Chapter 8

Strengths and Evidence Based Helping Strategies
## Two Approaches to Treatment

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Strengths-based</th>
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<tbody>
<tr>
<td><strong>Bio</strong></td>
<td><strong>Bio</strong></td>
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<tr>
<td>Looks to individual for cause</td>
<td>Multiple, interactive levels of influence</td>
</tr>
<tr>
<td>Dichotomy: Alcoholic vs nonalcoholic</td>
<td>Behaviors along a continuum</td>
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<tr>
<td><strong>Psycho</strong></td>
<td><strong>Psycho</strong></td>
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<tr>
<td>Problem focused</td>
<td>Strengths – possibilities</td>
</tr>
<tr>
<td>Labels: alcoholic &amp; codependent</td>
<td>Avoid negative labels</td>
</tr>
<tr>
<td>One size fits all</td>
<td>Individualized</td>
</tr>
<tr>
<td>Motivation irrelevant</td>
<td>Intervention; where client is at</td>
</tr>
<tr>
<td>Client seen as resistant / in denial</td>
<td>Client active participant; collaborate</td>
</tr>
<tr>
<td>Focus to prevent slip / relapse</td>
<td>Focus on moderations or abstinence</td>
</tr>
<tr>
<td>Expulsion from program for use</td>
<td>Meet client where they are at</td>
</tr>
<tr>
<td>Confrontation</td>
<td>Rolls with resistance</td>
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<tr>
<td><strong>Social</strong></td>
<td><strong>Social</strong></td>
</tr>
<tr>
<td>Identity as member of self help (12-step)</td>
<td>Holistic approach</td>
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<tr>
<td>Identify family dysfunction</td>
<td>Seeks strengths in upbringing</td>
</tr>
<tr>
<td>ID codependence in family members</td>
<td>Family as resource</td>
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</tbody>
</table>
Dennis Saleebey

• “Lexicon of Strengths”
  – Empowerment of individuals and communities
  – Membership or belonging
  – Resilience
  – Healing
  – Wholeness
  – Dialogue and collaboration
  – Suspension of disbelief in what the client says

• “Playing God” avoid the trap
  – Respect client’s ability to manage their own destiny
  – Client’s take responsibility for their choices
    • Use common sense – inform of consequences
3 Tenants of Strength Based

1. Choices—

- Harm reduction / abstinence
- Treatment options
  • out patient
  • intensive out patient
  • residential
  • mutual help

- Treatment methods
  • Cognitive – behavioral
  • 12 step
  • Solution focused
  • Motivational Interviewing

*
2) Providing options
   - Right to choose only helps if you have **options to choose from**
     • Counselor - develop network for referral
3) Pay attention to readiness to change / system to make change
   - Change is seen as a process
   - Relapse is part of recovery (change process)
   - Most in stage 1 & 2 pre-contemplation and contemplation
     • Yet very few treatment approaches for these stages
4 Strength Based Models

1. Harm reduction
   1. Stages of Change
2. Motivational Interviewing
3. Solution Focused
4. Narrative Therapy
1. HARM REDUCTION

• *Any positive change*

• Change that reduces drug related harm
  – Based on public health model of Prevention:
    • Primary - individual
    • Secondary – community (family / peers)
    • Tertiary – society
  • Alleviate social, legal and medical problems associated with use
  • HIV, Hepatitis, tuberculosis, violence, criminal activity, early death
1. HARM REDUCTION

Abstinence **not** precondition to treatment (1 of many means of improving)

1) Quit using

2) If you can’t or won’t stop using drugs, then stop injecting

3) If you can’t or won’t stop injecting, then don’t share needles or syringes

4) If you can’t or won’t stop sharing, then disinfect your needles & syringes

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**Local Needle Exchange**

Stop the spread. Use a sanitary needle instead.
HARM REDUCTION

• Study of opioid dependent clients; only successful if had/were:
  1) motivated to change
  2) stable
  3) social support

• Harm reduction
  1) Few methadone clinics
     • usually large cities
     • strict state & federal government rules
  2) Use is secondary to consequences of use
  3) Began due to HIV and needles
  4) Begin with most pressing
     • Who decides which is most pressing?
       – Cultural; racial and ethnical differences influence goals
     • Focus on
HARM REDUCTION

• Reducing the barriers
  1) Transportation
     – Out-reach sites

  2) Clinician not streetwise (culture / survival)
     – Needle exchange use recovering add
       » knowledge & trust

  3) Waiting lists for intake and treatment
     – Rapid intake

  4) Finances
     – Treatment coupons

  5) Abstinence required goal of treatment
Harm Reduction

• Why important:
  – 1 of 6 adults who inject drugs are in treatment at any given time
  – Less than 10% of substance abusers receive professional treatment
  – 7.2% of youth (7-12) who need alcohol treatment receive it
  – 10% of pathological gamblers will seek treatment

• “Queen of Hearts” Australia

  1. Timely access to counseling
     ➢ Mental health
     ➢ Financial

  2. Access to female counselors
     ➢ Disclose DV / SV
HARM REDUCTION

• Larimer – moderate drinking for some dependent clients
  – Majority of people with drinking problems self-recover w/o treatment.
  – Over time, rate of abstinence (compared to controlled) increases.
  – A choice of goals tends to result in greater tx retention.
  – When given choice:
    • people oten choose goal that is most appropriate for the severity of their problems.
HARM REDUCTION

• Why note this study?
  – Others like it discredited
  – 20% success
    » how do you determine success
  – Drinking in a less-than-catastrophic fashion
  – “For every alcohol addict who may succeed in reestablishing a pattern of controlled drinking, perhaps a dozen will kill themselves trying.”

» Situational excessive use

• College years
• Excessive drinking significant other
• Military
• Divorce
Stages of Change

- Stages of Change; Prochaska and DiClemente; a cyclical process
Stages of Change

• Pre-contemplation (outside the wheel)
  • Not even thinking about change
  • Defensive
Stages of Change

• Contemplation
  • Aware of problems
  • Ambivalent about change
  • Anxiety of what change will mean
Stages of Change

• Preparation
  • Intends to make change
  • Attempted action but failed
  • Gather information
Stages of Change

• Action – (many assume client here)
  • Action to make changes in behavior or environment
  • Abstinent or reducing use
Stages of Change

• Maintenance
  • Understands gains
  • Works to maintain abstinence
Stages of Change

- Relapse –
  - Seen as part of recovery process
  - May happen repeatedly at any stage
  - Can be teachable moment
<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Characteristics</th>
<th>Techniques</th>
</tr>
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</table>
| Pre-contemplation | Not currently considering change: "Ignorance is bliss" | Validate lack of readiness  
Clarify: decision is theirs  
Encourage re-evaluation of current behavior  
Encourage self-exploration, not action  
Explain and personalize the risk |
| Contemplation | Ambivalent about change: "Sitting on the fence"  
Not considering change within next month | Validate lack of readiness  
Clarify: decision is theirs  
Encourage evaluation of pros and cons of behavior change  
ID & promote new, positive outcome expectations |
| Preparation | Some experience with change and are trying to change: "Testing the waters"  
Planning to act within 1 month | Identify and assist in problem solving re: obstacles  
Help patient identify social support  
Verify that patient has underlying skills for behavior change  
Encourage small initial steps |
| Action | Practicing new behavior for 3-6 months | Focus on restructuring cues and social support  
Bolster self-efficacy for dealing with obstacles  
Combat feelings of loss and reiterate long-term benefits |
| Maintenance | Continued commitment to sustaining new behavior  
Post-6 months to 5 years | Plan for follow-up support  
Reinforce internal rewards  
Discuss coping with relapse |
| Relapse | Resumption of old behaviors: "Fall from grace" | Evaluate trigger for relapse  
Reassess motivation and barriers  
Plan stronger coping strategies |
Strength Based Models

- Strength based theories: “3rd wave of treatment”
  - 1st – Pathology- psychodynamic
    » problem is person
  - 2nd – Problem focused – behavioral therapy
    » problem within small interactive systems
  - 3rd – Strength based

Person the problem  Interaction the problem  Problem is the problem
Strength Based Treatment Models

1) **Motivational Interviewing (MI)**
   - Helps client move through change process

2) **Solution Focused Therapy (SFT)**
   - What client is doing differently once change occurs

3) **Narrative Therapy**
   - Change problem soaked story to one of hope & strength
2. Motivational Interviewing

- Motivational Interviewing
  - “just say no” too simple
  - Complex factors:
    - learning
    - conditioning
    - emotion
    - social influence
    - biology

1. Client centered
2. Directive method
3. Enhance intrinsic motivation to change; explore & resolve ambivalence

- Internal accounting of negative consequences of use &
Motivational Interviewing

• Scaling
  – Smoking
    • On a scale of 1-10 to give up smoking, where are you now?
    • If you were to quit, how successful would you be on a scale of 1-10?

• Questions
  – Why did you give yourself a score of 4?
    • Positive reason: “I know bad for my lungs”
  – What would it take to raise your score to 5?
    • “Test is way out of hand now.”
Motivational Interviewing

• 5 MI Steps to enhance motivation:

1. **Express empathy**
   - Warm
   - Respectful
   - Accepting
   - Irrational ideas accepted
   - Ambivalence about change accepted
   - Client is “stuck” not pathological

2. **Develop discrepancy**
   - Create and amplify discrepancies between behavior & goals
   - Reflective listening
Motivational Interviewing

3. **Avoid argumentation**

– Client will “dig in”

– Create your dynamic

• Instead:
Motivational Interviewing

4. Roll with resistance

- Resistance and ambivalence are natural part of the contemplation stage

- “It is really up to you what you would like to do.”
Motivational Interviewing

• Research:
  Brief interventions of 60 min. (or fewer) w/ heavy drinkers
  – 2x more likely to reduce alcohol use.

• Project MATCH
  – MET – (4 sessions)
  – Cognitive Behavioral coping skills – (12 sessions)
  – 12-Step – (12 sessions)
    • Overall – no difference in treatment method
      – Those with low motivation did better in the MET group
  – Long term outcomes (12 Months)
    • After care
      – 35% continued abstinence
      – 65% slipped or relapsed during that period
3. Solution Focused Therapy

Two tenants of Solution Focused Therapy

1. Solving problem more important than finding root cause
2. Clients have ability within themselves and/or social system to make change
Solution Focused Therapy

• Techniques:
  – Miracle question
    • “Suppose a miracle happened & problem is gone; what will be different?”
      – Alcohol: “Wake a ;over, have breakfast with son”
      – Positive outcomes: find the small steps to make a reality
Solution Focused Therapy

• Techniques:
  – Scaling questions
    • Assess motivation; stage of change (MI)
    • Hope
    • Determination
    • Confidence
    • Sadness

  – Coping questions
    • Survival strategies
    • Hope and self efficacy

“You have been through a lot this year with your gambling; how have you coped?”
Solution Focused

• Who does it treat?
  – Gambling
  – Substance use/miss-use
  – Eating disorders

• Environment:
  – Have client define conception of problems & goals to change
  – ID and use client strengths and abilities
  – Client – counselor collaboration throughout treatment
  – Highlighting and promotion of already occurring non-problem behavior
  – Meeting the clients goals
Solution Focused

- Glue sniffer – “Mister Gluehead”
  - Comes to treatment to not get arrested again
  - Counselor; “try sniffing on the back porch”
  - This was successful;
    - started sitting on front
    - liked better
    - reduced use
Solution Focused Therapy

• Helps clinician as well:
  – Less burnout
  – More optimistic
  – Less frustrating than trying to "sell" abstinence to those not buying

Research:
  – No empirical evidence
  – Evidence supports that it works as least as effective as other treatment*
4. Narrative Therapy

- Focuses on the innate strengths and resources
- Patterns of meaning reflected in life histories
- Intense listening
- Narrative-
  - Stories of people’s lives & the difference that can be made through telling & retelling
Narrative Therapy

3 Step Process

1. Externalization –
   - Client and counselor develop name
     - Alcoholic – person oppressed by the alcohol bully
     - Addict – person ground down by meth
2. ID problems effect

- “How long has anorexia been lying to you?”
- “What has your problem gotten you to do that was against your better judgment”
Narrative Therapy

3. Uncover evidence of past competence

- “So what is the longest time you stood up to the “alcohol bully”?”
- Help in rewriting a “new life story” (narrative part)
- “As you continue to stand up to “alcohol bully” how will your life change?”

  • Testimony from others
  • Letters
    - Saying goodbye drug of choice
    - Anti anorexia / bulimia leagues

• Group work emphasize positive & successes
  - Discourage stories of problems and failures
Narrative Therapy

• Research:
  – No empirical evidence
  – Nature of treatment is interpretation
Holistic Measurement of Successful Treatment

• Improvement that might include moderate use.

• Allow clients to choose which issues to focus on:
  – Homelessness
  – Childcare
  – Health issues
  – Employment
Levels of Care

• Prevention –
  – Education – Dare

• Level .5 - Early Intervention-
  – SAP programs
  – Experimental use

• Level I – Outpatient
  – abuse

• Level II – Intensive Out Patient (IOP)
  – Dependence
  – High motivation
  – Able to abstain

• Level III – Inpatient
  – Dependence
  – Low motivation
  – Toxic environment
Levels of Care

• Detox
  – 3-7 days
  – Stabilize; reduce withdrawal symptoms

• Outpatient
  – 1 session per week
  – 20 hours

• Intensive Out Patient
  – Adolescent = 6-9 hours per week
  – Adult = 12-15 hours per week
  – 75 hours
  – More structure than out patient
  – Less interference than residential
  – Followed by aftercare

• Inpatient
  – Structured 2 weeks to 2 years
  – 75+ hours
  – Risk of harm
  – Risk of relapse
Levels of Care

<table>
<thead>
<tr>
<th>Level</th>
<th>Care Type</th>
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<tbody>
<tr>
<td>Level 0.5</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>Level I</td>
<td>Outpatient Services</td>
</tr>
<tr>
<td>Level II</td>
<td>Intensive outpatient/partial hospitalization services</td>
</tr>
<tr>
<td>Level III</td>
<td>Residential/inpatient services</td>
</tr>
<tr>
<td>Level IV</td>
<td>Medically managed intensive inpatient services</td>
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</tbody>
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Five Levels of Care Assessed Over Six Dimensions

1. Acute intoxication and/or withdrawal
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery environment
1. Withdrawal
   • Risk of withdrawal symptoms

2. Biomedical
   • Medical issues that may interfere with treatment

3. Cognitive
   • Mental health issues that may interfere

4. Motivation
   • How motivated to change
   • What stage of change

5. Relapse
   • How many times tried to quit? Successes