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Opinion

An Eclectic Approach to Substance use Disorder Treatment

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Introduction

Substance Use Disorder is a problem in many populations. There exist many different treatment modalities. Counselors and other professionals are trained in many different schools of thought and theory. This research looked at four common taught modalities and found similarities that might be helpful in treatment of SUD. Of paramount concern was with regard to the client and that the client become an active participant in the path of recovery.

Stimulants are some of the highest abused drugs in American society. They are known for destroying lives, families, and even communities. Modern psychoactive medications such as Ritalin and Adderall have introduced a new wave of legal amphetamines. Some of the hardest substance abuse cases to treat are a product of stimulant addition. The difficulty in treating stimulant substance abuse is tied to how rewarding it is for the user, tolerance level, and induction of psychotic symptomology. In particular, methamphetamine has been shown to be highly prevalent in current society. However, various forms of treatment including group and psychotherapies have been found to be effective. In particular Cognitive Behavioral Therapy, 12 Step Groups, Motivational Interviewing, and Psychoanalysis have been found to have long standing results. Through examining specific elements of these theories, a more universal comprehension of treatment options for stimulant use disorders can be determined.

Stimulants affect the Central Nervous System (CNS). Stimulant use causes increased neurotransmitter activity involving dopamine, norepinephrine, and serotonin. Structurally, methamphetamine is similar to catecholamine neurotransmitters allowing for it to easily cross the blood-brain barrier. Stimulants can be smoked, snorted, injected, or eaten. "There is profound evidence for down-regulated presynaptic and postsynaptic dopamine function in stimulant addiction greatly effecting neuroactivity [1]. All forms of use cause an almost instantaneous effect of intoxication. Peak experience can occur anywhere from five minutes to one hour. Duration of intoxication can last anywhere from 4-8 hours.

Positive effects from stimulant use are euphoria, wakefulness, increased concentration, heightened energy, and increased sexuality. Some effects can be labeled as neutral depending on user preference. These include increased sociability and weight loss. Amphetamines have a long history of commercial use for both positive and neutral effects including in the weight loss industry, and for medicinal purposes like treatment of ADHD. Negative effects, however, include itchy skin; disturbed sleep patterns, nausea, anhedonia, depression, suicidal tendencies, and increased aggression. "Studies suggest stimulant use symptomology includes dysphoria, irritability, and somatic/vegetative symptoms. These are more common in short term use, and can lessen as effects during prolonged periods of abstinence [2]." Over time chronic use has been liked to fatal diseases involving organ failure, brain damage, psychosis, cardiovascular problems, and weakened immune system.

First documented use of amphetamines originates from China, in which a Chinese tea was made from Ephedra extract. In 1932 the first patent for an amphetamine was granted. Early uses were mainly medical in nature and used in nasal sprays and for weight loss. World War II marked the onset of the modern rise in amphetamine abuse. During World War II amphetamine tablets were given to solders as an attempt to increase performance

during battle. Use continued and then soared in the 1960s with the introduction of an injectable form of amphetamine. This led to greater public awareness to the dangers of methamphetamine, and resulted in the illegal status of in the 1970s. Another subtype, crystal meth, boomed in the 1990s. Currently, amphetamine abuse remains a problem, despite some data showing a decrease of illegal use. Legal forms of stimulants are still on the rise with prescription drugs and ADHD diagnosis on the rise yearly.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) has expanded the category for stimulant abuse under the title: Stimulant-Related Disorders. Among these conditions are stimulant use, intoxication, withdrawal, other stimulant induced disorders, and unspecified stimulant related disorder. For the purposes of this paper, stimulant use disorder from methamphetamine use is the primary concern. Stimulant use disorder is defined as "a pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress." This is supplemented by a qualification of at least two primary symptoms within a 1-year period. Symptoms include increased need, unsuccessful control, dedication of obtaining, craving, social/occupational dysfunction, and exposure to hazardous situations, tolerance, and withdrawal [3].

DSM-5 states that use of amphetamine like stimulants can lead to Simulant Use Disorder within one week. "Withdraw states are associated with temporary but intense depressive symptoms that can resemble a major depressive episode, the depressive symptoms usually resolve within 1 week. Tolerance to amphetamine-type stimulants develops that lead to escalation of the dose [3]." However, some users of methamphetamine can experience tolerance. Progression from mild to severe Stimulant Use Disorder can happen over weeks or months.

Rates of stimulant abuse vary by age and gender. Use is similar between male and female adult populations. Adolescent sees use higher than adult men by 2%. Caucasian and Hispanic populations are the highest populations of users in the United States. Use occurs in every socioeconomic status division and is more common in younger populations. In low SES populations use can be associated with societal problems. This is especially the case during school years (i.e. elementary though college). Ages 23 and 31 are the primary times for first time use and treatment entry, respectively.

Associated conditions likely to show in comorbid diagnosis include bipolar, schizophrenia, antisocial personality, and other substance use disorders. Bipolar disorder's manic/hypomanic phases can mimic effects of stimulant use. Some of these effects include decreased need for sleep, euphoria, flight of ideas, and increased grandiosity. Childhood disorders including OppositionalDefiant, and Conduct can be precursors to Stimulant Use Disorder. In cases of ADHD, treatments using stimulants can become precursors for amphetamine abuse, especially if there is an improper diagnosis.

Stimulant abuse can also cause psychotic symptoms, which can be mistaken for delusional and paranoid personality disorder. Often times psychotic periods will be accompanied by different types of hallucinations. Auditory and sensory hallucinations are most common. One of the more prominent sensory disturbances associated with amphetamine abuse is formication, the sensation of bugs crawling under the skin. Methamphetamine abuse is often accompanied byExcoriation Disorder.

Some of the most prominent ways to treat Stimulant Use Disorder are Cognitive Behavioral Therapy, 12 Step Groups, Motivational Interviewing, and Psychoanalytic Therapy. Each method has shown promise in helping clients suffering from disorders retain remission. An examination of the theoretical components, along with data looking at their effectives can help draw conclusions of universal treatment factors for Stimulant Use Disorder. The first model that will be examined is Aaron T. Becks Cognitive Model (Cognitive Behavioral Therapy).

Cognitive Behavioral Therapy is a mix of cognitive theory and behavioral therapy. Aaron Beck pioneered cognitive theory and the cognitive model. Beck states that dysfunctional thinking is the common link to all psychological disorders and symptomology. Psychological disturbances are activated by stimuli in the internal or external environment. Cognitive theory looks at the structure of the mind in layers. At the start of the model are schemas. Schemas are ridged beliefs that from that basis of psychological explanations for the world. Themes of schemas can be positive or negative which can look like, "I'm Worthless, I'm Unlikeable, I'm Great, I'm Likeable". Schemas are formed in early childhood usually through early experiences and interactions with caregivers.

The next level is intermediate beliefs. These are rules, assumptions, and expectations of the world. Intermediate beliefs give shape to schemas and can run along themes of, "People laugh at jokes if they like you, Polite people are early, Hard work pays off, My substance use is not a problem if I show up to work on time". Intermediate beliefs are formed through evaluations and observations of the world. They can also be thought of as inferences about situations, and are influenced through seeing what behaviors/beliefs/attitudes are rewarded, or punished.

The final layer is called automatic thoughts. These are thoughts that come instantaneously through the stream of consciousness. They are often evaluations of the internal and external environment. Automatic thoughts might sound like, "That's stupid, I should get high, I can't handle this". Automatic thoughts are a byproduct of conscious evaluation under the influence of intermediate beliefs and schemas.

CBT states that it is the interpretations an individual makes that determine emotion and behavior associated with a situation. For example, two people have a hard day at work and come home. One sees the future as bleak, and drinks 5 glasses of wine to cope with emotional distress. The other interprets while it was a bad day but tomorrow might be positive. He then continues with the night having one glass of wine. A particular emphasis is put on the way cognitions can become dysfunctional patterns or cognitive distortions. Cognitive distortions are ways a person's thinking changes from rational to skewed. Some common distortions are minimizing a problem (minimization), seeing only the negative

(filtering), and attributing biases based on personal experience (overgeneralization).

By looking at the model a better understanding can be developed of how a person might turn to substance abuse. A client might have a schema that states, "I'm unlikeable. Above this schema is the intermediate belief, "When I smoke meth people like me". A situation comes up where this client must be in front of people (i.e. work event, party). This situation activates the schema that they are unlikeable. The schema is supplemented by the intermediate belief they are likeable after they smoke meth. Then comes the automatic thoughts, "I need to smoke now, I have to get high before I go". The behavior becomes involves intoxication, followed by the physiological decrease of anxiety, and feelings of euphoria. This experience is then positively reinforced through a decrease of anxiety which leads to a pattern of abuse. "Negative symptoms are seen as maladaptive learned responses. CBT seeks to utilize therapeutic techniques that focus on creating new, healthier responses, and thought patterns. CBT is a descendent of behavior therapy that emphasizes the role of cognition when dealing with maladaptive beliefs [4]."

In a study by Kamila Green Greece CBT and a variation called Modified CBT (M-CBT) was chosen to examine effects in managing cocaine use and associated symptoms. In particular, emphasis was placed on populations that suffered from cognitive impairments due to cocaine use. One of the criticisms with cognitive behavioral therapy can be complexity, metacognition, and insights those with cognitive impairments might not be able grasp for treatment benefits. This study sought to test modifying CBT focusing on more behavioral components, and tested groups against traditional CBT type psychotherapy.

The traditional CBT used consisted of four treatment points. Sessions were given at a full hour, as opposed to normal 45-50 minutes. One session occurred a week for a 12 week period total. The content of therapy sessions was of didactic verbal presentation. This was accompanied by homework sessions focused on coping skills.

Modified CBT used shorter sessions that spanned only 30 minutes. Communication from the therapist was simplified and included motivational aspects. Therapeutic content was more visual in nature consisting of: "visual and audio aids, mnemonic devices, and interactive assignments) [5] Homework assignments were given in workbook format. These included things like coping skills, daily, and weekly assignments. Content taught in M-CBT was reviewed until there was an established mastery of skills from each module. Each module and task was also accompanied by a quiz. Focus was put on mnemonic devices and memory aids to help clients absorb content.

The study results showed that MCBT participants obtained more satisfaction than those treated with traditional CBT. In follow up studies and identifying symptomology MCBT was found to not be significant when compared with traditional CBT. Longitudinal follow ups found that there was little change in symptomology between participants in the two groups. "Randomized trials showed supporting evidence of technological aid, and modification when treating stimulant use with CBT [5]."

"These results present evidence of a need for modified theoretical tools to help clients. Especially when involving a more didactic approach, and visual aids (CM; Higgins et al., 2003; Stitzer&Vandrey, 2008) [5]". It is important to note that one of the major complicating factors in this study were cognitive impairments. Many of these cognitive impairments came from previous and continuing stimulant abuse. One of the enhancements noted to have positive effects in M-CBT was the addition of more visual aid components. Concrete examples were shown to be more engaging for clients. In particular, video and cartoon paper aids showed high levels of participation and retention.

Overall Cognitive Behavioral Therapy in traditional or modified versions appears to benefit those suffering from stimulant use disorder. While cognitive impairments can hold a client back there are ways to help modify psychoeducation for a more engaging experience. Overall satisfaction for both M-CBT and CBT were shown to be high, with lasting benefits to both groups. Factors like CBTs therapeutic alliance, psychoeducation, and homework are attributed to lasting benefits of psychotherapy. Another type of treatment shown to help those with Stimulant Use disorder are 12 step groups.

12-Step programs are among the oldest methods for handling substance use problems. Originally developed by Bill Wilson and Bob Smith, 12 Step Groups (TSG) have helped countless amounts of addicts. The model comes from the creation of Alcoholics Anonymous. Various offshoots and variations of the model are currently used include for those that wish to not adhere to spiritual components. TSG can be found throughout every city in the United States. "Twelve-step mutual self-help are a financially effect treatment and have been proven to be on par with traditional psychotherapy models [6]."

One of the key points of TSG is the adherence to the disease model of the addictive process. This model states that addiction is a biological illness. The disease is chronic, incurable, and fatal if left untreated. This model also looks at three subtypes of neurological effects to help explain the addictive process. The dispositional subtype states that some people have a predisposition to developing substance use problems. The neurological subtype explains substance disorders as the product of changed brain structure and chemistry though use. Finally the hijacked brain subtype states drugs in a sense take over the brain, removing control from the user. While variations of TSG views on recovery can differ, many see addiction only being treated with complete abstinence.

Another major tenant of TSG is a spiritual component. This often is represented by persons surrender to "A Higher Power". What that higher power can be is what makes different TSG so high in variation. Throughout working the twelve steps there are various actions where a person must surrender to a higher power, make peace with wrongs done to others, and learn to forgive themselves. None of this is done without first surrendering to the higher power, which is done through the first three steps.

Specific recovery activities are involved in steps 4-9. These are steps that can bring about struggle with clients. They involve cataloging all wrongs done under the influence of substances, and making things right where applicable. The purpose of these is also tied with helping the addict see a greater sense of community, and turning focus off the self. One of the key themes during these steps too is altruism. A person starts to learn the value of giving unto others with nothing expected in return.

Steps 10-12 are described as the hardest steps in the program. This is because they involve the person taking steps that ultimately forgive themselves, and make the transitions into remission. This point is the program also aligns with the Transtheroretical Model's maintenance, and termination stages. At that point in working the steps a person might take on a more experienced person as their mentor. This experienced person is called a sponsor, and is encouraged for people who have completed the steps.

TSG are built around group orientation with emphasis on community and fellowship. Group meetings are a structured process with rituals involving procedure. Ideally groups are 6-8 people with more experienced members serving as facilitators and educators. Group meetings use components of Psychoeducation and unstructured counseling (through members shared experiences). Sessions usually involve a particular topic, which are further expanded upon by members input. TSG have been shown to have a long history of benefit those suffering from amphetamine use disorders.

In an article by William A. Knack psychotherapy paired with TSG was examined to gauge effectiveness. Williams makes a point that "studies have generally found that 12-step approaches yield equivalent outcomes to such science based treatments as cognitive-behavioral treatment (CBT). In some cases, 12-step treatment yielded superior results" [7] Many factors also align what makes psychotherapy and TSP useful in treatment.

TSG and psychotherapy are noted to rely on people trained in specific procedures. This brings two specific benefits for those involved. First, it establishes what is known as the therapeutic alliance. Therapeutic alliances have been shown to be a universal factor in the treatment of any disorder when going through structured care. The training itself forms the second benefit. Once trained, a level of competence can be achieved with emphasis on Psychoeducation, therapeutic techniques, or both depending on which model is being utilized.

Both models of treatment also share what Freud called the talking cure. By allowance of unconditional positive regard from the therapist, or group members a person is able to gain a better sense of congruency. This congruency helps a person shift back to mental states where substance abuse is not needed as a coping mechanism. In TSG this is further aided by a sense of community and greater fellowship. This type of aid can also be achieved through psychotherapy in counseling based groups.

Knack takes time to breakdown different models of therapy that can align with TSG. Psychodynamic therapy is brought up in relation to how clients learn in both models new ways to cope, self-sooth, and retain better self-efficacy. Both forms of treatment work on the principles of helping a client works through defenses, resistance, and elect emotionally corrective experiences.

CBT is also examined for comparison and compatibility with TSG. Knack makes the argument that CBT is essentially a TSG. Both are didactic; rely on Psychoeducation, a strong therapeutic alliance, and aim to teach skills a client can use to become their own therapist/program head. Both models rely on the use of homework to help solidify principles. In CBT homework is usually focused on helping a client gain awareness of thought patterns, beliefs, and results from experiments constructed to test hypostasis about the environment. Homework is also focused on building better coping skills. Knack notes that working through the 12 steps is in essence similar homework. Working the first three steps involve admitting help is needed and a belief that the program can help. Steps 4-9 focus on homework that helps gain awareness, build a sense of agency, and practice coping skills. The last steps solidify what has been learned and focus on application to the self.

TSG goals, techniques, and principles hold many similarities to traditional psychotherapy. Studies have shown that in some cases TSG have even greater longitudinal benefits and smaller cases of relapse. Universal factors for both models such as the therapeutic alliance, competency, sense of agency, unconditional positive regard, and Psychoeducation make each mode of treatment compatible. TSG and psychotherapy groups also provide a sense of community where emotional corrective experiences have a greater chance of occurring. Another type of treatment shown to be effective is Motivational Interviewing.

Motivational Interviewing (MI) is a "collaborative, goal-oriented style of communication with particular attention to language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." (Lassiter, 2018) Motivational interviewing developed as a system to help clients process intrinsic motivation and increase activity-surrounding values. MI also works to lower psychological resistance with clients, and work to resolve ambivalence.

MI works through four primary processes. The first is engaging, which is a time of rapport building and getting to know the person. Engaging also is a stage where what a person is willing to talk about, resistances, and transference issues can be determined. Process two is called focusing. This is a time when behaviors and resistances can be specifically targeted. This stage is where discrepancies can be developed and explored. Evoking is the third stage, where change talk can be reinforced and internal motivation can be explored. This stage also puts reliance on ignoring the righting reflex. Planning is the last stage where the client learns how to start taking steps toward change. They will develop skills and make plans to act upon as the process of treatment continues.

Together paired with the concept of understanding make up MI spirit. Certain other MI principles are used in this type of treatment

for addiction. A MI therapist puts emphasis on avoiding arguments with clients. Clients are seen as having the answers, and the therapist is best left to help as a guide. The concept of rolling with resistance is also important. Clients, because of lack of confidence and ambivalence, can be very resistant to wanting to change. An MI therapist recognizes that the addicted person is not going to necessarily want to change. Change is not something that will also happen in one session, so a key practice is patience.

MI therapists focus on being able to express empathy for clients. This helps build the therapeutic alliance, and allows the client to be more genuine and exploratory though ambivalence. Therapists should also push clients toward enhancing self-efficacy. This theoretical orientation sees, in part, clients turning to substance abuse in order to gain a sense of themselves missing, damaged, or lacking in confidence. By helping a person regain self-efficacy therapists create a pattern that helps guard against relapse. Most principles fall under seeing the client as the source of answers, having empathy, understanding motivations, and empowering the person.

Implementation of MI can vary depending on a variety of factors. It can be used as a standalone approach, or paired with another system of therapy. Usually MI would be done in order to help a client decrease resistances, increase confidence, and gain higher self-efficacy. After this is done the client can be moved toward another system of psychotherapy that might be best suited for them. MI also offers many techniques to help achieve its goals. Some of these techniques include doing evaluation of feelings/motivations, weighing out different scenarios, and exploring what brought the client to counseling.

In a meta-analysis comparing the theories of Motivational Interviewing (MI) with Contingency Management (CM), motivation was shown to be a consistent factor in positive outcomes of treatment. The above study was a closer examination of intrinsic versus extrinsic motivation in the context of decreasing symptoms from substance abuse. "Understanding clients intrinsic and extrinsic motivation in sustained substance use is best understood by what factors provide long term treatment benefits [8]."

Results proved that MI and CM had greatest positive effects over stimulant, marijuana, and tobacco abuse. However, MI had the greatest long-term effects related to improved coping patterns. Follow up interviews showed CM having the greatest gains at three months post treatment, and MI at 6 months. This suggests that CM has the ability to help when it comes to short-term gains. MI benefits and new coping skills appear to have longer long-term effects.

Combining the two treatments also showed long-term benefits for stopping long term substance abuse. This includes stimulant class through the suggestion that combing intrinsic or extrinsic factors has a lasting effect. "CM benefits only showed to have impact for short term gains. MI was shown to have greater long term benefits six months post treatment [8]."

Future research behind MI and intrinsic motivation was suggested by the authors in order to look at more diverse populations, substances, and do more follow up stories. It is suggested that MI can be used to treat almost any substance use disorder. This appears to be attributed to MI techniques that help the individual understand themselves, and own psychological resistances. As per the results of the study it would seem that evidence point to internal motivation being a more powerful tool for change than external rewords.

A study done by the University of New Mexico further looked at internal techniques in trying to assess why MI is effective with substance use disorder populations. The primary focuses were on the concept of change talk (CT). Change talk is talk used by the therapist in a MI session that resolves around reconstructing ambivalences. Their study examined the neurological effects of change talk and found further evidence of lasting change coming from within the self. "The study suggests that CT is related to self perceptions of empathy. Through change talk participants were better able to understand self-expression and factors that held back lasting gains. There was also a greater awareness of a clients empathy process [9]."

MI holds strength in building self-efficacy for clients. It has some of the largest studies, which point to lasting change coming from motivating factors. Many theories of treatment look at external factors, operant conditioning, and rewords. MI sees an opportunity to use wanted change from within the individual. A theory that also follows this principle is psychoanalytic therapy. "Addictions been of interest to the field of psychoanalysis since its inception. Sigmund expressed that that masturbation was the source of all later addictions, and substance abuse was merely a substitute behavior [10]."

Freud's psychoanalysis has come a long way since its inception. As a dynamic therapy it has evolved over time, and even created a subset called psychodynamic psychotherapy. While many tenants of Freud's theory stay in place, theorists have created their own offshoots and schools of thought. Psychoanalysis lives on today and can still be worked toward in various programs throughout the United States. Many psychoanalytic concepts are now backed by neurological research.

Psychoanalysis views early experiences as the key to development of the self. These experiences form the basis of personality, and how a person relates to others. Many of these experiences are formed during pre language periods. These are stored as nondeclarative and non implicit memories in the unconscious. The unconscious is a psychic space that stores traumatic memories, repressed drives, and extreme emotions.

The unconscious also houses what Freud called the Id. Present at birth, the Id is largely unconsciousness and includes all life (eros) and death (thanatos) instincts. It uses energy from bodily processes and can be thought of as the pleasure principle, and the biological principle. In the next layer of the mind (the preconscious) lies material that is not unconscious, but out of awareness. A person can call this information into awareness as opposed to buried unconscious content.

The superego is the morality/society principle. It is ridged in demands for perfectionism and discriminates heavily between good/bad/right/wrong. Superego formation allows self-control to replace parental control. Ignoring the superego or going against it produces feelings of guilt, and anxiety. The structure of the Superego lies in the preconscious.

The ego is the reality principle, and core ''self''. While not present at birth this structure evolves over time becoming the mediator between Id and Superego. The ego holds a purpose to enact change. A healthy ego focuses on logic, and self-perseveration. It also integrates and mediates pressures felt from intrapsychic conflict.

When these conflicts become too much of a burden, or anxiety heightened the ego employs what are known as defense mechanisms. Defenses can be pathological (reality disconnection), immature (reality distortion), neurotic (reality relief), and mature (reality acceptance). All defense mechanisms serve as a way to lesion types of anxiety. Psychoanalysis views anxiety as being reality, neurotic, and moral. Reality anxiety is a response to real threats in the environment. Neurotic anxiety involves fear of loosing control. Moral anxiety deals with a person going against held beliefs or values. Defense mechanism can be positive or negative with a person generally using a select few.

Psychoanalysis views substance abuse as the result of intrapsychic conflict. Things like relapse are the result of anxiety being to much for a persons ego integrity to handle. Psychoanalysts use a variety of techniques to help elect causes of substance use. Some of these include projective tests, free association, and exploration of early childhood experiences. Generally as a client talks in session an annalist looks for common themes. These are brought up and discussed with the client in hopes to allow for the ego to tolerate and better mediate between the Id and superego.

In an article by Jeffrey R. Guess stimulant use explained and treated though psychoanalytic principles is examined. Guess points to early developmental feeling of inadequacy and separateness. Treatment is sough when moral, neurotic, and reality anxiety become to much to bear. "When intrapsychic conflict become to much for the ego to bear, individuals will seek treatment. There are feelings of loss and shame that pair with the inability to control unconscious urges. [11] Another treatment concern is the issue of transference/countertransference. Clients in many cases see the therapist as a new drug, which leads to temporary associations of positive experiences. Positive experiences for the client at this stage feel like drug use with unwanted symptoms decreasing, and a sense of self-efficacy that could not be felt under sober conditions.

When depression and fear of loss of control become overwhelming, individuals often seek or are referred for drug treatment. A sense of panic and shame accompany the experience of being unable to control one's use of sex and drugs.

Guess also makes a point to note the defense mechanism of projection, denial, minimization, and splitting. These are either applied to the person, drug, or therapist. Denial usually is the first major hurdle baring a person from diving into treatment. Common themes that emerge are a client thinking the problem is not severe, they are still able to function, and treatment has come from a lapse in judgment. Projection occurs through the client attributing the drug or therapist as the source of their ills, which allows intrapsychic conflicts to be ignored. Projection also serves to distract the client creating resistance from intrinsic needs. Minimization of problems serves to let Id drives take control while ignoring damaging effects of substance use.

Splitting is attributed as the most harmful defense mechanism. This psychotic defense causes the biggest rifts in therapy seeing the continuum of treatment in a black and white sense. This often relates to feelings of the ego paired with the substance. The self becomes viewed as being good/bad in the context of intoxication. For example, a client believes they are only enjoyable when using stimulants. Splitting also creates an atmosphere where the client sees substance use as being only good or bad. A problem noted by Guess is the elimination of anxiety that stimulants bring. This creates major hurdles in treatment and continued abstinence of the client.

Reviewing the issue of Substance Use Disorder and four theoretical orientations for treatment (Cognitive Behavioral Therapy, 12 Step Treatments Groups, Motivational Interviewing, and Psychoanalysis) several similarities were found that may aid in the treatment of Substance Use Disorder especially as it pertains to stimulants.

Findings were among similarities the most common across all four were a strong therapeutic alliance, intrinsic change, motivation, altruism, and raised awareness. In some cases, TSG prove to be just as, if not more, effective in long term changes from systems of psychotherapy. It can be concluded that while client situations can differ the above factors and further similarities found across all four modes of treatment should be considered when dealing with substance abuse. In particular interest is the cognitive behavioral study that showed cognitive impairments though stimulant use might be offset through certain modifications in didactic materials. These include visual aids such as comics, videos, graphs, and images. Simplistic language also appeared to be consistent across all four modes of treatment. Stimulant use disorder is a complicated issue, which will require not only the skill of a therapist, but also the client as guide as to what the best path for achieving full remission might entail.

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Conflict of Interest

No conflict of interest.

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