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Addiction Treatments

Joni Utley and Lisa M. Najavits
VA Boston Healthcare System and Boston University School of Medicine, U.S.A.

The term *addiction* is broadly used to refer to any activity pursued excessively, persistently, and with damaging consequences (e.g., activities such alcohol or drug use, gambling, internet, spending/shopping, sex). However, there is no one single definition in the field as it is not a *DSM-5* term. One widely used operational model is known as the *three C's of addiction*: behavior that is motivated by emotions ranging along the craving to compulsion spectrum, continued use in spite of adverse consequences, and loss of control (Shaffer, 1999).

For most of U.S. history, addiction has been viewed broadly as both *moral failure* and *physical disease*. Early on, the intersection of addiction and religion influenced an understanding of both the addict and substances themselves in the context of sin (i.e., moral failure). As medical science advanced, professionals increasingly gained greater insight into the addictive process, and began to conceptualize addition in the context of biological processes and genetic influences (i.e., physical disease). As early as the 1700s, Dr. Benjamin Rush (1746–1813) labeled addiction a disease (Thombs, 2006). He went to great lengths to define, study, and classify it as such, and identified abstinence as the only cure. His writings on addiction sparked increased attention to alcoholics and led to the formation of temperance organizations throughout much of the United States. The temperance movement, with its vehement opposition toward substances, particularly alcohol, led to Prohibition (1919–1933), essentially a federal ban on alcohol sales. The legal use of opiates and cocaine in the late nineteenth century, usually in the form of tinctures, tonics, and tablets, and the associated serious medical and social negative consequences of these, led to efforts to legislate many drugs as illegal during the early twentieth century.

These historical developments resulted in an increase in the quality and availability of addiction treatment, yet also to increased pessimism about recovery by both the general public and professionals. Those with addiction were often demonized and frequently ended up in prison or aging inpatient state psychiatric hospitals. In the eighteenth, nineteenth, and much of the twentieth century, the understanding of addiction as disease (i.e., the medical model), and the view of addiction as immoral (i.e., the

moral model) both prevailed. These two views, though distinctly different, had the same remedy in common—abstinence. Paradoxically, as public and medical professional opinion was becoming more negative toward addiction, several mutual aid organizations flourished. White (2009) documents a lengthy history of such organizations in the United States, including the Native American Wellbriety Movement, the Washingtonians, the Keeley Leagues, and eventually, in 1935, Alcoholics Anonymous (AA). The latter is also known as a 12-step group program (i.e., self-help fellowships of people with addictions who follow 12 spiritually based guiding principles, or "steps," toward recovery). Later versions included numerous variants, such as Cocaine Anonymous, Narcotics Anonymous, and behavioral addiction (nonsubstance) 12-step groups such as Overeaters Anonymous, Gamblers Anonymous, and others. AA remains one of the largest and most accessible mutual aid organizations in the world. Such movements gave credence to a philosophy of recovery in community, the idea the addict would need relationships and resources beyond the self to successfully heal, and that community service and amends to others are integral parts of this healing. The success of these organizations suggested that in order for a society to successfully treat the addiction, they would need to formulate and adopt an understanding of addiction that incorporates compassion and treatments that include community support.

Meanwhile, mainstream medicine and mental health did not address addiction until later mid to late twentieth century. Even then it was typical to refer out addicted patients to 12-step groups until they achieved sobriety, perhaps needing to "hit bottom" along the way (i.e., suffer serious consequences of addiction). Once "clean and sober," patients were perceived as able to benefit from mainstream medical and mental health efforts. There were exceptions, including attempts to make use of various medication treatments, but by and large, addiction treatment has been primarily psychosocial in nature through to the current era (in part due to the absence of medications that could reliably help a large number of addicted people).

AA conceptualizes alcoholism as a chronic, progressive disease based on loss of control, rather than based on characteristics of the substance or the user. Abstinence is viewed as the only remedy. AA emphasizes both spirituality and biological factors (e.g., gene heritability) in the etiology and recovery from addiction. The AA understanding of addiction remains one of the prominent views in the United States today, and many current treatment programs use an AA approach, encourage AA attendance, adopt the AA philosophy on the chronic nature of the illness, and advocate abstinence (Thombs, 2006).

However, alternative conceptualizations and clinical strategies have also emerged in the past few decades that are in contradiction to the AA philosophy, such as harm reduction (i.e., gradually decreasing use), controlled use (i.e., the idea that some can return to safe levels of use), and the idea that addiction may not be a life-long illness for everyone. Also, newer treatment models are typically not overtly spiritual, including motivational interviewing, cognitive behavior therapy (CBT) approaches, Self-Management and Recovery Training (SMART) Recovery (a CBT self-help approach), screening, brief intervention, and referral to treatment (SBIRT), and medication management (some of these are described in more detail below). In recent decades, there has been a trend in the field towards diversification of treatments, in sharp contrast to previous times when 12-step philosophy was often seen as the only choice. Another emerging trend has been the development of new treatments and adaptations of 12-step approaches for specific populations (e.g., women, adolescents, those with comorbid mental health conditions). This trend also has had the benefit of better identifying addiction in such populations, in whom it often was more hidden in years past. Another major treatment development is the increasing reliance on research as the

basis for treatment (i.e., evidence-based practice), rather than grassroots emergence of them such as occurred with 12-step and other recovery efforts in earlier eras. Several major new treatment trends are summarized below, followed by examples of prominent addiction therapies.

Evidence-Based Practices

The Institute of Medicine's *Quality Chasm* report (2001) cited Sackett and colleagues' 1996 definition of evidence-based practice (EBP) as "the integration of best research evidence with clinical expertise and patient values." Over the past several decades, EBPs have been adopted across many systems of care, including the addiction field. Though widespread, the implementation of these treatments has frequently been a hotly debated issue. Hesitation to adopt EBPs within the addiction field has been due to various factors, with workforce issues as a chief concern. For example, there are significant challenges and costs involved in training providers, particularly to a high-quality level of fidelity to the treatments. In addition, the composition of the workforce in the addiction field historically has been predominantly people in recovery themselves, who typically had less formal education and credentialing than clinicians in mental health or other areas of medical care. Many of these providers may have held strong beliefs about the need for continued use of 12-step approaches that helped their own recovery and thus may have been hesitant to change or add new treatment approaches (e.g., EBPs) due to personal experiences of success in recovery without EBPs. Other questions related to adoption of EBPs include whether treatment research generalizes to real world application, and whether EBPs are superior to standard clinical practice. Some of the major research trials on addiction treatments have, in fact, evaluated new models in comparison to 12-step approaches (Silverman, Najavits, & Weiss, in press). Finally, there are many differing standards as to what constitutes an EBP in the addiction field. Definitions of EBPs include those of the American Psychological Association's Division of Clinical Psychology, Substance Abuse Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP; www.nrepp.org), the Institute of Medicine, and the Cochrane Reports. In sum, there is currently no agreed-upon standard in the field of addiction for defining EBPs at present. Various treatments have been tested in randomized controlled trials (considered the gold standard for scientific evidence in treatment outcome research), and identified as EBPs in the addiction field.

Comorbidity

Another current development in the addiction field is an emphasis on comorbidity (i.e., focusing treatment on all psychiatric disorders that are present concurrently), as patients with addiction are highly likely to have one or more co-occurring psychiatric disorders. The National Comorbidity Survey conducted in 1994, the first large-scale field survey of mental health in the United States, provided the impetus for an increased focus on comorbidity in the mental health and addiction field (Kessler et al., 2005). Following this, in 2005, the National Comorbidity Survey Replication (Kessler et al., 2005) revealed important information about national comorbidity rates, showing the lifetime prevalence of alcohol abuse at 13.2%, the lifetime prevalence of any psychiatric disorder at 46.4%, 27.7% of respondents with two or more lifetime disorders, and 17.3% respondents with three or more lifetime disorders. Historically, addiction treatment did not attend to other comorbid disorders, and patients with such disorders were not identified nor given specific treatment for them. The prevailing wisdom was that substance abuse should be addressed first, and only after attaining abstinence should patients begin work on other co-occurring mental health disorders. It is now widely recommended that integrated care, treating both disorders at the same time,

is more likely to help patients achieve substance abstinence, as well as improvements in other areas. Indeed, evidence consistently indicates that working on both disorders at the same time results in positive outcomes in both, as well as related areas (Silverman et al., in press).

Examples of EBP Models for Substance Use Disorders

As the evidence for the treatment focus of the EBTs discussed below is more narrow than the broad concept of "addiction" used throughout this article to this point, from here forward, the term substance use disorders (SUD) is used to refer to the *DSM-5* definition of substance use disorder, which includes: (a) substance taken in larger amounts or over longer period than intended; (b) a persistent desire to cut down or regulate substance use; (c) significant time spent on the substance; (d) craving, strong desire, or urge to use a substance; (e) recurrent use resulting in failure to fulfill major role obligations at work, school, or home; (f) continual use of the substance despite social/interpersonal problems caused by the substance; (g) important social, occupational, or recreational activities given up or reduced due to substance use; (h) recurrent use in physically hazardous situations; (i) continued use despite knowledge of persistent or recurrent physical or psychological proglems likely to be caused or exacerbated by substance use; (j) tolerance (i.e., the need for greatly increased amounts of the substance to achieve intoxication or the desired effect or a markedly diminished effect with continued use of the same amount of the substance); (k) withdrawal (i.e., a maladaptive behavioral change with physiological and cognitive concomitants that occurs when blood/tissue concentrations of a substance decline in a person who had maintained prolonged heavy use of the substance). Currently, there are numerous EBTs for SUD. The list of EBTs below is not all-inclusive; the particular treatments listed here were selected based on general acknowledgment of evidence base and popularity in the field. Descriptions of treatments below are based on the SAMHSA (2012) NREPP website, Moos' (2007) article on effective treatments for SUD, and McGovern and Carroll's (2003) review of EBPs for SUD. First, evidence-based treatments most widely used for SUD are listed. Following these, evidence-based treatments developed for co-occurring disorders (i.e., posttraumatic stress disorder [PTSD] and SUD) are described. Finally, evidence-based group and family treatments with brief descriptions are listed.

General EBPs for SUD

Motivational Interviewing and Motivational Enhancement Therapy

Motivational interviewing (MI) and motivational enhancement therapy (MET) are patient-centered therapies in which the therapist's relationship with the patient is direct, but supportive and empathic, and focused on eliciting motivation for behavioral change by providing feedback that increases the discrepancy between current behaviors and desired change (SAMHSA, 2012 as listed in 2008). The approach by Miller and Rollnick (2002) is based on Prochaska and DiClemente's (1983) stages of change model and is based on the assumption that ambivalence is the primary obstacle to change. Central goals of these treatments are to help patients resolve ambivalence, to elicit and reinforce patient statements about change and to strengthen patients' commitment to changing substance use behaviors (Moos, 2007). The sessions are goal-directed and structured. Where MI can be considered a counseling style, MET is an adaptation of the approach that involves typically 1–4 sessions in which feedback is presented and discussed in order to enhance motivation to reduce substance use. MET is often used prior to initiation of treatment or as a stand-alone treatment to enhance motivation to reduce or cease substance use. Explicit attention is given in these approaches to strengthen the patients' self-efficacy and responsibility for change and to reward change behavior. MI and MET have

been found to be effective with alcohol use disorders and produced favorable outcomes in the NIAAA Project MATCH Study (McGovern & Carroll, 2003). MI has been effectively applied not only with SUD populations, but also with many other mental health disorders and to assist with medical and mental health treatment adherence (SAMHSA, 2012 as listed in 2008).

Twelve-Step Facilitation

Twelve-step facilitation (TSF) is a brief, manualized treatment based on 12-step fellowship (e.g., AA) principles and the disease model of addiction. This treatment is based on conceptualizing SUD in terms of cognitions, behaviors, and spirituality (SAMHSA, 2012 as listed in 2008). A central premise in treatment is that the patient must admit their substance use disorder and accept an identity as an alcoholic or drug addict and surrender to a "higher power" and/or the group conscience rather than relying on self (Moos, 2007). Abstinence is the ultimate treatment goal, and the TSF therapist actively encourages involvement in AA and/or other 12-step groups to complete the steps and to gain community and social support. Also, in this treatment, there is an emphasis on obtaining a sponsor, who becomes a critical role model and additional supportive relationship for the patient. Patients are rewarded for involvement in AA and other sober community activities as well as the progression to their helping others in recovery (SAMHSA, 2012 as listed in 2008). The TSF manualized treatment was compared against MET and CBT in the NIAAA Project MATCH Study, and TSF showed positive outcomes in terms of abstinence, retention in treatment, and other life functioning measures (McGovern & Carroll, 2003).

Contingency Management

Contingency management (CM) is based on the idea that substance use is initiated and maintained by environmental factors and can thus be changed by altering the consequences of substance use (Moos, 2007). CM assumes that substance use will decrease if the costs (defined broadly, to include all relevant domains of experience including, but not limited to: financial, emotional, social, etc.) of obtaining the substance increase and/or the negative results of using a substance increase. Additionally, if alternative rewards that satisfy a similar craving or need are available, substance use should decrease. CM thus provides incentives to make use less desirable and uses positive reinforcement, or rewards, to promote behavior change. Components of CM include: monitoring use (typically via urinalysis), providing rewards for abstinence (e.g., support, vouchers, prizes, encouragement, clinic privileges) and withholding rewards if the patient does use (Moos, 2007). CM is typically used as an adjunct to another treatment rather than as a stand-alone intervention for SUD. There is an extensive body of research supporting the efficacy of CM for SUD and other psychiatric disorders with positive outcomes typically in abstinence, achievement of other treatment goals, treatment attendance and compliance (Higgins, Alesso, & Dantona, 2002 as cited by Moos, 2007).

Cognitive Behavioral Treatments

CBT for addiction emphasizes conceptualization of the patient's core beliefs, automatic thoughts, and associated behavioral responses. CBT is based both on cognitive psychology and social learning theory; thus, it is assumed that substance use is a learned behavior that can be changed by modifying cognitive behavioral processes (Beck, Liese, & Najavits, 2005). Treatment focuses on identifying and increasing awareness of the patient's beliefs and automatic thoughts, and then on working collaboratively on challenging those thoughts and reality-testing them. Then, patients are taught new coping skills to replace problematic and destructive behaviors. Major multisite randomized clinical trials, including the National Institute on Alcohol Abuse and Alcoholism (NIAAA) Project MATCH and the National Institute on Drug Abuse (NIDA)

Collaborative Cocaine Treatment Study have studied CBT and demonstrated its effectiveness in SUD outcomes as well as other life domains; social and coping skills training are adaptations of CBT (McGovern & Carroll, 2003). CBT is the basis for relapse prevention, an evidence-based approach to both identify and prevent high-risk situations for substance use relapse.

Relapse Prevention Therapy

Relapse prevention therapy (RPT) is a cognitive behavioral treatment approach that teaches patients with SUD self-control techniques in the context of relapse (SAMHSA, 2012 as listed in 2009). The treatment prepares patients for coping with triggers for relapse by providing psychoeducation to patients to help them understand relapse and by helping patients to identify high-risk situations that may trigger relapse. The acquisition of new coping skills, particularly to deal with cravings and urges, is a key part of the treatment. RPT can be used as a stand-alone treatment or as an adjunct to treatment, and it has been used successfully with SUD and many other psychiatric disorders (Witkiewitz & Marlatt, 2004). RPT is commonly used in aftercare programs to sustain gains achieved during more intensive treatment. This treatment model is based on Alan Marlatt's (1941–2011) taxonomy of relapse and has been widely studied since it was first implemented in 1977 and has shown positive outcomes in terms of abstinence, sustained behavior change, and several other factors (Beck et al., 2005; SAMHSA, 2012 as listed in 2009).

Screening, Brief Intervention, and Referral to Treatment

Screening, brief intervention, and referral to treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders and those at risk of developing substance use disorders (Babor et al., 2007). SBIRT is designed for and has been implemented across a wide range of settings, including primary care clinics, specialty care clinics, and other community settings to provide early intervention opportunities those patients struggling with addictions. Research on SBIRT began in the 1990s and has been conducted nationally and internationally. Outcomes on SBIRT reliably demonstrate that SBIRT yields positive improvements on overall health and significantly reduces illicit drug use and drinking (Babor et al., 2007).

Examples of Comorbid SUD Therapies

Seeking Safety for Comorbid SUD/Posttraumatic Stress Disorder

Seeking safety (SS; Najavits, 2002) is a manualized, present-focused treatment for patients with a history of trauma and substance abuse. This treatment is used as a first-stage therapy for each of the disorders, designed to stabilize the patient, teach coping skills, and reduce destructive behaviors including substance use. The treatment employs a combination of interpersonal, cognitive behavioral, and case management strategies. It has a heavy emphasis on teaching and acquisition of new coping skills with explicit attention to the therapeutic alliance and case-management needs. The treatment consists of topics designed to restore ideals that have frequently been lost due to SUD or trauma. The evidence base of published SS studies represents a broad range of investigators and populations and includes over 20 outcome studies, with positive results in various domains including decreased substance use, increased coping skills, decreased PTSD symptoms, and improvements in various other life domains (Najavits, 2006).

Dialectical Behavior Therapy for Comorbid Disorders Including SUD

Dialectical behavior therapy (DBT) is a well-established cognitive behavioral treatment approach for individuals with multiple psychological disorders, including those who

are chronically suicidal. Because many of these patients also have SUD, Marsha Linehan (b. 1943) and colleagues developed DBT for SUD, which includes strategies to promote abstinence and reduce the adverse impacts of relapse. DBT has two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. Randomized clinical trials for the treatment have shown decreased SUD in patients with borderline personality disorder. The treatment also may be helpful for patients who have not responded to other evidence-based SUD therapies (Beck et al., 2005).

Couples and Family EBPs for SUD

Behavioral Couples Therapy

Behavioral couples therapy (BCT), or behavioral marital therapy, is a therapy using behavioral principles and contracting to reinforce abstinence and encourage the appropriate use of adjunctive pharmacotherapy treatments for SUD. Assumptions held within this treatment model are that powerful rewards can occur when partners reinforce abstinence and reducing couples' problems and distress reduces the risk for relapse (SAMHSA, 2012 as listed in 2007). The therapist works with both partners to achieve a relationship that helps to support abstinence. Positive outcomes have been demonstrated in terms of substance reduction, improved relationship variables, and decreased violence in relationships (McGovern & Carroll, 2003).

Brief Strategic Family Therapy (BSFT)

Brief strategic family therapy (BSFT) is a systems-focused treatment that assumes the family system influences all members of the family. It was originally developed for Hispanic adolescents and their families but has shown positive outcomes for African American families and individual children and adolescents as well (SAMHSA, 2012 as listed in 2008). The treatment is designed primarily to reduce or prevent a wide range of problem behaviors among adolescents, including not only substance use, but also other behavioral problems such as risky sexual behaviors and aggression. The therapist works to identify problematic patterns within the family and then to restructure the system to generate more adaptive, healthy patters of interaction (SAMHSA, 2012 as listed in 2008). The treatment has shown positive outcomes in terms of substance use reduction, improved family relationships and improved treatment compliance (McGovern & Carroll, 2003).

Multidimensional Family Therapy

Multidimensional family therapy (MDFT) is a comprehensive and multisystemic family-based outpatient or day treatment program for adolescents with current or those with high risk of SUD and co-occurring disorders (SAMHSA, 2012 as listed in 2009). The therapist working in this modality addresses the youth and/or the youth and his or her family to improve coping and problem-solving skills, with the idea that better interpersonal skills and relationships protect against SUD and related problems. Four key social areas are targeted: the youth's relationships with parents/peers, the parents' parenting skills, parent–youth interactions in therapy, communication between family members and other social systems. Research has shown improvements in substance use, substance use-related problem severity, treatment retention, and risk factors for other problem behaviors, among other variables (McGovern & Carroll, 2003).

Common Elements of All Effective Addiction Treatments

Key principles of effective addiction treatment have been described by various researchers and clinicians in journal articles and book chapters as well as outlined in various ways by different organizations such as the American Psychiatric Association's practice guidelines for addiction treatment (though currently outdated per their website), NIDA's principles of drug abuse treatment, and best practice

documents as published by the Addiction Technology Transfer Center, Division 29 (Psychotherapy) of the American Psychological Association, the Network for the Improvement of Addiction Treatment, and others (see Further Reading).

The following principles of effective addiction treatment are a compilation of strategies primarily adapted from two sources: Beck et al. (2005) and Moos (2007) and include: (a) a strong therapeutic alliance, (b) goal-oriented nature of sessions, (c) initial focus on present patient problems, (d) structured therapy sessions with active participation, (e) goal of increasing patient self-efficacy, (f) appropriately aiming for harm reduction/abstinence, (g) rewarding/reinforcing positive choices regarding substance use, (h) providing psychoeducation, and (i) acquisition/practice of new coping skills by patients.

Build Alliance

A strong therapeutic alliance is essential to the success of the treatment, and the goal is for the therapist to foster a caring, collaborative, and respectful relationship that encourages and solicits ongoing client feedback and relationship growth. The quality of the alliance between patient and therapist has consistently been associated with a host of positive treatment outcomes, including greater treatment attendance, greater engagement in the exploration of problems, greater reduction of SUD, improvements in mood and affect, and better long-term SUD outcomes, among others (Moos, 2007). Due to the high dropout rates with the SUD population, this alliance is essential; alliance scales can assist in measuring this relationship and facilitating a dialogue about the therapist–patient relationship (Beck et al., 2005).

Create Structure

Structure and organization, including goal orientation are particularly important in the effective treatment of SUD. There is no one way to do this, but typically, regardless of the treatment modality, describing and outlining the structure of therapy sessions, maintaining consistency, and continually monitoring substance use, with an emphasis on expected goals of treatment, tailored to the individual are recommended (Beck et al., 2005). For example, a therapist might set substance use goals with the patient from the outset of treatment and then use check ins, a very structured and specific way each session to monitor the substance use and work towards change. Emphasizing goals while improving patients' understanding of self are associated with positive outcomes in SUD treatment (Moos, 2007).

Focus on Specific Goals

Therapists initially emphasize current and specific problems that are distressing to the patient. Working on specific patient problems includes different techniques, depending on the therapy. Underlying all good SUD treatment, however, is a focus on the present distress in patient's life (in contrast to initially focusing on the past). When the patient has a comorbid diagnosis, it is important to address problems related to both.

Increase Self-Efficacy

SUD therapists work to increase patient self-efficacy. This is done with different strategies, depending on the type of therapy used, but a central theme no matter the modality of treatment is to always actively work on improving self-efficacy by supporting patient strengths, encouraging positive progress and utilization of support networks/coping skills, and eliciting and reinforcing the patient's values and ideas about change (Moos, 2007). Self-efficacy needs to be continually tended to as it is a known predictor of outcomes across all types of addictive behaviors.

Decide on Substance Use Goal

Abstinence is generally the safest goal in SUD treatment; however, for some patients harm reduction is a more achievable/adequate goal. Particularly with patients with co-occurring disorders, the reduction of substance use may increase other psychiatric symptoms (i.e., typical with PTSD), making abstinence all the more challenging and making attendance to

treatment crucially important to monitor safety and ensure clinical improvements. Thus, it is generally recommended that the decision on an appropriate substance use goal be thoughtful, collaborative, tailored to the individual, and explicit from the beginning of treatment. Then, clinicians can carefully monitor patients' progress objectively over time and work with them to hold them accountable and facilitate improvements.

Reward Positive Choices

Therapists should carefully balance holding the patient accountable for substance use limits/goals and promoting growth and goal attainment. It is crucial that therapists are realistic in expectations for substance use reduction in early recovery and that they reinforce and reward any and all positive choices and good coping that moves the patient's recovery forward.

Psychoeducation

Psychoeducation to help patients understand the etiology of their disorder, as well as how and why any distorted or inaccurate core beliefs that underlie SUD or other destructive behaviors formed, can be extremely helpful when done in an empathic and collaborative spirit. Additionally, a key area of focus in all successful SUD treatments is teaching patients new coping skills to manage various domains of their experience, including thoughts, behaviors, relationships, etc. (Beck et al., 2005). Homework is typically employed to solidify skills learned in session by applying them in the patient's outside world, and to maximize treatment gains. Homework should be tailored to the individual patient for best results.

Customize Treatment

Therapists should carefully select approaches developed for the appropriate specialty population or comorbidity when applicable. Research has consistently demonstrated that focusing on psychiatric problems in an integrated and holistic way is the most effective (e.g., rather than addressing SUD first, then working on any other psychiatric problems) (Beck et al., 2005). It is imperative that therapists carefully think through and assess for any comorbid disorders, as most individuals with SUD have one or more additional psychiatric illnesses (Kessler et al., 2005).

Future Directions in SUD treatments

Despite some of the innovations in the SUD treatment field described above, it is a young field and many important questions remain. Exciting future directions in addiction treatments include the following: evidence-based gender-appropriate and culturally responsive SUD treatments; evidence-based treatments for prescription drug abuse (the fastest growing drug problem in United States); technology-based approaches; equivalence of treatments (i.e., why is there a need for so many different evidence-based treatments if outcomes to all treatments are comparable in terms of efficacy); and workforce issues regarding training addictions clinicians in EBPs (e.g., creating decision rules about the investment of training in EBPs).

SEE ALSO: Alcohol-Related Disorders; Behavior Therapies; Cognitive Therapies; Combined Treatments (Medication plus Psychotherapy); Common (Nonspecific) Factors in Psychotherapy; Dialectical Behavior Therapy (DBT); Motivational Interviewing

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Further Reading

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Adjudicative Process

Rebecca Gray Klotzle
Attorney, Boston, U.S.A.

Generally, an adjudicative process is a form of dispute resolution. Adjudicative process refers to the legal process of decision making used to resolve an adversarial dispute. When two or more parties cannot reach resolution of a dispute on their own, one or more of the parties may elect to have their dispute settled by an impartial third party. The adversarial parties must be given notice of the adjudication and an opportunity to present evidence and arguments of their side before the neutral third party. This neutral third party acts as fact finder and considers the evidence and arguments in an effort to reach a fair, reasonable, and equitable resolution of the issue. The impartial fact finder has the authority to make a binding declaration of the rights of the parties and to award some form of judgment. Once the dispute has been adjudicated, the decision is binding and enforceable on both parties. In