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Response: Disconnects, Triggers, and Two-Edged Swords

Peter Banys, M.D.; Michael Levy, Ph.D.; and Bayley Raiz, L.C.S.W., M.B.A.

Bayley Raiz: The authors' discussion of the functional disconnect between a patient's attitude in treatment and behavior outside resonates with my own clinical experience. We regularly see patients who sincerely and intensely desire to quit abusing substances, but cannot yet "walk the walk" of recovery. This deserves all the emphasis the authors give it. Clinicians sometimes think that patients are either ready for change or not ready for change and so doubt that we can do anything for those who relapse.

Michael Levy: I tell clients I honestly believe they want to be clean and sober, but I know from experience that when they leave treatment they are going to want to abuse again.

We informally surveyed 350 clients who had relapsed, and the most commonly cited reasons were wanting to get high, believing they could use safely, and boredom. When I spoke to staff about this, a common reaction was, "How dare they want to get high?" But the point is, that's the disconnect.

Men, women, and triggers

Levy: I was pleased by the article's emphasis on internal feeling states as triggers for a return to drug use. I think this is crucial. When we looked at the responses to our survey, what amazed me was, first, the consistency of causes for relapse, and second, how much of the impetus was internal, from moods and feelings.

Peter Banys: One of the first things I learned as a clinician was that people relapse because of negative emotions. It took me another year to become convinced that people relapse because of positive emotions, such as falling in love or celebrating.

Raiz: It's so important to get into the client's feeling life and really understand that fully. It's not enough just to know that someone abuses when they feel depressed. The question is, "What makes you feel depressed?" Or, "What makes you use when you feel depressed?" There might be 10 different reasons. You have to get into it with the person and explore, explore, explore.

Banys: I was intrigued by Dr. Otto's speculation as to why women methadone patients responded better to his methodology than men. He felt women are more likely to abuse drugs to try to master dysphoric sensations, while men tend more to reward themselves with drug abuse.

Levy: We found that both men and women were susceptible to relapse tied to anxiety and boredom. One trigger that came up regularly for men, but not for women, was pay day. Women were far more likely to say depression caused their relapse.

Banys: I think clinicians are ahead of the research in this area. They have been focusing more on feelings and moods and their effects. Researchers have not looked at trying to delineate cues or internal emotional states more accurately, but instead have emphasized approaches like motivational enhancement and reward paradigms.

Exposure therapy

Banys: The distinction the authors make between context and cues is teachable and important. I think those two 'Cs' are a nice hook to hang interventions on.

Levy: We try to learn all the issues that endanger our clients' abstinence. For some clients, they are more external things and for others, more internal. We use a variety of methods to try to help them cope, including a relapse education model and role playing in group therapy. We've recently been working on distress tolerance, which teaches that it isn't always necessary to act on an emotion. The basic idea is to get people to sit with anxiety or other negative emotions and become desensitized. We'll say, "You're anxious; no big deal. It's not going to kill you. Feeling is okay."

Dr. Otto's cue extinction model, exposing people to cues in a controlled environment, seems to take these practices to a deeper level by forcing clients to actually experience volatile feelings instead of just talking about them or imagining them. I think the field could do more of this, but providers often are afraid of adverse reactions.

Banys: Exposure is a two-edged sword. Even discussions in AA can stimulate some craving. Before we start exposing people to triggers, we need to make sure safeguards are in place so they don't walk out of therapy sessions rattled and ready to use.

Raiz: On the one hand, we need to teach clients how to withstand exposures so they

won't be helpless when they encounter them outside. But if we bring up the triggers in the wrong way, there's danger of an adverse reaction.

Ideally, exposure might transform patients' cues into commonplace phenomena without any special significance. I was struck that the authors exposed patients to drug paraphernalia. In my experience, providers do not show or have clients visualize paraphernalia because they are such powerful cues.

Banys: I wouldn't at this point be ready to tell my staff to start exposing clients to white powders or paraphernalia. To my mind, the risks are too great.

It's important not to be cavalier about exposure treatments. People in the VA system learned their lesson about exposure with post-traumatic stress disorder (PTSD). Twenty years ago, exposure was considered a core treatment, but I think today it's seen as something to avoid.

I think this caution should be applied to drug abuse treatment as well. The notion that a patient should reexperience a trauma made sense in theory, but the practice turned out to be dangerous, particularly for patients who were less well-organized cognitively or emotionally.

Questions for research

Banys: Otto et al.'s paper has a solid basis in learning theory, in my estimation, but the empirical basis still needs strengthening. Of the clinical studies they mention, most were to help patients who wanted to stop taking benzodiazepines get through withdrawal. That's different from helping patients recover from addiction to substances that make them euphoric. In the one trial with patients who abused opiates and other euphoric substances, women responded to the intervention, but men didn't seem to.

We need more research on whether cue exposure is more powerful than more standard cognitive-behavioral approaches. And which sorts of cues should it be used for?

The real issue in this paper, I think, is to what extent and how cue extinction therapy ought to be systematized or manualized. I don't think that has been answered yet, and that's why I welcome further research.

Levy: It would be a great study to compare outcomes over time from exposure and other kinds of treatment. The concept of extinguishing cues is new to the substance abuse field. I imagine that's probably a primary reason the authors haven't addressed manualization. I think this is an area of potential growth. In time, I predict exposure techniques will become a major part of the treatment methodology we utilize with this population. &