Chapter 4—Practical Application of Treatment Strategies

The preceding chapter describes what is known about the effectiveness of treatments for stimulant use disorders. This chapter focuses on how to use that information to improve treatment efforts with stimulant users. Whenever possible, treatment recommendations will employ strategies with empirical support. However, because many stimulant use treatment issues have not been systematically researched, the recommendations of the TIP’s Consensus Panel as augmented by field review feedback are the basis for other recommendations.

Individuals seeking help for stimulant dependence receive the majority of their treatment in outpatient treatment programs. Accordingly, the treatment strategies described emphasize techniques employed in outpatient treatment programs. However, many if not most of these strategies and techniques can be integrated into programs other than structured outpatient treatment programs.

This chapter describes the key components of the stimulant use disorders in chronological order as they typically unfold to provide clinicians delivering treatment with a clinical road map. Treatment recommendations are offered to systematically address these clinical issues as they emerge.

This chapter is written with the assumption that abstinence from all mood-altering psychoactive drugs is the ultimate treatment and program goal. Although there is debate about the universal appropriateness of this position, the current treatment system in the United States is founded on this philosophy. This chapter also assumes that structured outpatient treatment will be viewed as one interdependent component of a larger substance use disorder treatment process and system. Many stimulant-dependent individuals experience medical problems or emergencies, psychiatric problems or crises, or various social, legal, or employment problems. As a result, although this chapter focuses on outpatient treatment of stimulant abuse and dependence, it acknowledges the critical importance of institutions and processes such as hospitals, medical/psychiatric management, and case management.

This chapter assumes that the client or the potential client is medically and emotionally ready for entry into outpatient care. Chapter 5 describes the medical/psychiatric factors that should be considered to ensure the safe admission of the client into an appropriate care setting. In addition to these safety elements, there are other considerations for some stimulant user groups (e.g., pregnant women, women with children, adolescents, those with coexisting disorders, the severely impoverished, and homeless individuals) in which the use of outpatient strategies may not be appropriate. Treatment considerations for client groups with these special needs are discussed in Chapter 6. Client Worksheets referred to throughout this chapter are located in Appendix B.

Treatment-Seeking Stimulant Users

Stimulant use disorder treatment is a health care service, and stimulant users are the customers for that service. For a treatment program to effectively meet the needs of stimulant users, it is essential to understand the perspective of the "customer" as she approaches, enters, and participates in treatment. For example, opiate-addicted individuals frequently initiate contact with the treatment system when they have exhausted all resources and are in fear of the discomfort of opiate withdrawal. Their initial overriding priority is for “treatment” to provide medication to prevent or alleviate symptoms of withdrawal. Treatment programs incapable of responding to this client priority are unlikely to successfully engage opiate addicts in treatment.

Stimulant users approach the treatment system with a different set of priorities than opiate users, because avoidance of the withdrawal syndrome is not a major motivating factor. The priorities of stimulant users and the assistance they are seeking vary more greatly than those of opiate-addicted individuals. However, there are some common themes in the pretreatment perspective of many stimulant users.

"Bad Things Are Happening"

Admission interviews with stimulant users provide substantial evidence that one of the major treatment-seeking considerations for most individuals is that their use of cocaine or methamphetamine (MA) has resulted in negative consequences. These consequences include legal, job-related, medical, family/relationship, financial, and psychiatric problems. Frequently, the treatment-seeking stimulant user is focused more on receiving assistance...
with these problem areas than on achieving abstinence from cocaine or MA.

"Life Is Out of Control"

Treatment-seeking stimulant users frequently say, "My life is out of control." They point to their excessive behaviors associated with obtaining, using, and recovering from the use of cocaine or MA. These behaviors include, but are not limited to

- Extreme financial irresponsibility and/or initiation of illegal activities
- Lack of routine self-care behaviors (e.g., eating, sleeping, bathing)
- Excessive or personally aberrant sexual behavior
- Severely deteriorated employment/ educational performance
- Escalating irresponsible behavior to family and spouse (e.g., spending subsistence money on drugs, failure to care for children, marital infidelity)

Accompanying these behaviors is an array of emotional turmoil including but not limited to

- Extreme cycles of euphoria and depression
- Intense anxiety, fear, guilt, and shame over medical, fiscal, legal, and personal relationships
- Anergia (lack of energy) and anhedonia (inability to feel pleasure) during periods of abstinence
- Anger, paranoia, and irritability during both periods of use and periods of abstinence

Cognitive Impairment/Clinically Significant Paranoia

As documented in Chapter 5, the use of stimulants produces significant cognitive impairment (van Gorp et al., 1998) and frequently is accompanied by severe paranoia. Users have difficulty concentrating, impaired short-term memory, and a relatively short attention span. Their ability to recognize the interconnectedness of their stimulant use and the chaos occurring in their lives is poor, and the pervading sense of paranoia (especially for MA users) makes the development of a plan to remediate their problems very difficult. In short, it is often difficult for stimulant users to make sense of what is happening to them.

Ambivalence/Skepticism About Treatment

Many uninitiated clinicians are frequently frustrated and angered by what they perceive as a "lack of motivation" or the presence of "denial" in treatment-seeking stimulant users. Few stimulant users enter treatment with unconditional enthusiasm about the goals and methods of treatment. A significant number present for treatment exhibiting hostility, skepticism about the need for treatment, and opposition to fundamental elements of many treatment plans (e.g., cessation of alcohol and secondary substance use, participation in self-help programs). Although many stimulant users profess a strong desire to discontinue stimulant use, their resistance to initiating recommended treatment behaviors is often a source of clinician frustration. The recognition of this ambivalence as an integral part of the stimulant addiction syndrome, rather than as a frustrating impediment to working on "the real treatment issues," can help clinicians recognize the importance of effective techniques to motivate positive behavioral change.

Craving

The experience of craving a substance is a hallmark of almost all substance use disorders. However, for stimulant users, the experience of craving plays an important role in the maintenance of drug use. The basic research findings described in Chapter 2 have documented the existence of neurophysiological correlates of stimulant craving. Virtually all stimulant users have experienced craving but have little understanding of the biological underpinnings of this subjective experience. The power and volatility of this craving response can be exceptionally difficult for some stimulant users to resist (especially those who use the rapid delivery ingestion methods of smoking or injection). For many, it is virtually impossible to imagine how "counseling" or some other form of nonresidential treatment will help with this "irresistible force."

This combination of behaviors, attitudes, and emotions is frequently present to varying degrees with the majority of treatment-seeking cocaine and MA users. Other issues that frequently are priorities to treatment-seeking stimulant users include the dysphoria that occurs upon discontinuation of stimulants, often referred to as "the crash" (Gawin and Kleber, 1986); the compulsive sexual behavior of many men (especially MA users), which is often reported as equally or more difficult to control than the drug use (Rawson et al., 1998b); and the
discouragement about previous attempts in and outside of treatment to discontinue stimulant use, only to experience relapse to even more severe levels of drug use. This set of attributes is, in many ways, the "raw material" that programs need to address in the treatment of stimulant users.

**Treatment Needs of Cocaine Users Versus Methamphetamine Users**

In one site in Southern California, a group of 500 MA users and a group of 224 cocaine users were treated using the same outpatient protocol (the Matrix manual), in the same office, with the same staff during the same time period (Rawson et al., 1996; Huber et al., 1997). Although there were some substantial demographic and drug use differences between the two groups, their response to the outpatient treatment protocol was virtually identical. MA users presented with higher ratings of depression, hallucinations, and several other symptoms, and exhibited a more prolonged period of symptom remission. Yet the data collected during treatment and at followup suggested comparable response to this outpatient experience.

There appears to be little empirical rationale for designating any one of the following psychosocial approaches as being differentially effective for the two stimulant user groups. Therefore, the following treatment recommendations apply to users of both cocaine and MA.

**Maximizing Treatment Engagement**

**Make Treatment Accessible**

Programs should maximize treatment accessibility. Research has shown that placing treatment programs in areas convenient to clients is associated with lower attrition rates (Stark, 1992). Treatment should be provided during the hours and on the days that are convenient for clients. If the majority of clients do not work and find boredom and lack of daytime activities a significant contributing factor to substance use, daytime treatment programming may be helpful. For programs with a substantial number of working clients it is essential to have evening hours. Some programs may need multiple sets of hours for different client groups. Programs should be located in the areas that are accessible to clients, such as near public transportation and in a part of town viewed as safe for evening visits. In rural areas, small satellite sites may be needed to bring treatment closer to clients. Facilities should be accessible to individuals with disabilities.

**Provide Support for Treatment Participation**

Research has demonstrated the importance of addressing clients' concrete needs, including transportation, housing, and finances (Chafetz et al., 1970). Providers may find it necessary to establish protocols for rapidly addressing transportation barriers, such as by providing bus tokens, bus and cab fare, and vans. Some logistical barriers can be overcome by onsite services, through agreements with subcontractors, or by referrals. These can include providing onsite child care services, referrals to temporary shelters, vouchers for lunches, targeted financial assistance, assistance with paperwork regarding insurance, or filing for disability.

Referrals should not be limited to providing clients with the name, address, and phone number of an agency. Rather, referrals should involve advocacy: networking with agencies and organizations, calling those contacts, and setting up the appointments or visits.

**Respond Quickly and Positively to Initial Telephone Inquiries**

Stimulant users often make their first contact with the treatment system on the telephone or as a result of an exploratory visit to a counselor or treatment program. The manner in which the receptionist, intake worker, counselor, or other staff person handles the initial contact with the prospective client may decide whether or not the individual decides to enter treatment. Timeliness is an important factor too. Having a counselor, intake worker, or other staff person available to answer telephone inquiries immediately for as many hours per day as possible will increase admission rates. Telephone inquiries should be answered without substantial delay (stimulant users are often impatient individuals, who hang up when placed on hold). Taking messages and calling back later will frequently result in a failure to find the individuals; or, when contacted, they may have changed their minds. Having 24-hour hotlines can be useful because some stimulant users or their family members make their initial treatment inquiries during late night and weekend hours.

Seeking help at an addiction treatment program can be a profoundly difficult and painful act. In fact, in many cases, a family member or friend often makes the initial contact with the treatment program. Data from telephone initial contacts to the Matrix Center clinics in Southern California indicate that approximately 45 percent of all initial treatment inquiries are not made by the potential client, but rather are made by a family member or friend.
In some treatment programs, there is a belief that unless the potential client makes the call for the initial appointment, it is inappropriate to schedule one. This policy is apparently based on the belief that requiring substance users themselves to make the initial call helps to reduce client "denial" and decreases the "no show" rate. Analysis of the data from the Matrix calls indicated no significant difference in "no shows" depending on who made the initial appointment. Because ambivalence about treatment is common among treatment-seeking stimulant users, methods to "screen out" those who are "in denial" are counterproductive and impede treatment entry.

Schedule Initial Appointments With Minimal Delay

The individual's decision to seek help may last for only a brief period of time. As a result, many individuals seeking help fail to show up for their initial appointment if it is scheduled too far in the future. For these reasons, the interview should be scheduled as soon as possible and within 24 hours after clients initially contact the program (Higgins and Wong, 1998). Figure 4-1 discusses the importance of scheduling.

Programs may not always have the resources to conduct thorough intake interviews whenever contacted. However, programs can provide interim services or minimal contact. For example, a brief interview or a partial intake within 24 hours would be preferable to making an appointment several days after the initial contact. The interview might identify any acute needs that require immediate attention. Also, treatment programs can provide orientation meetings in lieu of waiting lists. If a waiting list cannot be avoided, staff members can telephone the individual to express concern for the individual's well-being, conduct mini-assessments, and provide basic recommendations, such as attending a 12-Step meeting. Such efforts can serve as a temporary bridge between the initial contact and a thorough interview and assessment. These interim services can take advantage of fleeting motivations for change.

Assessment Procedures To Enhance Treatment Engagement

Keep Assessments Brief

Many programs conduct multiple assessments, often by several members of multidisciplinary teams. This technique may be useful for some clients, such as those with complex coexisting disorders. However, stimulant-dependent individuals are often irritated by lengthy and repetitive assessments. For such clients, it is essential that client assessments conducted early in treatment not become onerous or barriers to treatment. Accordingly, initial assessments should be brief, focused, and nonrepetitive. There are several clinical assessment questionnaires for stimulant users available in Washton and Rawson et al. (Washton, 1991; Rawson et al., 1991b).

Identify Clients' Expectations

It is important to identify clients' expectations, as well as their fears, concerns, and anxieties. For example, clients with previous treatment experiences may have anxieties about treatment failure. Programs should specifically make efforts to discover clients' worries and identify those issues that can be dispelled through information and education about the program and the treatment process. An important task here is to help eliminate their fear of the unknown.

Provide Clear Orientations

Individuals need a thorough, clear, and realistic orientation about stimulant addiction treatment. Clients should acquire a good understanding about the treatment process, the rules of the treatment program, expectations about their participation, and what they can expect the program to do for them. They should understand the basic components of treatment, the amount of time that will be involved, and what will happen next. An orientation can help to dispel fears and anxieties and can help to correct misunderstandings. Research has shown that providing effective orientations has a positive effect on program retention (Stark, 1992). Parts of the orientation may need to be repeated, because cognitively impaired stimulant-dependent clients may forget what they have been told.

Offer Clients Options

Motivation research demonstrates strongly and consistently that people are most likely to engage in an action when they perceive that they have personally chosen to do so. In order to perceive that one has a choice, there must be alternatives from which one can choose (Miller, 1985). Research suggests that substance use disorder treatment is more effective when a client chooses it from among alternatives than when it is assigned as the only option (Kissin et al., 1971). The ability to choose also seems to reduce client resistance and dropout (Costello,
Thus, it is important to provide clients with options and negotiate with them regarding the treatment approaches and strategies that are the most acceptable and promising.

**Keep It Simple**

Initial information and instructions should be simple and clear. Although clients with stimulant use disorders will vary, many will have cognitive problems that will limit their ability to follow long and complex instructions or explanations. As noted above, it is valuable to include clients in selecting their treatment plan. However, once the selection is made, it is important to be clear about the specific requirements of the treatment recommendation and the next step in the treatment process.

**Involve Significant Others**

Whenever possible, family and significant others who support the treatment goals should be involved in the treatment process, including the initial assessment and intake processes. Significant others can provide collateral information regarding the individual's addiction and can be evaluated regarding their potential for helping to promote the treatment goals or for hindering progress.

Significant others should be provided with information about the addictive process, the treatment program, assessment results, and the next steps for themselves as well as for the client. Individuals who walk away from a significant other’s assessment process without interacting with program staff members are likely to feel neglected and ignored. Also, significant others can be given information about their role in the addiction process. They also should be provided with information about codependency and self-help for significant others of addicted persons, such as that provided by Al-Anon.

**Staff Behaviors To Enhance Treatment Engagement**

**Treat Clients Respectfully**

Research has shown that welcoming clients and treating them with respect are important factors in improving immediate and long-term retention (Chafetz et al., 1970). Individuals who contact treatment programs should be treated with courtesy, friendliness, respect, and warmth. The importance of professional demeanor and a respectful attitude toward clients applies to all staff members with whom they have contact, including both clinical and nonclinical staff members. Potential clients should not, for example, be put on hold for long periods of time. Although it is true that some stimulant-dependent individuals can be difficult and provocative, these clients are often frightened, disoriented, and cognitively impaired. All program staff members should consider the courage that it takes to seek help for treatment and the shame and anxiety that most clients experience entering treatment. Staff members should provide individuals with positive feedback for asking for help and seeking treatment.

**Convey Empathic Concern**

A review of treatment research noted that evidence of high levels of therapist empathy is associated with positive treatment outcomes, and empathy was the predominant therapist characteristic associated with positive treatment outcomes (Landry, 1995). Counselors should be warm, friendly, engaging, empathic, straightforward, and nonjudgmental. Although many clients with stimulant use disorders respond poorly to confrontation and pressure, counselors should not hesitate to provide advice, especially behavioral prescriptions. Advice and recommendations should be provided in a caring and helpful way, not in a controlling or confrontational fashion. Counselors should make deliberate attempts to exert calming effects on clients and remain mindful of clients’ potential for extreme impulsiveness and irritability.

When stimulant users are treated in a calm and respectful manner, violent reactions are very rare. However, authoritarian and confrontational behavior by the staff can substantially increase the potential for violence.

**Do Not Fight Resistance**

Aggressive confrontations with clients must be avoided. It is counterproductive to fight resistance to change or resistance to treatment. Rather, take steps that promote the therapeutic alliance. (See Miller and Rollnick, 1991, for an excellent description of these methods.) Confrontational strategies designed to break through the “denial process” are counter-productive and may be dangerous with stimulant users (Lieberman et al., 1973; Milmoe et al., 1967). Client readiness for treatment and motivation for change are not static conditions. Rather, these are dynamic processes that can be increased (or decreased) through counselor efforts. Counselors should cultivate the motivation and readiness of clients for change and growth (Miller, 1995).
The Treatment Plan

Few data support specific recommendations on the appropriate duration for outpatient treatment episodes. Similarly, there is little empirical evidence to guide the selection of session frequency, session duration, or session format (group vs. individual) of outpatient services for cocaine/MA users. However, it does appear accurate to view treatment as a set of procedures that address a series of clinical issues in a fairly predictable sequence. To organize treatment strategies, it can be helpful to view the treatment process as consisting of (1) a treatment initiation period, (2) an abstinence attainment period, (3) an abstinence maintenance phase, and (4) a long-term abstinence support plan.

The Treatment Framework

One important function for any treatment plan is to give clients a clear structure and framework for their treatment experience. This structure sets up specific expectations and provides clients with the benchmarks they need to plan their treatment participation and measure their treatment progress.

Treatment Episode Duration

There are no data to clearly establish the proper duration for a treatment episode. However, it is necessary to provide clients with a framework for their treatment experience. Many of the research studies and those with extensive clinical experience have used 12 weeks (Carroll, 1996); 16 to 24 weeks (Rawson, 1986; Washton, 1989); or 24 weeks (Wells et al., 1994). In general, it appears that a duration of 12 to 24 weeks, followed by some type of support group participation, is a commonly used framework.

Session Frequency

There are reports in the literature that describe treatment plans scheduled from one session per week (Carroll et al., 1995b, 1995c) up to five sessions per week (Washton and Stone-Washton, 1993). One study that reported a negative treatment finding (Kang et al., 1991) reported that once-per-week psychotherapy was not an effective treatment for cocaine users. In general, the majority of reports have used multiple sessions per week (2, 3, 4) for at least the first several months, with a reduction to fewer (1, 2, 3) through month 6.

Session Length

The session lengths reported in the literature range from 30 minutes to 6 hours. In general, sessions of 45 to 120 minutes in length are most common.

Format

There is tremendous variability regarding the optimal session format. Treatment strategies described in the literature include individual therapy sessions (Higgins et al., 1993a); a specified combination of individual and conjoint sessions (Meyers and Smith, 1995); and a collection of individual, group counseling, classroom didactic sessions, and conjoint session formats (Rawson et al., 1995). Other organizations employ primarily a group approach with individual and conjoint sessions on an ad hoc basis (Washton, in press). There is no research to support the value of one format or combination of formats over another. The most compelling factor in choosing a format may be practical considerations. Individual sessions are generally more flexible for scheduling; group sessions are typically less expensive to deliver. Figure 4-2 presents considerations regarding treatment duration and format.

The only certainty about the treatment framework is that it is critical to give the client clear, specific expectations of his treatment involvement. If the expectation is two individual sessions for 4 weeks followed by one individual session for 8 weeks, or three group sessions per week for 24 weeks, this should be agreed upon in writing by the counselor and client. Clients should have a written schedule of expected attendance they can keep and give to family members who may be involved in treatment.

It does not appear appropriate to deliver these services on an ad hoc or as needed basis. The structure and expectation of a prescribed treatment regimen has clinical value, independent of the contents of the treatment materials. Certainly there may be modifications in the treatment plan as treatment proceeds, based on clinical progress or other considerations; however, the initial contract needs to be specific and clear.

Strategies for Initiating Treatment

During the first days and weeks of treatment, it is important to remember that although stimulant users do not have to contend with the uncomfortable withdrawal symptoms of the opiate or the alcohol dependent client, they
often are experiencing a set of dysphoric symptoms. The initial period of stimulant abstinence is characterized by symptoms of depression, difficulty concentrating, poor memory, irritability, fatigue, craving for cocaine/MA, and paranoia (especially for MA users). The duration of these symptoms varies; however, in general, they typically last for 3 to 5 days for cocaine users and 10 to 15 days for MA users. The severity of these symptoms and the dysfunction they produce may be sufficient to warrant hospital/residential care in order to establish a period of abstinence (see Chapter 5).

**Initial Treatment Goals**

The first several weeks of treatment have some relatively simple and straightforward priorities. They are to

- Establish treatment attendance
- Discontinue use of psychoactive substances
- Finish assessment of clinical needs
- Remediate stimulant "withdrawal" symptoms
- Resolve any immediate crises

The following recommendations for this period can be integrated into a variety of treatment frameworks.

**Establish treatment attendance**

Initiating a routine of treatment attendance involves giving the client a clear expectation of when and where this attendance should occur, what is going to happen when she attends, positive reinforcement when attendance occurs on schedule, and reminders when treatment is missed. During the initial weeks, clients will be early, late, come in under the influence, and frequently be in crisis and confusion. This initial period is an opportunity to "shape" appropriate behavior by reinforcing proper attendance. Staff should remember that simply attending the sessions is a major indication of treatment engagement and should be enthusiastically reinforced. There will be ample time to give clients corrective feedback on being late or missing sessions.

**Schedule frequent contacts**

Stimulant-dependent clients appear to benefit from frequent clinic visits, even if the contacts are brief. During the first 2 to 3 weeks, such clients should be scheduled for multiple weekly visits, even if the visits are 30 minutes or shorter (Higgins and Wong, 1998).

**Use positive incentives to reinforce treatment participation**

One of the most powerful strategies to increase treatment involvement and establish treatment engagement is to use incentives and other tangible positive reinforcers to reward progress in treatment (Higgins and Budney, 1997). The specific reinforcers will differ among client populations. Some clients prefer vouchers for retail items or coupons for fast food; others appreciate clothes for themselves or their children or rebates for payments. Some programs hold brief ceremonies or present certificates. Rowan-Szal and colleagues demonstrated the effectiveness of incentives for attendance at counseling sessions and substance-free urinalyses through the use of "stars" on an awards board (Rowan-Szal et al., 1994).

A primary message that should be conveyed to clients with stimulant use disorders is that they should return to the program, no matter what. Even if they use stimulants or other substances, they should return to treatment. Clients should be given appointment reminder cards, flyers, and schedules, with the message that they are expected to return and that they will always be welcomed back.

**Call no-shows**

Programs should routinely telephone clients who fail to show up for scheduled clinic visits. Clinic staff members should encourage clients to come in for the clinic visit and inquire about any possible crises that may have prevented their participation. Personal letters can also be used as reminders.

**Create a positive environment**

Research has demonstrated that providing treatment in smaller groups in friendly, comfortable environments is associated with lower attrition rates (Stark, 1992). Programs should be prepared for client feedback related to not belonging and not feeling comfortable. Clients with stimulant use disorders often feel that they do not belong in treatment because they are not addicted, because they do not like the appearance of the program, or because
they do not feel that they can relate to the other clients. Rather than simply assuming that these beliefs represent defense mechanisms, programs should take steps to improve the comfort level of the treatment program and experience. For example, whenever possible, programs should take steps to help clients maximize their ability to identify with other clients and not feel alone. This can include establishing a "buddy system" in which a somewhat seasoned client or alumnus is provided with opportunities to dispel fears and concerns about the program and treatment process. If "buddies" are matched according to assumed similarities in background, the process can help clients to feel that they can relate to others in the program.

**Discontinue use of psychoactive substances**

*Encourage abstinence immediately*

After an initial assessment interview, it can be useful to ask clients to agree to a "temporary" trial period of abstinence. Counselors can end the first interview with a specific plan for abstinence, such as abstaining from substances of abuse at least until the next clinic visit. Some form of structured preparatory treatment that can act as a bridge to the regular treatment program can be useful for clients who are unwilling to make such a commitment (Obert et al., 1997). These can include a preparatory group therapy that involves motivational enhancement techniques (Miller and Rollnick, 1991). These groups can be brief but frequent, such as three to five times per week, and can include urine testing.

It is important to recognize that an individual may be at different stages of readiness for change (Prochaska et al., 1992) regarding different substances. For example, an individual may have made the decision to stop using stimulants but is still contemplating the decision to stop drinking alcohol. The individual's hesitancy to enter treatment may reflect ambivalence about alcohol, not stimulants. A motivational group may help to move him from the contemplation phase to the decision and action phases with regard to alcohol.

*Establish daily schedule*

Time planning and scheduling should be promoted as an important way to deter spending a lot of time alone or having big blocks of time without planned activities. Typically, the daily routine of stimulant-dependent individuals revolves around seeking, using, and recovering from the effects of stimulants. To break this pattern, clients can be taught to use basic daily schedules through which they can provide structure and accountability to their lives. Counselors can provide clients with simple daily schedules such as those illustrated in Client Worksheet 1, Daily Schedule and Planner (see Appendix B for client worksheets). Clients should be vigorously encouraged to schedule and plan each day, especially during this early phase of treatment. Clients should be encouraged to plan time for clinic visits, 12-Step meetings, meals, healthy social activities, exercise, recreation, and leisure time.

*Initiate urinalysis schedule*

Immediately upon entering the treatment program, clients should be placed on a mandatory, vigilant, and frequent urine testing schedule. This schedule should continue throughout the treatment process, although the frequency of testing can be tapered as treatment progresses. Urine samples should be taken every 3 or 4 days so as not to exceed the sensitivity limits of standard laboratory testing methods (see the Strategies for Initiating Abstinence Section below for more on urine testing).

*Encourage 12-Step participation*

Clients should be encouraged to attend a 12-Step program meeting as soon as possible. They should be provided with a schedule of meetings that are easily accessible to them. Participation in self-help groups should be strongly encouraged but not required. Some individuals who refuse self-help participation nevertheless succeed in treatment. Thus, although self-help participation has been shown to be associated with positive treatment outcomes (Landry, 1995) and will be a great resource for many clients, it is not a necessary condition for all clients to succeed.

*Finish assessment of clinical needs*

*Assess psychiatric comorbidity*

Many stimulant users, especially those who use MA, will enter treatment exhibiting symptoms of depression and psychosis. Clearly not all stimulant users have co-occurring depressive illness or a psychotic disorder. With most stimulant users these symptoms subside over several days (for cocaine users) or several weeks (for MA users).
However, some stimulant users do have a co-occurring depression or thought disorder. During the initial 2 weeks it is important to assess the possible existence of these other psychiatric conditions and, if present, initiate appropriate treatment, including medication. Individuals who express suicidal ideation or planning should be taken very seriously and should be treated as any other potentially suicidal person.

Assess stimulant-associated compulsive sexual behaviors

Research demonstrates an association between stimulant use disorders and a variety of compulsive sexual behaviors (Rawson et al., 1998b). These behaviors include promiscuous sex, AIDS-risky behaviors, compulsive masturbation, compulsive pornographic viewing, and homosexual behavior for otherwise heterosexual individuals.

Stimulant-dependent clients can have tremendous concerns and anxieties about the compulsive sexual behaviors that they engage in while using stimulants. Such clients often assume that they are the only ones who have experienced such feelings and engaged in such behaviors. As a result, they may believe that they are perverted sexually or have sexual identity issues. These feelings can be barriers to treatment engagement and retention. Thus, programs can provide education to stimulant-dependent clients about the associations between stimulant abuse and compulsive sexual behavior.

Remediation of stimulant "withdrawal" symptoms

During the initial several weeks of treatment it is important to remind clients that proper sleep and nutrition are necessary to allow the neurobiology of the brain to "recover." Giving clients "permission" to sleep, eat, and gradually begin a program of exercise can help to establish some behaviors that will have long-term utility. These behaviors will also help clients begin to think more clearly and begin to feel some benefit from the initial efforts in treatment.

Provide crisis resolution

Clients should leave early treatment sessions with an assurance that the program can provide or secure immediate attention to critical medical and psychiatric problems. Clients should understand that the program will help them to obtain rapid access to medical and psychiatric evaluation and treatment if they need it. Written lists of community and self-help resources are helpful resources. Programs should develop and always have accessible for distribution a variety of self-help and community resource materials to provide to their clients. These materials should include the name, address, telephone number, and descriptions of 12-Step meetings, other self-help resources, medical clinics, social service agencies, temporary housing and shelters, battered women's shelters, and children's resources.

Strategies for Initiating Abstinence

During the first several weeks of treatment, most individuals stop or at least reduce their use of stimulants. However, even if people have difficulty achieving total abstinence, the first several weeks can be considered successful if treatment engagement is established and some initial steps toward abstinence are made. After the initial treatment engagement of 1 to 2 weeks, a clear focus is on the achievement of abstinence. Although there is no clear delineation between clients who are initiating abstinence and those maintaining abstinence, the initiating period occurs roughly from 2 to 6 weeks into treatment.

The primary goals of strategies used in this phase of treatment are to (1) break the cycle of compulsive, repetitive stimulant use, (2) initiate a period of abstinence from all substances of abuse, (3) encourage the establishment of behaviors that support abstinence, and (4) initiate changes in attitude, behavior, and lifestyle that help maintain abstinence. The following section describes techniques for accomplishing these goals.

Establish Structure and Support

Initiating abstinence from stimulant addiction is not a mental exercise but a specific plan of behavioral action. To initiate this plan, a basic structure and daily routine must replace the lifestyle dominated by drug seeking, using, and recuperating. Structure, stability, and predictability are provided by a simple plan that clients can follow on a daily basis. The daily structure should incorporate and build around the client's participation in the treatment program. This will include establishing short-term goals, frequent counseling sessions, frequent urine testing, developing a support system, and time planning (Washton, 1989).

Short-term goals should be set immediately and should be reasonably achievable. One such goal is complete abstinence from all substances for 1 week. Because many stimulant-dependent clients engage in binge use, a comparable goal is to achieve a period of abstinence approximately twice as long as the usual time period.
between binges. Brief, frequent counseling sessions can reinforce the short-term goal of immediate abstinence and establish a therapeutic alliance between the client and counselor. Events of the past 24 hours are reviewed in each session, and recommendations are provided for navigating the next 24 hours. Establishing a social support system and conducting frequent and regular urine testing are also critical to providing structure, support, and accountability.

**Daily schedule**

The daily scheduling exercise described in the previous section continues to be an extremely important organizing strategy through this phase of treatment. Proactively planning time is a direct counterpoint to the impulsive, free-form lifestyle of the substance user. Clients should write down their schedules during session time, and session time should be used to review compliance with the schedule prepared in the previous session. Many clients will find this task difficult and may resist this "regimentation" of their time. However, if counselors reinforce successive efforts to follow such schedules, compliance will improve.

**Conduct urine testing**

Stimulant-dependent clients in outpatient programs need structure that provides support for engaging in healthy behaviors. Urine testing is part of that structure. It should not be presented or used primarily as an investigative tool or as a method to test the honesty of clients. Rather, it should be used and presented as a means of support for initiating and maintaining sobriety.

Urine testing should be conducted for the primary stimulant and for secondary substances. Testing should be conducted in concert with the clinic visits. During this phase of treatment, urine testing should be conducted no less than once a week. Tests should be spaced so that the results are obtained from a previous test before conducting the next test, which generally means spacing tests no more frequently than every 3 days. Testing should be randomly conducted, although it is advisable to test on days that closely follow periods of high risk, such as holidays, paydays, and weekends. To ensure that the urine is a valid sample from the client, testing should be either observed or monitored through the use of temperature strips.

**Address Secondary Substance Use**

Most stimulant-dependent clients also use some other substance, such as alcohol or marijuana. They often do not perceive their use of a secondary substance as problematic. Indeed, for many clients, their secondary substance use may not have been associated with adverse consequences or compulsive use. As a result, such clients need help to identify the connections between the use of other substances and their stimulant addiction. Clients should learn that using another substance increases the likelihood of relapse to stimulants (Rawson et al., 1986; Carroll et al., 1993a, 1993b).

Clients should learn that some secondary substances of choice, such as alcohol, can have a disinhibiting effect and lead rapidly to stimulant use (Higgins et al., 1996). A similar finding has anecdotally been reported by MA users with regard to their use of marijuana (Rawson et al., 1996). Clients should learn that the dose or the frequency of use of the secondary substance is not important, but that disinhibiting effects and potent conditioned responses and cues can occur at low doses. Achieving abstinence helps clients learn to develop substance-free coping mechanisms.

Clients can be helped to examine some of the reasons for why they use secondary substances. For example, some stimulant-dependent women use alcohol as a way to tolerate an abusive situation. Also, clients can be taught avoidance strategies for the secondary substance, such as eschewing high-risk situations where alcohol will be served.

Clients are sometimes ready for treatment for the primary substance of choice but not their secondary substance. Thus, secondary substance use is common during this phase of treatment. Although programs should promote abstinence from all psychoactive drugs, clients who use their secondary substance should not be discontinued from treatment solely because of this use. Rather, they should receive treatment strategies to help them decrease the likelihood of doing so in the future.

**Establish Contingencies**

Contingency management (described in Chapter 3) reinforces desired behavior by providing immediate consequences. It can be used to improve compliance with treatment components and to promote abstinence. It sets concrete goals and emphasizes positive behavior changes.

In contingency management, a specific target behavior, such as providing stimulant-free urine samples, is
selected. The target behavior should be easily measured. Next, a specific and desirable contingency is identified and selected as a reward for each time that the target behavior is accomplished. The reward should not be exchangeable for cash, but can have a cash equivalent, such as a cash-equivalent voucher system or nonrefundable movie passes. The link between the targeted behavior and the reward should be specified. Finally, the agreement should be documented in a written contract and should specify the duration and any changes over time in contingencies. Contingency management interventions have been shown in controlled research studies to be effective for helping cocaine users to achieve and sustain abstinence (Higgins et al., 1994b; Silverman et al., 1996).

**Initiate Avoidance Strategies**

The process of identifying cues and triggers is dynamic and ongoing and will change over time. For example, as clients learn more about the associations between specific emotional states and stimulant cues, they can become increasingly sophisticated about identifying and avoiding or defusing potential triggers. However, there are several strategies that should be used very early in the treatment process to help clients to avoid certain external or environmental cues that are likely to be potent triggers for stimulant cravings and urges (Washton, 1989). These include discarding drugs, drug paraphernalia, and materials related to substance use; breaking contact with dealers and users; avoiding high-risk places; and developing basic refusal skills.

First, if the client has not already done so, a specific action plan must be developed to find and get rid of all substances (including alcohol) and drug-related paraphernalia. Clients should be encouraged to accomplish this task with the help of a family member, sober friend, or 12-Step sponsor to ensure that all drug-related items are found and permanently discarded. In addition to objects used to prepare or inject stimulants, materials associated with drug use that should be discarded include phone numbers of dealers and prostitutes, pornographic videotapes, containers used to hold drug supplies, mirrors or special tables used to cut stimulants, and weighing scales.

Second, it is essential for clients to develop specific action plans to break contacts with dealers and other stimulant users. When spouses and significant others are themselves stimulant users, it is important to develop a plan to assertively encourage the significant other to also seek help.

Third, an action plan should be developed to help the client avoid high-risk places. This involves identifying places strongly associated with stimulant use and making specific plans to avoid them. This may include taking different routes home from work, going to certain locations at times different than normal, or using a "buddy system" when going to a high-risk area. Finally, a plan of action should be developed to deal with confrontations with acquaintances who are still using stimulants. Clients should prepare specific drug-refusal statements that can be used when they encounter drug-using friends and practice with their counselor and fellow group members. This action plan must include immediately leaving the situation after the encounter. Client Worksheet 5, Action Plan for Avoidance Strategies (see Appendix B), can be used to assist clients develop strategies to avoid potent high-risk cues and triggers.

**Provide Client Education**

Clients with stimulant use disorders often do not understand many of the things that they have experienced as a result of their stimulant use, such as impulsive behaviors, anger and hostility, and cognitive deficits. They require education to help them understand the learning and conditioning factors associated with stimulant use. Similarly, they need information about the impact of stimulants and other substances on the brain and behavior, such as cognitive impairment and forgetfulness. Information about stimulant-induced behavior can help them understand the episodes of anger, hostility, and sexual compulsivity.

Clients, especially those with MA use disorders, should be educated about the early abstinence syndrome and protracted abstinence. Also, they should learn how their secondary substance of choice has an important role in relation to relapse to stimulant use. They require education about the biopsychosocial processes of addiction, treatment, and recovery. They should also learn about the stages of treatment and recovery, as well as the specific tasks, goals, and pitfalls of each.

**Teach Basic Conditioning**

Although many clients with stimulant use disorders in early treatment phases have poor retention of information and temporary cognitive deficits, they can understand basic information about cues and triggers. They can be taught how conditioning factors can elicit drug cravings and urges, that these cravings and urges are a natural part of early abstinence, and that there are methods to deal with them. Clients with stimulant use disorders should be provided with basic education about the conditioning process and how this process is applied to their disorder.
These educational efforts should describe basic conditioning factors related to stimulant use as described in Figure 4-3.

Identify Cues and Triggers
Stimulant (and secondary substance) use becomes strongly associated with certain people, places, objects, activities, behaviors, and feelings. Because clients with stimulant use disorders may have engaged in stimulant use hundreds or thousands of times, their daily life is filled with numerous reminders or cues that can trigger stimulant cravings and stimulant use. Although it is common for many clients to have some of the same cues and reminders, such as seeing the drug or the dealer, there are wide differences among clients regarding the specific type, strength, and number of cues. Accordingly, it is important for counselors to help clients to acknowledge and identify the cluster of cues unique to their lives.

The primary tasks here are to teach clients how cues are developed and how these cues can trigger drug craving and use, and to encourage them to actively identify their cues and triggers. This can be accomplished through exercises and worksheets. Client Worksheet 2, Identifying External Cues and Triggers, and Client Worksheet 3, Identifying Internal Triggers, can be the basis of exercises to help clients accomplish these tasks.

Develop Action Plan For Cues and Triggers
External and internal cues often pervade every aspect of stimulant users' lives. As a result, clients should develop action plans with specific behavioral and mental steps to prevent cues from becoming triggers. They should be taught to avoid, wherever possible, external cues that strongly remind them of stimulant use. They should be taught to leave situations that are making them think about stimulants or experience cravings. They should be taught specific techniques to stop drug thoughts from becoming drug cravings. Finally, they should be taught immediately achievable techniques that can defuse stimulant cravings from leading to drug use. Client Worksheet 4, Action Plan for Cues and Triggers, can be a valuable part of such educational efforts.

Enlist Family Participation
Families and significant others should be encouraged to participate in treatment. The family should receive education about the addictive process, its role in the process, and its role in the treatment and recovery processes. Family members also need information about the effects of stimulants on the brain and behavior in order to understand the stimulant-induced behavior. They should receive a primer on the classical conditioning aspects of stimulant use disorders, and look at cravings as a conditioned response.

The information should be clear and simple, and not too conceptual or abstract. The ideal format is a group psychoeducational session, consisting of a brief didactic session, followed by a video and a group discussion. The process should help to elicit discussions and examples about how what they heard and saw applies to them. Also, family participation can be an opportunity to do an informal evaluation of the substance use disorders of other family members. Through this process, program staff members may be able to identify certain treatment needs, which may require treatment or referral.

For clients who are actively working on achieving abstinence and who have a stable marriage or relationship with someone who is not using stimulants, involving the spouse and client in couples or relationship counseling can be valuable. This strategy can help to improve communication skills and the relationship. Research has shown that marital and relationship counseling can have positive effects on substance treatment (Landry, 1995; Stanton and Shadish, 1997). If relationship counseling is considered, the significant other must not have problems with substance use (excepting nicotine), and the significant other must agree with the basic treatment goals of abstinence and be willing to engage in behaviors that support sobriety. Some research results related to behavioral relationship therapy are presented in Figure 4-4.

Establish Social Support Systems
Clients with stimulant use disorders, especially during the early phases of abstinence, seem to have low frustration tolerance and appear to be restless in group sessions. But as soon as clients are able to do so (generally within a few days), they should be introduced to a structured and therapeutic group process, such as a beginner's recovery group. These groups can provide a preexisting support network and a forum for openly talking about early abstinence problems. At the same time, participation in 12-Step meetings, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Cocaine Anonymous (CA), should be strongly encouraged. Clients can be given the short-term goal of attending ninety 12-Step meetings in 90 days.

Also, clients can be encouraged to establish or reestablish relationships with nonsubstance-using friends and
family and, perhaps, to establish a “buddy system” with a healthy family member, friend, or 12-Step sponsor to call during crises.

**Address Stimulant Use-Associated Compulsive Sexual Behaviors**

Some clients with stimulant use disorders develop significant stimulant-induced compulsive sexual behaviors. These can include compulsive masturbation, compulsive or impulsive sex with prostitutes, and compulsive pornographic viewing. For these clients, interventions can be conducted, the result of which is to decrease the likelihood of both the compulsive sexual behaviors and stimulant relapse.

A first step involves asking clients to agree to a temporary sex abstinence plan for 2 to 4 weeks. Next, clients should be made aware that sexual feelings, thoughts, and fantasies are conceptualized as very high-risk triggers that will be acted out if they are not talked out. For people who have this problem, even normal, routine sexual thoughts and contacts can quickly become major triggers.

Programs should provide a safe environment for such clients to talk about these issues, either within the context of a group session or individual counseling. Discussions should be held about safe and unsafe sexual behaviors in regard to relapse prevention. Specific and clear recommendations should include not having sex with anyone with whom the client has gotten high, and not pursuing sex with anonymous or unknown partners. Client fears should be addressed, such as the fear that sex without drugs will be boring or impossible.

Many of the avoidance strategies used with psychoactive substances can be employed for these clients in relation to sexual cues. For some clients, the sexual behavior has a higher reinforcing effect than the stimulant.

Clients will need reminders to stay away from people, places, and things related to sexual behaviors. These can include porno shops, certain streets with prostitutes, and video shops. Also, clients should be educated about reciprocal relapse, in which one compulsive behavior is inextricably involved with another, and therefore, engaging in the behaviors associated with one condition can cause one to act out behaviors associated with the other condition.

**Respond to Early Slips**

It is rare for clients to go from active, full-blown stimulant addiction to complete abstinence. Rather, most clients go through a phase during which there are days without substance use and occasional days with substance use. In fact, substance use during this early transition from abusive or dependent use to abstinence should not be considered relapse because there was not a genuine period of abstinence from which to relapse.

Thus, substance use during this period of transition should not be characterized as relapse but rather as difficulty in breaking the pattern of stimulant use. Also, clients should understand that substance use is normal during this difficult phase, despite their hard efforts to the contrary. Program staff members should understand that substance use during this phase is not a sign of poor motivation but reflects multiple processes, including cues and triggers and a not-yet-stable brain. Slips can also be thought of as a behavioral indicator of conflict and ambivalence about stopping. At the same time, counselors should clearly communicate that they are not giving clients permission to use. Rather, they are making efforts to keep the client engaged in treatment.

Early slips should be considered opportunities for adjusting the treatment plan and trying other strategies. They can be opportunities for gaining an appreciation of the strength of cravings and triggers, and learning new methods to handle them. They can be an opportunity to examine if the treatment plan is adequate and appropriate or to increase the frequency of contact with treatment and/or the support system, such as self-help meetings and contacts with the sponsor. Some recommendations for guiding group discussions of slips are listed in Figure 4-5.

Early slips should not be considered as tragic failures but rather as mistakes. When slips occur, counselors can make a verbal or behavioral contract with clients regarding short-term achievable goals. This can include such simple tasks as agreeing not to use psychoactive substances for the next 24 hours, to attend a specific number of clinic sessions over the next couple of days, and to bring a significant other to treatment the next day. This process can involve having the client identify areas that need to be addressed or enhanced. It may be important to take a closer look at cues and triggers and determine if anything has changed.

**Strategies To Maintain Abstinence**

Many stimulant users can discontinue the use of cocaine or MA for periods of time without the assistance of treatment involvement. As previously mentioned, "withdrawal" is a less important consideration for stimulant users than it is for users of substances that produce a physically uncomfortable withdrawal, such as opiates, alcohol,
and benzodiazepines. For stimulant users, the trick is not in stopping, but in staying off, or avoiding relapse. In the treatment of stimulant users, achieving abstinence is the "warm-up act"; sustaining abstinence is "the main event."

The dichotomy between strategies to achieve abstinence and strategies to maintain abstinence is somewhat artificial and arbitrary because many of the same principles apply and many of the same techniques are used over the course of treatment. However, there are some issues that appear to increase in importance over the 1- to 4-month period typically needed for learning how to maintain abstinence. These are discussed below.

Protracted Withdrawal Symptoms

Once stimulant use is discontinued and a client’s sleeping and eating habits are normalized, the majority of symptoms described as the "crash" typically lessens. However, the resolution of the crash symptoms does not signal that the brain is back to normal. Clinical observations show that there are significant biological and psychological symptoms that continue to hamper the functioning of stimulant users 90 to 120 days after discontinuation of substance use. The symptoms described include a mild dysphoria, difficulty concentrating, anhedonia, lack of energy, short-term memory disturbance, and irritability.

The existence of these "protracted withdrawal" symptoms has been the subject of some debate. Recently, evidence from positron emission tomography (PET) scan research has provided tangible evidence in monkeys that MA use produces very significant changes in brain functioning that last for more than 6 months (Melega, 1997a). The brain areas involved and the neurochemical deficits observed in these PET scans are consistent with the clinical symptomatology of this "protracted withdrawal syndrome." Although there is still reason to be cautious about specifying the precise cause or time course of this syndrome, there does appear to be neurophysiological evidence to support the factual basis of this phenomenon.

Predictable Relapse Scenarios

There are a number of common patterns to the relapse episodes of stimulant users who are attempting to maintain abstinence (Havassy et al., 1993). These include

- **Alcohol/secondary substance use leading to stimulant relapse.** Several studies have reported on the relationship between alcohol use and cocaine relapse, and other reports have supported this same pattern with alcohol and marijuana for MA relapse (Rawson, 1986; Carroll et al., 1993a, 1993b).

- **Return to substance-using friends.** The Panel’s clinical experience suggests that returning to substance-using friends is a primary reason for a stimulant user’s relapse.

- **Sexual behavior associated with substance use.** Particularly for men, sexual behaviors especially associated with stimulant use (e.g., prostitutes, pornography) are an important element contributing to stimulant relapse (Rawson et al, 1998b).

- **Craving elicited by external and internal stimuli.** The powerful influence of Pavlovian conditioned cues on the production of craving has been reported by many stimulant users as a contributor to stimulant relapse (O’Brien et al., 1993).

- **Negative affective states.** Emotional states can be important antecedents to relapse (Havassy et al., 1993). Stimulant users find anger, depression, loneliness, frustration, and boredom quite difficult to manage, and these feelings can initiate a behavioral sequence that ends in stimulant use.

Need for New Activities

Many stimulant users have spent a good portion of the years leading up to treatment entry with their lives revolving around substance use. Frequently, during the initial 6 to 12 months of abstinence they have little idea what to do with their lives. In particular, they often have very poor social and recreational behavior repertoires. The creation of new, positively reinforcing activities and interests is an important part of this period of treatment.

Abstinence Maintenance Techniques

The strategies recommended for maintaining abstinence draw primarily from the behavioral and cognitive-behavioral models described in Chapter 3. One overall theme in the following materials is that newly abstinent stimulant users can be taught a set of information and skills that can help them avoid relapse. The following strategies have been found to help stimulant users maintain their abstinence.

Teach Functional Analysis Of Stimulant Use
The purpose of functional analysis is to teach clients how to understand their stimulant use so that they can engage in problem-solving solutions that will reduce the probability of future stimulant use. The core components of a functional analysis are (1) teaching clients to examine the types of circumstances, situations, thoughts, and feelings that increase the likelihood that they will use stimulants; (2) counseling clients to examine the positive, immediate, but short-term consequences of their stimulant use; and (3) encouraging clients to review the negative and often delayed consequences of their stimulant use. Client Worksheet 29, Components of a Functional Analysis, gives clients an overview of these components.

Maintain Positive Reinforcement

Employing contingency management agreements can help sustain initial treatment gains. When contingency management is used, the behavioral contract must be based on objective criteria such as urinalysis results and attendance at group therapy sessions. All specifics must be clearly detailed in the written contract. Systematic and consistent implementation of the agreement is crucial: Reinforcement must be delivered promptly when the contract is satisfied and withheld when it is not. Frequent, positive reinforcement of success is critical.

Client Worksheet 28, Sample Behavioral Contract for Stimulant Abstinence, can be modified and used to help meet the treatment needs of specific clients. As this sample contract illustrates, contingency management can involve receiving "points," credits, money, or other benefits or incentives.

Relapse Prevention Techniques

Relapse prevention techniques teach clients to recognize high-risk situations for substance use, to implement coping strategies when confronted with high-risk events, and to apply strategies to prevent a full-blown relapse should an episode of substance use occur (Marlatt and Gordon, 1985). The techniques involve several cognitive-behavioral interventions that focus on skills training, cognitive reframing, and lifestyle modification.

Relapse prevention techniques fall into several categories:

- Psychoeducation about the relapse process and how to interrupt it
- Identification of high-risk situations and relapse warning signs
- Developing coping and stress management skills
- Enhancing self-efficacy in dealing with potential relapse situations
- Counteracting euphoric recall and the desire to test control over use
- Developing a balanced lifestyle that includes healthy leisure and recreation activities
- Responding safely to slips to avoid escalation into full-blown relapse
- Establishing behavioral accountability for slips and relapse via urine monitoring and/or Breathalyzer® testing

As reviewed in the previous chapter, there is a substantial body of literature on the use of relapse prevention techniques with stimulant users. The manual developed by Kathleen Carroll provides an excellent set of relapse prevention exercises, which can be directly applied in treatment settings (Carroll, 1996). The Matrix manual (Rawson et al., 1991b) previously described has a section on conducting relapse prevention training in a group setting and supplies handouts and instructions for their use. Washton has published a set of relapse prevention materials that can be easily incorporated into treatment programming (Washton, 1990a, 1990b). Also, Figure 4-6 sets out basic precepts to be used in addressing relapse. The following treatment themes are critical to the relapse prevention-based treatment strategies.

Provide Psychoeducation About Relapse Prevention

One major element of a relapse prevention approach is the delivery of information to stimulant users about a variety of use-related topics. One frequently used format for delivering this information is in psychoeducation groups. These groups consist of a mixture of education, peer support, and recovery-oriented therapy. The group leader provides a brief discussion or shows a short videotape on a specific topic that is relevant to the group participants. The group members are encouraged to discuss the topic as it is personally relevant to them. Also, the group leader encourages group members to discuss the problems, challenges, and successes that they are currently experiencing.

The topics typically discussed in a psychoeducation group for clients with stimulant use disorders include
Cravings and conditioning
Protracted abstinence
Stimulants and the brain
Identification of high-risk situations
Developing coping and stress management skills
Enhancing self-efficacy in dealing with relapse-risky situations
Counteracting euphoria and the desire to test control over use
Developing a balanced lifestyle
Responding safely to slips to avoid escalation
Establishing behavioral accountability

Many of these are addressed in the sections below. Some recommendations for running a relapse prevention group are presented in Figure 4-7.

Address High-Risk Situations

During the previous phase of establishing abstinence, clients should have learned skills for negotiating high-risk situations. In particular, clients should be able to identify cues and triggers, develop action plans for cues and triggers, and deal with early abstinence symptoms.

Enhance Self-Efficacy Regarding High-Risk Situations

Once clients learn to identify, manage, and avoid high-risk situations, the counselor and client should try to determine if the client is confident in her ability to use those skills in the real world. It is important to evaluate and have clients engage in self-evaluation to determine if they are overconfident regarding their avoidance and refusal skills, and to determine if they actually have more skills than they imagine. Client Worksheet 11, Evaluating Your Self-Efficacy Regarding Relapse, can help clients to evaluate how they think they would handle certain high-risk situations that they cannot avoid. Similarly, Client Worksheet 12, Increasing Your Self-Efficacy, involves role-playing exercises designed to simulate real-world high-risk situations and to increase the client's self-efficacy.

Counteract Euphoric Recall And the Desire To Test Control

Two important risk factors for stimulant relapse are euphoric recall and the desire to test control over stimulant use. Euphoric recall is the act of remembering only the pleasures associated with stimulant use and not the adverse consequences. Euphoric recall is a potent relapse risk factor because it minimizes clients' perceptions of stimulants' danger, promoting an ambivalence about quitting. For these reasons, so-called "war stories" that include euphoric recall and selective memory are powerful relapse triggers and should be strongly discouraged in recovery groups. Client Worksheet 18, Selective Memory About Stimulant Use, can help clients to explore this issue.

After beginning to feel healthier, more in control of their lives, and free of some of their stimulant-related problems, some clients feel that they are ready to try a new approach to stimulant use. For example, some may feel that if they are "careful," they can use stimulants without losing control over their use. Others may feel that this is a good time to try using stimulants "one last time," just to see if they can do it without escalating into compulsive use and loss of control. Clients should be taught that urges to test their control over stimulant use are a powerful relapse warning sign. Client Worksheet 19, Fantasies About Controlled Use, can be part of psychoeducation efforts designed to recognize these fantasies as warning signs that need to be addressed. Also, Client Worksheet 20, Those Ugly Reminders, can help clients make lists of negative consequences of stimulant use, which can be reviewed when they experience cravings, fantasize about controlled use, or romanticize their experiences with stimulants.

Respond to Slips To Avoid Escalation

Stimulant slips and relapses are mistakes, not failures, and indicate a need to adjust the treatment plan. After a slip, a relapse-specific session should be scheduled as rapidly as possible. The counselor should reassure clients that he has not given up on them. Counselors and clients together review and analyze the events leading up to the slip and identify which warning signs were present. Clients should be encouraged to consider the events of the previous few weeks, such as changes at work, at school, in social networks, or in family situations. Similarly,
they should closely examine events and issues that occurred in treatment, such as getting new counselors, moving from one phase of treatment to another, or events happening to another client.

Clients should be helped to identify specific steps that can be taken to avoid future relapses in the event that a similar set of circumstances recurs. Most importantly, slips and relapses should prompt revisions in the treatment plan. Such revisions may include increasing the number of self-help meetings, participating in individual counseling for a brief period of time, or obtaining a 12-Step sponsor. Also, clients should receive recommendations and guidance to handle the negative thoughts and feelings caused by slips. Client Worksheet 7, Permission to Relapse, is a useful client handout for this purpose.

Teach Drug Refusal and Coping Skills Training

Stimulant users in recovery are often surrounded by individuals who continue to use: dealers, neighbors, friends, or family members. The ability to refuse stimulants when offered requires a special type of assertiveness, hence the need for a special type of assertiveness training. Drug refusal training reminds clients that individuals offering them stimulants do not have the client's best interests in mind. Rather, clients are taught to think of such individuals (even if friends or family members) as “drug pushers” who must be discouraged. Clients are taught that their primary goal is to refuse offers of stimulants. They are taught that their secondary goals are to reinforce their commitments to not use and to feel good about themselves for doing it.

This approach emphasizes the following elements that should be incorporated into encounters with individuals offering stimulants or inviting the client into high-risk situations.

- The first thing that should be said to the person making an offer of stimulants is "No."
- The person making the offer should be clearly told not to make such offers now or in the future.
- The client should make good eye contact and adopt an expression and tone that clearly indicates the seriousness of the request.
- Offer an alternative and healthy activity if the client wants to be with the individual (such as taking the children for a walk or going to a workout).
- Change the subject to a new topic of conversation.

In this approach, the counselor guides the client through three scenarios involving specific individuals, specific times of the day, and specific situations. Based on these scenarios, the client and counselor engage in role-playing exercises so that the client can practice these behaviors. Furthermore, clients are encouraged to engage in additional role-playing exercises with significant others or other appropriate people.

Other Strategies Useful in Maintaining Abstinence

Provide Relationship Counseling

The overall goal of relationship counseling is to develop effective communication skills to help couples achieve and maintain abstinence, change their lifestyle, increase enjoyment in their relationship, and learn better ways to problem solve. Specific exercises for conducting these sessions can be found in the Community Reinforcement Approach Manual (Budney and Higgins, 1998).

Provide Social and Recreational Counseling

These treatment exercises are designed to increase participation in prosocial activities that may serve as alternatives to stimulant use. This includes helping clients to develop interests and participate in recreational and social activities that do not involve stimulant or other substance use. Potential activities can be evaluated by the counselor and client according to how interesting they are to the client, how costly, to what degree they involve others, how much time they require, how likely the client is to engage in them, and how much physical exertion they require. Potential coparticipants are identified. The next step involves the development of an action plan to identify the specific steps necessary to engage in the activities. These should be incorporated into the treatment plan. Examples of these exercises are included in several of the aforementioned manuals.

Provide Social Skills Training

The social skills training efforts are used to help clients learn and practice skills that will facilitate nonsubstance alternatives for socializing, recreating, and coping with stressful interpersonal situations. The goal is to help clients experience more positive reinforcing effects and fewer negative, adversive effects from social interactions. The
training can be especially helpful for clients who have problems meeting nonsubstance-using peers or interacting with coworkers, and who feel uncomfortable in social settings. Social skills training techniques have been developed for anger management, anxiety in social situations, initiating pleasant conversations, and assertiveness training (Alberti and Emmons, 1982; Chaney, 1989; Monti et al., 1995).

Provide Vocational Counseling
This counseling is focused on helping unemployed clients locate a job, and helping improve the employment situations of clients with unsatisfactory jobs or jobs that are high-risk for relapse.

Promote a Balanced Lifestyle
Treatment, recovery, and relapse prevention efforts should address biological, psychological, social, and spiritual areas of life. Clients should be taught the value of recreational and leisure activities and how to incorporate them into their recovery program. Many recreational activities can offer opportunities for clients to learn or practice social skills, such as cooperation, teamwork, healthy competition, and leadership.

Vigorous physical exercise helps clients feel good about themselves, decreases anxiety and depression, increases appetite, and often helps clients sleep better. Clients should be taught the value of regular aerobic exercise and how to incorporate it into their daily or weekly schedule. Clients should be provided with a variety of options for exercise, such as dancing, walking, biking, jogging, tennis, swimming, skating, aerobics, and weightlifting. Client Worksheet 23, Exercise and Recovery, and Client Worksheet 24, Examples of Exercise Activities, can help clients understand the value of exercise in their recovery, review potential types of exercises, and learn to incorporate exercise into their recovery program.

Many clients in treatment for substance use disorders have problems related to nutrition and diet. Stimulants decrease appetite, leading to decreases in the intake of calories and nutrition. Clients with stimulant use disorders eat insufficiently, and when they do eat, often eat impulsively and eat foods with negligible nutritional value. As a result, these clients should receive a formal nutritional assessment conducted by a nutritionist as well as guidance regarding eating a nutritionally balanced diet, discarding patterns of infrequent and impulsive eating, and learning to plan and schedule nutritionally appropriate meals. Client Worksheet 25, Nutritional Self-Assessment, can help clients evaluate their own unhealthy patterns of eating and need for structure regarding nutrition.

Monitoring Disulfiram For Alcohol/Cocaine
In the Community Reinforcement Approach, all clients who meet the diagnostic criteria for alcohol dependence or who report that alcohol use causes problems in their attempts to achieve abstinence from stimulant use are offered disulfiram therapy. A typical disulfiram dose is 250 mg/daily unless the client reports being able to consume alcohol at that dose without a reaction. In such situations, the dose is increased to 500 mg. Disulfiram ingestion is observed by clinical staff members when clients come for urinalysis monitoring. Take-home doses are provided for the other days. (See Figure 4-8 for related research on disulfiram therapy.)

The Role of Self-Help Strategies
Self-help strategies can be valuable components of all phases of treatment. Self-help strategies, especially those that focus on substance use, are especially valuable as ancillary activities that support the treatment goals of maintaining abstinence. In general, self-help programs help clients to develop appropriate social skills, create healthy social networks, establish healthy intimate relationships, and engage in substance-free healthy activities. They also provide opportunities to learn socially appropriate mores and norms, how to receive and give advice, and how to mentor others.

The most frequently used and available self-help strategy is the 12-Step approach. It is the rare city that does not have many AA group meetings every day, and most larger cities have numerous CA and NA meetings. Clients should be provided with information regarding the 12-Step process, such as meeting format, the spiritual component, the basic content and meaning of the 12 Steps, the role of the 12-Step sponsor, and the role of anonymity.

Although the Consensus Panel recommends participation in a 12-Step group, providers should not require clients’ participation. Rather, it is better to encourage and recommend 12-Step participation, especially because 12-Step programs are self-described as voluntary self-help programs of recovery. Similarly, family members of clients should be encouraged to participate in 12-Step programs designed for family members, such as Al-Anon. Such encouragement can be provided by having meetings on site. Both clients and family members should receive lists with the addresses and times of meetings, and provide transportation when necessary.
Also, self-help strategies other than the 12-Step programs can be valuable components of treatment. Some are specifically related to substance use, such as Rational Recovery, Save Our Selves, and Women in Sobriety. These may be particularly helpful for individuals who are reluctant to participate in the 12-Step programs. These include such activities as church-related groups, cancer survivor groups, and domestic violence groups. Some research findings on AA are shown in Figure 4-9.

The Role of Psychodynamic Therapy

Substance use counseling generally consists of therapeutic efforts that focus primarily on solving present-day problems that interfere with abstinence and recovery. Although there is variation, counseling generally focuses on current issues and involves advice, guidance, and encouragement. It is typically conducted in group formats.

In contrast, psychodynamic therapy, typically conducted in individual session formats, focuses on intrapsychic processes that impair effective coping and damage relations. Psychodynamic therapies differ greatly, but when used in substance use disorder treatment, they often assume that substance use is at least in part a strategy to self-medicate problems or a coping mechanism to deal with such problems as trauma, victimization, and low self-esteem.

Views differ regarding the appropriateness of individual psychodynamic therapy for clients with stimulant use disorders. As a result, the Consensus Panel makes the following recommendations. First, clients should be thoroughly evaluated to determine their need for this type of treatment. Are the client's individual treatment needs elicited through the treatment planning process best met by individual psychodynamic therapy or by providing basic skills to maintain abstinence? Second, clients should be thoroughly evaluated with regard to their readiness for psychodynamic therapy. Because psychotherapy can stimulate feelings and thoughts that may provoke relapse triggers, clients should be evaluated regarding their readiness to handle such triggers. Do clients have the emotional stability, relapse prevention skills, and social supports to handle this therapy? Third, if individual psychotherapy is introduced, it should be consistent and coordinated with other treatment strategies, especially group counseling and self-help involvement. For example, psychotherapy oriented to the stages of recovery can be especially useful (Wallace, 1992).

Overall, the Consensus Panel suggests that not all clients with stimulant use disorders are appropriate for, need, or want individual psychotherapy to establish or maintain abstinence. When provided, there should be an explicit treatment need, the client should have the requisite skills, and the therapy should support abstinence.

Next Steps

Because treatment should be based on the individual client's unique needs, the length of treatment should not be dictated by the number of weeks in the program. In particular, termination of the abstinence maintenance phase of treatment should be based specifically on achieving the treatment goals documented in clients' treatment plans.

The end of the abstinence maintenance phase is a good opportunity to help clients review their treatment experiences. Counselors should engage in activities and exercises that help clients to critically examine their treatment successes, the areas where they experienced problems, and the ways in which they addressed these problems. Similarly, counselors should help clients to evaluate the strength of their current recovery program and identify areas where they need strengthening. Through this process, the counselor and client should develop a continuing-care treatment plan that identifies remaining treatment needs and strategies that will be used to meet those needs.

Termination of the abstinence maintenance phase of treatment should be a transition to a lower level of care, not a termination per se. Abrupt termination should be avoided. Rather, programs should have or develop strategies that allow and encourage clients to remain connected with the program. Furthermore, programs should develop strategies that specifically educate clients about the continuing care treatment services available to them and that actively encourage clients to utilize these services. Ways in which programs can help clients to remain in contact with the program include:

- Continuing care or aftercare group meetings--which clients can attend weekly or more often as needed
- Individual counseling or psychotherapy--which can be made available to clients on an as needed basis
- Family therapy--made available to clients and their families, and to families without the client, such as during relapse episodes
- Clean and sober alternative activities--focusing on recreation, leisure, education, and social activities (e.g., dances, field trips, summer barbecues, picnics, holiday events, lectures on topics not necessarily related to treatment or recovery)
- Treatment program alumni meetings--such as quarterly meetings during which all program graduates are invited
- Treatment program alumni clubs--in which programs sponsor and encourage regional groups of alumni to have regular meetings and events (programs can provide speakers on motivational and educational issues)
- Peer mentoring programs--in which program alumni help newly arriving clients by sharing experiences, advice, and program expectations
- Surveys and newsletters mailed to program alumni as a way to collect posttreatment data, to encourage participation in alumni activities, and to encourage contact with program, especially during times of need
Boxes

Figure 4-1: Schedule Appointments Quickly
Making an appointment within 24 hours of initial phone contact significantly increases the likelihood of showing up for an initial appointment (Festinger et al., 1995, 1996; Stark, 1992; Stark et al., 1990). Such research suggests that an accelerated intake is a low-cost and effective method of reducing the high attrition rates commonly observed between the initial clinical contact and intake interview.

Figure 4-2: Treatment Duration, Frequency, and Format

- Research has not yet demonstrated the optimal duration, frequency, and format of treatment for stimulant addiction (Higgins and Wong, 1998). Some research suggests that longer treatment durations of 6 or 12 months are associated with better outcomes for cocaine-dependent individuals (Carroll et al., 1993a; Higgins et al., 1993a; Wells et al., 1994), but the research is not consistent and has not evaluated MA treatment.

- Experience suggests that the duration of the initiating treatment is a minimum of several weeks. Most stimulant-dependent clients require 2 to 4 weeks to establish an initial period of abstinence and to overcome certain cognitive impairments. It is common for programs to encourage frequent visits during the first 2 to 4 weeks of treatment followed by less frequent visits.

- For clients with stimulant use disorders during this phase, the frequency of visits or sessions seems to be more important than their length. For example, three or four weekly visits of approximately 30 minutes appear to be more beneficial than fewer weekly visits that last longer. There is no evidence that clinic visits lasting more than 90 minutes are more effective than shorter visits. The greater frequency of clinic visits can help to establish behavioral accountability, contain impulses, and create daily structure.

- In practice, the most common format for stimulant use disorder treatment is group rather than individual therapies. Experience suggests that stimulant-dependent clients are capable of full participation in group-oriented therapies, although their low tolerance for frustration may make lengthy group sessions onerous. However, clients who are still paranoid and distrustful of others may not be willing to participate in group therapy, but may be willing to participate in individual counseling as an initial strategy and bridge into group treatment.
Figure 4-3: Basic Conditioning Factors in Stimulant Use

- Stimulant cravings are the predictable results of chronic stimulant use and typically continue long after the stimulant use is stopped.
- Stimulant cravings can be triggered by people, places, situations, things, and feelings that were previously associated with stimulant use. Anything that reminds clients of stimulant use can be a trigger for stimulant cravings.
- Stimulant cravings are typically strong during the early abstinence period and become less frequent and severe over time. They lose their power only when not reinforced by stimulant use.
- The strength of cravings does not diminish merely through the passage of time but because clients do not give into to the cravings when they occur.
- Complete abstinence from all psychoactive drugs is the best way to ensure the most rapid and complete extinction of stimulant cravings.
- Determination and willpower are poor defenses against cravings. Rather, specific actions must be taken to counteract cravings and urges whenever they occur.
- Cravings and urges are always temporary. They are usually fleeting sensations lasting no more than a few minutes and tend to disappear quickly when immediate action is taken to remove oneself from the situation that has prompted the craving.

Source: Adapted with permission from Washton, 1989, p. 107.

Figure 4-4: Related Research: Behavioral Relationship Therapy

A review of research evidence regarding behavioral relationship therapy and substance use disorder treatment outcomes (Landry, 1995) noted that

- Behavioral relationship therapy can improve the quality of interpersonal relationships, promote rapid reductions in substance use, enhance maintenance of sobriety, enhance treatment outcomes, and decrease the probability of treatment dropout. Relationship therapy both during and following treatment improves treatment outcomes.
- Spouse involvement in treatment yields better results than treatment without spouse involvement. Unilateral treatment of the spouse with the person with the substance use disorder has been found to increase the client's motivation for treatment.

Similarly, a meta-analysis of controlled studies that compared family therapy with other therapy approaches to substance use disorder treatment (Stanton and Shadish, 1997) noted that

- Family therapy was more effective and had higher retention rates than individual counseling or therapy, peer group therapy, and family psychoeducation.

Figure 4-5: Responding to Slips in Group Sessions

- Ask the person to provide a detailed account of the sequence of feelings, events, and circumstances that led to the slip.
- Encourage group members to ask the person for further details, and to help him identify early warning signs and self-sabotaging behaviors.
- Encourage group members to state their concerns for the individual.
- Encourage group members to offer advice and recommendations about preventing further slips.
- Ask the person to discuss his thoughts and feelings about what has been said in the group and what he intends to do differently.
Figure 4-6: Addressing Relapse

An integral aspect of relapse prevention involves eliminating and correcting dangerous myths and misconceptions regarding the process of relapse and the appropriate treatment response to it. The Consensus Panel recommends that the following concepts be incorporated into educational efforts for clients, counselors, and nonclinical staff members.

- Relapse is not necessarily a sign of poor motivation. Although relapse can be a sign of extreme ambivalence or poor motivation to quit using stimulants, even the most highly motivated and sincere clients can relapse. Relapse is a sign that something is wrong with the client's recovery plan, not with the client.

- Relapse is not a sign of treatment failure. It is a temporary interruption in the client's abstinence. It means that the client's recovery plan is incomplete and is a signal that the client is doing something that he shouldn't do, or that the client should be doing something that he isn't.

- Relapse is predictable and avoidable; rarely is it unpredictable. It is preceded by warning signs that the counselor and client should be trained to identify. It is the endpoint of a progression of attitudes and behaviors. It is interruptible and preventable.

- Relapse is not a single event invariably involving drug use. Rather, relapse is a process, as is addiction, treatment, and recovery. It has a beginning, a midpoint, and an end. Returning to drug use is the endpoint, not the beginning of the process.

- Relapse does not erase positive recovery changes. Clients need not "start over" but should avoid further drug use, remain in treatment, resume the recovery process where last left off, and enhance the treatment plan to avoid future relapses. A temporary setback can provide invaluable information about weaknesses in the treatment plan and suggest ways to prevent it from recurring in the future.

- The absence of relapse does not guarantee successful recovery. Abstinence is an opportunity to recover but is not a guarantee of recovery. Many clients who experience relapse make tremendous strides in personal growth and maturity, although some clients with uninterrupted abstinence never experience substantial changes or achieve lasting growth. Abstinence is an important first step in the recovery process but is not the final goal.

Source: Adapted with permission from Washton, 1989.

Figure 4-7: Recommendations for Running a Relapse Prevention Group

- A relapse prevention group is a forum for clients to create a program of recovery and relapse prevention. The group provides a setting for sharing information about relapse and relapse prevention and spotting signs of impending relapse. Clients heading toward relapse can be redirected, whereas those who are on a good course can be encouraged. The group setting allows for mutual client assistance within the guiding constraints of the group leader.

- A group can be led by a therapist group leader and a recovering coleader. Ideally, the group leader also sees group members for individual sessions. The group leader must be clearly, actively, and unquestionably in control of the group and is responsible for setting the time limits and ensuring that all group members have opportunities to speak. The coleader can answer questions about and be an example of long-term sobriety.

- The group meeting begins with an introduction of new members, who are asked to give a brief history of their drug use.

- Following introductions, the group leader gives a casual and didactic presentation on a specific topic for approximately 15 minutes and/or presents an equally brief video.

- Next, relapse and recovery are discussed among the group members for approximately 45 minutes.

- For the next 30 minutes, the group leader elicits from the group members any recent problems that
they want to discuss. Quiet and uncommunicative members are encouraged to talk about how they are feeling.

- At the end of the group session, the group leader ties up loose ends and summarizes the discussion. Unresolved issues may be acknowledged, and discussions can be carried over to the next scheduled meeting. Clients who appear troubled, angry, or depressed, and those who mentioned cravings can be asked to remain. The group leader and coleader can encourage such individuals to speak with their therapist as soon as possible. All sessions should end with a confidentiality pledge and a commitment to attending the next group session.


**Figure 4-8: Related Research: Disulfiram Therapy**

An uncontrolled study by Higgins et al. (1993a) noted that supervised disulfiram therapy was associated with significant decreases in alcohol and cocaine use among outpatients with cocaine-related disorders. A subsequent controlled trial by Carroll et al. (1993b) provided support that disulfiram therapy can reduce cocaine and alcohol use in outpatients who use both substances.

**Figure 4-9: Related Research: Alcoholics Anonymous (AA)**

A comprehensive review of the research on AA reveals several important findings:

- Research demonstrates a strong association between AA participation that occurs during or following professional treatment and improvements in drinking behaviors and abstinence.

- Research suggests a strong association between increased frequency in attending AA meetings and improvements in drinking behavior measures, such as abstinence and decreases in alcohol consumption.

- Research suggests a modest association between increased participation in and affiliation with AA (such as obtaining or becoming a sponsor) and improvements in drinking behavior measures, such as abstinence, decreased drinking, and decreased relapse.

- Research suggests modest associations between AA participation and improvements in several areas of psychosocial functioning.

Source: Landry, in press.

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