Mutual Help - Earley

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00:00

This presentation is entitled Patient Interventions: Mutual Help, Psychotherapy, and Social Support. I will now pass it over to Dr. Paul Earley to begin our presentation.

00:09

Good afternoon. Our next lecture is about Patient Interventions: Mutual Help, Psychotherapy, and Social Support, a very wide topic and a very broad topic that we have a short period of time to zoom right through. So let's get started.

00:32

I have no relevant financial disclosures for this lecture. So introducing this topic, these are the topics that we're going to cover today: recovery support services, relapse prevention training, 12 Step support systems, recovery coaching, contingency management, addressing trauma, recovery-based partner therapy.

00:54

There are other interventions which are covered by my good friend, Dr. Marienfeld. And those are cognitive behavioral therapy, dialectical behavioral therapy and ACT therapy. So those will not be covered here, but you'll get them from Dr. Marienfeld.

01:12

So let's first talk about therapies. And let's talk about you as an addiction medicine physician. Even though you may not be providing these therapies, it's critical for you to understand and know what they do. And in fact, I encourage everyone who gets involved in taking care of patients with addiction

disorders, to become somewhat conversant in at least one type of therapy, one type of way of working with patients, so that you can learn the complexities of what we're going to be talking about today.

01:44

Now, therapies are divided into two groups, there are behavioral therapies that are done on an individual setting. And then there are therapies that are done in a group setting. Each has its benefits and problems. Individual therapies offer more privacy, they offer more flexibilities to address issues as they arise. They focus on that unique individual's relevant issues. They provide, they're more practical for some providers, because you don't have to organize people together to have a group. And they're also better for certain patients, especially at first, patients with schizophrenia as a dual diagnosis, of trauma history which is causing problems with being involved in groups, or those that are extremely socially anxious. Those are the benefits. And those are the of the individual types of therapy.

02:36

Group therapy is utilized quite a bit. And the reason for that is- we talked about that when I talked about the different types of history of treatment. But group therapy is more cost effective. It has an increased access in more places. Importantly, peers in the community are what we call the "mileau," becomes a important agent of change. Group therapy can have more fidelity in a particular model, because it's led by counselors who have an experience in that area. It also teaches something very critical for people in recovery, which it teaches a healthy interdependence, a way of relating to each others which does not exploit another person, and also allows people to be vulnerable to change.

03:29

And the advantages are that we can define, watch, and practice things such as relapse and relapse prevention and other types of skills. We can have public affirmations about- within that group about the disease process, the problems they had. And that all those cause shame and when that's shared in a group, shame is reduced. And finally, it provides an entree into networks of support, which I believe are, and most researchers believe are, important for long term remission.

04:03

So let's go through this list that I introduced to you earlier, starting with recovery support services. Briefly, I'm going to talk about recovery support services that are not discussed later. If someone is moving into recovery, and they don't have these types of services available to them, if needed, then the process of attaining recovery will fail. If they don't have ability to translate issues of their- because English is not their common first language or whatever language you're operating in. If they can't get to a treatment or evaluation setting, they're in trouble. If they don't have housing or family care, if they don't have parenting and child care, if they didn't have cultural and gender discrimination issues addressed properly. If they don't have employment, which will allow them to have a gainful moving forward process outside of the therapy that you're providing. If they have

financial and legal issues. And finally if they need schooling and training so they can reenter society in a healthy way which will create a sense of meaning and well being. All of these need to be addressed in any patient that arrives in your door.

05:18

Let's next talk about a particular type of cognitive behavioral therapy called relapse prevention training. Probably the most important tool and one that every addiction medicine physician should know something about and know how to address in each time they meet with a patient.

05:37

There are two types of research validated techniques in relapse prevention training. Relapse prevention training provides definitive skills that are taught and practiced. Both of these validated techniques, research validated techniques, arose from the University of Washington and Alan Marlatt's group that really focused on this extensively. Dr. Bowen has since moved from University of Washington and and she's still training elsewhere.

06:15

So what does relapse prevention training do? First of all, it helps people recognize cravings. Cravings are really a normal part of the human experience, whether that's craving for alcohol or craving for chocolate cake. So understanding cravings is important. And every person who has had cravings can understand the cravings within their patients. Recognizing that in addiction, once addiction takes hold, they are much much more intense. What happens is addiction disorders just grab on to the brain process of cravings, and in addiction recovery, those cravings can be quite intense and often persistent, sometimes lasting years or decades. In fact, many people that are in long term recovery will tell you that they have cravings for alcohol or other substances from time to time, they have just learned how to manage them. The strength, frequency, and duration of cravings vary from person to person. However, importantly, having cravings is not necessarily a predictor of relapse. Having no skills in managing cravings, however, is a predictor of relapse. Therefore, learning to manage cravings is a central part of a healthy remission.

07:34

It's important for us to understand that there are different types of cravings. There are emotional cues, emotional events that an alcoholic used to drink over, that's the third one down, or the first one- the environmental cues, seeing the drugs, smelling tobacco, watching a movie where people are drinking or using drugs. Hearing music that was- accompanied past using events is a very strong trigger that can often come up unconsciously, and wrap itself around an individual before they realize it. Having visceral events, body sensations- taste or smell- can often cause a trigger. And finally, some individuals have memory tapes or intrusive visual scenes that play in the mind and cause that individual to sometimes shake in their boots with discomfort.

08:26

Learning how to manage these is critical. One model of relapse is the- comes from Alan Marlatt's- is a process model of relapse. I'm gonna go over this very quickly. It's fairly complex. And it is not something you take to a patient and on the first session and say "Here, memorize this and learn from it." There's several important takeaways that I'll go over today. A more in depth evaluation is really beyond the scope of this. On the left hand side of your screen, you see that dark blue circles as high risk situation. Importantly, Dr. Marlatt's work identified that there are high risk situations that every individual with a substance use disorder needs to identify and then have a pre-planned way of managing that high risk situation. An example might be an individual in early alcohol remission who goes to a family gathering where other family members are drinking. Early on in recovery this is really contrarindicated. But later on in recovery, they may need to go to some such a situation- how are they going to handle that?

09:38

When you're in a high risk si- situation, having a pre planned coping response is often critical. And individuals in therapy will often talk about their high risk situations and have them listed out and have a way of managing them as they move forward. If you have a coping response to a high risk situation, it increases a sense of self-efficacy and improves your recovery. If you don't have a coping response, then this cascade of events occur that you see at the bottom of your screen. And those wind up placing the individual at higher and higher risk of relapse as they move to the right.

10:17

Importantly, there's this concept called an abstinence violation effect. When an individual violates their abstinence, even with a single small amount of a drug, a whole cascade of events occur, which is almost impossible to derail. That's why avoiding the first exposure is critical.

10:38

So what do we learn from the process model? I alluded to them already. Collating a list of high risks, situations, and clues for when they may occur is important. Considering a coping response for high risk situations ahead of time is powerful medicine. This concept of negative self talk or self-attribution is extremely counterproductive. People will get in high risk situations and having negative thoughts about it only serve the illness, not the recovery. Enacting coping responses decreases the probability of future relapse. Those are the essential elements. And if you have more interest, you can study more about the relapse prevention model and have ways of helping your patients in the future.

11:25

A second type of well studied relapse prevention is mindfulness based relapse prevention. What this does is teaches the individual to work on developing a mental state by focusing on awareness in the present moment, calmly acknowledging and accepting one's feelings, thoughts and bodily sensations. This mindfulness calms the mind when an- and is especially helpful if an individual happens to stumble on a situation where where past using occurred or a situation or a feeling that comes up. Learning how to calm the mind decreases the impulsivity and and allows the individual to recognize

and not act. Mindfulness based relapse prevention teaches people to focus on increasing self-awareness, decreasing judgment, and shifting from reacting to skillful responding. This is the work of Sarah Bowen and her colleagues, as you see below.

12:24

What about 12 Step support systems? Let's talk- and I'm going to spend some time talking about this. First of all, it's important to know that there are many different types of peer support systems. The 12 Step programs are myriad as well. And they're listed in front of you: Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Crystal Meth Anonymous, Nicotine Anonymous. Those are all for people who suffer from the illness of addiction and need psychosocial support. There is a type of support network for individuals who have suffered at the hands of the illness, Al Anon for spouses, or Nar Anon, for spouses and parents and children, of people that have narcotics problems. And then a program called Adult Children of Alcoholics. All of these are free, and, and accessible in most, most towns and cities across the United States.

13:28

There are other national support groups with somewhat less experience, but may be helpful for individuals who, for any number of reasons, don't get along with 12 Step programs such as Smart Recovery, Women for Sobriety and Refuge Recovery. And then finally, there are other types of groups including the religious-affiliated, Christian, Celebrate Recovery, and other church groups, and synagogue groups. And there's also continuing care groups and treatment centers, all of these provide support.

14:02

So let's dive into what this Alcoholics Anonymous does. And in here, we're actually going into the research. The- one of the primary articles is at the bottom of the page. This is a review article by John Kelly et al. and talks about how do people recover? What are the elements that Alcoholics Anonymous has within it that improve the recovery prognosis?

14:30

First of all, AA teaches individuals to recover through common process mechanisms, enhancing self efficacy, coping skills and motivation and by facilitating adaptive social network changes, Alcoholics Anonymous is a highly structured social network, which is- which is solely interested in people attaining and remaining in remission. It focuses an individual on long term goals and provides a holding place in which patients can evolve, meaning- maybe a pun on the word "patients" and patients evolve and also they have increasing patience. But the idea there is that individuals early in recovery are extremely impulsive and that by it teaches individuals to focus on longer term goals, which calms down that impulsivity.

15:22

It teaches the relapse prevention skills, not in a scientific way, but in a way that has evolved over

It teaches the relapse prevention skills, not in a scientific way, but in a way that has evolved over many, many decades as highly effective. It normalizes the experience of loss of control, the slippage of moral values that occur when people develop substance use disorders, and normalizes the trauma that people feel. People with alcohol and drug problems are literally traumatized by their illness. And it talks about how that occurs. It sets discontinuation of substances as the primary goal. It provides a path to reconciliation of the past, and provides a social network that's relatively free of substance use. Most AA meetings in most towns now, for instance, are tobacco free.

16:09

So with all this great stuff, why won't my patients go to AA? Well, there are some roadblocks, if you will, but ones that can be overcome if one is knowledgeable about AA. So I want to urge all of you to consider attending some AA meetings, learning more about it, and learning from your patients who are attending AA what works for them. Sometimes patients won't go get to a- because there's a focus on spiritual print- principles. And this sometimes bleeds over in to religious tenants in some locales and situations. It's focused specifically on it not being religious, per se, but they tend to bleed over from time to time because that's its roots. Spiritual references are often a turn-off the- they turn-off the agnostic or atheist if they don't mesh with their feelings of the group. So learning, understanding a person's particular spiritual belief system is important when you're making referrals.

17:14

Also, many patients with addiction disorders have varying levels of social phobia. Social phobia is the most common problem in patients with substance use disorder, and often can make people anxious about attending support group meetings. Newcomers find the format unusual and look for hierarchical structures. And most patients are not not naturally drawn to AA.

17:38

So this is a nice little chart here. How patients approach their situation, for instance, is they're interested in short term goals: "I want to get my family back" or "I want to get my job back." AA teaches long term goals. Instead of a quick fix, they focus on gradual change. Importantly, people who come into treatment all think they're different. But AA teaches that in many ways we're all the same. Due to time I'm not going to go over this entire chart, but it's worth you looking at when you understand the differences of what AA- what can turn off the person and how you can work with them to have them understand its benefit.

18:19

What do patients like about AA? Listening to stories of hope and transformation, not being forced to talk- no one needs to talk. There's no dues or fees, ease of access, many cities have hundreds or even 1000s of meetings a day, a sense of warmth and comfort, acceptance and unconditional love. And unfortunately in some meetings, cigarettes.

18:44

So the core concepts, though, in AA are always the same: acceptance of the illness, working through what they call denial, and accepting that the illness has made them powerless over it. Developing a mentoring relationship with others who teach the pathway towards recovery. It is, remember, it's all free. Importantly, meetings are like old-fashioned antibiotics. They're effective, but they have- have to be taken often for it to work. Going to an AA meeting once a week at the beginning is almost useless. Really attending a meeting every day early in remission helps people begin to understand to- and have this, this subtle process, become part of the worldview.

19:31

Encourage people when they go to explore what is helpful and at first, if it's not helpful, discard it. Over time, more will become helpful. I'm going to have to skip this slide and the interest of time but I want to get to the research for you.

19:49

Because this is really important when we're talking we're living in an era of research- of evidence-based medicine. And we have some medications which are evidence-based but Alchoholics Anonymous also has a very strong research base. In fact, this 2020 Cochrane Review, the gold standard in evidence validity, conducted by John Kelly, Keith Humphreys and Dr. Ferri did an incredible job over multiple years looking at 1000s of participants in controlled trials or quasi-controlled trials, and they compared motivation enhancement therapy and cognitive behavioral therapy with 12 Step programs and 12 Step facilitation. This very well evidenced review, which everyone here should read, showed that AA usually produced higher rates of continuous abstinence than other established treatments, and may be superior for increasing the percentage of days of abstinence, especially thinking in the longer term. So strong evidence for this evidence-based technique called Alcoholics Anonymous.

21:07

They also concluded that it performs as well as other treatments for reducing intensity of alcohol consumptions. Four of the five economic studies showed substantial cost saving benefits for AA and that led Dr. Kelly to have this wonderful quote, "It's the closest thing in public health we have to a free lunch." So importantly, evidence-based medicine has become conflated with medication assisted treatment, and it's actually wider than that. We have Alcoholics Anonymous, as well to know is a evidence-based treatment.

21:43

But what about opioid use disorder? People say, "Oh, that's great for alcohol. But what about opioid use disorder?" Well, the benefits of active referral to 12 Step programs is somewhat less clear, mostly because of the numbers of studies. But one large recent review of over 21,000 patients provided, that had people divided into three separate groups: medication management only, limited psychosocial therapy, and finally a recovery-oriented 12 Step orientation plus medication management, and took a look at the outcomes. And the outcomes were quite clear. Urine drug test negative opioids at the time of the second buprenorphine prescription, you can see them right there. 34% for medication

management alone, 56% for the limited psychotherapy, and 62% for recovery-oriented systems of care, significant at the .001 level. So the evidence is not as broad, but it is looking like recovery-oriented systems of care in opioid use disorder is powerful medicine as well.

22:51

What about recovery coaching? We're moving on to a totally different topic now. Recovery coaching is a new field one you're going to see more and more of in the field, because it's the fastest growing group of individuals who care for, for, for patients with substance use disorder. It is- these individuals are paraprofessionals. They have some limited training and ongoing supervision, and it's designed to sustain a connection and help with day to day choices. Recovery coaching is a non-judgmental individual who encourages self-reflection, promotes actions that promote and endorse remission behaviors. Recovery coaching can work with individuals who are actively using and those in early remission. And recovery coaches are not primary treatment, and do not diagnose. But they are a support network, which is in some ways can be thought of as a bridge to things like Alcoholics Anonymous, or a bridge to learning when it's time to engage in psychotherapy. They encourage strength-based support.

23:59

Recovery coaching is often done ad hoc over the telephone or via electronic communication with a given patient. Oftentimes, it's linked with other tools such as contingency management, urine, drug screening and social services. And limited research shows evidence of improvement in these four areas you see in front of you. So recovery coaching, really important.

24:24

The next- I told you we're moving fast- the next. The next type of intervention is contingency management. Contingency management is a tool that is really among the most thoroughly researched. It's among the most clinically effective approaches. It's cost effective. And it can be used in patients across the change spectrum, all the way from decreasing use to maintaining remission. It increases compliance with medications to treat addiction and yet, oddly enough, it's rarely utilized. But why is that?

24:59

Well first of all, contingency management is a very specific tool that has to be well-honed and well-practiced. It's based upon operant conditioning or behavioral economics. And it breaks down the recovery process into concrete, attainable and realizable goals. When you attain a specific goal, you receive a small reward, often several dollars or a voucher to get a milkshake at the local McDonald's or something like that. By rewarding critical recovery based behaviors, it creates a prioritization which is important. In readjusting reward intensity. The important part about it is the rewards have to be closely linked temporally to the event. If an individual goes to a support group meeting, for instance, they should be rewarded almost immediately, with 50 cents or $1 for going to that meeting. Surprisingly enough, small goals are effective even with people who have means to get along in life, and are not financially strapped.

26:12

Rewards therefore should be immediate, tangible and intermittent. So you could actually have a way of decreasing the cost by pulling a ticket from a punchbowl that may contain a prize. But it might be more cost-effective. Now, you might think this sounds like gambling. But interestingly enough research, studies that you see from Nancy Petry below, shows that it does not increase gambling.

26:38

I'm just going to skip over these. These are efficacies in different venues: actively using individuals, for instance, cocaine use and methadone clinic, or individuals in a remission status. And you can see these curves of individuals who had contingency management, that the higher the negative drug screens on the bottom and the retention on top, were both improved by contingency management.

27:10

So how do you implement contingency management? Well, that is complex. Staff may have problems with it. Setting up concrete measurable goals, recording responsive tray- tracing and dispensing rewards is difficult. So I just want to say that the easiest method of implementation are newer organizations that are promoting this through technology. Basically having an app on your phone, which you log into and you use when you attend an AA meeting. You record the AA meeting and of the app on the phone immediately rewards you a small amount of money for your behavior.

27:50

What about affect regulation and recognition? This is an area that I think is important to know about even if you're not a psychotherapist, so you can understand what's happening with people. There are different types of difficulties handling feeling states, affect states, or regulating feeling states. Some people have problems recognizing and understanding feeling states, other people have problems responding in a productive manner to those feelings. What happens with addiction is it entraps and induces strong emotions and creates difficulties in handling those emotions, especially around triggers for relapse. So therefore, learning how to manage emotions is helpful in preventing relapse. And there are many ways of doing that. For individuals that have difficulties managing it.

28:43

A subset of individuals have a disorder which is labeled alexithymia, which is the inability to recognize and name feeling states, and this is felt to be maybe even felt to be a neurologic or a learned behavior. So people with alexithymia need to learn how to recognize their feelings.

29:04

And finally, we're gonna move on to partner therapy. What about the partner in treatment? Well, several different partner therapies have been studied and shown to be effective and- in increasing

remission. The partner or the couples or the home life of the individual is very important. And we all know that from helping people stop smoking, if you have someone that you want to have stop smoking, and their partner smokes, the prognosis for remission from nicotine is zero, nearly zero, I think probably zero. So it's important to understand what's happening in the home, what's happening in the partnership, and to figure out whether the interactions between the partnership is triggering or causing a relapse. During partners, couples therapy, you explore the partners relationships to substances as well. That's very important, and you figure out how to create safety for your primary patient who's involved with you or have the other half of that couple enter remission simultaneously. It's important to encourage reasonable accommodations by the partner to support remission: getting drug paraphernalia out of the house or ensuring that people that are triggering to the person early in remission don't come around the house. So it's important to understand what's going on to create a, a place where the individual can be safe in remission. So understanding their living situation and if they have a partner what their living situation involves, is critical. So at least some amount of partners or couples therapy will help your patients under- will help you have the best prognosis for your patients.

30:49

And finally, EMDR. Let's talk for just a second about trauma and addiction. Over the past decade or so it's become clear- more and more clear that physical, emotional, sexual or religious trauma tends to mi- co-migrate through addiction disorders. The incidence of addiction is higher in the traumatized patients. It's- we're unclear why that is. And there is a suggestion that childhood trauma contributes to the development of addiction disorders. The- hard data on this is difficult because of the complexity of addict- of trauma. But it's no doubt that what happens is, individuals that are traumatized are more susceptible to addiction, and it's more difficult for them to attain sustained remission. In addition, addiction itself traumatizes its victim with random flashbacks of addiction related memories which can trigger relapse

31:43

For this reason, having some trauma work is important. The primary type of trauma remission technique was designed by Francine Shapiro in 1987. And is proved effective for many individuals. It's a skill which has to be learned- how to do EMDR. But it's a relatively easy skill to to work with in a talented therapist. Basically, it's a reprocessing of the trauma by yoking it to lateralizing eye movements or even lateralizing touching on either part of the hand to that causes a reprogramming in the brain. It's unclear why this happens, but it's fascinating that it does. So EMDR is helpful if your patients have trauma.

32:34

So I guess that's general we're just about out of time. But it's important to know about EMDR to refer your patients to EMDR. And to ask- ask about trauma when you have a patient who comes in for addiction, because you'll be surprised at how many people are victims of trauma who wind up with addiction as young adults or adults.

32:58

All right, so what do we know? We know that a wide variety of psychosocial interventions are

All right, so what do we know? We know that a wide variety of psychosocial interventions are available to assist in recovery. That careful assessment is the first and most important step in matching treatment to a particular individual's issues. That not addressing psychosocial issues definitely leads to worse prognosis and is basically bad medicine. Engaging patients with all psychosocial interventions requires an approach which is based on compassion and concern and careful time spent with the patient. Physicians, all of you, should have a basic understanding of the many types of therapeutic interventions in order to help them engage in the various types of therapy when indicated. How you do that is you develop a referral network, if you're not providing that yourself, throughout your city or town so individuals can get more of what they need. And that's all for my lecture today. Thank you.