# Week 7 - Non-Pharmacological Interventions

Fri, Sep 15, 2023 9:12AM 54:13

**SUMMARY KEYWORDS**

treatment, patient, idea, confidentiality, questions, person, community, substance use disorders, therapeutic, alcohol use disorder, substance, general, therapy, recovery, group, outpatient, outcomes, benefit, cognitive behavioral therapy, approach

**SPEAKERS**

Carla Marienfeld

---

00:03

Hello everyone and welcome in. I believe at this point everybody that was in the waiting room has joined and has their audio connected. So welcome, we see a lot of familiar names again, so happy to see you all back. As usual, as you know, my name is Giuila DeMello. I work here at ASAM, and I'll be here to facilitate this meeting. We'll go as we usually do through some practice questions, like including the answer choices in the rationales. And then we also have some time for additional questions. So if you have any questions throughout the meeting, feel free to type them into the chat or to unmute and share your thoughts. Also, at the end, we'll come back if we have enough time to address any additional questions. So today, we'll be focusing on non-pharmacological interventions. And we have here Dr. Carla Marienfeld with us and so I'll turn it over to her to introduce herself.

00:50

Awesome. Thank you, Giulia. It's "interventions." I think there's a typo there. Sorry about that. So my name is Carla. There's my credentials down there. For those of you who attended the review course, I gave a talk on on motivational interviewing and cognitive behavioral therapy. And so we're going to go through some of that, as well as some of the topics around AA, mutual help groups, and therapeutic communities and things like that. So some of the non-pharmacologic treatment options. I'll run through the slides. I think there are, I think there are 42 slides as I recall. And so I'll be happy to pause and answer any questions. If you want to use the chat. I'll try to keep an eye on it over here. But also feel free to unmute yourself and ask. All right, so first question, in a patient with alcohol use disorder, prescribing naltrexone and cognitive behavioral therapy, focused on coping with a slip are an example of: A- divergent strategy. So this is so- if you've got a patient with alcohol use disorder, and you're... it sounds like they had a slip, right? Is is doing both a behavioral and a pharmacologic approach considered a divergent strat- strategy, a strict abstinence model, a convergent strategy, or a poor treatment strategy with no evidence base? Right...so answer amongst yourselves. So the answer is a convergent strategy. And the idea behind that really is that while sometimes with certain medications, the medications have a robust effect, and we don't see additional benefit of adding non-pharmacologic treatment... This is particularly true with opioids. In most settings and in most types of research designs, we do see a benefit of the combination. And they target different things. So the

naltrexone can help with cravings. Whereas the cognitive behavioral therapy can can help with sort of coping skills. And so they're both sort of coming at it from different angles to manage the same thing. So you guys were putting C as your answers there, so great, awesome, excellent job. Okay, and then... So social network reconstruction. So this is this idea of thinking about networks of people in your life- networks can be families, networks can be friend structures, etc. But reconstructing the social networks early in recovery, is apt to be problematic and may undermine sobriety if which of the following group affiliations is pursued in early recovery? Right? So- So when would it be a problem? So we talk about addiction thrives in isolation, you hear sometimes the opposite of addiction is connection. So this idea of re... you know, instituting social networks can be really powerful. So when might it be a challenge? Is it when there's A- seeking out affiliation in a congenial Alcoholics Anonymous group, B- re-affiliating with relatives prone to vent anger directed toward the person early in recovery, C- joining a recreational or hobby group or D- volunteering for an organization devoted to charitable or community development goals? So everybody's putting B. So again, you know, you want to be thoughtful about who the networks are that you're reconstructing with. In general, when people have supportive family members involved, that is predictive of a better outcome in terms of substance use outcomes. However, if there's a lot of family dynamics that might put the person at risk for relapse, or if there's a lot of family dynamics with ongoing substance use or things like that. Then re-affiliating with those relatives kind of early on may jeopardize somebody's progress. So excellent. You guys all got it? There you go. Which of the following is best described as a common element shared by effective psycho-therapies for substance use disorders? Okay, so common element: fostering a treatment alliance, exerting punitive measures for non-adherence or non-compliance, dismissal of patients from the clinic for non-adherence or non-compliance, or confrontation for denial? So, yes, every- you guys are getting it right, A. So in general, I had a teacher early on in my residency training, who said, you know, the most helpful thing is just talking to the doctor. And there are some studies that really show that there's a couple of like Project MATCH and Project COMBINE and things like that, sometimes the, the intervention of just sitting down with a doctor and checking in has a profound effect on on people's functioning. And if you are able to foster that treatment alliance, and develop that partnership that can really improve patient's outcomes. So this idea of punitive measures, you know, there's a lot of data on when and how to apply what we call a positive... so a positive reinforcer, aka a punishment. So when you talk about conditioning, you know, people use positive to mean good and negative to mean bad. But in classical terms, positive means you add something and negative means you take things away. So a positive reinforcement is a punishment, you add something bad to try to decrease, or reinforce a certain behavior or choice, versus a negative thing is like taking away a privilege or something like that. Anyway, all of that is to say, you know, there's a lot of thought that goes into how we apply rewards and punishments and how we add things and take things away and all of that, and those can have impact on patient outcomes. But in general, typically speaking, punitive measures are more effective in very short-term settings, and less effective over the long term. And having positive benefits from not using is typically associated with a more sustained, long-term benefit. So dismissal of patients for the clinic well, so if somebody's not doing well, and then you kick them out of treatment, you know, their chances of doing better because now they don't have access to treatment are pretty slim. Confrontation: So there's a lot of study around this idea of sort of confronting patients, you know, confronting the denial about things that that, you know, that really is what's needed to help them recognize that there's a problem. For the most part, we recognize that most people are already aware of their problems, sometimes they're defensive about it. And a lot of times, sort of realigning with them so that they feel like it's a safe space where they can talk about the challenges, often then, is a better way of getting somebody to accept or discuss or talk about the problems as opposed to confronting their denial, which has typically the opposite effect of making them more defensive and ingraining their defensive of the problem. All right. So based on studies with post-treatment outcome measures, right, so we're looking at, you know, after, after they've had whatever treatment they've had for their substance use, looking at those outcomes, the beneficial effects from contingency management and community

reinforcement approach, right. So, these are two different things, but they both utilize conditioned responses to people. So based on studies, which of these are: A- so the beneficial effects are still observed through six months post-treatment for both of those. Ended following the termination of the contingency management program? Ended following the termination of the community reinforcement approach? Or continued through the lifetime of the individual? Yeah, so. So this is an important area of study, because the question is how enduring are our treatments? You know, so I'm a psychiatrist in my in my background, and, in general for most of our treatments, you have to keep taking the medications. If we think for example, about antidepressants we generally see and assume that after you stop antidepressants, that you don't continue to receive the benefits. But now we have some things like potentially psilocybin, potentially ketamine that with one treatment, we can see sustained benefit for longer periods of time. And so, so this is an important question around medication management. But in particular, when we talk about behavioral treatments, the idea is that people learn skills and build new ways of being that are sustained beyond just that period of time where you're actively engaged in the treatment. And so it's good to see that you can still see benefits and behavioral changes up to six months after. All right, which of the following is the motivational interviewing principle? Okay, so this is, when we talk about the principles of motivational interviewing, this is from the second edition of the textbook, which came out I believe, in 2001, or 2002, maybe. And we've since had the third edition of the textbook that came out in 2012. And now we just have the fourth edition of the textbook, which just came out, like two weeks ago, two or three weeks ago. And so, so there's some shifting, but the core ideas are the same. But this idea of a principle uses some of these, like sort of catchy terminology here. They call it REDS. And so this is a concept that still is helpful to think about for MI but isn't necessarily emphasized in the more recent, third and fourth editions. But for those of you who learned this early on, and we know that you know, exams are a little behind, it's a helpful thing to be aware of. So which of the following is an MI principle: discourage disagreement, or redirect attention, develop details or support self efficacy, and I see everybody put D, which is correct. So support self efficacy, which is actually kind of interesting, if I may go on a tangent for education for a moment. The new fourth edition talks about the spirit of motivational interviewing, and it still uses the same mnemonic of PACE, which stands for partnership, acceptance, compassion, and the E used to be evocation where you're really trying to elicit and evoke from the person, their values and what's important to them. But now that E stands for empowerment. And so there was a little bit of that idea of self-efficacy and empowerment, that may have been lost in the third edition that's coming back out again now. So this is still a really important concept. When compared with individual-oriented care, which of the following is supported by metaanalyses, and reviews of studies focusing on family- oriented treatment approaches? Right. So when we're thinking about family treatment approaches versus individual therapy. So which of the following is supported by meta- metaanalyses of family approaches? Excuse me, family-oriented treatment approaches are associated with positive treatment outcomes. family-oriented treatment approaches are associated with poor rates of engagement, family-oriented treatment programs are associated with less participation in aftercare, or D- the Donson Institute intervention, aka confrontation was more effective than community reinforcement and family training in improving identified patient engagement. Okay, so I see people are saying A- family-oriented treatment approaches are associated with positive treatment outcomes. So that is true. And I mentioned this kind of briefly earlier. But when you have family involvement, in general, the outcomes are better for for patients, it's predictive of a better response. You know, there's some caveat to that, where if the family dynamics are particularly prone to triggering relapses and/or there's ongoing substance use in that immediate environment, that can be a challenge. But in general, when you have family approaches, they do better when family is involved. In particular with things like CRAFT, right, so the family-Community Reinforcement and Family Training, the whole point of it is to help train family members to know how to respond- and and so you know, how to train family members or concerned significant others, CSOs, in how to respond to patients so that you allow them to have natural consequences. And you try to set up natural rewards- set up rewards and or natural rewards, or reinforcers for

positive behaviors. So yeah, Um, so family positive treatment outcomes, better rates of engagement and more likely to participate in aftercare programs, right. So, you know, lots of patients will participate in sort of a residential level program, and then they don't necessarily follow up with the recommended sort of step down idea along that continuum of care if you remember the ASAM level of care and patient placement criteria. So those levels of care, you know, you kind of ramp people up based on need along the six dimensions, and then you kind of ramp them back down slowly afterwards. And so people who participate in aftercare do better, people who have family involved are more likely to participate in aftercare. And again, feel free to jump in with questions if you have any. So which statement is true about recovery coaches: so recovery coaches are only effective with individuals who are currently abstinent. One primary task of a recovery coach is to help individuals recognize they have an illness. Recovery coaches are best utilized as part of a comprehensive treatment plan for addiction, or recovery coaches have little efficacy. Yeah, so I've seen a lot of Cs there. That is true. So recovery coaches are a relatively modern idea, I think it's more of a reincarnation of all kinds of ideas. We've talked all about peer supports, and we've talked about, you know, recovery communities, and all kinds of different things over the years, but you know, they don't tend to be covered by insurance. So it can be sort of a luxury item. But overall, they are best utilized as part of a comprehensive treatment plan. And they can be an important complement to medication management, individual therapy, family therapies, group therapies, etc. And so so they definitely have a role to play. There is some data supporting their enhanced effectiveness, so D is wrong. And they're usually coming in kind of after the person has been assessed and as part of their treatment plan. So the idea of first recognizing you know, that you have a problem, that sort of, you know, initial part of AA, for example, probably has already happened if the person's you know, engaging in some kind of a treatment plan. And it's not really necessarily related to this idea of the medical model, disease model of having an illness anyway. But anyway, and they can be helpful in patients who haven't already achieved abstinence, but they can be helpful in either maintaining abstinence or managing lapses, trying to prevent them from becoming relapses, etc. How are they different from peer support? Or is it a different name? So peer support is usually somebody who has had a substance use disorder and is in recovery. That's why they're a peer. So the peer part isn't necessarily like the same age or same other demographic characteristics. The peer part is that, you know, they've they've had lived experience with a similar-ish disorder. recovery coaches don't necessarily have to have a- be in recovery or have a substance use disorder. Although I, in my limited experience with them, many of them do. And so one route for people who sometimes feel like they want to give back is that, you know, they'll participate as sponsors, for example, through programs like AA, sometimes people will go on and get counseling certificates for being a drug and alcohol counselor, and then sometimes people will get on- become coach- recovery coaches, and I forget the exact certification process, but there is one to be kind of like a certified recovery coach. And so, again, I think, peers, it tends to be somebody who's had the disorder, whereas recovery coach does not necessarily although often does. Alright. Of the following, the most effective treatment approach for substance use disorders in adolescents, right, so adolescents: short-term residential residential rehabilitation programs, unstructured outpatient group therapy, family therapy, or aversion therapy? So I'm seeing lots of Cs, right? So. So shorter-term programs, so adolescents are kind of notoriously the most difficult to engage in treatment and often have the worst outcomes. And that's often because they're not the primary drivers of seeking treatment many times. They also haven't always experienced as many of the significant consequences of substance use problems. And so our focus is often on preventing them from having those significant consequences. But they may not be as motivated or as worried. Adolescents, you know, because of their cognitive developmental level may not have as much of an appreciation for consequences and longer-term things, etc, etc. So, short-term programs really don't have enough time to develop new behavioral patterns and those kinds of things. Unstructured outpatient groups can sometimes result in sort of influenced by by peers. And sometimes we see sort of, you know, what, I'm not looking- I'm trying- the word of this "glamorization" keeps coming to my mind, but that's not what I'm looking for. Romanticization or

whatever of drug use. Aversion therapy again, you know, aversive types of things are often very motivating immediately. But they don't tend to have much lasting effect as things that have positive reward in terms of long term behavior change. But family therapy that engages the family, and that, you know, helps with communication patterns and family dynamics that may underlie some of the adolescent's behaviors can prove helpful. All right, we have a vignette. So this is a 45 year old female patient with a history of generalized anxiety disorder who was previously successfully treated with a selective serotonin reuptake inhibitor. Presents to your clinic for consultation of increased restlessness and insomnia. So while on the SSRI, her anxiety improved considerably, and for several months, several months, she thought that her symptoms were in remission. Unfortunately, she started to experience vivid dreams, which she attributed to the SSRI. And so she discontinued the medication. Over the past year, she has tried several other medications, but has been confronted with other side effects. Sleep initiation is becoming an increasing problem. Sleep initiation, aka, you know, insomnia, she starts to fixate on her inability to fall asleep. You consider some options. She's also concerned about her susceptibility to addiction because her father has had a severe alcohol use disorder, the most appropriate approach that would avoid her concern for addiction and other potential side effects might include: Okay, so A- a calcium channel, alpha2delta ligand, B- cognitive behavioral therapy, specifically for insomnia. C- a benzodiazepine receptor agonist with an FDA approved indication for insomnia or D- a sedating anti-psychotic. So I'm seeing lots of B, and that is, in fact, the correct answer. So basically, you know, what they're saying is that this is somebody who has anxiety. You know, as the old saying, goes, anxiety keeps you up, depression wakes you up. So people with depression classically have that early morning awakening pattern of insomnia, with what's sometimes called middle insomnia. This person has more of a typical pattern with anxiety of delayed onset of sleep, or you call it latent sleep initiation, there's a lot of these terms where, you know, it's harder to fall asleep because they have these like ruminating thoughts and catastrophizing and anxiety. And so they're showing you here that she has had benefit from an SSRI. And in fact, somebody prescribed a good first line approach for treatment of the GAD. But now, you know, she can't use it anymore, because she's having side effects. And she wants to avoid her family history. We know that in people who've had either family history or who've had problems with other substances, their risk is slightly higher for developing a problem. So while the calcium channel alpha2delta ligand and the sedating antipsychotic are not necessarily associated with misuse, we probably do want to be careful of the Z drugs, or any short-acting benzodiazepines that can be initially effective for initial insomnia, but, but do have some risk for dependence. I think in general, I often talk to patients about the need to not train your body that you have to take something to help you fall asleep and instead use CBT to develop better associations. What you need to do so that your body knows it's time to go to sleep. So cognitive behavioral therapy for insomnia has been adapted to really target, you know, healthy behaviors, having a good sleep ritual, using cognitive behavioral therapy to manage your anxiety thoughts, like the cognitive distortions associated with the anxiety, and then help in those ways. Alright, what is the principal goal of network therapy with regards to a patient's substance use? Alright, is it A- aid in sustaining the patient's abstinence? B- creating symptom relief in network members? C- enabling network members to achieve self-realization? Or D- scrutinizing the motives of individual members? Looks like we're getting some differences of opinion here. Yeah, so network therapy, again, network is broadly defined, you know, there's lots of different networks we have or systems or networks of people that we interact with. But in general, some of the original work of of network therapy really was how do you work within the network of people to support the person to have them help aid in sustaining the patient's abstinence? Right. And so the idea of creating symptom relief in the network members doesn't make sense because it's about the person who's got the problem, not the not the members necessarily. Who cares about if they achieve self-realization? It's not about them. No, just kidding. And it's not really about the motives, it doesn't really matter what what their motives are, it's really round focusing on how the network can support the person. Which of the following are part of Marlatt and Gordon's 1985 model of relapse prevention utilizing cognitive behavioral therapy, adapted for the treatment of substance use disorders? So all of

that is a fancy way of saying that Marlatt and Gordon basically developed what we call relapse prevention as an outgrowth of CBT that was adapted for substance use disorder. So which of the following is part of that: A- eliciting change talk from the patient, B- earning vouchers for negative urine drug screens, C- targeting cognitive, affective and situational triggers for substance use, there's some commas missing there, D- conducting a moral inventory. So C- targeting cognitive, affective and situational triggers for substance use. So when we talk about A- eliciting change talk, that's definitely motivational interviewing. Alright, motivational interviewing is all about change talk. And it's all about doing whatever you can to facilitate the conversation to elicit change talk from the patient. B- earning vouchers for negative urine drug screens, that's like the most common and classic example of contingency management, which is you get a positive reinforcer, right? So for the negative urine drug screen, you get something so it's positive, the reinforcer, the voucher, for that behavior of the negative urine drug screen. And then D conducting a moral inventory. This is typically a part of mutual help, 12 Step programs. So cognitive behavioral therapy in general, is, as you might recall, this idea that, you know, we have these automatic thoughts about things that are based on, you know, our internalized... how we grew up- all of our stuff. How we think about things affects how we feel, how we feel affects what we do, right? And so it's hard to change how you feel. But you have some ability to change what you think. And so if you change how you think, that changes how you feel, which changes what you do. And so that's the idea behind cognitive behavioral therapy. When we think about it for substance use disorders, we are targeting various cognitions- I, you know, how do I think about it? And situational triggers, right? So we're targeting cognitions, about how we think about triggers, how we manage our anxiety, our thoughts, all of those kinds of things, to prevent relapse into using the substance. So anytime you hear things about coping skills, if you see any questions about coping skills, triggers, those kinds of things, or you hear, you know, cognitive aspect of things, most likely that's going to be a question about CBT and or relapse prevention. Which of the following characterizes the findings of research on the relative effectiveness of treatment in residential and outpatient settings? Okay, so we're looking at effectiveness of treatment in residential and outpatient settings. So A- the relative effectiveness is best identified by the, quote "box score" approach to synthesizing the research literature, B- they show that more impaired patients benefit from an initial episode of inpatient or residential treatment than from outpatient treatment alone. The research shows that treatment in residential settings generally leads to better outcomes than treatment in outpatient settings. or D- they are especially robust because of the ability to randomize patients to treatment in either setting. All right, so what do we think about residential versus outpatient and what does the data support? So I saw that a lot of Cs up there. So when- this gets back to kind of what we were talking about with the ASAM patient placement criteria, and those six dimensions that you can look across in terms of like medical need, and housing, and comorbid, psychiatric and medical conditions, and, you know, readiness to change- all of those kinds of characteristics, those dimensions, and what level of care is appropriate. And just like if you know, somebody has like a raging infection, and you start them on, like, you know, a low dose, oral antibiotic, you're not going to get, you know, as much benefit as you would, if you put them on, you know, high doses or an appropriate dose of an IV antibiotic. And so it's the same kind of principle here. A lot of times patients will come into contact with healthcare setting, settings and all kinds of different ways, potentially through outpatient. And then we determined that that really, based on the patient placement criteria, they would benefit from a higher level of care. But overall, research does support that the initial episode of inpatient or higher level of treatment can be more effective if somebody has a more severe disease process. So C, a lot of people put C and the reason that that is wrong, is because if outpatient setting is the right level of care, then that's okay. However, what happens sometimes in residential programs is one- they're not followed with aftercare or appropriate outpatient follow up. And so a lot of the the gains that you get are lost without kind of that sustained reinforcement. Also, in, in a residential program, it's easy to be- it's- you have a lot of external supports and controls. And so it's easier to stop certain behaviors in that environment. Those behaviors become harder to translate into your everyday life, when you have those same sort of

stressors and problems and exposures that were there before. And there's less sort of control on those external things than you had. And so sometimes that transition from residential to outpatient may not be that well done. And actually learning a lot of the skills and implementing them in an outpatient program, where you can learn and do those in your normal environment may have a longer- may be one reason why there's there's some benefit from outpatient. And yes, it's definitely easier to randomize and have control in an inpatient setting. And I don't know what the "box score" is. So I'm sorry, I can't answer what that is. All right. Next question. A 32 year old woman with borderline personality disorder and a severe opioid use disorder is referred for treatment. She has attempted suicide several times in the past five years and has a history of self mutilation, depersonalization and derealization stemming from physical abuse during childhood. She has chronic nightmares. She has been arrested for using illegal drugs and for occasional shoplifting. Numerous previous professionals have given up on her. The first goal in the therapist's treatment plan should be to work towards which of the following. So this is a person who has clearly a lot of challenges and likely has had a lot of negative interactions with healthcare settings that often treat patients like this very, very poorly. So if you're this person's therapist, what would you like to work towards initially: A- attending 12 step meetings, B- receiving regular medical attention, C- reducing suicidal ideations and para-suicidal behavior, or C or D- refraining from calling the therapist after 10pm. So I'm seeing some C's, right. So when, when you initially want to work with this person, I think the first goal really is to establish some kind of raport and engage the person, because that's what's going to help you tackle the most immediate sort of life-threatening concern for this person, which are those suicidal thoughts and the suicidal behaviors. Medical attention may also be necessary if that comes up, but it doesn't sound like at least according to the prompt, that there were any immediate medical concerns. Really, the suicidal behaviors are going to be the most life-threatening, and then somebody with borderline personality disorder, oftentimes there can be this quote, unquote, sort of cry for help, or this idea that, that these para-suicidal behaviors are either self-soothing, or a way of playing the sick role and getting some secondary gain from that. But sometimes people can be very impulsive in this situation, and whether they have a true intent or plan to harm themselves end up actually harming themselves. And so all of these things are very, very high risk. You know, her impulsivity, her childhood trauma, she has a number of factors as to why she's a very high risk for for self harm, potentially acutely, but definitely chronically. And so that would be the most important thing. Some of the other things might be more helpful in the long run. Oftentimes, patients with borderline personality get Dialectical Behavioral Therapy, where therapists are available 24 hours a day, and they really work with patients in that. That's hard to actually access like true Dialectical Behavioral Therapy. But it would also potentially be an important treatment option targeting the suicidal ideations. And also Dialectical Behavioral Therapy has been adapted for substance use, just like cognitive behavioral therapy has, in ways and so it really also talks a lot about substance use as well if if that was a big concern for you. You are seeing a 15 year old female for the first time who presents with concerns regarding her cannabis use. Before she agrees to discuss her concerns with you she requests to discuss issues regarding the confidentially- confidentiality of her medical information with you. From your knowledge of adolescent research on confidentiality, which of the following statement is true? I wouldn't say from your knowledge of adolescent research, but I would say from your knowledge of of laws about confidentiality regarding adolescents, which of the following is true? The value adolescents place on confident- Oh, okay, sorry. Now, I see. Okay, so when doing research about confidentiality in adolescents, which of the following is true? A- the value adolescents place on confidentiality is generally uniform, and not significantly associated with parental relationships or experience with high risk behaviors. B- psychological research has shown that around age 14 adolescents have the cognitive ability to understand information necessary for consent. C- although adolescents desire confidentiality in medical care, confidentiality concerns do not usually prevent them from seeking care from their regular providers, or D- despite uniform desire for confidentiality, only about 25% of high school students report having health concerns they would like to keep private from their parents. Yeah, seeing lots of B there, right. So so the idea of confidentiality requires a certain level of, of

cognitive development. And that happens a little bit earlier than some of our other facilities come online, around executive functioning. But around age 14 or so the idea to understand information, to process things, and to consent for things is likely, although typically, depending on the state you're in, there's often still laws around assent and not consent for minors. With regards to substance use treatment, there are several states that do allow people under age 18 to consent to substance use treatment, but that varies from state to state and you should know your state's guidelines. I think A is wrong because adolescents' situations are going to dramatically impact the value they place on confidentiality. And so, so that's probably not terribly uniform. And I think very much the desire for confidentiality can impact the likelihood that somebody's going to seek treatment. And in particular, this vignette supports that. You know, for these don't have to memorize which states do. But I think you know, I think in general, having some idea that adolescents are- might have some rights to seek substance use treatment would be a general principle to be aware of. But no, the exam is not going to ask that level of detail. Which of the following interventions have shown efficacy in the treatment for addiction to nicotine? A- aversion therapy, B- buspirone, C- fluoxetine or D- brief physician advice? Excellent. You guys are all great physicians, I think it's that three minutes of physician advice can result in a 10% quit rate, and 10 minutes of a physician advice can result in a 20% quit rate. And this is that was based on cigarette smokers, most of whom tend to want to quit. I don't know if that study has been replicated in people who vape nicotine or not. Although my guess would be it has not but regardless, in general, brief physician advice still is really critical thing which gets back to my earlier point about meeting with the physician is therapeutic and beneficial. And even just having small conversations can sometimes be really helpful for some folks. So aversive therapy, that's typically more like disulfiram for- for for alcohol use disorder, you know, where they would get really sick if they drink on top of it. So there are some things that look at, you know, where nicotine is- there's some thoughts that certain things, certain medications might worsen the experience with nicotine. This is thought a little bit with bupropion, for example. And that might help reduce the use. But in general, aversive therapy isn't isn't widely used. And the bupropion is thought mainly to act through not only its effects on norepinephrine and dopamine, but also some actions on the nicotine receptor. Buspirone sounds a little bit like Bupropion. And so I'm guessing that's why it was a distractor. But to my knowledge, that's mostly for anxiety and hasn't been looked at in nicotine use disorder or if it was looked at it, it wasn't found to be effective. And fluoxetine, remember Prozac is an SSRI for depression, which which primarily works through the serotonin reuptake inhibition and doesn't impact the norepinephrine and dopamine reuptake inhibition the way that bu- bupropion does. But in general, this is a thing on non-pharmacologic treatments. So physician advice is the correct answer. But it's an important thing you should know about. Other things that might get asked about here the five A's of smoking cessation, the you know: ask, advise, assess, assist in a range, which sometimes comes up as a way of approaching how to manage smoking- a treatment for- for nicotine use disorder. All right, you are seeing a 42 year old male patient for follow up on an alcohol use disorder. He has remained abstinent from alcohol for eight weeks by participating in so this is a 12 Step is kind of the older name. Now they're more called mutual help groups. Because there's a lot of in the community and many of them are not 12 Step-oriented. But anyway, so he has a 12 step program that has been helpful for abstinence from alcohol for eight weeks. He's going to meetings daily and once-weekly group therapy sessions through a continuing care group. He now asks you if there's really a difference between the group therapy and his 12 Step/Alcoholics Anonymous/mutual help groups. You explain to him that the primary difference between the group therapy and an Alcoholics Anonymous group meeting is: A- confidentiality, B- supportive interaction. C- group bonding or D- profess- professional facilitation. I see some Bs, but mostly Ds. And that is correct. So there is something called 12 Step facilitation, that is basically a manualized way of helping to connect people and support their engagement and participation in AA and 12 Step programs. So that would have kind of a professional facilitation. But in general, AA is a peer-led decentralized modality. And so it doesn't have that facilitation aspect by somebody who theoretically is sort of knowledgeable and has a, you know, some kind of therapeutic milieu environment or group therapy approach that they're using.

Group bonding and peer connection, I think are identified as the quote unquote, sort of active ingredient in a lot of group therapies. And pure input has a huge impact on behavior. I hope and I think that in general, the idea behind groups is to have it be a supportive interaction, whether it's done in a, you know, therapy setting, or a professional medical-type setting. Or if it's done in a community-based mutual help group, and confidentiality in general is, I think, respected amongst both of them. You know, in a, in a medical setting, we have laws around confidentiality, whereas in AA, you know, the name anonymous, makes it a pretty important aspect of it, although I don't believe that you're violating any laws to my knowledge of confidentiality, if you do disclose. Give me just one second here. Right, to attend AA meetings, it's expected that the person will: A- have been referred by the courts or by a professional, B- have a desire not to drink alcohol, C- be completely abstinent from alcohol or D- agree that his or her sponsor can contact family members for further information. So this is where it gets to be kind of fuzzy. And I think this is where that peer-led decentralized approaches comes into play. So there's still a big book. And there's still kind of some things that that are consistent that people do amongst things. But but different meetings vary quite a bit. And different groups have sort of different expectations. In general, when you look at the literature, it's a desire not to drink alcohol. And AA really does sort of want to help people who have lapses. But there isn't a requirement that you must be abstinent in order to participate. So it's really around that desire not to drink. So if your goal is moderation, then that wouldn't be an appropriate fit for you. It's really around a desire not to drink alcohol at all. In terms of addiction treatment, what is the primary therapeutic goal of the modern therapeutic community. Therapeutic communities are super interesting, and they have a very, very long history of some potentially questionable results and activities that are fascinating to learn about. However, you know, there there is an underlying framework behind them, and then the approach. And so the primary therapeutic goal of a therapeutic community is that: A- addressing societal inequalities, B- diminishing the consequences associated with a particular substance of choice, C- engagement and healthy life skills and development of behaviors that reduce risk of return to substance use, or D- changing the patient's immediate living environment. I'm seeing lots of Cs, and you guys are correct. So the idea is to really have- develop an intentional community that supports the person in- and the other people in that community- in sort of healthier behaviors and skills that are going to, in that those behaviors kind of become ingrained. They kind of you know, you fake it till you make it and then it becomes a part of you and the idea is that you keep doing that even if you're no longer in that supportive community to reduce the risk of certain substance use. So the D- changing the patient's immediate living environment, that's often more of like a residential program, where the idea is you take somebody out of their immediate living environment and move them into like a rehab. Diminishing the consequences associated with this, the particular substance of choice. So so if anything, they would be potentially enhancing or letting the natural consequences of the substance of choice occur. And then addressing social inequalities or societal inequalities rather, I think that sometimes there's a lot of concern about societal inequalities and access to care and dynamics that were going on in these therapeutic communities. That is a whole other topic area. But they were not designed to address societal inequalities that influence a lot of what we know about substance use. Which of the following reflects the alterations in the modified therapeutic community for persons with co-occurring disorders? So are they- so which of the following reflects the alterations in the modified therapeutic community? Okay. So is it A- less flexibility in program activities, B- longer duration of various activities, C- more confrontation and intensity of interpersonal interaction? Or D- greater sensitivity to individual differences? Yes. So it is greater...intention... So therapeutic communities got a bad rap, they had some bad outcomes, they changed a little bit. And now they're a little bit more flexible, shorter duration of activities. We all know from adult learning are, you know, our attention spans... less confrontation, which we already talked about why that's less effective in intensity of interpersonal interaction. So you're not like yelling at people and, you know, breaking them down in order to build them back up, again, kind of idea that was prevalent in certain periods. So D, greater sensitivity to individual differences. How would you characterize the evidence for the effectiveness of therapeutic communities: A- little or no,

B- only anecdotal, C- positive outcomes associated only with modified therapeutic communities or D- positive outcomes with associated with retention and treatment. So it's actually D, that, you know, the longer you participate in, in pretty much any treatment for substance use disorders, the- you have better outcomes, and patients who are retained in treatment longer, tend to do better. And so that's why we look at that as an outcome measure in a lot of addiction studies, whether it's medication or therapies, things that people continue using result in better outcomes. And so in some ways, you know, the that's a way of assessing their efficacy, because if, if it's not working, people won't stick with it. All right. So we went through all of those questions. We have a couple minutes left for question and answer. So excuse me, I'm losing my voice here a little bit. I have to say, I'm impressed you got through all of those questions that require- Even with all of my commentary, hopefully that was useful.

52:59

Thank you. It was indeed, and as a reminder, you'll all welcome to unmute yourselves and share any questions that you might have or comments.

53:18

So far, just lots of thank yous.

53:21

You're very welcome.

53:26

All right, I think we might be good to go. Don't see any questions popping through. Do you have any closing thoughts or comments or any tips that you would want to share before we finish the session for today?

53:45

Think the board exam. What it is- the BEST- the board exam study tool is that what it is? Needs more motivational interviewing questions, but aside from that.. All right. Well, thank you guys. I appreciate it.

54:04

All right. Thank you, everyone. And I hope to see you all next week. And thank you, Carla, for being here with us today.

54:09

54:09

You're very welcome.