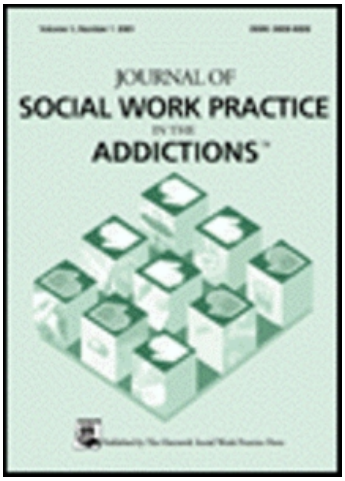

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The Addiction Treatment Roundtable: A Clinical Wisdom Study

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The Addiction Treatment Roundtable: A Clinical Wisdom Study

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Over the last 70 years, the treatment of drug and alcohol problems has been an exciting, creative, heroic, and, at times, contentious endeavor. Although this is beginning to change, the numerous factions and traditions in the field have often emphasized their areas of difference rather than those of agreement. To help remedy this, the Addiction Treatment Roundtable was created as an opportunity for interdisciplinary dialogue and interaction, and professionals from a wide range of treatment perspectives were invited to join. The Roundtable invitees were asked to reflect on the question of how patients get better and what psychosocial treatment factors might be at work in this process. The hope was that one or more models or visions of effective addiction treatment might emerge from these dialogues, and that these could then be used to guide the creation of more effective programs.

The 25 participants were all from the New York City metropolitan area. In terms of work settings, they each came from one or more of the following clusters: (a) standard/traditional treatment (i.e., outpatient treatment, methadone maintenance, therapeutic communities); (b) harm reduction (i.e., needle exchange, harm reduction psychotherapy); (c) psychology-based treatments (i.e., psychoanalysis, contingency management, relapse prevention, motivational interventions); and (d) other (i.e., research, funding, clinical leadership, dissemination, education). The Roundtable was held at New York University on June 15 and June 22, 2007, and the participants

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attended for all or part of one or both days.[1] On average, they had been working in the field of addiction treatment for 18.6 years ($SD = 9.72$) and 78% identified themselves as clinicians, whereas 74% identified themselves as administrators; they all had advanced degrees (MA, MSW, PhD, MD). The structure of each day was a mixture of presentations and discussions, and participants were specifically requested to refrain from discussing financial challenges and problems with funding.

Building on the work of the various note-takers who were present, 20 mechanisms of change and 5 treatment guidelines were identified and these were used to create the Psychosocial Mechanisms of Change/Treatment Guidelines Questionnaire.[2] This questionnaire was then completed by 23 participants (including the two authors), and an intervention or approach was deemed significant if 75% or more of the participants gave it a high rating on the questionnaire.

When we envisioned the Roundtable, we expected that there might be some disagreements and perhaps displays of tension and strong emotion. To our surprise, however, we found very high levels of agreement from the outset. Clearly one of the insights of the study is that when clinicians are removed from their institutional settings and are able to speak freely, they largely agree on how addicted people change and what is need to improve the quality of care.

Interestingly, the mechanisms of change that emerged from the findings included practices that are widely used, approaches that are seldom used, and new ways of envisioning current treatments. To start, we found an emphasis on the unique journey of each addicted individual, which meant that a truly individualized treatment plan should be the norm. Seeing patients as possessing positive strengths was also quite common, and there was a general emphasis on improving their sense of self-efficacy. In terms of directly empowering patients to address the addictive experience, the relapse prevention method was almost universally endorsed.

Recovery was understood as a process that frequently takes place within the context of an affirming relationship matrix. This was reflected in a central emphasis on the therapeutic relationship, family therapy, and involvement with recovering peers and self-help groups.

Across the board, patients were perceived as being ambivalent about ceasing their use of substances. In response, the participants felt that

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[1] The participants in the Addiction Treatment Roundtable included Marylee Burns, Molly Carmel, Sarah Church, Lydia Fleck, Kathryn Grooms, John Hamilton, Richard Juman, Scott Kellogg, Ana Kosok, Nicholas Lessa, Patricia Lincourt, Bart Majoor, Kasia Malinowska-Sempruch, Ira Marion, Susan Ohanian, Fernando Perfas, Joyce Rivera, Debra Rothschild, John Rotrosen, Michelle Stocknoff, Andrew Tatarsky, Daniel Wolfe, and three other anonymous participants. This study was approved by the New York University Institutional Review Board.

[2] A copy of the Psychosocial Mechanisms of Change/Treatment Guidelines Questionnaire can be obtained from the first author at scott.kellogg@nyu.edu.

the various motivational interventions (i.e., motivational interviewing, the decisional balance) should be common practice, and that harm reduction practices and philosophies should be a central part of treatment. The strong endorsement of harm reduction certainly reflects a sea change in the attitude of treatment providers.

Another major shift was found in the general understanding that many or most patients are using substances in part because of inner pain and psychopathology and that this suffering needs to be addressed through individual psychotherapy from the commencement of treatment. Intertwined with this was an appreciation of the fact that people might be using the same substance in different ways and for different reasons at different times. The reasons, which could include seeking pleasure, affirming group membership, numbing oneself, lessening psychiatric symptoms, rebelling against authority, or coping with social oppression, need to be clarified and, in some cases, might require direct and specific treatment.

In a related vein, the group agreed that many addicted individuals might have a great deal of difficulty experiencing pleasure from normal hedonic sources. To help them access healthy sources of pleasure, addiction treatment programs should consciously make this one of their goals and should include such somatic practices as yoga, massage, acupuncture, tai chi, sex therapy, and other disciplines to help patients rebalance themselves.

Finally, the group addressed the issue of sustaining a long-term recovery. As a way to fundamentally change one's life, an existential exploration of what one's values have been, what they currently are, and what one would like them to be in the future is a place to start. A strategy could then be created to manifest them in a concrete way, and the patient could then take action to implement the plan.

The group also endorsed the idea that long-term recovery is predicated on the creation and embrace of viable personal and social identities that conflict with and ultimately replace those based on the addictive use of substances. The recovering person might eventually become a worker, father, artist, social activist, entrepreneur, minister, or something else; however, to successfully support the recovery process, this new identity must be existentially meaningful, socially and personally reinforcing, and in direct conflict with the use of substances.

Whether this kind of consensus has actually existed for a long time or if it is something new is not clear; however, when these professionals stepped out of their specific treatment cultures, a common, if complex, view of change and healing emerged. We are heartened by what we found, and we hope that this roundtable process will be replicated by others. We can all gain from this kind of wisdom.