SUBSTANCE USE

BEHAVIORAL DEFINITIONS

1. Consistently uses alcohol or other mood-altering drugs until high, intoxicated, or passed out.
2. Unable to stop or cut down use of mood-altering drug once started, despite the verbalized desire to do so and the negative consequences continued use brings.
3. Produces blood study results that reflect a pattern of heavy substance use (e.g., elevated liver enzymes).
4. Denies that chemical dependence is a problem despite direct feedback from spouse, relatives, friends, and employers that the use of the substance is negatively affecting him/her and others.
5. Describes amnestic blackouts that occur when abusing alcohol.
6. Continues drug and/or alcohol use despite experiencing persistent or recurring physical, legal, vocational, social, or relationship problems that are directly caused by the use of the substance.
7. Exhibits increased tolerance for the drug as evidenced by the need to use more to become intoxicated or to attain the desired effect.
8. Exhibits physical symptoms (i.e., shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, depression) when withdrawing from the substance.
9. Suspends important social, recreational, or occupational activities because they interfere with using the mood-altering drug.
10. Makes a large time investment in activities to obtain the substance, to use it, or to recover from its effects.
11. Consumes mood-altering substances in greater amounts and for longer periods than intended.
12. Continues abuse of a mood-altering chemical after being told by a physician that it is causing health problems.

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LONG-TERM GOALS

1. Accept the fact of chemical dependence and begin to actively participate in a recovery program.
2. Establish a sustained recovery, free from the use of all mood-altering substances.
3. Establish and maintain total abstinence while increasing knowledge of the disease and the process of recovery.
4. Acquire the necessary skills to maintain long-term sobriety from all mood-altering substances.
5. Withdraw from mood-altering substance, stabilize physically and emotionally, and then establish a supportive recovery plan.
6. Utilize behavioral and cognitive coping skills to help maintain sobriety.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the type, amount, frequency, and history of substance abuse. (1)	1. Gather a complete drug/alcohol history from the client, including the amount and pattern of his/her use, signs and symptoms of use, and negative life consequences (e.g., social, legal, familial, vocational).
2. Complete psychological tests designed to assess the nature and severity of substance abuse. (2)	2. Administer to the client an objective test of drug and/or alcohol abuse (e.g., the *Addiction*

	Severity Index, the *Michigan Alcohol Screening Test*); process the results with the client.
3. Participate in a medical evaluation to assess the effects of chemical dependence. (3)	3. Refer the client for a thorough physical examination to determine any physical/medical consequences of chemical dependence.
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)	4. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
	5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
	6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with an evaluation by a physician for psychotropic medication. (8, 9)

8. Assess the need for psychotropic medication for any mental/emotional comorbidities, and discuss the use of acamprosate (Campral), naltrexone (Vivitrol), or disulfiram (Antabuse) where applicable to discourage chemical abuse and strengthen recovery.

9. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals.

6. Explore and resolve ambivalence associated with commitment to change behaviors related to substance use and addiction. (10, 11, 12, 13)

10. Using a nondirective, client-centered, empathic style derived from motivational enhancement therapy (see *Motivational Interviewing* by Miller and Rollnick; *Motivational Interviewing and Enhancement* by DiClemente, Van Orden, and Wright), establish rapport with the client and listen reflectively, asking permission before providing information or advice.

11. Ask the client to make a list of the ways substance abuse has negatively impacted his/her life (e.g., medically, relationally, legally, vocationally, and socially) and the positive impact nonuse may have (or assign "Substance Abuse Negative Impact versus Sobriety's Positive Impact" in the *Adult Psychotherapy Homework Planner* by Jongsma).
12. Ask open-ended questions to explore the client's own motivations for change, affirming his/her change-related statements and efforts (see *Substance Abuse Treatment and the Stages of Change* by Connors, Donovan, and DiClemente).
13. Elicit recognition of the discrepancy gap between current behavior and desired life goals, reflecting resistance without direct confrontation or argumentation.

7. Commit self to an action plan directed toward termination of substance use. (14, 15)

14. Encourage and support the client's self-efficacy for change toward the goal of developing an action plan for termination of substance use to which the client is willing to commit.
15. Develop an abstinence contract with the client regarding the termination of the use of his/her drug of choice; process client's feelings related to the commitment.

8. Attend Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings as frequently as necessary to support sobriety. (16)

16. Recommend that the client attend AA or NA meetings and report on the impact of the meetings; process messages the client is receiving.

9. Agree to make amends to significant others who have been hurt by the life dominated by substance abuse. (17, 18)

10. Verbalize increased knowledge of alcoholism and the process of recovery. (19, 20)

11. Verbalize an understanding of factors that can contribute to development of chemical dependence and pose risks for relapse. (21, 22)

17. Discuss the negative effects the client's substance abuse has had on family, friends, and work relationships and encourage a plan to make amends for such hurt.

18. Elicit from the client a verbal commitment to make initial amends now to key individuals and further amends when working Steps 8 and 9 of the AA program.

19. Conduct or assign the client to attend a chemical dependence didactic series to increase his/her knowledge of the patterns and effects of chemical dependence; ask him/her to identify several key points attained from each didactic and process these points.

20. Assign the client to read a workbook describing evidence-based treatment approaches to addiction recovery (e.g., *Overcoming Your Alcohol or Drug Problem* by Daley and Marlatt); use the readings to reinforce key concepts and practices throughout therapy.

21. Assess the client's intellectual, personality, and cognitive vulnerabilities, family history, and life stresses that contribute to his/her chemical dependence.

22. Facilitate the client's understanding of his/her genetic, personality, social, and family factors, including childhood experiences, that led to the development of chemical dependency and serve as risk factors for relapse.

12. Identify level of happiness in various areas of life. (23)

23. Approaching the client with empathy and genuine caring, administer *The Happiness Scale* (see *A Community Reinforcement Approach to Addiction Treatment* by Meyers and Miller); review results in session.

13. Develop goals to increase satisfaction and pleasure in unsatisfactory, nondrinking areas of life. (24)

24. Assist the client in defining specific goals and strategies for achieving increased happiness in problematic, nondrinking areas of life, so that the role of alcohol and/or drugs as the major determinant of an individual's happiness is diminished (consider assigning "Setting and Pursuing Goals in Recovery" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

14. Learn and implement communication and problem-solving skills toward achieving goals. (25, 26, 27, 28, 29)

25. Using modeling, role-playing and behavioral rehearsal, teach the client communication skills including how to make statements that convey understanding, accepting partial responsibility for problems, and offering to help solve the problem.

26. Teach the client problem-solving skills (identify and pinpoint the problem, brainstorm possible solutions, list and evaluate the pros and cons of each solution, select and implement a solution, evaluate all parties' satisfaction with the action, adjust action if necessary); use role-playing to assist the client in applying these steps to life issues to increase happiness (or assign "Plan Before Acting" in the *Adult Psychotherapy Homework Planner* by Jongsma).

15. Cooperate with exploration of increasing satisfaction in areas of life that can support sobriety such as employment, recreation, and relationships. (30, 31, 32, 33, 34)

27. Teach the client assertiveness skills that can be used to support drink refusal.
28. Assign the client to read about general social and/or assertiveness skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).
29. Assign homework to encourage the client to apply the newly learned behavioral skills to achieving the happiness goals identified (see "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma); review progress, reinforcing success and redirecting for failure.
30. Evaluate the role of the client's living situation in fostering a pattern of chemical dependence; process with the client.
31. Facilitate development of a plan for the client to change his/her living situation to foster recovery (or assign "Assessing My Needs" in the *Addiction Treatment Homework Planner* by Finley and Lenz); revisit routinely and facilitate toward accomplishing a positive change in living situation.
32. Teach the client skills necessary for finding a job, keeping a job, and improving satisfaction in a job setting.
33. Assist the client in identifying new sources of non-drinking

recreation and social friendships, using problem-solving and communication skills to overcome obstacles.

34. Direct conjoint sessions that address and resolve issues with a partner so as to increase the number of pleasant interactions and reduce conflicts.

16. Participate in behavioral couples therapy designed to increase the non-substance-using partner's reinforcement of sobriety and to reduce relationship conflict. (35, 36, 37, 38)

35. Develop a sobriety contract with the couple that stipulates an agreement to remain abstinent; limits the focus of partner discussions to present day issues, not past hurtful behaviors; identifies the role of AA meetings; and schedules a daily time to share thoughts and feelings.

36. Ask each partner to make a list of pleasurable activities that could be engaged in together to increase positive feelings toward each other (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the list and assign implementation of one or more activities before the next session.

37. Teach the couple problem-solving skills (identify and pinpoint the problem, brainstorm possible solutions, list and evaluate the pros and cons of each solution, select and implement a solution, evaluate all parties' satisfaction with the action, adjust action if necessary); role-play the use of these skills applied to real life

issues of conflict for the couple (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).

38. In light of the recovery contract, review the client's sobriety experience and the couples' interaction since the last session; address any relationship conflicts, assisting the couple in improving their communication skills (e.g., "I messages," reflective listening, eye contact, respectful responding, etc.) by using role-play in the session.

17. Identify, challenge, and replace destructive, high-risk self-talk with positive, strength-building self-talk. (39, 40, 41)

39. Explore the client's schema and high-risk self-talk that weaken his/her resolve to remain abstinent; challenge the biases; assist him/her in generating realistic self-talk that corrects for the biases and builds resilience.

40. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success.

41. Assign the client a homework exercise in which he/she identifies high-risk self-talk, identifies biases in the self-talk, generates alternatives, and tests through behavioral experiments (consider assigning "Replacing Fears With Positive Messages" in the *Adult Psychotherapy Homework*

	Planner by Jongsma); review and reinforce success, providing corrective feedback toward improvement.
18. Earn rewards by submitting drug-negative urine samples. (42)	42. Implement a prize-based contingency management system by rewarding the client with desired prizes starting at the low end of a $1–100 range and increasing with continued abstinence.
19. Earn rewards by maintaining attendance in treatment. (43)	43. Implement a prize-based contingency management system by rewarding the client with desired prizes starting at the low end of a $1–100 range and increasing with continued attendance.
20. Participate in EEG biofeedback treatment to reduce fear of bodily sensations that can trigger substance abuse. (44)	44. Administer to the client or refer the client to a certified biofeedback practitioner for training in using EEG relaxation feedback to cope with arousal-related bodily sensations that may trigger substance abuse.
21. Verbalize an understanding of lapse and relapse. (45, 46)	45. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.
	46. Evaluate past lapses and prescribe self-monitoring to assess current risk factors for lapses (or assign "Relapse Triggers" in the *Adult Psychotherapy Homework Planner* by Jongsma and/or the *Alcoholism and Drug Abuse Patient Workbook* by Perkinson).

22. Implement relapse prevention strategies for managing possible future situations with high-risk for relapse. (47, 48, 49, 50)

47. Use stimulus control techniques such as avoidance of specific triggers to reduce exposure to high-risk situations.

48. Use instruction, modeling, imaginal rehearsal, role-play, and cognitive restructuring to teach the client cognitive-behavioral skills (e.g., relaxation, problem-solving, social and communication skills, recognition and management of rationalization, denial, and apparently irrelevant decisions) for managing urges and other high risk situations.

49. Instruct the client to routinely use strategies learned in therapy (e.g., problem-solving, stimulus control, social skills, and assertiveness) while managing high-risk trigger situations (or assign "Aftercare Plan Components" in the *Adult Psychotherapy Homework Planner* by Jongsma).

50. Supplement relapse prevention work done in session by recommend that the client read material on how to avoid relapse (e.g., *Staying Sober: A Guide to Relapse Prevention* by Gorski and Miller; *The Staying Sober Workbook* by Gorski; *Overcoming Your Alcohol or Drug Problem: Effective Recovery Strategies—Workbook* by Daley and Marlatt).

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	303.90	Alcohol Dependence
	305.00	Alcohol Abuse
	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	305.60	Cocaine Abuse
	304.80	Polysubstance Dependence
	291.2	Alcohol-Induced Persisting Dementia
	291.1	Alcohol-Induced Persisting Amnestic Disorder
	V71.01	Adult Antisocial Behavior
	300.4	Dysthymic Disorder
	312.34	Intermittent Explosive Disorder
	309.81	Posttraumatic Stress Disorder
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
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Axis II:	301.7	Antisocial Personality Disorder
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild

291.2	F10.27	Moderate or Severe Alcohol Use Disorder With Alcohol-Induced Major Neurocognitive Disorder, Nonamnestic-Confabulatory Type
291.1	F10.26	Moderate or Severe Alcohol Use Disorder With Alcohol-Induced Major Neurocognitive Disorder, Amnestic-Confabulatory Type
V71.01	Z72.811	Adult Antisocial Behavior
300.4	F34.1	Persistent Depressive Disorder
312.34	F63.81	Intermittent Explosive Disorder
309.81	F43.10	Posttraumatic Stress Disorder
304.10	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe
301.7	F60.2	Antisocial Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.