions that invites the client to give easy, short answers that require no introspection, exploration, or analysis. This trap is common for new or rushed professionals. This situation reinforces the providers as the authority (i.e., the interrogator) and the client as passive. It also creates a nonempathic environment that is predictable and shallow. Avoid this trap by gathering checklist type information in the intake form and reserve enough time in the clinical interaction to share and explore change in a relaxed atmosphere. During the clinical interaction, only rely on open-ended questions, reflections, and affirmations. The client should be doing most of the talking and the clinician should rely on multiple reflections for each open-ended question asked.

Taking Sides  This is when providers tell the client they have a problem and argue for the changes the client should be making. This naturally leads to defensiveness or passivity and puts the client in the position of arguing against change (i.e., resistance). This is the opposite of MI. It is the client, not the provider, who should be arguing for change. It is important for the provider to not defend one side of the argument but to help the client explore the pros and cons of both sides: change and not changing.

Expert Trap  This is when the provider sends the message that they have all the answers. This leads to passive resistance. This trap is endemic in treatment planning processes that are not person-centered and is obvious when the provider both identifies the problem and generates the solutions while the client sits passively, waiting to go home and ignore the plan the provider has so expertly developed for them. It is important to open up space for the client to explore their ambivalence about the problem. Ambivalence is best summarized in the “Yes, but…” statements clients may give in response to change. Ambivalence is both wanting to change and not wanting to change at the same time. Use reflections to identify this ambivalence and then ask, “What do you make of this? How can you resolve this and move forward?”

Labeling Trap  The labeling trap is when providers feel it is important for the client to admit they have a problem or a particular diagnosis (e.g., depressive, alcoholic, addict), and if they don’t they pronounce them as “in denial.” This approach is mostly ineffective and can drive people who are ambivalent about change away from help. It engenders resistance in the highest form because you are forcing peo-
ple to accept a label they do not necessarily agree with or are interested in accepting. This also leads directly into a struggle for power and authority in the interview. Avoid this trap by de-emphasizing labels and focus instead on behavior and how it may be in conflict with a person’s values and goals.

**Premature Focus Trap** The premature focus trap can happen due to a busy environment and an eagerness to help. The provider attempts to focus in on the problem behavior too soon in the interview and creates resistance. In this trap, the provider seeks to force the conversation to focus on what they think the problem is. This can lead to defensiveness with the client and an ensuing struggle. In MI, you want to go where the client takes you, gently selecting and amplifying any comments focused on change and ambivalence. Clients often want to talk about things that are related to the problem. This can be an opportunity to learn about how the problem behavior is affecting the client’s life and provide an opportunity to develop discrepancy. For instance, the client may score highly on harmful drinking behavior, but wants instead to focus on his anger and how it is destroying his relationship with his partner more so than the drinking. This is an opportunity to explore how his drinking and anger are linked. Focusing on addressing his anger and relationship issues first may represent in indirect way to address drinking by developing discrepancy by asking later in the interview something like, “It sounds like your anger is something that you want to work on changing. I’m also curious to know if you think there may be a relationship between your drinking and your anger. What are your thoughts about that?” (Miller and Rollnick 2002, 2013).

11.3.2.2 Common Practice Skills for Motivational Interviewing: OARS

There are four common practice skills that serve as the foundation to motivational interviewing that make the acronym OARS: (1) Open-ended Questions, (2) Affirmations, (3) Reflections, and (4) Summaries. OARS can be used to create and amplify ambivalence around change and highlight discrepancies between: (1) what clients would like their life to be; (2) what is happening now; and (3) how their substance use is interfering in their pursuit of their goals and impacting their health. The use of OARS can help evoke these discrepancies and help the client identify their own reasons for change from their point of view (Humeniuk et al. 2010b; Miller and Rollnick 2002, 2013).

**Open-Ended Questions** Open-ended questions invite the client to explore a particular topic and to do most of the talking. Open-ended questions usually begin with stems such as: “Tell me about…,” “I’m curious to know….” “Help me understand.” Open-ended questions create a context that is marked by acceptance, respect, and exploration. Open-ended questions invite people to explore their lives or topics. As a general guideline, you should follow up on an open-ended question with a series of reflections and affirmations and then a summarization of the topic before moving on to another area (Humeniuk et al. 2010b; Miller and Rollnick 2002, 2013; SAMHSA 1999).
**Examples of Open-Ended Questions**

- What brought you here today?
- How did the problem start?
- What concerns do you have about your use?
- What concerns do others have about your use?
- I curious, what do you think about your use?
- How has your drinking been a problem for you? For other people?
- What are some of the benefits you get from using? What are the “not-so-good things” about drinking or drugs?
- In what ways does your score on the drinking scale concern you?
- What makes you sure that you can make a change if you decided to do it?

**Affirmations** Providers can occasionally use affirmations that highlight client strengths and qualities and acknowledge a positive development or action. Affirmations should be used sparingly and acknowledge client attempts, their strength in surviving any adversity they may share, and the courage to be talking to you at all. For instance, a question one might ask to affirm and to elicit change could be, “You being here shows me that at least in some ways you think it is time to do something different. What reasons do you have for changing? What makes you think you need to make a change?” The emphasis should be on genuineness and authenticity (e.g., don’t fake it) and focused on courage, competence, strengths, and endurance (Miller and Rollnick 2013; SAMHSA 1999).

**Reflective Listening** Reflective listening is the most important skill in MI. Reflective listening requires practitioners to listen intently to a person’s words, body language, and tone of voice in order to infer the explicit and implicit meaning of their statement and to reflect that information back to them in the form of a statement. This involves not only listening to what the person is saying, but then also reflecting back the underlying meaning of what they said. Table 11.1 lists examples of several types of reflective statements. In simple reflections providers reflect the words a client has said back to them to elicit more talk. More complex reflections use words that get at the deeper meaning beyond a client’s statement. Slightly underestimating the intensity of a comment by using words such as “a bit” or “a little” may lead a person to continue to explore their feelings and thoughts, while over-estimating or amplifying will cause a person to stop or go in the other direction. A double-sided reflection (e.g., On the one hand…and on the other hand…) is a good tool to reflect a client’s ambivalence about change. When the client uses a “Yes, but” statement to refer to a problem, this is often a signal that it is a good time for a double-sided reflection. See the following example.

*Client:* My family is probably right. I sometimes overdo it on the weekends and I know I should probably cut down.

*Provider uses simple reflection:* So it sounds like you agree that you need to cut down on your drinking?

*Client:* Yes, but I enjoy it. I like going out with my friends and having a good time. I deserve it. I work hard.
Provider uses double-sided reflection: So it sounds like on the one hand, you recognize that your drinking is causing you some problems with your health and family and you should cut down, and on the other hand you feel that you deserve to have some fun with your friends. It sounds like there are some benefits to drinking that you’re not sure you want to give up.

In this example, the client’s “yes, but” statement revealed some important information that could lead to a discussion of how the client could continue to socialize and enjoy the benefits of his friends, while also cutting down on his drinking and preserving his health. Note the use of “and” instead of “but” in the double-sided reflection. You do not want to use “but” because it negates the statement that came before it. Instead, use “and” or “yet” in double-sided reflections to recognize the importance and validity of both statements. In MI, providers must decide which of the statements from the client they will reflect. These usually involve statements focused on ambiguity and change talk. It is wise to follow open-ended questions with two to three reflections (Miller and Rollnick 2013). Using simple, amplifying, and double-sided reflections are important ways to help people develop discrepancy using their own words. It also keeps the conversation moving (Humeniuk et al. 2010b; Miller and Rollnick, 2013).

**Summarizing** Summarizing, or “picking the flowers,” can be used to collect and consolidate information, reinforce what has been said, check accuracy of information, and transition to another topic. At their best, summaries communicate to the client that you have listened to them, and reinforce important information in one place so the client can reflect and move forward to the next step. Summaries can be used periodically to collect information that has been said on a topic and to link one set of information with another set. Lastly, summaries can transition to another topic area. As with double-sided reflections, when summarizing a client’s statements, avoid using “but” as this can be confusing. Instead use “and,” “on the one hand and then on the other hand,” or “at the same time.” These statements more accurately capture the ambivalence around change. Both things can be true: wanting to change and wanting to continue the status quo (Miller and Rollnick 2013).

**11.3.2.3 Eliciting Change Talk**

Eliciting change talk is a directive way to resolve ambivalence toward change. It is important to first be able to recognize change talk when you hear it. There are several types. Table 11.2 lists the main strategies for eliciting change talk. The first type of change talk is acknowledging disadvantages of the status quo or of things staying as they are. These are statements of recognition and insight. The client has indicated that they recognize that their current trajectory is untenable and that there are clear consequences and disadvantages to the status quo (Miller and Rollnick 2013).

A second form of change talk is recognizing the advantages of making a change. Clients may acknowledge that change would be good for them and recognize that making a change would have some positive consequences (Miller and Rollnick 2013). A third type of change talk is when clients express optimism for change. This
type of change talk goes beyond recognizing the disadvantages of things staying as they are and the advantages of making a change, to demonstrating the recognition that the person could make the change. This type of change talk includes notes of confidence and intention (Miller and Rollnick 2013). The last form of change talk includes expressing clear intentions to change. This type of change talk indicates the importance of change and signals to the therapist that the person is entering the preparatio/action stage of change (Miller and Rollnick 2013). Table 11.3 lists some

Table 11.1 Examples of reflections in motivational interviewing (Based on Miller and Rollnick 2013)

| Client comment                                      | Provider response                                                                 | Reflection type and purpose                                                      |
|-----------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| I don’t need help. I can quit on my own.            | You have the ability to do this by yourself.                                    | Simple reflections: Using reflection to recognize what the person is saying and feeling in the moment. This can repeat using the same words or, even better, to capture the feeling and perspective of the person. |
| I’m not interested in quitting smoking.             | You don’t think quitting smoking would work for you right now.                  |                                                                                   |
| My partner is exaggerating. My drinking isn’t that bad. | So there are no problems in your relationship because of your drinking. | Amplified reflection: Amplifies or exaggerates what the person says. Used to get people to tone down a statement or argue the other side. Be careful to not go too far. Use judiciously or you will get resistance. |
| My grandfather smoked his whole life and he lived until he was 85. | So smoking doesn’t really lead to any health problems. |                                                                                   |
| My grandfather smoked his whole life and he lived until he was 85. | You don’t expect any health problems no matter how long you smoke. |                                                                                   |
| My grandfather smoked his whole life and he lived until he was 85. | Your grandfather didn’t experience any health problems due to his smoking, and so you won’t either. |                                                                                   |
| I know I may drink too much sometimes, but I work hard and like to spend time unwinding with my friends. | On the one hand you realize your drinking is causing problems in your marriage, yet on the other hand it is important for you to spend time with your friends and unwind after work. | Double-sided reflection: Attempts to capture the full range of ambivalence about a problem. In this approach you identify ambivalence for and against a health behavior. The key is to use “and,” “yet,” or “on the one hand…yet/and on the other hand.” by avoiding the “but,” you do not cancel what came before. Instead you capture both sides of the issue. You may have to use information the client has given you in the past regarding the behavior. |
examples of change talk that you may hear from clients and different types of responses that can elicit more change talk.

11.3.2.4 Using Rulers to Assess Readiness, Importance, and Confidence

Readiness implies a level of confidence and importance. In order to understand a client’s level of readiness to change it is useful to know how important a person thinks it is to change, how confident they are that they can make a change, and how ready they are to make a change. Using “rulers” can help you know whether you need to help the person see the importance of making a change, or whether you need to help build up the person’s self-efficacy for making a change. The use of rulers to measure these aspects can shed light on a client’s level of ambivalence and readiness to change as well as open up some conversations about making changes. It may also guide the provider on where to go next. Some clients have high confidence, but do not see the need or importance of making a change. For others, they know they should make a change and the importance is high, but they have low confidence due to failed past attempts or they do not see a way forward (i.e., they don’t know how). For others, they have low importance and low confidence indicating they are not ready to make a change. For those with high confidence and high importance, they are ready to take action and providers should begin planning for next steps.

Implementing change rulers is a relatively straightforward process. Providers ask clients three questions (they may also show the client the ruler so they can see a visual): (1) How important is making this change for you on a scale of one to ten with one being not at all important and ten being extremely important. Where would you say you fall on this scale?; (2) How confident are you that you could make the change? On a scale from one to ten with one being not at all confident and ten being extremely confident, where would you say you fall on this scale?; and (3) How ready are you that you could make the change? On a scale from one to ten with one being not at all ready and ten being extremely ready, where would you say you fall on this scale? It is not necessary to ask clients each question in a row, but providers can use the rulers at different times during the session or across multiple sessions. Providers can also start with the importance and confidence rulers first to indicate where to focus efforts (e.g., on building importance or building confidence).

After using each ruler, it is important to ask the client why they chose the number they did and not a lower number. This can open up opportunities for change talk and helps emphasize to people that they are ready to change. Asking them why they are not at a higher number suggests that they should be at a higher number (i.e., Taking-Sides Trap) and can lead to defensiveness and resistance. After you discuss why they weren’t at a lower number, ask them what it would take for them to go from their current number to a higher number. This opens up an opportunity to identify areas to focus treatment, build skills, or increasing knowledge about how their behavior is impacting their lives.
In the decisional balance exercise providers explore four domains (in this order): (1) the advantages of the status quo (e.g., drinking, using drugs), (2) the disadvantages of status quo, (3) the disadvantages of changing, and (4) the advantages of changing (Mueser et al. 2003; Miller and Rollnick 2013). Figure 11.1 provides an example of the decisional balance exercise. These domains can be positioned as four quadrants on a sheet of paper and the client can list their answers within each quadrant. Providers should go clockwise starting from the top left quadrant (e.g., advantages of status quo) and end with the “advantages of change” quadrant in the bottom left. Decisional balance is a way to develop discrepancy and explore the importance of change. The decisional balance sheet can provide an opportunity for the client to explore the advantages and disadvantages of the status quo and change in a non-judgmental environment so that they can consider the importance of change and their level of readiness. It can also reveal a client’s motivations for their use and the ways to help clients mitigate their concerns about change (Miller and Rollnick 2013).
Table 11.3  Examples of change talk and eliciting questions (based on Miller and Rollnick 2013)

| Type of change talk                                   | Examples                                      | Eliciting questions                                                                 |
|-------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------|
| Acknowledging disadvantages                          | “This is having an impact on my family.”      | “Tell me the ways in which this information worries you?”                           |
|                                                      | “I can’t go on like this much longer.”        | “What are some of the negative consequences you’ve experienced by your use?”        |
|                                                      | “Things are getting pretty bad now.”          | “What do you think will happen if things don’t change?”                            |
|                                                      | “Maybe I need to do something different.”     | “What are some of the disadvantages of not making a change?”                        |
| Recognizing the advantages of making a change        | “My family would sure appreciate it.”         | “What would be some good things about making a change?”                             |
|                                                      | “People would get off my back.”               | “How would your life be different if you made a change?”                           |
|                                                      | “I’d have more money.”                        | “What are some of the advantages of making a change?”                              |
|                                                      | “I probably would feel better.”               |                                                                                     |
|                                                      | “I’d be able to enjoy my children more.”      |                                                                                     |
|                                                      | “I’d be a better role model for my kids.”     |                                                                                     |
| Expressing optimism for change                       | “If I put my mind to it, I can do it.”         | “How confident are you that you could make a change?”                              |
|                                                      | “I did it before and so I can probably do it again.” | “What or who do you need to be successful in making a change?”                  |
|                                                      | “I’m pretty sure I can do it with some help.” | “What qualities or strengths do you already possess that will help you make a change?” |
|                                                      |                                               | “When were other times that you have made a change?”                               |
| Expressing clear intentions to change                | “I’m tired, it’s time to make a change.”       | “How important is making a change for you right now?”                              |
|                                                      | “I’ve had enough, it is time I did something.” | “What things would you be willing to try to make a change?”                        |
|                                                      | “I can’t keep going on like this, I need to change.” | “What do you think about your drinking right now?”                                |
|                                                      |                                               | “What are you going to do about this?”                                             |

Case Study 11.2 James

James is a 27-year-old white, cisgendered male who works in an IT department at a large pharmaceutical company. He is speaking to a social worker at an individual

---

2All names and other identifiers of this case have been changed to protect privacy and confidentiality.
intake interview as part of a 10-week program of couples counseling initiated by his partner to improve communication. James has reluctantly agreed to participate in the program. His partner has told him that she is considering leaving the relationship unless they receive help in communicating better and to address his problem drinking. James has experienced a long history of problem drinking. He drinks about 3–4 times per week and during those episodes he drinks 4 or 5 beers at a time. He has been fighting with his girlfriend of 3 years (whose father was a severe alcoholic) about his drinking. She says if he doesn’t cut down she’s leaving. As a child, he grew up in a large extended family that engaged in regular drinking during celebrations and crises. James’s father would regularly consume 3–5 beers per day after work and more on the weekends. “I work hard. I deserve it. Give me a break,” he would say. His parents would often fight due to his father’s drinking because of extended time spent in bars (all Saturday afternoon) and that James’s father would come home in an argumentative mood. James, himself, spent his youthful years drinking with friends in the woods when they were underage and in bars 3–4 times per week when they were older. He has had a history of minor bar fights, broken relationships, and one driving under the influence (DUI) citation (i.e. drunk driving) approximately 1 year ago.

Provider: James, thank you for coming. What brought you here today?
James: I guess my girlfriend has had enough and wants to see if we can figure this out or she’s moving on.
Provider: I’m curious to know what your perspective is on this? Why do you think you’re here?
James: My drinking, I guess. Her father was a drunk and she is sensitive about my drinking. Verbally. Not physically. I guess she’s tired of it.

| Advantages Not Changing/Status Quo | Disadvantages of Not Changing/Status Quo |
|----------------------------------|----------------------------------------|
| People have seemingly good reasons for use |
| Short circuits resistance |
| Identifies barriers to change |
| Where ambivalence/change talk begins |

| Advantages of Changing | Disadvantages of Changing |
|------------------------|----------------------------|
| Most of change talk happens here |
| Elicits client’s own arguments for change |
| Short circuits resistance |
| New areas may come up |
| Short circuits resistance |
| Elicits fears around changing behavior |

Fig. 11.1 Decisional balance (based on: Miller and Rollnick 2013; Mueser et al. 2003)
Provider: Sounds like she’s concerned about your use of alcohol. Based on your screening results you are at a higher risk of health problems, relationships problems, and accidents. I’m curious to know what you think about your drinking?

James: I’m not a drunk. You probably hear that a lot, but I work, I don’t drink every day. I don’t even drink a lot. I drink less than all my friends. But when we go out to a party or have a party at our house or I go out with my friends everything goes well for a while, but then I start drinking and one becomes two, and two becomes four, and the next thing I know me and my girlfriend are fighting about something and then I apologize the next day for something stupid I said. I don’t have more than four drinks when she is around (she won’t let me). But when I start, I find it is hard to stop. I always go to four. Always. And I’d probably go five or six. Since she has been on me I’ve noticed this ‘tug’ when I drink. I just want another one. Maybe that’s what she sees since her father was a lousy drunk. I don’t like that feeling. I also find that when I drink more than three beers I magically turn into my father. Which is to say, I become an argumentative asshole, if you will. I like my girlfriend and I want to stay in the relationship. I hope we’ll get married some day and have children. I don’t want to be my father (when he drinks). He’s fine when he is not drinking, but three beers in and he starts to turn. You can see it. And I guess I do the same thing.

Provider: So it sounds like you value your relationship and that you recognize that your drinking has caused some problems in that area of your life. I’m also hearing that you are concerned about some not very positive similarities you’re seeing between your drinking behavior and your father’s. What are some positive things you get from drinking?

James: I’ve been drinking with the same guys my whole life—since high school, which is now 10 years. We’ve all done the same thing each weekend. Our girlfriends all know each other. We’re all good friends. I love my friends. We’ve always got each other’s backs. I want to drink less but when I start I can’t seem to stop without some help like my girlfriend’s dirty looks, but I don’t want my relationship with my friends to get screwed up either. They wouldn’t be kind to me if suddenly I stopped drinking or got weird or something. What am I supposed to do? I don’t need AA or any of that stuff and I don’t want to change my friends or routines. I want this relationship to work. I probably need to cut down, but I don’t want to lose my friends either.

Provider: So it sounds like on the one hand you recognize that your drinking is a problem and you want to do something about it, and on the other hand you’re not sure what to do and you’re afraid if you change you will lose some friends. Is that right?

James: Yeah, I guess that is right.

Provider: What are some concerns you have for the future if you do not change your drinking?

James: I’m afraid that my girlfriend will leave me and I will be all alone. I have this image that I’m going to be that older guy at the bar all alone and that all my friends will have successful jobs, and marriages and kids and I’ll be the loser that still does the same shit 20 years later. It’s already starting. People are making their moves with careers and getting more serious. Two of my friends are now engaged and talking house and kids. I start thinking about how I’ll be left out because who wants to hang out with “that guy.” I imagine I’ll be in the same apartment, same job, same life and everyone else will move on and I admit, I get really panicky about it. Hyperventilate and all that. I sometimes wake up in a cold sweat at night thinking about it. My girlfriend threatening to leave me doesn’t help. I get real upset when I think about that and I worry about it all the time. You’d think this would motivate me – but I just feel paralyzed sometimes. I don’t know what to do. I guess things are more messed up than I thought before I came in here.

Questions
• How would you characterize James’s drinking?
What is your working hypothesis for James’s drinking, depression, and anxiety problems?
What stage of change is James in right now in regard to his drinking? What is your evidence?
Can you identify the different OARS skills used by the provider?
What are some examples of additional open-ended questions, reflections, and affirmations that could be used with James in this interview?
What would a summary of this interview look like?
What other elements of motivational interviewing could be used in this interview such as strategies to elicit change talk, decisional balance exercise, and readiness and confidence rulers?
What are some traps to avoid in this interview?
What are some motivational and/or cognitive behavioral intervention options that would be appropriate to include in your menu of options for James?

11.4 Brief Cognitive Behavioral Treatment Approaches

Cognitive behavioral therapy (CBT) for substance use disorders is an effective approach to substance abuse treatment. Providers use CBT to teach people skills to manage addictive thoughts, feelings, and behaviors in order to establish and maintain sobriety and prevent relapse (Carroll and Kiluk 2017; Darker et al. 2015; Gates et al. 2016; Magill and Ray 2009; Magill et al. 2019; McHugh et al. 2010; Naar and Safren 2017). CBT has also been found to be effectively combined with psychopharmacology, contingency management, and motivational approaches to help people with substance use disorders achieve and maintain treatment gains (Carroll and Kiluk 2017; Naar and Safren 2017). Combining CBT with motivational approaches that prepare people for change represents a powerful and effective combination of interventions designed to address substance misuse and substance use disorders (Carroll and Kiluk 2017; Chan Osilla et al. 2016; Gates et al. 2016; McHugh et al. 2010; Naar and Safren 2017). CBT approaches, including functional analysis, psychoeducation, skills training, and substance abuse counseling, are most often deployed in persons who are in the action and maintenance stages of change. Persons in the action stage are fully committed to change, have achieved some success, and are fully engaged in behaviors designed to lead to recovery. People in the maintenance stage of change seek to prevent relapses and develop long-term changes to promote a healthier lifestyle.

Four CBT techniques help people recover in a number of ways. These include: (1) functional analysis to analyze and understand the factors that trigger substance use and the consequences of use; (2) psychoeducation to learn the role substance use has played in their life and how addictive behavior develops over time through expectancies and reinforcement; (3) skills training to help manage addictive behavior and maintain sobriety such as understanding and responding to triggers for use, craving management techniques, communication, and problem-solving skills to
recognize and manage situations that may lead to relapse, planning for emergencies, and anger management; and (4) teaching people how to incorporate new activities and develop sober social networks (Chan Osilla et al. 2016; Kadden et al. 2003; McHugh et al. 2010; Monti et al. 2002). In the next sections, we will explore the cognitive behavioral model for change and review the four specific cognitive behavioral practices that have been found to be effective in treating substance use disorders described above.

11.4.1 Cognitive Behavioral Model of Substance Use Disorder

The cognitive behavioral model of substance use disorders has two main considerations. First, problematic substance use is a learned behavior that is the result of powerful physical and psychological conditioning and reinforcement patterns. When the physiological and psychological effects of a substance are repeatedly associated with contextual cues in the person’s environment or subjective experience (e.g., emotions, thoughts, physiological reactions), the person can be conditioned to experience craving responses in the presence of the substance or cues associated with the substance (e.g., classical conditioning) (McHugh et al. 2010; SAMHSA 2012). For persons with substance use disorders, being in the presence of alcohol, drugs, or any cues associated with use (e.g., certain people, places, or things such as money, equipment, advertisements, emotions such as anxiety, joy, depression) can act as cues that trigger a physiological withdrawal response (i.e., craving) and thought patterns (e.g., one drink won’t hurt anyone) that can lead to relapse or problematic use patterns. Furthermore, substance use is negatively and positively reinforced through operant learning principles. Substance use can be positively reinforced by invoking positive feelings of euphoria, social bonding, and warmth that the person may be susceptible to due to past trauma and neglect, or genetic or other biological risk factors (Mate 2010). The immediate and temporary alleviation of psychological and physical pain associated with distress, dysphoria, craving, or withdrawal that substance use brings to the person also negatively reinforces substance use behavior. This rewarding of substance using behavior can lead to problematic use patterns over time (Koob 2017; SAMHSA 2012). Second, the decision to use substances is heavily influenced by maladaptive thinking patterns. These thinking patterns include: (1) negative beliefs about the self as helpless, unlovable, worthless; (2) irrational global expectancies about substances as a good way to solve problems; (3) low distress tolerance; and (4) thinking patterns that are generally rigid/inflexible, dichotomous (e.g., black or white/all or nothing), and automatic.

These two factors when combined with the effects of physical dependence can lead to problematic patterns of substance use marked by a loss of control, intense cravings when substances are not present or when cues to substances emerge, and use despite experiencing negative health and social consequences. In order to break these patterns of abuse and dependence, providers using CBT rely on the following approaches: (1) psychoeducation, functional analysis, and cognitive reframing to
help clients identify and change maladaptive thinking patterns that can lead to problematic use; (2) contingency management strategies to reward abstinence and reduce use in order to break the pattern of positive and negative reinforcement that leads to substance abuse; and (3) teaching and practicing coping skills designed to help manage cravings and recognize and negotiate situations that can lead to use and relapse (McHugh et al. 2010). These approaches can address the main neurocognitive issues associated with addiction such as executive functioning deficits that impair problem-solving and impulse control, chronic dysphoria, negative emotions, and incentive salience or strong associations between substances and reward. These approaches can improve skills associated with problem-solving, planning, threat recognition, decision-making, and overall executive functioning. Coping skills designed to manage cravings and recognize and change negative thoughts can improve negative emotions by improving cognitive flexibility, increasing positive affect, and improving the ability to tolerate distress. Learning refusal skills and preparing for seemingly irrelevant decisions and emergencies can improve assertiveness, the ability to deal with stress, and reduce cravings (Carrol and Kiluk, 2017; Kwako et al. 2016). There are four main elements of cognitive behavioral therapy for substance use disorders: (1) functional analysis; (2) craving management; (3) coping skills development; and (4) relapse prevention. These strategies will be discussed briefly in the sections that follow.

11.4.2 **Functional Analysis**

Therapy usually begins by conducting a functional analysis (FA) of substance use behavior. The FA is designed to help the provider and the client understand the antecedents (e.g., internal and external triggers or cues) that can lead to substance use and the consequences of substance use in the person’s life such as negative health impacts, interpersonal problems, and problems in occupational and other functioning areas (Chan Osilla et al. 2016; Kadden et al. 2003; McHugh et al. 2010; Monti et al. 2002; Mueser et al. 2003). A functional analysis can begin with a conversation about stress. What kinds of situations, people, or events cause stress in the client’s life? What are some typical things that the client does to handle or relieve stress? What stressful situations, feelings, or thoughts commonly lead to drinking or substance use? How does using substances relieve stress? These questions can lead to a conversation about cues or triggers for substance use.

Providers inform clients that triggers or cues are the external people, places, things, and internal emotions and thoughts that can lead to substance use. Triggers can lead the person to crave a substance physically or psychologically and then initiate automatic thoughts (e.g., rationales for use) that justify substance use. Providers work with clients to identify high-risk drinking or substance use situations that often or always lead to problematic substance use. They explore the thoughts, feelings, and behaviors that occur before, during, and after these situations to better understand the external and internal contexts that led to substance use and the
It may be helpful to identify specific thoughts that the client has when they experience internal and external triggers. Providers conducting an FA can use the three-column thought record (see Chap. 9) for this purpose that identifies: (1) a situation or event; (2) the automatic thoughts triggered by the situation; and (3) the feelings (e.g., anger, sadness, panic) and behaviors (e.g., use) that result from the thoughts. This can be done as an imaginal exercise where the client recounts an experience of a trigger and tries to reimagine the thoughts they had before they engaged in substance use, or as an in vivo exercise they can do in between sessions. Once internal and external triggers that lead to substance use are identified, it is helpful to collaborate with the client to identify ways to avoid external triggers and positive and healthy ways to deal with internal triggers that can replace substance use.

### 11.4.3 Craving Management

An important way to help people with substance use disorders reduce or eliminate their use and prevent relapse is through helping them manage their cravings (SAMHSA 2012; Marlatt and Gordon 1985; Kadden et al. 2003; Monti et al. 2002; McHugh et al. 2010). A craving is a strong desire and compulsion to use a substance. Cravings are most often triggered by cues associated with using substances. Like waves, cravings generally tend to build in intensity, peak, and then dissipate over the course of 10–15 min. During a craving a person may think of nothing else and believe that the strong urge for substances will only grow rather than dissipate. This fundamental misperception of craving can lead to substance use. People with substance use disorders have difficulty tolerating distress, making decisions, planning, and controlling impulses. These deficits compound the challenges in helping people manage cravings (Kwako et al. 2016). However, cravings are common, and clients who experience them can learn how to manage them in different ways. Cravings also tend to lessen in frequency and severity over time with continued abstinence or reduced use.

Providers can teach clients a number of skills designed to help them manage cravings. First, the functional analysis is used to identify high-risk situations and harmful activities that can trigger cravings and lead to drinking or drug use such as gatherings where alcohol or drugs will be consumed and/or situations where there will be pressure to drink or use substances. The provider and the client work together to identify ways the client can anticipate and avoid those situations and use healthy alternative activities and strategies instead. These activities can be used as a substitute for engaging in activities and situations deemed to be risky, or they can also be relied upon to help the client cope with cravings when they happen. The client and the provider also identify any potential barriers to doing healthier alternatives and brainstorm ways to overcome those barriers. Barriers can include low motivation,
problematic thoughts, low confidence, or cost (Chan Osilla et al. 2016; McHugh et al. 2010; Carroll and Kiluk 2017; Marlatt and Gordon 1985).

Activities to manage cravings are numerous. One model is called “urge surfing” or “white knuckling it.” This is a mindfulness-based strategy in which the person focuses on the urge as it increases in intensity and then dissipates (i.e., like a wave) over time. In this strategy the client notices, without judgment, how the craving feels, thoughts that come to their mind, and how the craving passes in a nonjudgmental way. This strategy can be practiced in session through rehearsal and imaginal exposure approaches. The use of distraction is the most common way to manage cravings. When a client identifies that they are experiencing a craving they engage in predetermined activities to distract them from the craving until it passes. There are hundreds of simple activities that can be used to distract from a craving. The provider and the client work together to generate a list of healthy activities the client has done in the past, uses currently, or wants to try out. They can be as simple as taking a walk, calling a friend or sponsor, exercising, listening to music, praying, completing a household chore, or running an errand, to more complex and ongoing activities such as attending a self-help meeting, solving a personal problem, or learning a new language or musical instrument. The key is for clients to: (1) know what cravings are; (2) realize they are common, normal, and temporary; (3) know how to avoid situations that can lead to cravings; (4) recognize when cravings happen; and (5) be prepared to engage in specific healthy alternatives to using when cravings occur.

| Internal Cues (e.g., Thoughts, Feelings) | External Cues (People, Places, Things, Events) |
|-----------------------------------------|-----------------------------------------------|
| Stress                                  | Being in the presence of alcohol, drugs, or injection equipment |
| Depression                              | Celebrations or holidays                       |
| Loneliness                              | Being with friends or intimate partners that use |
| Boredom                                 | Before or after sex                           |
| Anger                                   | A certain time (e.g., “happy hour,” the weekend, or payday) |
| Anxiety                                 | Having money                                   |
| Guilt/Shame                              | Arguments with family                         |
| Joy                                     | Remembering the “good old days” of drinking with friends |
| Excitement                              | Being by oneself                               |

Fig. 11.2 Common triggers for substance use (based on: Chan Osilla et al. 2016; Kadden et al. 2003; Monti et al. 2002)
11.4.4 Coping Skills Training

**Psychoeducation** Coping skills training begins with psychoeducation about the cognitive behavioral therapy model and how substance use is conceptualized from a CBT perspective. This can be done through handouts that describe the model and then through questioning the client about the thinking patterns that can lead to substance use. As mentioned, the cognitive behavioral model positions substance use as learned behavior that is reinforced over time. Persons who use substances are often triggered by external cues in the environment (e.g., people, places, and things) as well as internal cues such as strong emotions (e.g., anxiety, anger, joy, distress, depression) and irrational thinking patterns (e.g., one drink can’t hurt, drinking will take away this pain, I will never be able to do this, I am worthless). A person, when faced with one or more of these triggers, will then be more likely to use substances because this behavior is reinforced over time. The goal of cognitive behavioral therapy is to understand and interrupt these patterns of negative thinking and reinforcement, help the client notice when triggers are present, and give them the coping skills and tools to respond to those triggers in healthy ways (SAMHSA 2012).

**Refusal Skills and Assertive Communication Strategies** Certain people can represent a significant trigger for substance use. It is important to help clients learn effective communication strategies including assertiveness and drug and alcohol refusal skills when confronted with people who may trigger their use. First, providers work with clients to identify how people can trigger their use through cravings and who those persons may be. This can include friends who the person may have used with in the past (e.g., an old drinking buddy) and who may ask or pressure them to use again, or it may also include family or friends who are overly critical or otherwise cause the person distress that can then lead to cravings and relapse. Second, the provider and the client then work together to identify how the client can utilize assertive communication strategies to avoid use situations, get their needs met, and prevent relapse (Chan Osilla et al. 2016; Carroll and Kiluk 2017; Kadden et al. 2003; Monti et al. 2002; SAMHSA 2012).

Assertive communication involves reviewing three types of communication: Passive, Aggressive, and Assertive. Passive communication strategies involve deferring or withholding one’s own emotional needs, opinions, and desires in order to please or not upset another person. In this type of communication strategy, the client assumes they are powerless to change the situation and either withdraws or “goes along” with the other person sacrificing their own needs and goals, in exchange for respecting the needs of someone else. Anger, helplessness, shame, and self-loathing are often associated with this type of communication style. Aggressive communication uses strategies such as shouting, expressing anger, hurling insults, arguing, or using threats or violence to express one’s thoughts and emotions. The person using aggressive communication gets what they want through disrespecting the needs of others. Anger and guilt are often associated with this communication style. Both strategies are rooted in fear, insecurity, and a lack of skills. Both are wholly
ineffective and can lead to relapse since helplessness, self-loathing, guilt, and anger are all common internal cues that can lead to drinking or substance use as a coping strategy.

Assertive communication, on the other hand, respects the needs of both parties. In this type of communication style, clients learn how to express their needs in a way that is effective, clear, and respectful to the other person. The style is devoid of negative emotion, is direct, and provides a clear message. Assertive communication uses “I” statements to communicate needs, emotions, thoughts, and desires in a clear, nonjudgmental, and direct way. The use of assertive communication relies on the following steps: (1) identify who the person is who you want to communicate to; (2) use “I” statements to describe and express thoughts and feelings such as, “I feel…” or “I think…”; (3) give a clear request; and (4) provide a statement at the beginning or end that acknowledges the other person’s situation and communicates appreciation such as, “I know you’re busy” or simply “Thank you.”

It is helpful for providers to help clients anticipate situations where they may be approached to drink or use drugs (e.g., being asked to go out to a bar, someone buying them a drink, being offered drugs) and to rehearse and practice refusal skills. Assertive refusal skills include the following: (1) refuse alcohol or substances with a clear and unequivocal “No”; (2) change the subject or suggest an alternative activity; and (3) request a behavior change if the person persists (e.g., please stop asking me, the answer is “no,” let’s do something else). If the person persists it is advised that the client inform the person that it was good to see them, but that they are going to have to leave and say goodbye. It is not advised for the client to offer excuses or give false information such as, “I don’t feel like it,” “I have to work in the morning,” “I’m not feeling good,” or “maybe some other time.” This is passive and indirect communication that invites the other person to try to convince or persuade the client to see their side. A clear, firm, and polite “No” combined with a request to change the subject or a behavior change is the best course (Chan Osilla et al. 2016; Carroll and Kiluk 2017; Kadden et al. 2003; Monti et al. 2002; SAMHSA 2012).

Managing Negative Thoughts  People with substance use disorders often engage in negative thinking patterns that can lead to anxiety or depression and trigger substance use. Negative self-talk can often include focusing only on negative events or traits (e.g., mistakes, failures, shortcomings, “the bad” in a given situation) and ignoring positive evidence (e.g., refusal to take credit for successes, positive attributes, accomplishments, or see “the good” in a situation). Clients may also “catastrophize” or exaggerate negative attributes and failures and minimize success and positive developments and engage in “all-or-nothing” or “black-and-white” thinking (e.g., things will never improve, I can’t do anything right, I’m never going to be able to stop drinking). Negative thinking patterns can trigger substance use directly (e.g., “just one drink won’t hurt,” “I deserve this drink,” or “No one cares about me so I might as well drink”) or indirectly by triggering depressed or anxious mood states. It is important to help clients catch and challenge negative self-talk and replace it with more realistic statements combined with a behavior change (Chan Osilla et al. 2016; Carroll and Kiluk 2017; Kadden et al. 2003; Monti et al. 2002;
Persons with substance use disorders tend to have attributional styles that are internal (it’s all my fault), global (I’m completely worthless or a bad person), and stable (I will always be a drunk/addict). They also tend to hold negative expectancies about themselves, others, the world, and the future, and positive expectancies about alcohol or drugs (“I’ve had a bad day and I need a drink” or “Drinking will solve this problem”). It is important help clients identify and challenge these thinking patterns (SAMHSA 2012).

Thought change records can be used to help clients identify and interrogate negative automatic thoughts and cognitive distortions that lead to distressful emotions and replace them with more realistic thoughts. When using thought change records, clients clearly identify a situation that preceded a drinking or drug-use episode. The client identifies the different thoughts that emerged in their head as the episode unfolded. The provider explores the emotions that each thought produced (e.g., anger, sadness, anxiety) and the subsequent behavior. A “hot thought” is identified that led to the most intense negative emotion and was most likely the thought that resulted in substance use. The client and the provider explore any cognitive distortions and problematic expectancies that may have been operating and then examine the evidence supporting and challenging the thought (see Chap. 9 for more information on this technique). Based on the data that is collected, the provider and the client work together to identify a more realistic way of thinking about what happened that is more balanced, healthy, and positive. This constitutes the replacement thought. The client then identifies a more healthy behavior that could replace drinking or drug use. This exercise could be role-played in-session and could also be used in hypothetical scenarios to plan for the future. The approach can be combined with coping cards that identify negative thought patterns that lead to substance use and that remind the client of more positive ways to think about a situation along with some distraction activities to help avoid relapse.

Seemingly Irrelevant Decisions and Planning for Emergencies It is often the case that relapse occurs as a result of seemingly minor and irrelevant decisions. It is important to help people plan for when cravings may strike and how to evaluate situations with high-risk potential, so they can be avoided if possible. If avoiding the situation is not possible, then it is important for people to anticipate emergencies and plan ahead (Chan Osilla et al. 2016; Kadden et al. 2003; Monti et al. 2002; SAMHSA 2012). This involves two components. First, providers work with clients to play the “what if game” for every seemingly irrelevant decision. For instance, if a client wants to attend a wedding, funeral, reunion, or celebration, the provider may ask a series of “what if” questions—what if you are offered a drink? What if you see X, your old drinking buddy, and he asks if you want to have a drink? What if X is there and starts to criticize you? What if you’re in the bathroom and an old friend asks if you want to get high? What if you are handed a glass of champagne during the toast? What if they go to the family reunion and have a fight with a sibling? What if they are asked to go to the afterparty at a bar? What if they are at the grocery store and they bump into a former partner who asks them out for a drink? It is not unreasonable to want to attend a friend’s wedding or a family gathering; how-
ever, it is precisely these decisions that can leave people unprepared for situations in which they find themselves triggered by external cues. People need to evaluate every decision, assess the risk, and make one of two decisions: (1) to avoid the situation entirely or (2) to not avoid the situation but anticipate and mitigate risk by having a plan. Help clients identify all possible scenarios that may lead to relapse and then help them plan for emergencies. It is a good idea to have clients rehearse what they will say and practice assertive communication and refusal skills through role-plays and reverse the role-plays where they play the other side, so they can see assertive communication in action. Help clients plan for other ways they can cope if they are triggered. Several strategies include: (1) limiting their time at the event; (2) choosing to be seated away from alcohol and away from former drinking partners; (3) making a preemptive announcement that they are not drinking and are the designated driver; (4) going with a supportive friend; (5) rewarding themselves afterward for not drinking with a healthy activity, meal, or buying something nice; or (6) having a friend or sponsor be ready to take your call if you need some support.

It is also useful for people to anticipate unavoidable situation that may trigger a relapse. These might include events that cause stress such as evaluations, planned events, court dates, project deadlines, reunions, anniversaries, deaths, or times of the year (e.g., seasonal, holidays) that may be times of increased emotionality or stress (positive or negative) that could increase cravings. It may be helpful for the person to engage in mitigating actions such as increasing pleasant activities, going to self-help meetings, increasing therapy appointments, and engaging in activities designed to manage emotions such as meditation, eating healthy, mindfulness, exercise, and socializing with healthy and supportive people during these times.

11.4.5 Relapse Prevention

The fourth important component in CBT for substance use disorders is relapse prevention. Relapse prevention includes four elements: (1) building self-efficacy; (2) changing expectancies about substances; (3) managing slips; and (4) developing healthy lifestyles. Relapse prevention strategies rely on the functional analysis by identifying high-risk situations for relapse (Chan Osilla et al. 2016; Carroll and Kiluk 2017; Kadden et al. 2003; Monti et al. 2002; SAMHSA 2012).

Build Self-Efficacy Providers use the FA to help clients understand their cues for cravings and to identify high-risk relapse situations. The provider then helps the client avoid those situations or plan for how to manage those situations and the cravings that result when they occur. Providers can help clients build self-efficacy by encouraging them to slowly expose themselves to situations that may trigger cravings and use the strategies developed in-session to manage high-risk situations. For instance, the provider may encourage the client to attend the wedding of their friend knowing that alcohol will be readily available and former drinking companions will be present. Using strategies and plans developed and rehearsed in-session, clients
can then go out and try those strategies in real-world situations. Successful implementa-
tion can lead to a more developed sense of self-efficacy. Clients should only
engage in these exposure experiences when they feel they are adequately prepared
and able to handle the situation competently. They should not engage in activities or
situations that are too overwhelming.

**Changing Expectancies** Another strategy is to challenge clients’ strongly held
positive expectancies about alcohol and substance use. Clients holding strong posi-
tive expectancies about alcohol and drugs are more prone to relapse than clients
who recognize the negative impact alcohol and drugs can have on their physical,
emotional, and social health. It is important for providers to explore positive expect-
cancies around drugs and alcohol and to help clients develop more balanced expect-
cancies. This involves gathering evidence that challenges positive expectancies of
substance use and that highlights the negative consequences that alcohol and drugs
have had on the person’s physical and social well-being. Decisional balance exer-
cises as part of motivational interviewing strategies reviewed previously can be use-
ful in exploring expectancies (Miller and Rollnick 2013).

**Managing Slips** A third area of relapse prevention is managing slips. Drug and
alcohol relapse is the expectation rather than the exception. Clients should be
informed that relapse presents an opportunity to learn new strategies and to develop
better relapse prevention plans. One problem that clients often experience is when
slips (e.g., having a drink, smoking a joint or cigarette) become full-blown relapses
due to negative thinking patterns. For instance, a client may have a fight with a
spouse or partner that triggers an urge to use. The client may then have one drink.
The client then starts to feel powerless over their alcohol use and ashamed that they
“failed.” These feelings of being out of control may lead to stronger urges to drink
and so the person gives up (i.e., Oh, the hell with it!) and drinks to intoxication, hav-
ing decided that they are incapable of controlling their use. This process is called the
*abstinence validation effect* and is a powerful driver of relapse that is rooted in a
lack of self-efficacy and negative thinking patterns that include the person thinking
that they are a total failure and that their drinking problem is permanent and out of
their control.

Providers can help clients manage these situations by helping them to realize
that: (1) a “slip” is a normal part of recovery and can be avoided or mitigated; (2)
there is wisdom to be learned in analyzing what caused this slip; (3) a slip is not
evidence of failure, permanency of the problem, or requires the person to have to
“start all over again”; and (4) after a slip it is important to talk about what happened
and plan for the future. Providers can help clients avoid slips by planning for emer-
gencies and ensuring that clients have tools at their disposal in case they do have a
slip. These tools include: (1) knowing the warning signs of craving and being trig-
gered; (2) having contact information of helpful people whom they can call for
support or intervention such as a sponsor, family member or friend, or counselor;
and (3) a concrete list of activities to engage in to manage any cravings or slips in
order to prevent further relapse (Kadden et al. 2003; Monti et al. 2002; SAMHSA 2012; Marlatt and Gordon 1985).

**Developing Healthy Lifestyles** The last important area of relapse prevention is ensuring that the person has developed healthier lifestyle habits and activities. The development of these activities leads to a reduction in triggers such as boredom or loneliness and can lead to an increase in positive feeling and self-efficacy. The establishment of solid, healthy daily routines is important. These may include exercise, eating healthy meals, praying or meditation, and managing stress through a balanced lifestyle that has adequate time for work, leisure, and social relationships. The establishment of a network of sober social support is also important. This involves cultivating healthy relationships with friends and family that boost sobriety, letting go of relationships that are risks for relapse, and managing the grief that may accompany letting those people go. Lastly, people can integrate routine professional support to help them become more psychologically healthy such as individual, family, or group therapy as well as self-help and peer support to continue to establish and maintain healthy lifestyles (Marlatt and Gordon 1985).

**Case Study 11.3 Ms. Carla Delgado**

Carla is a 32-year-old, cisgendered white woman. She has been referred to your outpatient behavioral health treatment team by the courts for assessment and treatment for major depressive disorder and substance abuse. Carla is a bright and engaging individual with a dry sense of humor. Carla likes to be in the outdoors, walking in the park or otherwise being in nature. She has been taking martial arts lessons off and on for 10 years as a release, although she has not trained in the last 2 years. In the past, she has also found yoga to be helpful in clearing her mind and relaxing. She is a voracious reader and enjoys journaling and writing poetry and short stories. She also likes to “dabble” in art, particularly in the use of oil paints and multimedia sculpture when she can afford it. She was an English major at a small liberal arts college. She dropped out in her junior year. She refers to this as, “my biggest mistake. I loved it there. But I can never seem to finish anything.” She has dreamed of teaching creative writing or art to high school students, or at a community college someday. At this point she says, “I would like to get a job, move into a safe, affordable apartment, find a partner, and lead a calm, stable life without any drama.” In the past year, Carla has lost three jobs due to her substance use. Twice she was fired for not showing up to work due to her substance use, and another time she was fired for being verbally aggressive with other co-workers who criticized her work performance. She currently lives in a studio apartment and is unemployed. Earlier this year she was homeless and staying with various friends. She is currently living on savings and unemployment benefits.

Carla has a history of severe stimulant use disorder, moderate alcohol use disorder, major depressive disorder (recurrent), and she suffers from symptoms of partial

---

3 All names and other identifiers of this case have been changed to protect privacy and confidentiality.
PTSD (nightmares, intrusive thoughts, negative alteration in cognitions and mood, and hypervigilance). She does not currently meet full diagnostic criteria for PTSD, but these symptoms are present and distressing. Carla is also 20 pounds overweight, has a history of asthma, and is prediabetic. During the initial intake assessment Carla reveals that she recently relapsed after 2 years of sobriety from cocaine. Her relapse was initiated after she lost her last job as a clerk in an art supply store after verbally insulting her supervisor following a poor review. Carla states that after she was fired she went to a local bar and drank to the point of intoxication. After the bar closed she left with a group of friends and used cocaine for the remainder of the night and into the morning. She states that she then went on a cocaine, marijuana, and alcohol binge for the next several days.

Carla: I have real friends that are close and that support me and love me. And then I have these other friends that I get high with like at the bar. I had cut these friends off while I was sober – but then I went to the bar, had a few and texted them. Big mistake. I only went to the bar to blow off some steam and have a couple of beers. But then I made the mistake of texting one of them because I was afraid to go back home. I was afraid I was going to go home and sulk and mope and get depressed and I just didn’t want to do that. I wanted to have some fun. So I texted them they came up and that’s when all hell broke lose. I didn’t text them to get high…I don’t think. I texted them because they are a fun crowd to be with and they won’t let you mope around feeling sorry for yourself. I wanted to have a couple more beers and commiserate and laugh and forget. I guess I should have texted my other friends. But I texted, they came, we laughed and then the drugs came out and that’s when I should have left – but I wanted to keep going and so first we smoked weed, and then the cocaine comes out and away we went. I guess that’s the pattern.

During that binge, she was arrested for getting into a fight in a bar with another patron a few days later. She was arrested and was referred to behavioral health and drug treatment at your agency.

Carla has a history of major depressive disorder and symptoms and PTSD. Carla reports she was sexually abused by her mother’s live-in boyfriend when she was 12 for 2 years. She was also physically assaulted when she was 21 in a robbery. That precipitated her taking martial arts lessons. When she is depressed, she often sleeps all day, refuses to see anyone, does not eat, and becomes suicidal. Carla has attempted suicide on two previous occasions. She often drinks and uses cocaine more when she is in a depressed state.

“When I go through one of those periods my life is blown to pieces, yeah. And then my friends and family have to come and clean it up just like now. And then once it’s cleaned up and I think I’m doin’ OK, the darkness comes again and I go under. It’s like I’m trying to keep my head above water in the darkest, scariest place on earth and there is no one there to save you. It swallows you up.” She states, “I just shut myself off from the world. I don’t eat. I turn the phone off. I stop showering and I just sit and cry all day when I’m not sleeping. I just can’t do anything. Then at night I stay up and think about what a piece of garbage I am. All that goes through my head is: ‘Everyone hates me.’ ‘I can’t do anything right.’ ‘I’d be better off dead.’ ‘I’m the biggest fuck-up in the whole world.’ Like a recording in my head. I get these bouts of nerves too. I feel like I can’t breathe and I pace around the house freaking out, smoking, and shaking and worrying about everything. It’s not a pretty picture.”

Carla states that she began using cocaine when she was 16. By the time she was 19 she was using it every day and needing more and more of it to get high. Once she
starts using, it is hard for her to stop. She says, “it takes over my life. I can’t think about anything else but getting high. Cocaine helps me feel alive. When I’m depressed, I just want to crawl up and die. All I think about is the abuse and what a piece of crap I am and cocaine always helps lift me out of that. The problem is, once I start, I can’t stop.”

Carla says that she has always used alcohol since she was 14. “Alcohol helps me sleep and helps loosen me up. It’s cheap and it helps me feel better. It’s true that I get a little crazy when I’ve had too much, but I like the way it makes me feel. I’m not a drunk. I don’t drink everyday. Sometimes I don’t drink for a couple of weeks. I don’t think about it or crave it. I can have one or two and stop. I am not a drunk no matter what my file says. A cocaine addict? Yes. But I’m working on that. I can have a few beers or cocktails and stop whenever I want. It’s when I start to use cocaine, or sometimes weed, that things start to spiral. I should be careful, but I don’t need to quit drinking. Cocaine is my problem. I need help staying clean from cocaine. I crave it (cocaine) when I feel bad. I crave it when I feel good. When I’m balanced and occupied – I’m OK. When I use it, my life gets really bad. I can’t stop myself. I crave it. I’m really tired of this. I need to learn how to avoid it, how to keep it out of my life so I can just get on with it. I have not used it in like almost two months. I’m ready to never use it again. I know how to get clean. I need to learn how to stay clean. So I can do what I want to do with my life. Can you help me do that?”

**Case Analysis Guiding Questions**

What is your case conceptualization of Carla based on the information in the vignette?

What symptoms does she experience?

Do Carla’s symptoms meet criteria for one or more behavioral health disorders and, if so, which one(s)?

What are 3–5 treatment goals and objectives that would make a good treatment plan for Carla?

What symptoms would you target?

How would you describe the inter-relationship between Carla’s depression, cocaine, marijuana, and alcohol use?

What stage of change is Carla in with regard to her cocaine use? Alcohol use? Depressive symptoms?

Discuss the treatment strategies that would be appropriate for Carla’s substance use and depressive symptoms—particularly in regard to helping her maintain sobriety from cocaine use. What interventions would be helpful?

How might these interventions be sequenced?

What strengths and resources does Carla have that she can rely on to solve her problems?

What kind of situations can be used to help Carla address her fears and depressive symptoms?

What is your assessment of Carla’s risks for suicide and how will you respond to this risk assessment?
11.5 Summary and Conclusions

Substance use disorders exert a tremendous toll on physical and behavioral health. Three important approaches to treating substance use in integrated behavioral health settings are harm reduction, motivational interviewing, and cognitive behavioral therapy. These approaches are brief and highly adaptable to a range of health and behavioral health settings. They also span the stages of change. Knowing when to deploy these interventions is vital to effective treatment. The global COVID-19 pandemic has changed how health care is practiced. To mitigate the risk of spreading the virus, health and behavioral health settings are increasingly turning toward virtual telehealth and computer/web/app-mediated approaches. Fortunately, substance abuse treatment has been exploring these approaches for several years. For instance, virtual interventions for screening, brief intervention, and relapse prevention, including internet or web-based approaches (Boumparis et al. 2017), computerized brief interventions (Gryczynski et al. 2015), and smartphone applications (Gustafson et al. 2014), are showing promise. Computerized versions of CBT (e.g., CBT4CBT), a virtual CBT treatment with minimal clinical interaction or monitoring for substance abuse treatment, have shown the approach to be comparable to face-to-face, professionally delivered CBT. The approach was efficacious, durable, and had high satisfaction and low dropout rates compared to standard treatment (Kiluk et al. 2016, 2018). These approaches as well as other innovations, such as delivery of opioid substitute medication and clean injecting equipment and virtual self-help meetings, are expected to grow in use in future years, perhaps transforming how we deliver behavioral health care. Regardless, effective substance abuse treatment will continue to be predicated on relationships that are warm, nonjudgmental, and accepting. These relationships enhance treatment engagement and retention, which is associated with better outcomes and more durable recoveries.

References

Adams, J. M. (2018). Increasing naloxone awareness and use: The role of health care practitioners. *JAMA, 319*(20), 2073–2074. https://doi.org/10.1001/jama.2018.4867.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (5th ed.). Arlington: American Psychiatric Association.

Aspinall, E. J., Nambiar, D., Goldberg, D. J., Hickman, M., Weir, A., Van Velzen, E., Palmateer, N., Doyle, J. S., Hellard, M. E., & Hutchinson, S. J. (2014). Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: A systematic review and meta-analysis. *International Journal of Epidemiology, 43*(1), 235–248. https://doi.org/10.1093/ije/dyt243.

Boumparis, N., Karyotaki, E., Schaub, M. P., Cuijpers, P., & Riper, H. (2017). Internet interventions for adult illicit substance users: A meta-analysis. *Addiction, 112*(9), 1521–1532. https://doi.org/10.1111/add.13819.

Broyles, L. M., Binswanger, I. A., Jenkins, J. A., Finnell, D. S., Faseru, B., Cavaiola, A., Pugatch, M., & Gordon, A. J. (2014). Confronting inadvertent stigma and pejorative language in addic-
tion scholarship: A recognition and response. Substance Abuse, 35(3), 217–221. https://doi.org/10.1080/08897077.2014.930372.

Busch, S. H., Fiellin, D. A., Chawarski, M. C., Owens, P. H., Pantalon, M. V., Hawk, K., Bernstein, S. L., O’Connor, P. G., & D’Onofrio, G. (2017). Cost-effectiveness of emergency department-initiated treatment for opioid dependence. Addiction, 112(11), 2002–2010. https://doi.org/10.1111/add.13900.

Carroll, K. M., & Kiluk, B. D. (2017). Cognitive behavioral interventions for alcohol and drug use disorders: Through the stage model and back again. Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors, 31(8), 847–861. https://doi.org/10.1037/adb0000311.

Centers for Disease Control and Prevention (CDC). (2020). Wide-ranging online data for epidemiologic research (WONDER). Atlanta: CDC, National Center for Health Statistics; 2020. Available at http://wonder.cdc.gov

Chan Osilla, K., D’Amico, E. J., Lind, M., Ober, A. J., Watkins, K. E. (2016). Brief treatment for substance use disorders: A guide for behavioral health providers. Santa Monica, CA: RAND Corporation. Retrieved on April 28, 2020 at: https://www.rand.org/pubs/tools/TL147.html

Csete, J., Kamarulzaman, A., Kazatchkine, M., Altice, F., Balicki, M., Buxton, J., Cepeda, J., Comfort, M., Goosby, E., Goulão, J., Hart, C., Kerr, T., Lajous, A. M., Lewis, S., Martin, N., Mejía, D., Camacho, A., Mathieson, D., Obot, I., Ogunrombi, A., et al. (2016). Public health and international drug policy. Lancet, 387(10026), 1427–1480. https://doi.org/10.1016/S0140-6736(16)00619-X.

Darker, C. D., Sweeney, B. P., Barry, J. M., Farrell, M. F., & Donnelly-Swift, E. (2015). Psychosocial interventions for benzodiazepine harmful use, abuse or dependence. Cochrane Database of Systematic Reviews, 5, CD009652.

Denis-Lalone, D., Lind, C., & Estefan, A. (2019). Beyond the buzzword: A concept analysis of harm reduction. Research and Theory for Nursing Practice, 33(4), 310–323. https://doi.org/10.1891/1541-6577.33.4.310.

Des Jarlais, D. C. (1995). Harm reduction—a framework for incorporating science into drug policy. American Journal of Public Health, 85, 10–12.

Des Jarlais, D. C. (2017). Harm reduction in the USA: The research perspective and an archive to David purchase. Harm Reduction Journal, 14(1), 51. https://doi.org/10.1186/s12954-017-0178-6.

Dieterich, M., Irving, C. B., Bergman, H., Khokhar, M. A., Park, B., & Marshall, M. (2017). Intensive case management for severe mental illness. The Cochrane Database of Systematic Reviews. https://doi.org/10.1002/14651858.CD007906.pub3.

D’Onofrio, G., O’Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., Bernstein, S. L., & Fiellin, D. A. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. JAMA, 313(16), 1636–1644. https://doi.org/10.1001/jama.2015.3474.

Gates, P. J., Sabioni, P., Copeland, J., Le Foll, B., & Gowing, L. (2016). Psychosocial interventions for cannabis use disorder. Cochrane Database of Systematic Reviews, 5, CD005336. https://doi.org/10.1002/14651858.CD005336.pub4.

Gryczynski, J., Mitchell, S. G., Gonzales, A., Moseley, A., Peterson, T. R., Ondersma, S. J., O’Grady, K. E., & Schwartz, R. P. (2015). A randomized trial of computerized vs. in-person brief intervention for illicit drug use in primary care: Outcomes through 12 months. Journal of Substance Abuse Treatment, 50, 3–10. https://doi.org/10.1016/j.jsat.2014.09.002.

Gustafson, D. H., McTavish, F. M., Chih, M. Y., Atwood, A. K., Johnson, R. A., Boyle, M. G., Levy, M. S., Driscoll, H., Chisholm, S. M., Dillenburg, L., Isham, A., & Shah, D. (2014). A smartphone application to support recovery from alcoholism: A randomized clinical trial. JAMA Psychiatry, 71(5), 566–572. https://doi.org/10.1001/jamapsychiatry.2013.4642.

Hawk, M., Coulter, R., Egan, J. E., Fisk, S., Reuel Friedman, M., Tula, M., & Kinsky, S. (2017). Harm reduction principles for healthcare settings. Harm reduction journal, 14(1), 70. https://doi.org/10.1186/s12954-017-0196-4
Harm Reduction International. (2020). What is harm reduction? Retrieved from https://www.hri.global/what-is-harm-reduction on April 1, 2020.

Hawk, K., & D’Onofrio, G. (2018). Emergency department screening and intervention for substance use disorders. *Addiction Science and Clinical Practice, 13*, 18. https://doi.org/10.1186/s13722-018-0117-1.

Hawk, M., & Davis, D. (2012). The effects of a harm reduction housing program on the viral loads of homeless individuals living with HIV/AIDS. *AIDS Care, 24*(5), 577–582. https://doi.org/10.1080/09540121.2011.630352.

Humeniuk, R. E., Henry-Edwards, S., Ali, R. L., Poznyak, V., & Monteiro, M. (2010b). The ASSIST-linked brief intervention for hazardous and harmful substance use: Manual for use in primary care. Geneva: World Health Organization.

Kadden, R., Carroll, K., Donovan, D., Cooney, N., Monti, P., Abrams, D., Litt, M., & Hester, R. (2003). Cognitive behavioral coping skills therapy manual. A clinical research guide for therapists treating individuals with alcohol abuse and dependence. National Institute on alcohol and alcoholism: Project MATCH monograph series volume 3. NIH Publications No. 94-3724.

Karamouzian, M., Dohoo, C., Forsting, S., McNeil, R., Kerr, T., & Lysyshyn, M. (2018). Evaluation of a fentanyl drug checking service for clients of a supervised injection facility, Vancouver, Canada. *Harm Reduction Journal, 15*(1), 46. https://doi.org/10.1186/s12954-018-0252-8.

Kennedy, M. C., Hayashi, K., Milloy, M. J., Wood, E., & Kerr, T. (2019). Supervised injection facility use and all-cause mortality among people who inject drugs in Vancouver, Canada: A cohort study. *PLoS Medicine, 16*(11), e1002964. https://doi.org/10.1371/journal.pmed.1002964.

Kerr, T., Small, W., Buchner, C., Zhang, R., Li, K., Montaner, J., & Wood, E. (2010). Syringe sharing and HIV incidence among injection drug users and increased access to sterile syringes. *American Journal of Public Health, 100*(8), 1449–1453. https://doi.org/10.2105/AJPH.2009.178467.

Kiluk, B. D., Devore, K. A., Buck, M. B., Nich, C., Frankforter, T. L., LaPaglia, D. M., Yates, B. T., Gordon, M. A., & Carroll, K. M. (2016). Randomized trial of computerized cognitive behavioral therapy for alcohol use disorders: Efficacy as a virtual stand-alone and treatment add-on compared with standard outpatient treatment. *Alcoholism, Clinical and Experimental Research, 40*(9), 1991–2000. https://doi.org/10.1111/acer.13162.

Kiluk, B. D., Nich, C., Buck, M. B., Devore, K. A., Frankforter, T. L., LaPaglia, D. M., Muvvala, S. B., & Carroll, K. M. (2018). Randomized clinical trial of computerized and clinician-delivered CBT in comparison with standard outpatient treatment for substance use disorders: Primary within-treatment and follow-up outcomes. *The American Journal of Psychiatry, 175*(9), 853–863. https://doi.org/10.1176/appi.ajp.2018.17090978.

Koob, G. F. (2017). The dark side of addiction: The Horsley Gantt to Joseph Brady connection. *The Journal of Nervous and Mental Disease, 205*(4), 270–272. https://doi.org/10.1097/NMD.0000000000000551.

Krieger, M. S., Goedel, W. C., Buxton, J. A., Lysyshyn, M., Bernstein, E., Sherman, S. G., Rich, J. D., Hadland, S. E., Green, T. C., & Marshall, B. D. L. (2018). Use of rapid fentanyl test strips among young adults who use drugs. *International Journal of Drug Policy, 61*, 52–58. https://doi.org/10.1016/j.drugpo.2018.09.009. Epub 2018 Oct 18.

Kwako, L. E., Momenan, R., Litten, R. Z., Koob, G. F., & Goldman, D. (2016). Addictions neuroclinical assessment: A neuroscience-based framework for addictive disorders. *Biological Psychiatry, 80*(3), 179–189. https://doi.org/10.1016/j.biopsych.2015.10.024.

Larimer, M. E., Malone, D. K., Garner, M. D., Atkins, D. C., Burlingham, B., Lonczak, H. S., Tanzer, K., Ginzler, J., Clifasefi, S. L., Hobson, W. G., & Marlatt, G. A. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *JAMA, 301*(13), 1349–1357. https://doi.org/10.1001/jama.2009.414.

Liebschutz, J. M., Crooks, D., Herman, D., Anderson, B., Tsui, J., Meshesha, L. Z., Dossabhoi, S., & Stein, M. (2014). Buprenorphine treatment for hospitalized, opioid-dependent patients: A
randomized clinical trial. *JAMA Internal Medicine, 174*(8), 1369–1376. https://doi.org/10.1001/jamainternmed.2014.2556.

MacArthur, G. J., Minozzi, S., Martin, N., Vickerman, P., Deren, S., Bruneau, J., Degenhardt, L., & Hickman, M. (2012). Opiate substitution treatment and HIV transmission in people who inject drugs: Systematic review and meta-analysis. *BMJ, 345*, e5945. https://doi.org/10.1136/bmj.e5945.

MacArthur, G. J., van Velzen, E., Palmateer, N., Kimber, J., Pharris, A., Hope, V., Taylor, A., Roy, K., Aspinall, E., Goldberg, D., Rhodes, T., Hedrich, D., Salminen, M., Hickman, M., & Hutchinson, S. J. (2014). Interventions to prevent HIV and hepatitis C in people who inject drugs: A review of reviews to assess evidence of effectiveness. *The International Journal on Drug Policy, 25*(1), 34–52. https://doi.org/10.1016/j.drugpo.2013.07.001.

Magill, M., & Ray, L. A. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs, 70*(4), 516–527.

Magill, M., Ray, L., Kiluk, B., Hoadley, A., Berstein, M., Tonigan, J. S., & Carroll, K. (2019). A meta-analysis of cognitive-behavioral therapy for alcohol and drug use disorders: Treatment efficacy by contrast condition. *Journal of Consulting and Clinical Psychology, 87*(12), 1093–1105.

Mancini, M. A., & Linhorst, D. M. (2010). Harm reduction in community mental health settings. *Journal of Social Work in Disability & Rehabilitation, 9*, 130–147.

Mancini, M. A., & Wyrick-Waugh, W. (2013). Consumer and practitioner perceptions of the harm reduction approach in a community mental health setting. *Community Mental Health Journal, 49*(1), 14–24.

Mancini, M. A., Hardiman, E. R., & Eversman, M. H. (2008a). A review of the compatibility of harm reduction and recovery-oriented best practices for dual disorders. *Best Practices in Mental Health: An International Journal, 4*(2), 99–113.

Mancini, M. A., Linhorst, D. M., Broderick, F., & Bayliff, S. (2008b). Challenges to implementing the harm reduction approach. *Journal of Social Work Practice in the Addictions, 8*(3), 380–408.

Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behavior, 21*, 779–788.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.

MATE, G. (2010). *In the realm of hungry ghosts*. Berkley: North Atlantic Books.

McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive-behavioral therapy for substance use disorders. *Psychiatric Clinics of North America, 33*(3), 511–525. https://doi.org/10.1016/j.psc.2010.04.012.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Preparing people for change* (3rd ed.). New York: Guilford Press.

Milloy, M. J., & Wood, E. (2009). Emerging role of supervised injecting facilities in human immunodeficiency virus prevention. *Addiction, 104*(4), 620–621. https://doi.org/10.1111/j.1360-0443.2009.02541.x.

Monti, P., Kadden, R., Rohsenow, D., Cooney, N., & Abrams, D. (2002). *Treating alcohol dependence: A coping skills training guide* (2nd ed.). New York: Guilford Press.

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press.

Naar, S., & Safren, S. A. (2017). *Motivational interviewing and CBT: Combining strategies for maximum effectiveness*. New York: Guilford Press.

Olsen, Y., & Sharfstein, J. M. (2014). Confronting the stigma of opioid use disorder--and its treatment. *JAMA, 311*(14), 1393–1394. https://doi.org/10.1001/jama.2014.2147.

Pinkerton, S. D. (2011). How many HIV infections are prevented by Vancouver Canada’s supervised injection facility? *The International Journal on Drug Policy, 22*(3), 179–183. https://doi.org/10.1016/j.drugpo.2011.03.003.
Potier, C., Laprévote, V., Dubois-Arber, F., Cottencin, O., & Rolland, B. (2014). Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence, 145*, 48–68. https://doi.org/10.1016/j.drugalcdep.2014.10.012.

Prochaska, J. A., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviour. *American Psychologist, 47*, 1102–1114.

Salyers, M. P., Stull, L., & Tsemberis, S. (2013). Assertive community treatment and recovery. In V. L. Vandiver (Ed.), *Best practices in community mental health* (pp. 103–115). Lyceum Books: Chicago.

Sharma, M., Lamba, W., Cauderella, A., Guimond, T. H., & Bayoumi, A. M. (2017). Harm reduction in hospitals. *Harm Reduction Journal, 14*(1), 32. https://doi.org/10.1186/s12954-017-0163-0.

Strathdee, S. A., Ricketts, E. P., Huettner, S., Cornelius, L., Bishai, D., Havens, J. R., Beilenson, P., Rapp, C., Lloyd, J. J., & Latkin, C. A. (2006). Facilitating entry into drug treatment among injection drug users referred from a needle exchange program: Results from a community-based behavioral intervention trial. *Drug and Alcohol Dependence, 83*, 225–232.

Substance Abuse and Mental Health Services Administration. (1999, 2012). *Center for Substance Abuse Treatment. Brief interventions and brief therapies for substance abuse*. Treatment Improvement Protocol (TIP) Series, No. 34. HHS Publication No. (SMA) 12-3952. Rockville, MD.

Substance Abuse and Mental Health Services Administration (SAMHSA). (1999). *Center for Substance Abuse Treatment. Enhancing motivation for change in substance abuse treatment*. Treatment improvement protocol (TIP) Series, No. 35. HHS Publication No. (SMA) 12-4212. Rockville, MD.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651–656. https://doi.org/10.2105/ajph.94.4.651.

Tsui, J. I., Evans, J. L., Lum, P. J., Hahn, J. A., & Page, K. (2014). Association of opioid agonist therapy with lower incidence of hepatitis C virus infection in young adult injection drug users. *JAMA Internal Medicine, 174*(12), 1974–1981. https://doi.org/10.1001/jamainternmed.2014.5416.

Turner, K. M., Hutchinson, S., Vickerman, P., Hope, V., Craine, N., Palmateer, N., May, M., Taylor, A., De Angelis, D., Cameron, S., Parry, J., Lyons, M., Goldberg, D., Allen, E., & Hickman, M. (2011). The impact of needle and syringe provision and opiate substitution therapy on the incidence of hepatitis C virus in injecting drug users: Pooling of UK evidence. *Addiction, 106*(11), 1978–1988. https://doi.org/10.1111/j.1360-0443.2011.03515.x.

Watkins, K. E., Ober, A. J., Lamp, K., Lind, M., Setodji, C., Osilla, K. C., Hunter, S. B., McCullough, C. M., Becker, K., Iyiewuare, P. O., Diamant, A., Heinzerling, K., & Pincus, H. A. (2017). Collaborative care for opioid and alcohol use disorders in primary care: The SUMMIT randomized clinical trial. *JAMA Internal Medicine, 177*(10), 1480–1488. https://doi.org/10.1001/jamainternmed.2017.3947.

Wilson, D. P., Donald, B., Shattock, A. J., Wilson, D., & Fraser-Hurt, N. (2015). The cost-effectiveness of harm reduction. *The International Journal on Drug Policy, 26*(Suppl 1), S5–S11. https://doi.org/10.1016/j.drugpo.2014.11.007.

Wilson, N., Karisa, M., Seth, P., Smith, H., 4th, & Davis, N. L. (2020). Drug and opioid-involved overdose deaths – United States, 2017–2018. *MMWR. Morbidity and Mortality Weekly Report, 69*(11), 290–297. https://doi.org/10.15585/mmwr.mm6911a4.

Wodak, A., & Cooney, A. (2004). Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Geneva: World Health Organization.

Wodak, A., & Maher, L. (2010). The effectiveness of harm reduction in preventing HIV among injecting drug users. *New South Wales Public Health Bull, 21*, 69–73.