

Best Practice Principles In The Treatment Of Substance Use Disorders

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[Terry Gorski and other member of the GORSKI-CENAPS Team are Available To Train & Consult On Areas Related To Best Practice Principles In The Treatment Of Substance use disorders](#)
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This article describes the basic research-based principles upon which the GORSKI-CENAPS Model of treatment is based. The article is divided into two parts.

Part 1: The Nature of Substance Use Disorders: Part one describes the best scientific understanding of the nature of substance use disorders.

1-1. Substance-Related Disorders

1-2. Progressive Symptoms of Substance Dependence

1-3. DSM-IV Progressive Symptom Model

1-4. Biopsychosocial Progressive Symptom Model

1-5. Characteristics of Substance Use Disorders

1-6. Drug-based Symptoms

1-7. Abstinence-based Symptoms

Part 2: Principles Governing Effective Treatment: Part two describes the best scientific understanding of the principles that govern the effective treatment of substance use disorders. A listing of the references from which these principles were derived is listed at the end of the article.

Part 1: The Nature Of Substance Use Disorders

Substance use disorders are primary biopsychosocial conditions that result from the use of mind altering substances by people who have biopsychosocial (physical, psychological and social) risk factors that positively reinforce continued use of mind altering substances and negatively reinforce abstinence.

1-1

Substance-Related Disorders

There are three types of Substance Related Disorders: Substance Abuse Disorders, Substance Dependence Disorders, and Substance-induced Disorders. The Substance-induced Disorders can coexist with either Substance Abuse or Substance Dependence Disorders. (*American Psychiatric Association, 1994*)

- 1. Substance Abuse Disorders** marked by serious psychosocial problems related to alcohol and drug use that do not meet the criteria of a Substance Dependence Disorder. Abuse Disorders may result from initial experimentation with mind altering substances, involvement in a lifestyle or subculture where alcohol and drug problems are a social norm, or as a consequence of related personality or mental disorders. Patterns of substance abuse may be self-limiting or they may become chronic. The severity of problems associated with substance abuse can vary in response to the seriousness of stress and related life problems. In some cases substance abuse will progress into substance dependence.
- 2. Substance Dependence Disorders** marked by an abnormal biological responses to the ingestion of mind altering substances that results in progressive tolerance and withdrawal that causes a a pattern of compulsive use of the substance to develop which impairs the ability to control substance use and results in the development of substance related life problems.
- 3. Substance-induced Disorders:** There are number of reversible disorders that can be caused by the frequent and heavy use of alcohol and other drugs that common that commonly coexist with substance use disorders. These substance related disorders may be associated with either substance abuse disorders or substance dependence disorders. If these Substance Induced Disorders are not identified and stabilized they can interfere the successful treatment of before both substance abuse and substance dependence disorders. The Substance-induced Disorders are: Intoxication, withdrawal, and Substance-induced Mental Disorders.
 - (1) Intoxication:** Intoxication is a reversible set of substance-specific symptoms that are caused by the recent ingestion of alcohol or other drugs. The symptoms consist of significantly maladaptive behaviors caused by impairments in the ability to think clearly, manage feelings and emotions, and self-regulate behavior. Intoxication is often marked by severe impairments in judgment and impulse control. The symptoms persist as long as the blood alcohol or drug level is high enough to cause them. Different substances can cause similar symptoms or interact synergistically to create distortions of the symptoms commonly associated with each drug when used separately. (*American Psychiatric Association 1994 pp. 183 - 184*)

- (2) **Withdrawal:** Withdrawal is a reversible set of substance- specific symptoms that are caused by the cessation or reduction in heavy and prolonged substance use. (*American Psychiatric Association 1994 pp. 184 - 187; NIAAA 1989*)
- (3) **Substance-induced Mental Disorders:** Substance-induced Mental Disorders are symptoms caused by the long term effects of frequent and heavy use of alcohol or other drugs. These effects cause impairments to the brain & nervous system; impaired cognitive & affective functioning; or problems with behavioral control and regulation. The symptoms may be related to intoxication, acute withdrawal, post acute withdrawal (PAW), or long-term brain dysfunction caused by alcohol or drug use. PAW and long-term brain dysfunction are described as *Substance-induced Persisting Disorders* in DSM-IV. (*American Psychiatric Association 1994 pp. 192 - 195*) The primary Substance-induced Mental Disorders are:

- **Substance-induced Delirium:** Perceptual problems that include: difficulty maintaining environmental awareness; difficulty focusing and sustaining attention on a task or object; difficulty shifting attention from one central focus to another; difficulty maintaining orientation to person, place, time and context; and problems understanding and communicating ideas verbally and in writing. The symptoms are caused by the effects of substance use that extends beyond the period of intoxication and acute withdrawal. There are two common types of Substance-induced Delirium - Intoxication Delirium and Withdrawal Delirium. (*American Psychiatric Association 1994 pp. 127 - 129*) If not properly treated, mild to moderate symptoms of Substance- induced Withdrawal Delirium may persist for as long as 60 to 180 days following the cessation of substance use and become worse during periods of high stress.

- **Substance-induced Persisting Dementia:** Cognitive impairments including: memory impairments involving the impaired ability to recall previously learned information and/or learn and retain new information (*American Psychiatric Association 1994 pp. 152 - 155; NIAAA 1989b*). The most common substance-induced cognitive impairments are:

Disturbances In Executive Functioning that make it difficult to plan, organize, sequence, abstract central organizing principles, apply past experience to current situations, and project logical consequences of current behavior into the future.

Language Disturbances (aphasia) that make it difficult to comprehend what is read and understand complex or abstract

verbal communication.

Motor Function Impairments (apraxia) resulting in problems with hand-eye and psychomotor coordination which often manifests in clumsiness, slowed reflexes, and mild disturbances in balance and gait.

Sensory Recognition Impairments (agnosia) that make it difficult to immediately recognize familiar objects by touching, hearing, or seeing them.

- **Substance-induced Persisting Amnesic Disorder:** Memory impairments that make it difficult to learn & recall new information, recall previously learned information, or recall past events. The memory impairments cause problems with interpersonal relationships, occupational functioning, or the performance of routine acts of daily living. (*American Psychiatric Association 1994 pp. 161 - 162*)
- **Substance-induced Psychotic Disorder:** Difficulty maintaining orientation to person, place, time, and context caused predominately by hallucinations and delusions. (*American Psychiatric Association 1994 pp. 310 - 315*)

Hallucinations can occur in any sensory modality causing people to see things that aren't there such as poorly formed shapes or shadows to detailed objects and persons (visual hallucinations); hear things such as annoying poorly formed sounds to specific words and statements (auditory hallucinations); feel things such as bugs crawling on them (tactile hallucinations); *smell things* that aren't there (olfactory hallucinations), *taste things* that aren't there (gustatory hallucinations);

Delusions: Delusions are strongly held beliefs not supported by evidence and not affected by the presentation of evidence that demonstrates they are not true. Delusions may vary from mild to extreme and may include a variety of themes including: *Beliefs about wellness* when presented with evidence of the symptoms of illness; *Beliefs about normal functioning* and the absence of problems when presented with evidence of dysfunction and problems; *Beliefs about past accomplishments* that are grandiose and exaggerated in the absence of evidence or when presented with contradictory evidence; *Beliefs about being persecution* when no such persecution exists; *Beliefs of religious significance* such as being God or being in direct communication with God or some other spiritual or religious being in the absence of evidence.

- **Substance-induced Mood Disorder:** A disturbance in mood characterized by either: *depressed mood* marked by: diminished interest in all or most activities; diminished ability to experience pleasure; *manic mood* marked by an extreme elevated sense pleasure and excitement, an expansive response to others, or extremely irritable reactions to others; or *Manic Depressive Swings* marked by rapid and unpredictable swings between depressed moods and manic moods. (*American Psychiatric Association 1994 pp. 370 - 375*)

- **Substance-induced Anxiety Disorder:** A state of excessive worry marked by a tendency to believe that negative experiences will occur in the future, difficulty controlling or distracting self from the worrying thoughts, restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating, having a tendency for the mind to go blank, irritability, severe muscle tension, and sleep disturbances that include difficulty falling, difficulty staying asleep, or restless unsatisfying sleep. (*American Psychiatric Association 1994 pp. 439 - 444*)

- **Substance-induced Sexual Dysfunction:** The inability to perform sexually as a result of the effects of intoxication, or withdrawal. (*APA 1994 pp. 519 - 521*)

- **Substance-induced Sleep Disorder:** Substance-induced Sleep Disorders (*APA 1994 pp. 601-607*) consist of difficulty with the sleep-wake cycle that include: *insomnia* marked by difficulty falling, difficulty staying asleep, or restless unsatisfying sleep (*APA 1994 pp. 553 - 557*); *hypersomnia* marked by excessive sleepiness marked by difficulty staying awake (*APA 1994 pp. 557 - 562*); *parasomnia* marked by the inappropriate activation of autonomic nervous system, motor systems, or cognitive processes during sleep, specific sleep stages, or sleep wake transitions such as nightmares, sleep terrors, excessive tossing and turning, and sleep walking. (*APA 1994 pp. pp. 579 - 592*)

1-2

Progressive Symptoms of Substance Dependence

Once substance dependence develops, a progressive series of self-reinforcing symptoms begin to develop. Two models of the progressive symptoms will be presented: (1) *The DSM-IV Progressive Symptom Model*; and (2) *The Biopsychosocial Progressive Symptom Model*.

The DSM IV Progressive Symptom Model was developed by completing a three step procedure:

Step 1: Analyzing the DSM-IV criteria for substance use disorders,

Step 2: Dividing specific criteria that contained more than one identifiable symptom into separate symptoms,

Step 3: Arranging the symptoms in a logical progression supported by both face validity and studies of widely accepted models that sequence addiction symptom development (Jellinek 1960; Glatt 1982; APA 1994, NIAAA 1995).

The Biopsychosocial Progressive Symptom Model was developed by completing the following steps:

Step 1: Reviewing past progressive symptom model (Jellinek 1960; Glatt 1982),

Step 2: Reviewing recent related to models of addiction containing biological, psychological, or social symptoms (Tarter et al 1988; Tabakoff 1988; NIAAA 1996; NIAAA 1995);

Step 3: Isolating specific symptoms from all models, grouping into similar categories, and eliminating duplication; and

Step 4: Integrating the newly identified symptoms into the The DSM-IV Progressive Symptom Model in proper order of development.

1-3

DSM-IV Progressive Symptom Model

1. **Increased Tolerance (DSM-IV Criteria #1):** Tolerance is defined by either: (1) a need for markedly increased amounts of the substance to achieve intoxication or the desired effect; or (2) a markedly diminished effect with continued use of the same amount of the substance.
2. **Withdrawal (DSM-IV Criteria #2):** Biopsychosocial withdrawal symptoms consistent with the drugs being used appear when the person attempts to stop using. The symptoms disappear when the same or a closely related drug is taken.
3. **Self-Medication Of Withdrawal (DSM-IV Criteria #2):** Using alcohol or drugs to make the symptoms of withdrawal (dysphoria, agitation, depression, impaired mental functioning) go away.
4. **Loss of Control Over Quantity (DSM-IV Criteria #3):** Using alcohol or drugs in larger quantities than intended;
5. **Loss of Control Over Duration (DSM-IV Criteria #3):** Using alcohol or drugs for longer periods of time than intended.
6. **Loss of Control Over Frequency (DSM-IV Criteria #** Using alcohol or drugs
7. **Increased Time Spent Using DSM-IV Criteria #5):** Spending a Great deal of time getting ready to use alcohol or other drugs, using, or recovering from the

effects of using.

8. **Neglect Of Life Responsibilities (DSM-IV Criteria #6):** Failing to meet major life responsibilities because of intoxication, or withdrawal.
9. **Neglect Of Life Activities (DSM-IV Criteria #6):** Neglecting or given up work, social, or recreational activities because of alcohol or drug use.
10. **Alcohol And Drug Relate Problems (DSM-IV Criteria #7):** Have You Had Any Physical, Psychological, Or Social Problems That Were Caused By Or Made Worse By Your Alcohol Or Drug Use?
11. **Desire To Cut Down (DSM-IV Criteria #4):** The desire to control the use of the substance by using smaller amount, using less frequently, or limiting time spent using.
12. **Attempts To Cut Down (DSM-IV Criteria #4):** Conscious attempts to control the use of the substance by using smaller amount, using less frequently, or limiting time spent using.
13. **ContinuedUse In Spite Of Problems (DSM #7):** Have You Ever Continued To Use Alcohol Or Drugs In Spite Of Knowing That They Were Causing Or Making Physical, Psychological, Or Social Problems Worse?

1-4

Biopsychosocial Progressive Symptom Model

1. **Biological Reinforcement:** Biological reinforcement that promotes continued use of alcohol and other drugs. (NIAAA 1996)
2. **Tolerance:** Progressive tolerance that requires increased amounts to achieve the desired state of reinforcement. (DSM-IV Criteria #1)
3. **Withdrawal:** Acute & Post Acute Withdrawal Syndromes when substance use is stopped. (DSM-IV Criteria #2)
4. **Loss of Control:** Inability to control over the quantity of substances consumed and length of substance use episodes.
5. **Inability To Abstain:** Inability to maintain long-term abstinence.
6. **Addiction Centered Lifestyle:** The development of an addiction-centered lifestyle. (DSM-IV Criteria #5)
7. **Addictive Lifestyle Losses:** Giving up previously valued lifestyle activities due to substance use. (DSM-IV Criteria #6)

8. **Progressive Substance-related Problems:** The development of progressive substance-induced biopsychosocial problems. (DSM-IV Criteria #7)
9. **Continued Use In Spite Of The Problems:** The pain caused by the problems creates craving for more drug use rather than a desire to correct the problems. With renewed drug use awareness of the problems recedes from conscious awareness. (DSM-IV Criteria #7)
10. **Biopsychosocial Deterioration:** Progressive physical, psychological and social deterioration as long as substance use continues which ends in serious physical illness. Serious psychiatric illness, suicide, death, or involvement in treatment.

1-5

Characteristics of Substance Use Disorders

1. **Involuntary:** Substance Use Disorders develop involuntarily. People do not develop progressive problems with alcohol and other mind altering drugs because they willfully choose to do. Most choose to experiment with substance use as a result of normal social and cultural pressure. Their personal risk factors create an involuntarily biopsychosocial reaction to substance use that leads to the abuse of, addiction to, and dependence upon the mind-altering substances. (NIDA 2000)
2. **Genetically Influenced:** Genetic factors influence but do not cause substance use disorders. Genetically inherited predisposition must interact with developmental and environmental risk factors for substance use disorders to develop. People with a strong genetic history of substance use disorders are more susceptible to substance-related brain dysfunction and hence more vulnerable to other psychosocial risk factors. Many people have genetically inherited protective factors that lower risk of abuse and dependence.
3. **Psychosocially-influenced:** People are more likely to develop substance use disorders if they are the product of a culture that supports frequent, heavy, and abusive use of alcohol and drugs and have developed the following addictive beliefs: Alcohol and drug use is safe and it is good for me, not using is bad for me. I must use alcohol and other drugs to function well and have a good life. Without alcohol and drugs there will be many important things that I won't be able to do. People who support my substance use are my friends and people who oppose it are my enemies.

1-6

Drug-based Symptoms

Symptoms that develop during active episodes of chemical use and include:

1. **Urgency In Initial Consumption:** The rapid consumption of the substance to achieve the desired euphoric state.
2. **Euphoria:** A unique state of well being caused when the drug of choice causes the

release of a flood of pleasure chemicals in the brain.

3. **High Tolerance:** Over time it takes large quantities of the substance to produce the desired euphoria.
4. **State-dependent Memory:** What is learned during drug use is forgotten when abstinent.
5. **Unpredictable Episodes of intoxication:** Although normally functioning well when using substances due to high tolerance, periodic and progressively more frequent episodes of rapid onset intoxication begin to occur causing a loss of behavioral control and substance-related problems.

1-7

Abstinence-based Symptoms

Symptoms that develop when substances are not used that create dysphoria, pain, and problems.

1. **Progressive Substance-induced Brain Dysfunction:** The long-term use of mood-altering chemicals causes brain dysfunction that disorganizes personality and causes social and occupational problems.

This brain dysfunction is most severe in genetically predisposed people.

This brain dysfunction is present during periods of intoxication, short-term or acute withdrawal, and long-term or post acute withdrawal, and chronic residual symptoms of permanent brain chemistry dysfunction.

In the late stages of substance dependence many clients develop substance-induced organic mental disorders which seriously impair their ability to respond to psychological, behavioral, and social treatments.

As this substance-induced brain dysfunction becomes more severe it causes difficulty in thinking clearly, managing feelings and emotions, remembering things, sleeping restfully, recognizing and managing stress, and psychomotor coordination. These symptoms often improve when mind-altering substances are used and return during periods of abstinence. The symptoms are most severe during the first 6 - 18 months of sobriety, but there is a life-long tendency of these symptoms to return during times of physical or psychosocial stress.

2. **Progressive Substance-induced Personality Disorganization:** As Substance Use Disorders become more severe they cause progressively more severe personality problems.

Definition of Personality: Personality is the habitual way of thinking, feeling, acting,

and relating to others that develops in childhood.

Factors Influencing Personality Development: Personality develops as a result of the interaction among genetically inherited temperaments, the consequences of prenatal care including parental substance use, and early developmental experiences in the family of origin.

Perpetuation of Personality Style: There is a strong tendency for childhood personality patterns (both self-enhancing and self-defeating) to be unconsciously perpetuated in patterns of adult living.

Dysfunctional Families: People raised in dysfunctional families often develop self-defeating traits or personality disorders (which AA calls character defects) that interfere with their ability to recover.

Personality Change: Although core personality styles are firmly imprinted and resistant to change, most people experience personality change over the course of their life as a result of three processes: the gradual development of personal maturity and as a result of life experience, education, and reflection; positive intense corrective emotional life experiences; and negative traumatic life experiences.

3. Relationship Of Personality & Substance Use Disorders: Self-defeating personality traits and personality disorders do not cause substance use disorders to occur but they can affect the rate of progression and the response to treatment. Self-defeating personality traits and personality disorders can cause: a more rapid progression of symptoms; difficulty in recognizing addiction; refusal to seek treatment in the early stages; difficulty benefiting from treatment; an increased risk of relapse;

4. Personality & Brain Dysfunction: Personality disorganization occurs because the substance-induced brain dysfunction interferes with normal thinking, feeling, and acting. All substance abusers will experience progressive personality disorganization with regular and heavy use. Substance Abusers with preexisting personality and mental disorders will decompensate more rapidly than those with more healthy and integrated personalities. Some of the personality disorganization is temporary and will spontaneously subside with abstinence as the brain recovers from the dysfunction. Other personality traits will become deeply habituated during the addiction and will require treatment in order to subside.

5. Progressive Social Dysfunction: Social dysfunction, including family, work, legal, and financial problems, emerges as a consequence of brain dysfunction and resultant personality disorganization. The progression of social problems typical moves from a normally integrated social life, to an alcohol and drug centered social life, to and addiction and crime centered social life, to addictive isolation.

6. Denial: People with substance use disorders have difficulty recognizing their

problems with substances for a number of reasons: (1) They have misinformation the nature of mind altering substances and addiction; (2) They are immersed in an alcohol and drug centered culture that glamorizes drinking and drug use, supports frequent, heavy, and abusive use, and enables alcohol and drug-related problems; (3) Their perceptions and memories of substance-related problems are distorted as a result of intoxication and withdrawal; (4) They develop progressive substance-induced brain chemistry dysfunction that causes by impairments in perception, abstract reasoning abilities, judgment, and impulse control; (5) Progressive personality disorganization causes dramatic changes in values, beliefs, mood, and behaviors and results in chaotic and unpredictable shifts in mood and personality; (6) There is a lack of available and socially acceptable and effectively designed resources for assessment and early intervention. (7) Family members lack knowledge about substance use disorders, effective intervention strategies, and addiction-specific treatment resources to support their intervention efforts; (8) The criminalization of drug abuse by the current war on drugs policy makes substances abusers and their families unwilling to place themselves or loved ones at risk for incarceration by seeking treatment.

7. **Tendency Toward Relapse:** Addiction is a chronic disease that has a tendency toward relapse. Relapse is best understood as the process of becoming dysfunctional in recovery that ends in physical or emotional collapse, suicide, or self medication with alcohol or drugs.

Part 2: Recovery & Treatment

1. **General Principles of Treatment:**

The most effective treatment programs recognize that effective treatment is based upon the principles of treatment availability, dignity & respect, voluntary & involuntary equivalence, and standardization.

- 1-1. **Recovery With & Without Treatment:** The most effective treatment programs recognize that many if not most people with substance use disorders will require proper treatment and self-help group involvement for an appropriate duration of time in order to recover. They also recognize, however, that some people are able to resolve problems related to substance use disorders without the benefit of professional treatment or self-help group involvement.
- 1-2. **Dignity and Respect:** The most effective treatment programs requires that all substance abusers be treated with dignity and respect at all stages of the treatment and recovery process.
- 1-3. **Treatment Availability:** Treatment needs to be readily available during all stages of recovery and is available upon within a reasonable period of being requested. Because individuals with substance use disorders may be uncertain about entering treatment,

it is important to take advantage of opportunities when they are ready to enter treatment. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

- 1-4. **Voluntary & Involuntary Equivalence:** The most effective treatment programs recognize that treatment does not need to be voluntary to be effective. Initial motivation, or lack of it is not critical to treatment outcome. Strong motivation can facilitate the treatment process, but initial approaches in treatment can create such motivation even in clients who are initially strongly resistant to the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions. The motivational status at time of admission, however, is not related to treatment outcome.
- 1-5. **Manualized Treatment System:** The most effective treatment programs utilize a manualized clinical system that includes reading assignments, journal assignments and self-assessment questionnaires, and preparation assignments for group and individual therapy sessions. Effective manualized treatment needs to match the content of treatment manuals, the modalities in which the content is processed with the problems of the client.
- 1-6. **Alcohol & Drug Testing:** The most effective treatment programs recognize that alcohol and drug testing can be an important adjunct to but not a replacement for treatment. Since substance use disorders are chronic and often relapsing conditions, lapses to drug use can occur during treatment. The appropriate objectives of alcohol and drug monitoring during treatment are:
 - 1-6-1. To help the patient withstand urges to use drugs; and
 - 1-6-2. To detect alcohol or drug use early so that individual's treatment plan can be adjusted to permit an early intervention, reevaluation of the client's needs in treatment, and adjustment of the treatment plan to better match the client's needs.
- 1-7. **Client Characteristics:** The most effective treatment programs recognize that client characteristics play an important role in predicting response to substance abuse treatment and that any comparison of outcome rates across treatment programs must take those differences into account.

1-7-1. Characteristics Associated With Positive Treatment

Outcome: The client characteristics associated with positive response to alcohol and drug treatment has been associated with being: married, employed, of a high social class, financially secure, socially active, well adjusted to work and marriage, and having little history of arrest. And low severity of psychiatric symptoms at admission

1-7-2. **Characteristics Associated With Negative Treatment**

Outcome: The client characteristics associated with negative response to treatment aggressiveness, high rates of attempted suicide, organic brain syndrome sociopathic personality, and dual diagnosis (a psychiatric diagnosis and a diagnosis of alcohol or drug abuse and dependence).

1-7-3. **Characteristics Not Associated With Outcome:** Client characteristics not associated with treatment outcome are gender and the degree or level of motivation at time of admission.

2. **Treatment Goals:**

The most effective treatment programs recognize that most appropriate goal for the treatment of substance dependence is the development of a personally meaningful lifestyle that involves productive functioning in the family, workplace, and society. This typical involves:

- 2-1. **Abstinence:** Abstinence from alcohol and other mind altering drugs. (At certain stages in the recovery process abstinence may not be realistically possible. At those times, effective programs provide harm reduction and motivational counseling processes can then be used to prepare the client to accept the goal of abstinence.)
- 2-2. **A Structured Recovery Program:** The development of a structured recovery program that supports abstinence and the development of a lifestyle centered around sober and responsible activities.
- 2-3. **Repair of Biopsychosocial Damage:** Repair of the physical, psychological, and damage caused by the substance use disorder.
- 2-4. **Treatment of Coexisting Disorders:** The treatment of coexisting mental and personality disorders that interfere with abstinence and responsible living.
- 2-5. **Positive Personality & Lifestyle Change:** Personality and life style changes that support continued abstinence.

3. **Treatment Methods:**

- 3-1. **Cognitive-Behavioral Therapy (CBT):** The most effective programs use addiction-focused cognitive-behavioral therapy that focus upon each specific drug of abuse (Carroll 1998). Cognitive-behavioral treatments:
- 3-1-1. are among the most frequently evaluated psychosocial approaches for the treatment of substance use disorders;
 - 3-1-2. have a strong level of empirical support;
 - 3-1-3. have been studied in regard to various types of substances including tobacco, alcohol, cocaine, marijuana, opiates, and other types of substances;
 - 3-1-4. are more effective when compared with no-treatment controls;
 - 3-1-5. are superior to or comparable to other treatment approaches studies;
 - 3-1-6. are effective in reducing the severity of relapses when they occur;
 - 3-1-7. enhance the durability of treatment effects;
 - 3-1-8. are most effective for patients at higher levels of impairment along such dimensions as psychopathology or dependence severity.

4. **Developmental Recovery Process:**

The most effective treatment programs conceptualize recovery from Substance Use Disorders as a long-term developmental process that progresses through stages. To successfully complete the long-term recovery process often requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence, successfully progress through all stages of recovery, and achieve fully restored biopsychosocial functioning. The stages of recovery are:

- 4-1. **Stage 0 – Active Addiction (Precontemplation):** During this stage substance abusers are actively using alcohol and other drugs,

receiving substantial perceived benefits from their use, experiencing few perceived adverse consequences, and as a result see no reason to seek treatment

- 4-2. **Stage 1 – Transition:** During this stage patients recognize that they are experiencing alcohol and drug related problems and need to pursue abstinence as a life style goal in order to resolve these problems;
 - 4-3. **Stage 2 – Stabilization:** During this stage patients recover from acute and post acute withdrawal and stabilize their psychosocial life crisis;
 - 4-4. **Stage 3 – Early Recovery:** During this stage patients identify and learn how to replace addictive thoughts, feelings, and behaviors with sobriety-centered thoughts, feelings, and behaviors;
 - 4-5. **Stage 4 – Middle Recovery:** During this stage patients repair the life style damaged caused by the addiction and develop a balanced and healthy life style;
 - 4-6. **Stage 5 – Late Recovery:** During this stage patients resolve family of origin issues which impair the quality of recovery and act as long-term relapse triggers.
 - 4-7. **Stage 6 – Maintenance:** During this stage patients continue a program of growth and development and maintain an active recovery program to assure that they don't slip back into old addictive patterns.
5. **Tendency Toward Relapse:**
- As with other chronic lifestyle related diseases, people with Substance Use disorders have a tendency toward relapse.
- 5-1. Relapse does not indicate a treatment failure.
 - 5-2. Relapse is best viewed as the process of becoming dysfunctional in sobriety due to sobriety-based symptoms that lead to either renewed alcohol or drug use, physical or emotional collapse, or suicide.
 - 5-3. The relapse process is marked by predictable and identifiable warning signs that begin long before alcohol and drug use or collapse occurs. This makes intervention possible for some clients before alcohol or other drug use begins. ([Miller & Harris 2000](#))

5-4. The appropriate response to a relapse is stop the relapse quickly by using a preplanned intervention, stabilize the client in the appropriate level of care, assess the factors that contributed to the relapse, revise the recovery plan, and get the person back to working a personal recovery plan as quickly as possible.

6. **Patient Treatment Matching:**

The most effective treatment matches each individual's particular problems and needs to the type of treatment. This involves the use of:

6-1. **Addiction-focused Biopsychosocial Framework:** The most effective treatment attends to the multiple needs of the individual, not just his or her drug use. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems. The most effective treatment of substance use disorders is biopsychosocial in nature focusing both upon motivating the substance abuser to stop using mind altering substances, self-evaluate their substance use and its benefits and disadvantages, make a commitment to abstinence, explore higher values that can provide meaning and purpose to a sober life, and identify and resolve related personal and life problems.

6-2. **Comprehensive Assessment System:** The most effective treatment programs start with a comprehensive assessment that evaluates the clients severity of addiction, profile the presenting problems, identifies the current stage of recovery and assesses other biopsychosocial conditions or disorders that are related to successful recovery from addiction.

6-2-1 **Detoxification:** The most effective treatment programs recognize that Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

6- 2-2. **Medical Problems Related To Substance Use Disorders:** The most effective treatment programs provide assessment for medical problems that often coexist with substance use disorders including HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases. When such coexisting

illnesses are present, counseling should be provided to help patients modify or change behaviors that place themselves or others at risk of infection, avoid high-risk behavior, and deal with the emotional and practical issues of managing their illness.

6-2-3. **Coexisting Psychiatric Disorders:** The most effective treatment programs recognize that addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

6-3. **Appropriate Medication Management:** The most effective treatment programs recognize that:

6-3-1. Medications can be an important element in the treatment of substance use disorders for many patients suffering from severe withdrawal or coexisting mental and emotional problems;

6-3-2. Appropriate caution must be exercised to avoid cross addiction,

6-3-3. Provide medication management as part of a comprehensive treatment program that combines medication management with counseling, other forms of behavioral therapies, and participation in self-help groups.

6-4. **Length of Treatment:** The most effective treatment programs recognize that substance use disorders are chronic and lifestyle related health problems that require consistent long-term care. As a result they keep clients in treatment for an adequate period of time at a level of care appropriate to their current needs in recovery. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6-5. **Levels Of Care:** The most effective treatment programs use a level of care system that matches the client's level of stability and needs in treatment to a specific level of care including inpatient, residential,

outpatient, case management. Although the primary focus of treatment is upon the delivery of long-term outpatient services, effective treatment can increase and decrease the intensity of the level of care based upon changes in the client's level of stability during treatment..

- 6-6. **A Variety of Treatment Modalities:** The most effective treatment programs have a broad spectrum of treatment modalities within each level of care that include education, group therapy, individual therapy, and self-help groups. Patients are matched to specific treatment modalities based upon their unique profile of individual needs.
- 6-7. **Self-help Program Participation:** The most effective treatment programs recognize that participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.
- 6-8. **Multidisciplinary Team:** The most effective treatment programs are staffed by multidisciplinary treatment teams whose members develop close formal and informal relationships with each and with the substance abusers they treat. Patients are matched to specific members of the treatment team based upon their unique profile of individual needs.
- 6-9. **Treatment Coordination:** The most effective treatment programs coordinate and integrate all aspects of treatment into an individualized treatment plan that focuses upon developing a personal recovery program that involves a schedule of professional, self-help, and personal recovery activities.
- 6-10. **Continuing Assessment & Treatment Plan Updating:** The most effective treatment programs recognize that an individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.

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