Chapter 3

Strengths Based Helping Strategies
# Two Approaches to Treatment

## Traditional

**Bio**
- Looks to individual for cause
- Dichotomy: Alcoholic vs nonalcoholic

**Psycho**
- Problem focused
- Labels: alcoholic & codependent
  - One size fits all
  - Motivation irrelevant
- Client seen as resistant / in denial
- Focus to prevent slip / relapse
- Expulsion from program for use
- Confrontation

**Social**
- Identity as member of self help (12-step)
  - Identify family dysfunction
- ID codependence in family members

## Strengths-based

**Bio**
- Multiple, interactive levels of influence
  - Behaviors along a continuum

**Psycho**
- Strengths – possibilities
  - Avoid negative labels
  - Individualized
  - Intervention; where client is at
  - Client active participant; collaborate
  - Focus on moderations or abstinence
  - Meet client where they are at
  - Rolls with resistance

**Social**
- Holistic approach
  - Seeks strengths in upbringing
  - Family as resource
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; MI

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 preconetmplation 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 primary, secondary and tertiary prevention
  • Alleviate social, legal and medical problems associated with use (tertiary level)
    • HIV, Hepatitis, tuberculosis, violence, criminal activity, early death

• Abstinence not precondition to treatment
  – 1 of many means of improving
    • Quit using
    • If you can’t or won’t stop using drugs, then stop injecting
    • If you can’t or won’t stop injecting, then don’t share needles or syringes
    • If you can’t or won’t stop sharing then disinfect your needles and syringes w/ bleach btw sharing
HARM REDUCTION*

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

• Harm reduction
  – Few methadone clinics
  • usually large cities
  • strict state & federal government rules
  – Use is secondary to consequences of use
  – Began due to HIV and needles
  – Begin with most pressing

• Who decides which is most pressing?
  – Cultural; racial and ethnical differences influence goals

• Focus on
  – legal consequences
  – Incarceration
  – loss of children
  – homelessness
HARM REDUCTION*

• Reducing the barriers
  – Transportation
    • Out-reach sites
  – Clinician not streetwise (culture / survival rules)
    • Needle exchange use recovering addicts; knowledge & trust
  – Waiting lists for intake and treatment
    • Rapid intake

• Finances
  • Treatment coupons

• Abstinence required goal of treatment
  • Use harm reduction model
  • Controlled gambling? Reduce amount bet
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)
  3. Accessible services
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 & broader range to problem drinkers.
  – When given choice, people tend to choose the goal that is most appropriate for the severity of their problems.

• Be a critical thinker
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.”

» Alcoholism on a continuum of sorts
  • Situational
  • college years; excessive drinking significant other; military
Stages of Change*

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

Stage 1: No intention to change; often unaware of the problem

Stage 2: Contemplation: Aware the problem exists and serious evaluation of options but not committed to take action

Stage 3: Preparation: Intends to take action and makes small changes; needs to set goals and priorities

Stage 4: Action: Dedicates considerable time and energy; makes overt and viable changes; develops strategies to deal with barriers

Stage 5: Adaptation / Maintenance: Works to adapt and adjust to facilitate maintenance of change

Stage 6: Evaluation: Assessment and feedback to continue dynamic change process
Stages of Change

• Precontemplation (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>
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| 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" | 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" | 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 never the problem; the problem is the problem

1) Motivational Interviewing (MI)– helps client move through change process
2) Solution Focused Therapy (SFT)– what client doing differently once change
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 neg. consequences of use & hope that behavior can change
  – Clinicians act as mirrors – look at cost of use and means to change
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 sale 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 to see amount of lung damage”

• Asking the right questions;
  “Tell me about a period when you were doing, well?”
Motivational Interviewing*

5 MI Steps to enhance motivation:

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

2. **Develop discrepancy**
   - Create and amplify discrepancies between behavior and goals
   - Reflective listening
     - “You say it is important to you not to get into debt, but when you gamble you lose hundreds of dollars. Tell me about this?”
Motivational Interviewing*

3. Avoid argumentation

– Client will “dig in”; create you against me dynamic

– Client: “I really don’t want to be here.”

– Counselor: “Let’s look at what is going on. I would like to help you see the potential risks you are facing and what, if anything you would like to do about it.”

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
  Those who received intervention; 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

• Out patient
  – 19% complete abstinence
  – 46% heavy drinking period; rest slipped
3. Solution Focused Therapy*

- Two tenants of Solution Focused Therapy

1. Solving problem more important than finding root cause
2. Clients has 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 and feel good, w/o hangover, have breakfast with son”
      – Positive outcomes – find the small steps to make a reality
  – The personal narrative
    • Eating disorder:
      – “goal to get taller”; Ca deficient; began eating Ca rich foods = medicine not calorie
  – Scaling questions
    • Assess motivation; stage of change (MI)
      • Hope, determination, confidence, etc.

Solution Focused*

- Who does it treat?
  - Gambling, substance misuse/dependence; 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
  - Construction solutions not resolving client problems

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

• Helps clinician as well:
  – Less burnout
  – More optimistic
  – Less frustrating to attend to those not buying
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 and 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
    - Letters to the anti-anorexic and anti-bulimic league

• Group work emphasize positive & successes
  - Discourage stories of problems and failures
  - Participants are experts in their knowledge, skills & resources in their experiences
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
1. Withdrawal
   • Risk of withdrawal symptoms

2. Biomedical
   • Medical issues that may interfere with treatment

3. Cognitive-
   • Mental health issues that may interfere with treatment

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

5. Relapse
   • How many times tried to quit? Successful?
TEDs

- Research: 2000
  - Completion of program:
    - 55% inpatient
    - 38% (alcohol) long term, inpatient
    - 67% (alcohol) short term, inpatient
    - 41% Intensive out patient
    - 34% outpatient