Using “Wise” Psychosocial Interventions to Address Social Stigma and Substance Use Relapse in Persons with Co-Occurring Disorders

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Abstract

Interventions that address stigma surrounding mental health and addiction may maximize the benefits of treatment; however, few interventions exist that address stigma among persons with co-occurring disorders. Developing and implementing strategies to reduce internalized stigma as a barrier to recovery and mediate its impact on the individual’s perceived sense of belonging was critical to minimizing the impact on the individual’s social environment and society. Early intervention may also help to forestall the emergence of acute COD presentations. The purpose of this work was to shed light on the relevance of stigma, its relationship to substance use relapse in persons with COD, and to propose using ‘wise’ interventions that are currently and effectively in play in other contexts to address similarly potent social and behavioral problems, and to address opportunities in service delivery to increase motivation for the process of recovery in this population.
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**Introduction**

The Substance Abuse and Mental Health Services Administration (SAMSHA) states that roughly 8.9 million adults in the U.S. have a co-occurring substance use and mental health disorder. Co-occurring disorders (COD) are linked with more severe symptoms, greater disability, and a longer course for the illness (de Graaf, Bijl, Smit, Vollenbergh, & Spijker, 2002). When substance use and mental health problems co-occur, there is higher risk for relapse. This represents a significant public health problem with costly social and economic implications for affected individuals, families, and communities.

Streuning et al. demonstrated 20 years ago that interventions that address stigma may maximize the benefits of treatment, but few interventions exist that address stigma among persons with co-occurring disorders (Rodrigues, Serper, Novak, Corrigan, Hobart, Ziedonis, & Smelson, 2013). In addition, interventions that target service settings are scarce (Carrâ & Johnson, 2009). Developing and implementing strategies to reduce internalized stigma as a barrier to recovery and mediate its impact on the individual’s perceived sense of belonging, is critical to minimizing the impact on the individual’s social environment and society. Early intervention might also help to forestall the emergence of acute COD presentations (Rodrigues, et al., 2013).

The purpose of this work is to briefly shed light on the relevance of stigma and its relationship to substance use relapse in persons with CODs, to propose borrowing knowledge and interventions that are currently and effectively in play in other contexts to address similarly
potent social and behavioral problems, and to address opportunities in service delivery to increase motivation for the process of recovery in this population.

The paper will first provide background and definitions for key concepts, including substance use relapse in the context of COD, discuss historic barriers in service delivery, followed by a discussion of how these conditions are conceptualized and reinforced within the framework of Individual Psychology (IP). It will then introduce ‘wise’ psychosocial interventions, describe how they work, and follow with several examples of interventions with proposed adaptations for application in treatment settings for persons with COD, followed by general discussion and implications.

**Background and Key Concepts**

**Co-Occurring Conditions**

COD’s are common presentations characterized by the presence, either simultaneously or in succession, of two or more specific psychiatric disorders in an individual within a specific period (de Graaf, et al., 2002). SAMSHA estimates lifetime diagnosis of a COD at roughly 50%. The most common COD presentations are substance use disorders and anxiety, PTSD, and depression. Of those affected, 7.4% receive treatment for both conditions, and most (almost 55%) receive no treatment at all.

COD’s are associated with lower quality of life, higher incidences of chronic medical conditions, poverty, homelessness, and criminalization and these relationships can be accounted for by the presence of psychiatric symptoms associated with stressful histories or trauma (Drake & Green, 2013).

People with COD’s have higher instability and difficulty accessing appropriate integrated treatment (Drake & Green, 2013). In many cases of non-professional treatment, substance use
replaces psychotropic medication in order to bring relief from acute mental health symptoms and helps temporarily mediate feelings of social isolation, increasing the individual’s perceived sense of well-being (Klott, 2013). The physical, emotional, and psychological addiction to drugs is often one consequence of a behavior that had, at the time, provided an attractive motivation.

Clinicians must be aware of and address predisposing factors, such as the vulnerability to self-medicate, if relapse, recidivism, and treatment noncompliance are to be decreased and motivation for change increased. According to Klott (2013), the guiding principles of effective treatment for COD’s involves treating the person (as opposed to a person’s symptoms or diagnosis), respecting that all behaviors are purposeful, and remaining mindful that no one changes behavior without motivation.

**Substance Use Relapse in Persons with COD**

Merriam-Webster’s online dictionary defines ‘relapse’ as “the act or an instance of backsliding, worsening, or subsiding” or “a recurrence of symptoms of a disease after a period of improvement”. Personal triggers for substance use relapse in persons with COD can be external or internal. They include stress, a small amount of the substance, and environmental cues the person previously associated with substance use (Taylor, 2010). Stressful events have been identified as the most frequent precipitant of relapse (Littrel, 2010). Factors such as the cumulative number and types of stressors, onset of a substance use problem (before or after the stressors occur) and the presence of a co-occurring mental illness can also negatively impact rates of substance use relapse in persons with COD (Reyes, Pagano & Ronis, 2009).

Substance use relapse in persons with COD after a period of abstinence is one way an affected person might express discouragement, the need for coping skills, a desire for relief or represent a habitual and unconstructive social behavior while under stress. White (2010), a
prolific writer and contributor to the care systems knowledge base, asserts that while relapse may be a part of the way these illnesses express, substance use relapse is not necessarily a part of recovery.

Substance use can exacerbate mental health symptoms. For instance, one of the key hormones involved in the stress response, has been implicated in the pathophysiology of CODs, particularly those related to anxiety and addictive disorders (Back & Brady, 2008). Although some substances provide short-term relief from the symptoms of stress or anxiety, anxiety is actually induced with chronic substance use and withdrawal, creating a ‘feed forward’ cycle of increased acuity of both conditions.

Reducing substance use relapse in persons with COD is therefore desirable. Research supports the efficacy of Relapse Prevention (RP) strategies in improving outcomes for persons with COD, and RP protocols have evolved over the last several decades to become core ingredients in many bio-psychosocial treatment models (Taylor, 2010). Most of these protocols build awareness of and promote limiting exposure to risks and triggers and link clients to coping skills.

Developing and implementing additional strategies at the level of the client and at the level of service delivery to minimize stress can reduce symptom acuity, including relapse, and help individuals “stay the course” in the face of the inevitable challenges and setbacks that will occur in the process of recovery. Focusing on positive, long-term outcomes such as recovery (as opposed to the elimination of problems), has been shown to increase motivation for change in persons with COD (Davidson & White, 2007).
Social Stigma and Chronic Threat

Stigma can roughly be defined as a social-psychological experience that is associated with belonging. When people’s sense of social connectedness is threatened, their ability to self-regulate suffers. Even minimal cues of social connectedness can affect important aspects of self and increase motivation around a performance task (Walton, Cohen, Cwir, & Spencer, 2012). Compared to other mental health disorders, public stigma in individuals with an alcohol use disorder is high. As numerous previous studies have documented, stigma is a significant barrier to treatment for persons with COD (Cook, Purdie-Vaughns, Garcia & Cohen, 2012).

Social environments, like work or school, expose people to the risk of negative evaluation and rejection (Rodrigues, et al., 2013). Negative social evaluation can be thought of as the threat of ‘uncertain belonging’. Being a member of a marginalized or negatively stereotyped group can contribute to underperformance by undermining both engagement and motivation (Cook, et al., 2012). Public stigma can be internalized (self-stigma) by persons with co-occurring disorders, in part due to negative stereotypes regarding dangerousness and unpredictability of the condition. Internalizing a negative preconception associated with membership in a stigmatized group has been linked to poor treatment utilization, treatment noncompliance, and relapses that impede recovery. These individuals may be prone to perseverating on internalized perceptions of stigma that can impede changes that might lead toward more adaptive thinking (Yeager, Miu, Powers, & Dweck, 2013). The adverse effects are understandable and reliable, especially in long-term contexts such as education, or rhetorically, during the experience or process of recovery; because these smaller, situational threats recur over time, creating an experience that is chronically stressful.
Motivation is highly sensitive to social relationships. Cues that evoke a sense of working together on a challenging task (rather than working in parallel to others), robustly increases motivation, even when people are working independently (Walton, et al., 2012). Interventions or efforts designed specifically to address stigma in clients with COD may maximize the benefits of treatment by increasing both engagement and motivation, especially in the face of setbacks (Rodrigues, et al., 2013).

**Problems in Service Delivery Related to Substance Use Relapse**

COD’s require long-term illness management strategies. Illness management often begins in formal treatment settings, the corrections systems, and in peer recovery groups. It is not uncommon for clients to experience incongruent messages on how to manage their illnesses in these settings. Some say that relapse is an ‘inevitable’ part of having COD’s, whereas others say that with strict adherence to ‘a program’ and honesty, acuity and symptoms such as substance use relapse may be tempting, but can be avoided. Without a clear understanding of the mechanisms in the brain involving volition that are at work in persons with COD, these messages miss a critical point: That no one wants to be bodily or mentally different from others. It is precisely this sense of ‘otherness’ that threatens belonging for people in early recovery.

Another confusing message clients sometimes receive is that they must identify themselves with their chronic illnesses, and that resistance to the label of ‘addict’ or ‘alcoholic’ indicates treatment resistance. If we place ourselves in the psychological mindset of the client, it is easy to imagine why someone might eschew such a label. Even in recovery and full remission, labels like ‘recovering addict’ still carry a strong social stigma. Social stigma has a powerful impact on treatment utilization. SAMSHA estimates that of the roughly 1 in 10 people who will need help for a COD condition, only 10% of those will actually utilize services.
Historically, the knowledge base of the field of addiction treatment was drawn primarily from a study of pathology and there continues to be gaps between knowledge from research within pathology and intervention paradigms and front line practice. For example, some programs still address substance use relapse with automatic discharge. Kicking someone out of treatment for expressing symptoms of their condition, then holding the person accountable for not having failed to exercise ‘power’ is a confusing and discouraging environmental message (White, 2010). Instead of conceptualizing clients that re-engage in the treatment process as resilient, caregivers might inadvertently create further discouragement by labeling these people ‘chronic relapsers’; inferring the identification of the person with their behavior. One can easily imagine clients wondering how they could have failed, losing a sense of hope in their prospects for positive change and feeling a further sense of isolation and disconnection. Human beings show consistent neurobiological bias for strategies that promote reward versus punishment (Tomer, et al., 2014).

Not focusing on pathology and problems in the service of illness management will feel counter-intuitive for some providers, but going forward, service providers should be mindful of the messages our environments send to people about how they fit in in the larger social community and make sure that our care environments are ‘identity-safe’. Collaborative, encouraging, and evidence-based strategies like motivational interviewing do not require a disruption in the service delivery when an individual moves from one stage of change to another that may compound clients’ concerns regarding their ability to change and whether they will be able to belong in recovery (Prochaska, Norcross & DiClemente, 1995). People are not to be blamed, treated with less dignity, or conceptualized as lacking personal efficacy for having these conditions or the symptoms that characterize them. Rules that promote structure, safety, and
respect in the treatment environment are needed and valid, and providers must also consider how these messages are delivered.

**Resonant Principles in Individual Psychology**

Ironically, some of the ‘new’ learning associated with evidence-based treatment of COD’s harmonizes with conceptualizations of human personality proposed by Alfred Adler in the early 20th century. Adler was a constructionist who believed that people are hard-wired to move in the direction of positive self-development. He described that innate potential ‘social interest’ - a feeling of community for others, developed in a social context through the nurture and encouragement of others (Ansbacher & Ansbacher, 1956).

The assistance of others is critical to the process of change, because others can help to facilitate insight and the courage to act in the face of discouragement. Adler believed that ultimately, people create their views on things and move about in the world according to their views (Ansbacher & Ansbacher, 1956). Such ‘private logic’ and the behavior that stems from it have specific purposes.

Private logic is developed early in life. Usually by the age of four or five, children have fully developed ideas about themselves, others, and the world that they’ve devised to move them toward a primary goal that affirms the child’s significance and belonging (Ansbacher & Ansbacher, 1956). The ways that people move in support of their goal are very creative, not necessarily rational, and largely, carried out unconsciously.

Problems arise because although children are excellent observers, many of their ideas about life, themselves, and the world are based on false or mistaken interpretations of reality
In order to relieve the discomfort of this ‘cognitive dissonance’, people compensate, which serves to protect the self from the threat of feeling inferior (Ansbacher & Ansbacher, 1956).

Adler thought of mental health symptoms like depression and problematic substance use as ‘sideshows’ - compensating behaviors whose purpose is to waste time (Ansbacher & Ansbacher, 1956). Any symptom can be used as a sideshow. Wasting time creates distance between the person and a task in a life domain (i.e. work, love, family, etc.) for which he feels unprepared. While sideshows are often an unconscious act of identity-preservation, they’re ultimately less than useful because the individual is unwilling to cooperate with his own life circumstances. The result is psychic disturbance, which is often painful and distracting, thus, limiting one’s ability to be present to others and to the tasks of living at hand (Ansbacher & Ansbacher, 1956).

In this framework, people experiencing symptoms are viewed as discouraged rather than ‘sick’. Common forms of distance seeking include backward movement, standing still, hesitation and creating obstacles (Carlson, Watts & Maniaci, 2005). If we presume that stress significantly increases the risk of substance use relapse in persons with COD, the experience itself can be conceptualized as a sideshow whose purpose is safeguarding and compensation from an unconscious and stressful task. In the analysis of client behavior as it relates to relapse prevention in the COD client, pertinent questions include (Carlson & Slavik, 1997):

- What is the client doing?
- What could be the goals of this behavior?
- What kind of relationship is the client constructing or maintaining?
- What is it they are avoiding, denying, pushing away?
Adler felt that people are not to be blamed, but educated. Moving from an unconstructive pattern to a constructive one is accomplished through the development *insight and social interest* (Mosak & Maniacci, 1999). By its social nature, encouragement catalyzes belonging, creating the context for education, and insight, and also increases tolerance so that people become able to bear increasing levels of threat to their self-esteem without losing the courage to keep trying new things (Ansbacher & Ansbacher, 1956).

Adler likened the school as the place between family life and society (Ansbacher & Ansbacher, 1956). While treatment settings for persons with COD provide other practical and structural supports, one of their key objectives is education. Ansbacher and Ansbacher claim that Adler understood psychiatry itself as a social task, reasoning that adult maladjustment could be reduced most-effectively by correcting mistakes in a person’s private logic. In order to reach more of the population earlier, Adler embarked on ‘teaching the teachers’ who confront the private logic of many students every day. Adler made it his work to help teachers learn skillful ways to use encouragement to establish, maintain, or affirm a vulnerable sense of belonging.

Regardless of why the individual might have these ideas or resulting behaviors, it is critical for service providers to assess the overall mindsets of the client that might be giving rise to their interpretations and when possible, intervene on those aspects which might diminish social interest and therefore, motivation for the process of recovery. The therapist in a COD setting can be likened to that of an encouraging educator whose most important role, in light of the aforementioned conceptualization, is seeing to it that no one is discouraged at, or by treatment. If someone arrives to treatment *already discouraged*, it should be a primary goal of the treatment center and individual providers working there to help clients regain confidence in their abilities and sense of belonging. Adler’s collaborative, recovery-oriented, process-focused
perspective that increases client well-being through encouragement and social interest harmonizes with the evidence-based principles advocated by Klott (2013) in treating persons with COD.

**Wise Psychosocial Interventions**

Numerous experiments over the last decade demonstrate that commonly, and more than one might have thought, fears about belonging and ability contribute to a wide array of social problems (Walton, 2014). An intervention is considered wise when it (a) depends on a precise understanding of an individual’s subjective psychological reality – what it is like to be them and how they construe themselves and their social world, (b) targets the specific aspects of those psychological processes that present barriers to positive outcomes, and (c) aims to change them (Walton, 2014). Interventions designed to promote pro-social behavior and well-being might induce changes in the brain that support positive behavioral outcomes (Davidson & McEwen, 2012).

In the scientific literature on wise interventions, implicit mindsets are referred to as ‘fixed’, core beliefs about the malleability of specific traits and abilities like intelligence, empathy, and creativity (Yeager et al., 2013). Implicit beliefs frame people’s interpretations of events in their social world and play a role in shaping judgments and reactions, including a person’s response to setbacks. For instance, students who believe that intelligence is a fixed and unchangeable trait are more likely to attribute setbacks to a lack of ability rather than to a lack of skills that are improvable through persistent effort.

A psychologically precise intervention will target a specific aspect of the individual’s mindset that presents a barrier. For example, the ‘implicit’ (and erroneous) belief that one’s ability to recover is a fixed, innate aspect of one’s personality, rather than a malleable skill that
can be cultivated and developed over time, is an excellent target for intervention in persons with COD, because they can serve to undermine the process of recovery. If a client relapses after a period of abstinence and the meaning they attribute to the experience is that they won’t be able to maintain belonging in recovery, the psychological effect can destabilize emotional and psychological well-being (Yeager & Walton, 2011).

‘Incremental theory’ interventions; those that shift the individual’s perception to the relevance of the experiential process rather than to a specific fixed hereditary or other privilege - reduce hostile intent attributions and aggressive desires that can derail the trajectory of desirable outcomes (Yeager & Miu, et al., 2013).

Importantly, wise interventions are brief (sometimes being completed in less than an hour) and context dependent. An intervention that increases motivation by removing barriers will improve outcomes only when learning opportunities already exist in the environment (Yeager & Walton, 2011). Wise interventions; therefore, can be brief because they do not replace, but complement traditional and readily available resources. In the context of recovery, structural supports might include peers, providers in the treatment setting, Relapse prevention and other educational curricula/content, and the 12 Steps in peer recovery communities. Wise interventions do not replace, but leverage and complement existing opportunities in the environment for learning and have been shown to have lasting effects over time (even if when the individual isn’t aware of getting or participating in the intervention), by tapping into recursive processes where positive experiences facilitate encouragement that can facilitate lasting changes over time (Walton, 2014).

In addition, when these interventions are delivered does matter. Tapping into recursive processes for learning early is critical. Periods of transition (i.e. early in the treatment process,
moving to a different level of care, or during significant life changes such as divorce, retirement, empty-nesting, or graduation from high school or college) have been shown to be particularly stressful, and therefore potent points of intervention, because the individual’s sense of self identity is in flux and their existing social support circles are disrupted (Sherman et al., 2013).

Importantly, wise interventions are delivered in ways that are indirect (meaning that the client does not know that they are participating in an intervention. Such approaches may be more effective because they feel less controlling and may minimize resistance (Yeager & Walton, 2011). Studies have shown that directly communicated information is less effective in affecting psychological change than self-generated messages, especially in people who lack confidence (Canning & Harackiwicz, 2015). Thus, for each the proposed examples for use with COD clients, the clients participate in or actively generate the intervention themselves, rather than inviting them to passively receive an appeal.

**Wise Interventions for Use in COD Settings**

**Intervention 1: Writing about trauma.** On four consecutive nights, the person writes down his/her deepest thoughts and emotions about a particularly stressful event or experience and how it relates to the rest of their lives.

The traumas that cause prolonged stress are usually the ones we can’t make sense of; they’re especially challenging because they seem like meaningless, random acts, or experiences. The traumas topple world views about life being safe and predictable. Pioneered by social psychologist, Joseph Pennebaker, this writing intervention uses a story-editing technique designed to redirect people’s narratives about themselves and the world (Wilson, 2011). The approach is most useful with people who have failed to come up with a coherent interpretation of an important, traumatic, or stressful past event that has ‘gotten under their skin’ by inducing
them to make sense of the event. The intervention allows the person to step back and reframe what happened, which can help mitigate its power over the person’s current life experience.

While research supports the efficacy of the Writing About Trauma exercise in disrupting the power of intrusive thoughts without additional support, the intervention can go further, becoming ‘wise’ in a COD setting, by leveraging the structural supports present in the environment (i.e. a therapist, counselor, peer or sponsor) to support the individual in ‘testing’ and learning from the new narrative. The encouragement the individual receives can affirm their sense of belonging and safety in the present, and the person’s ability to integrate the experience into their lived experience of recovery going forward. Not unlike students who learn to believe that they can get smarter over time, when people believe that they can and will recover over time, they are more likely to use effective learning strategies (Yeager & Walton, 2011).

**Intervention 2: Values affirmation**: Clients are asked to identify two or three values that are personally important and write about why those values matter to them.

When people see their environment as threatening rather than safe, they tend to become vigilant to cues that signal threat. This heightened vigilance requires the individual to expend (sometimes an enormous amount of) energy that can ultimately destabilize the person’s sense of belonging and self-efficacy (Cook et al., 2012). Giving people the opportunity to self-affirm turns out to be protective against threat (Wilson, 2011). Self-affirmation theory proposes that people are motivated to maintain the perception of self-worth and integrity. Reminding people of the diverse, positive aspects of themselves can lead people to see negative events and information as less threatening and thereby reduce stress (Yeager & Walton, 2011). This exercise can be used to calm the self, bolster self-integrity in the face of threat, and can prevent threat and poor performance from recurring. For persons belonging to a potentially negatively
stereotyped group (i.e. clients on methadone, IV-using mothers, or persons with multiple treatment attempts resulting in relapse) by initiating a positive shift in how the individual construes safety in their environment and how they perceive personal competence and their ability to adapt in a social world.

The timing of this intervention is important in that it should be delivered early in the person’s introduction into a new context or environment or during other stressful times (Cook et al., 2011). For example, given at the beginning of service utilization (perhaps as a part of the orientation process) may provide a sense of focus for the formal and informal processes involved in introducing the client to the community. At the end of a particular phase in the care process (i.e. stepping down to outpatient or sober living from a residential care environment) completing or graduation ceremonies where the client has an opportunity to tether the treatment experience to their personal values can help the individual to self-affirm and also affirm others.

**Intervention 3: Growth mindset.** Clients listen to a 30-60 minute lecture (or watch a video of a lecture) about the neurobiology of learning which educates them on the biological processes involved in learning, and which shows that learning is developed and reinforced through persistence, effort, and repetition. Clients are then directed to perceive the experience of recovery as a form of experiential learning, and that they and anyone can develop and refine recovery ‘skillfulness’ over time.

Story prompting is a technique that redirects people down a particular narrative with subtle prompts (Wilson, 2011), and is particularly effective in forestalling global inferences of non-belonging (Yeager & Walton, 2011). Story prompting interventions do not change people’s minds, but help keep them from over-interpreting discouraging events that might happen in the future. Several studies have found that ‘students’ that adopt a growth mindset of intelligence
begin interpreting academic challenges as opportunities to learn - not as evidence of inability - and respond by trying harder (Walton, 2014).

This intervention can be particularly effective for helping COD clients manage the stress of increased interpersonal engagement that is afforded by recovery. Increased interpersonal engagement increases a person’s sense of belonging and at the same time, increases the likelihood of interpersonal disputes, which are inherently stressful for this population as they most benefit from developing and implementing pro-social skills in the treatment environment. The intervention could be delivered in a series of educational sessions followed by small group discussions and reflecting or writing exercises. The first session might teach about the anatomy and function of the brain, followed by a session on brain neuroplasticity, and the brain’s ability to reorganize and change when people do and think in new ways. A following session could focus on motivation, essentially showing research that people are motivated to do things because of specific thoughts and feelings that live in their brains and that these thoughts and feelings have the potential to be changed throughout a person’s life (not an overnight affair, it should be emphasized). Finally then, clients can be directed to apply the information following interpersonal conflicts with peers, family, or staff through small group discussions, or roleplaying. When people’s ability to change is emphasized we prepare them to face life challenges resiliently (Yeager & Dweck, 2012).

**Intervention 4: Social belonging.** One or two days before, and as a client prepares for discharge, they are asked to complete a written assignment, where they must write a letter to an unknown, incoming client. In the letter, the alumni is to address: (a.) Their personal experience of arriving at the program – specifically addressing how they too may have arrived feeling afraid or uncertain, and how these feelings went away with time; (b.) Their experience of handling the
daily struggles of the treatment process; and (c.) What value they’ve gotten from the treatment experience. Alumni letters are put in envelopes and one letter is included in the intake materials for each new client.

The social belonging intervention does not seek to change the client’s mind or remove stressful experiences, but supports the client in not over-interpreting the significance of these experiences using self-persuasion to target negative thoughts, feelings, and beliefs. Perceived usefulness or value, predicts motivation, interest and sometimes, performance (Canning & Harackiewicz, 2015). When a person with COD copes effectively with a high-risk situation, they are likely to experience increased self-efficacy. Such positive self-regard mitigates stress and increases motivation (Taylor, 2010). Relative to other dimensions of well-being, feeling a sense of purpose in life appears to be particularly important in predicting future health, better ability to perform day-to-day activities, and less future disability by providing motivation to constructively learn and reappraise ‘negative’ events in an adaptive manner, avoiding brooding, and helping people to quickly refocus on one’s goals. Self-reported psychological well-being is important for both health and longevity, potentially through mechanisms promoting resilience in the face of adversity (Schaefer, Boylan, Van Reekum, Lapate, Norris, Ryff, & Davidson, 2013). This intervention increases the individual’s sense of usefulness and belonging (by being helpful to another person), autonomy and self-direction by providing the opportunity to address unrelated but pertinent aspects of the treatment experience. It can be a potent intervention for mediating the stress of the transition to the treatment milieu, and for the client who is soon discharging out of the current milieu (the alumni). If clients feel more secure in their belonging, they may be more likely to approach others in the environment for help, adopt more positive attitudes, build better relationships, and lay the groundwork for success (Yeager & Walton, 2013).
**Intervention 5: Expectancy value.** At the end of the day, clients are asked to pick one or two topics or coursework discussed in treatment that day and write brief essays describing the relevance of the topic or coursework to their lives.

The key for this exercise is to unlock learning by increasing engagement with the treatment material, especially among those who expect to perform poorly or those with low motivation. For everyone, the expectation of competence or doing well on a given task is also a predictor of motivation (Sherman, et. al., 2013). Asking clients to write about the perceived value of the coursework may be one way to ‘catch the attention’ of less confident clients because thinking about how the material applies on a personal level makes the material more appealing and engaging (Canning & Harackiewicz, 2015). For clients who expect to perform poorly (i.e. clients who have made a past attempt at recovery resulting in relapse), making treatment relevant to multiple domains of their personal life (i.e. work, family, community, love, spirituality, relationship with self, etc.) may alleviate some of the pressure of performing well by giving the clients the opportunity to picture themselves using the content (with relative mastery) in their day-to-day lives in the future. In one study, when students with low confidence were told why the content is relevant to them instead of generating their own reasons, they were reminded that they might not be able to accomplish their goals and interest decreased (Yeager & Walton, 2011).

A key benefit of self-generated expected value may be that allowing clients to personalize the educational coursework or content makes irregularities in delivery less relevant. Personalization also allows each client to make the content ‘his own’, thereby mitigating client cultural or other differences in client demographics.
**Intervention 6: Do good-be good.** Clients attending treatment in either a medium intensity residential setting or in a less-intensive outpatient setting, are encouraged to attend two or three community-based peer recovery meetings (i.e. A.A., N.A., Health Realization, Smart Recovery) each week, and to obtain a ‘service commitment’ – that is, they are to volunteer to do something to be of service to the group attending one of the meetings – and begin volunteering within 2 weeks and 1 hour each week for the duration of the treatment experience. Each week as a part of the shared group experience, clients are also asked to write about and then discuss their individual experience of attending meetings, questions they have, how they feel about the meetings they are attending, who they are getting to know, and other data.

The do-good be-good principle is based on the idea that one of the best ways to change people’s self-view, is to change their behavior first. People are motivated to view themselves as good, competent people (Wilson, 2011). The volunteer portion of the intervention is designed to reduce alienation, increase engagement, and make clients feel like they are part of a larger whole that is making a difference. A side benefit of helping other people is happiness. Clients are also likely to build social support by making friends. By exposing clients to like-minded peers who are also helping others and providing a context for them to process their new experiences together, clients can foster beliefs of being effective people with a stake in the community – increasing their global sense of belonging.

For most clients, going to peer recovery meetings will be a challenge simply because of the novelty of the experience and because they have limited social connections there. Focusing group discussions on the process of taking on and overcoming such challenges, without using substances, provides a context for providers to pay attention to client’s subjective and less-than
useful mindsets and encouragingly point out that clients can effect change for themselves through effort, new strategies, learning, help from others, and patience (Yeager & Dweck, 2012).

For clients who are extremely resistant to attending peer recovery meetings, clients can be encouraged for a limited period of time to see ‘from the inside’ the merits and demerits of peer recovery meetings from their own perspectives in an effort to determine whether attending them to support their recoveries going forward will be in their best interest or not. It is less important in this intervention that the person appreciate or be devoted to peer recovery groups (where they are volunteering), but rather, that the individual experiences volunteering and thereby exposes themselves to the benefits that can come from it – even for just an hour a week. When the intervention is completed, providers might encourage clients to continue the volunteering experiment, in the service of something they are particularly invested or interested in.

**Conclusion**

Using non-pharmacologic treatments in addressing COD’s has practical value. Learning strategies to self-regulate anxiety and stress related to belonging can interrupt the ‘self-medication’ cycle and help individuals acquire and implement alternative coping strategies (Back & Brady, 2008). This strategy also requires an intentional shift in tone and focus for providers and care systems.

Adapting and implementing wise interventions that have been used to positively affect social problems in education, civic behavior, health, close relationships, and intergroup relationships in treatment settings for persons with COD, can increase motivation for change – especially in the face of setbacks – by addressing client’s subjective fears about their ability to recover and about belonging in recovery. For the client who is not vulnerable to these fears, the effect of these interventions will be expected to have little, if any effect. But for those who do,
particularly persons who have had multiple past attempts at treatment and periods of abstinence followed by substance use relapse, the use of these interventions represents the person-centered, recovery-oriented consciousness advocated by Klott (2013) and others as best-practice illness management strategy for COD conditions.

It would be particularly compelling for providers deciding to implement these interventions and the mindsets associated with them, to measure client outcomes, particularly the outcomes of clients who might be considered higher risk in terms of relapse proneness. In addition, supports for providers which focus less on specific client outcomes and more on creating an encouraging environment for learning, such as weekly consultation groups where providers are encouraged to share encouragement strategies and tactics with peers, will encourage a growth and recovery-focused mindset, which many researchers have found so especially helpful in effecting positive change.

Identifying and building on client strengths that will inevitably surface through the intervention and treatment experience can reinforce and embolden the client’s sense of control, autonomy, efficacy, and belonging. This practice can encourage them to repeatedly use existing, traditional supports already in place in the treatment environment. Wise interventions are useful because they place responsibility for recovery with the person most directly affected by the conditions – themselves. Davidson and White (2007) asserted that, recovery is more than the overcoming of symptoms from an unchanged life. Transcending the stigma associated with COD’s and improving well-being requires the development of new muscles that leaves clients feeling stronger - through the encouragement of others, their own creativity and resourcefulness, and a felt sense of purpose and belonging in the greater community of living.
References


