

Nintendo's Mario

Introducing the Character

Mario is the iconic star of Nintendo's globally known video game series of the same name. The character—a diminutive, Italian, mustachioed plumber complete with overalls—was created by Japanese manga artist Shigeru Miyamoto, was first introduced in 1981 as “Jump Man” in the early video game *Donkey Kong*, and by now has starred in more than 100 Nintendo games.

The many incarnations of the original video game featuring Mario were loosely based upon the cartoon character Popeye. Mario, who has incredible jumping ability, continually battles against his nemesis, Bowser, to rescue Princess Peach from a variety of dangerous situations. Mario has appeared in many video games; has crossed over into television shows, comic books, and movies; has been imprinted on lunch boxes, T-shirts, magazines, and shampoo bottles; and has even been incarnated as a plush toy. Considered by many to be as recognizable as Mickey Mouse, Mario is Nintendo's mascot and earned seven world records in the 2008 gamers' edition of *Guinness World Records*. These records include: best-selling video games series of all time, first movie based on an existing video game, and the most prolific video game character. Expanding on what is known about the Mario character, the following basic case summary and diagnostic impressions fill in more of our own imagined details about Mario and describe areas of dysfunction we believe he has been confronting since adolescence and throughout adulthood, stemming from his problematic use of cocaine and alcohol, along with some self-aggrandizing personality features.

Basic Case Summary

Identifying Information. Mario Alito, born Nunzio Alito, is a 44-year-old European American of Italian family heritage who resides in both South Beach, Florida, and Beverly Hills, California. Mario currently is employed as a photographic and action model, working primarily as the image of Mario of the Nintendo games, and as

“Mario the Romancer,” whose visage has been featured on the cover of more than 200 teen romance novels. In this occupational role, he is known as the “Fabio of video games.” His appearance was appropriate for the interview.

Presenting Concern. Mario arrived at this private Beverly Hills Drug Rehabilitation Center at the urging of his agent, following what was described as a “2-week cocaine binge” that resulted in the threat of losing his video game contract and primary source of income. His agent first referred him as a contestant on the television reality show *Celebrity Rehab*, but he was rejected for the show because his condition was assessed as being too fragile. At the center, his intake was performed by a multidisciplinary team comprising a psychiatrist, a psychologist, a milieu specialist, and the substance-abuse coordinator. Up to this most recent incident, Mario insisted he had used cocaine “only recreationally” but had decided to “let it all go” soon after discovering that his contracts with both Nintendo and Teen Heart Publishing might not be renewed.

Background, Family Information, and Relevant History. Mario Alito was born in Miami, Florida. His family of origin included his father, mother, and two siblings; both of his older sisters were in middle school at the time of his birth. Mario described his parents as devout Catholics who had hopes that he would become a priest. He attended private Catholic schools in Miami where, according to the client, his “charm, stunning good looks, and athletic prowess” garnered him popularity among male and female peers as well as his teachers. He described academic difficulties during his elementary and middle school years that may have been associated with an undetected learning disability and reported compensating by cheating as well as manipulating more vulnerable students to do his work for him. Apparently his parents knew nothing of these negative activities and believed instead that their son was living up to all of their expectations for him.

During high school, Mario excelled at gymnastics and won the state high-jump championship during each of his 4 years, which earned him the attention of the media. In addition, by the time he was a sophomore, Mario was working occasionally in modeling for local fashion magazines and on television commercials. Mario reports he was popular and highly socially active with male peers and socially and sexually active with high school girlfriends. At the same time, it appears he began sometimes alienating friends and teachers by dwelling

on his accomplishments, talents, and what he saw as an unlimited future of success and wealth. During his junior year in high school, Mario began drinking alcohol on weekends at football games, parties, and other social events, usually becoming at least mildly intoxicated and usually driving himself and dates or friends home. He reports being introduced to cocaine in the summer before his senior year, and he said in retrospect “I loved the rush . . . the parties got better, girls really noticed me, and I was one of the coolest kids.” He reports that his use increased to weekly, usually on weekends. When he was arrested at age 17 for a minor cocaine possession, his parents denied that their son was involved in drugs, quickly bailed him out of jail, and took him to the mandatory 6-week drug-abuse counseling program – where he essentially manipulated the therapist into believing that he had used cocaine on only a few occasions.

During a gymnastics competition in his senior year, Mario was approached by a talent agent who was well connected with the video game industry. In fact, an advertising representative from the Nintendo Corporation noticed Mario and believed that his image would be perfect for the prototype of an Italian video game character that was in development and was based on the cartoon character Popeye. Within 2 years, Mario’s athletic prowess was transformed into what would become the most famous video game character of all time, Mario. As a sideline, he capitalized on his physical attractiveness and unique looks by modeling for teen romance novel covers. By that time, Mario was in his late 30s, wealthy, famous, and world renown. He apparently engaged in a lifestyle described by his agent as “week-long cocaine binges, jet setting, and womanizing.” After recently being arrested for public indecency and intoxication, his contracts with both Nintendo and Teen Heart Publishing were in jeopardy of being canceled. Over this time period, Mario has had diminishing contact with his parents and sisters; friends, colleagues, and professional contacts other than his agent appear to have distanced themselves from him.

Problem and Counseling History. With the exception of his brief psychoeducational intervention during high school, Mario has neither received nor sought counseling services for his substance use. He made it quite clear from the outset that “I don’t really think I have a problem. . . . If you were losing your livelihood, what would you do?” Mario sat impatiently throughout the intake interview, seemingly more interested in entertaining the

interviewers and providing a resume than he was in disclosing relevant personal information about himself. He spoke frequently and intensely about his fame and popularity and the “enormous pressure that comes with being an icon.”

Information gathered suggests that Mario’s alcohol use has increased since his early high school years. His weekend use appears to have increased during his teen years and early 20s to half-week use, often from Wednesdays through Sunday or Monday. However, it appears that this use has remained about the same or diminished some in recent years as he has increasingly used powder cocaine. His present alcohol use seems most present when he is unable to locate cocaine, his drug of choice (e.g., when he is traveling by airplane between his two home cities). It is notable that he has missed several video game filmings and photo obligations due to hangover symptoms, in spite of warnings from his employers and agent. However, outside of minor hangovers, he does not report losing interest or giving up other social or life activities and does not seem to have increased his use beyond long weekends or “in between” cocaine episodes.

Information gathered also suggests that Mario’s cocaine use has increased since his early high school years. His weekend use appears to have increased during his teen years and early 20s to half-week use, and at times, week-long use, especially in between work obligations. He reports that “although I certainly don’t have a problem,” he has several times attempted to curb use at the request of a romantic partner or his agent but generally found himself unable to “just cut down.” In fact, he appears to be spending more of his income, and a greater amount of his time, locating and using increasing amounts of cocaine (in comparison with his steady alcohol use rates). He says the increase is so that “I can still feel that great rush.” Further, he seems to use this substance at unplanned times to ward off extreme tiredness, nightly trouble sleeping, and feeling agitated and irritated when he stops use. Of note, he finds that sleep becomes difficult when he is using cocaine and then does not return to normal, and he said he rarely sleeps through the night; the client attributes his sleep deficits and fatigue to long work shifts and frequent publicity events.

Goals for Counseling and Course of Therapy to Date. When asked if he would like to once again admit himself into the clinic’s substance-abuse rehab program for treatment beyond the intake screening, Mario adamantly

denied having “a problem with drugs.” He did agree to short-term counseling “as long as I can get back on my feet, clean up my image, and get back out there on stage where I belong.”

Diagnostic Impressions

304.00 (F11.20) Opioid Use Disorder, Moderate; 292.85 (F11.282) Cocaine-Induced Sleep Disorder, With Onset During Intoxication, Insomnia Type; 305.00 (F10.10) Alcohol Use Disorder, Mild.

Other factors: V62.29 (Z56.9) Other Problems Related to Employment—Threat of job loss; V61.10 (Z63.0) Relationship stress—Unstable relationships.

Discussion of Diagnostic Impressions

Mario’s arrival at the Beverly Hills Drug Rehabilitation Center was prompted by a cocaine binge that resulted in the threat of job loss. Although during his evaluation Mario denied “having a problem,” his history indicates that his cocaine use has steadily increased since it began during his high school years. He describes feeling agitated and irritable when he stops use, which are signs of withdrawal. According to his history, his pattern of use includes periods during which he was unsuccessful at cutting down his use despite his efforts to do so; his spending excessive time, effort, and money to obtain cocaine; and continued use despite his knowledge that it is interfering with his intimate relationships and work obligations. In addition, his history of recurrent alcohol use has resulted in missed work obligations and drinking to the point of having hangovers, despite his knowledge of these ill effects. Finally, Mario disclosed in the interview that he has prominent disturbances in sleep that developed during his cocaine use and withdrawal.

The Substance-Related and Addictive Disorders of the *DSM-5* comprise all of the Substance Use Disorders and Substance-Induced Disorders (Intoxication, Withdrawal, and substance/medication-induced mental disorders) related to the use of 9 classes of drugs (including alcohol), medications, and toxins. Diagnosable *DSM-5* Substance Use Disorders do not address nonproblematic experimentation and the social or

recreational use of alcohol or other drugs; rather, diagnosable disorders pertain only to clinically significant patterns of substance-related behavior resulting in negative life consequences (Inaba & Cohen, 2000).

Expanding on his video game persona by filling in our own imagined details, we described Mario as presenting problematic use of cocaine and alcohol, including negative effects on his sleep. His cocaine use comprises a maladaptive pattern in which he experiences unsuccessful efforts to cut down, commitment of substantial time to use and recovery, and persistence even in light of negative consequences in his interpersonal and work life. This kind of substance use pattern indicates a diagnosis of Opioid Use Disorder. The diagnosis is subtyped as Moderate because Mario meets 4-5 symptoms of the diagnostic criteria presented in the *DSM-5*. His alcohol use comprises a maladaptive pattern in which he continues drinking despite his knowledge of negative consequences at work and in other areas of his life. Finally, his sleep disruption seems sufficiently problematic as to interfere with his daily functioning and therefore warrants a diagnosis. His sleep problems developed during cocaine intoxication and are not better accounted for by another cause, indicating a diagnosis of Cocaine-Induced Sleep Disorder. Mario's problem is trouble maintaining sleep rather than excessively sleeping and began during cocaine use rather than withdrawal; therefore, the diagnosis is subtyped With Onset During Intoxication, and the specifier Insomnia Type is used.

Differential diagnoses might include a more severe subtype of Alcohol Use Disorder; and, regarding sleep, Circadian Rhythm Sleep Disorder, Shift Work Type. However, unlike Mario's cocaine use, his alcohol use pattern meets the criteria for the less advanced diagnosis. Likewise, although the client attributes his sleep difficulties to a mismatch between his sleep-wake schedule due to his demanding work, there is no evidence to support this, and his insomnia is better accounted for by his substance use.

To complete the diagnosis, Mario's work and relationship stressors are emphasized in the "Other factors" section. This information is consistent with the substance use diagnostic pattern.

Case Conceptualization

When Mario came into the private Beverly Hills Drug Rehabilitation Center, he participated in an initial screening and assessment process conducted by a multidisciplinary evaluation team. During the process, as

much information as possible was collected about the symptoms and situations leading to Mario's referral. Included among the intake materials were a thorough psychosocial, medical, and substance use history; client report; team observations; and other reports. Based on the evaluation, his counselor and the team developed diagnostic impressions, describing his presenting concerns by Opioid Use Disorder, the insomnia type of Cocaine-Induced Sleep Disorder, and Alcohol Use Disorder. A case conceptualization next was developed. Whereas the purpose of diagnostic impressions is to *describe* the client's concerns, the goal of case conceptualization is to better *understand* and clinically *explain* the person's experiences (Neukrug & Schwitzer, 2006). It helps the counselor understand the etiology leading to Mario's substance use and related problems and the factors maintaining these concerns. In turn, case conceptualization sets the stage for treatment planning. Treatment planning then provides a road map that plots out how the counselor and client expect to move from presenting concerns to positive outcomes (Seligman, 1993, p. 157)—helping Mario reduce or eliminate his problematic substance use and improve his sleep.

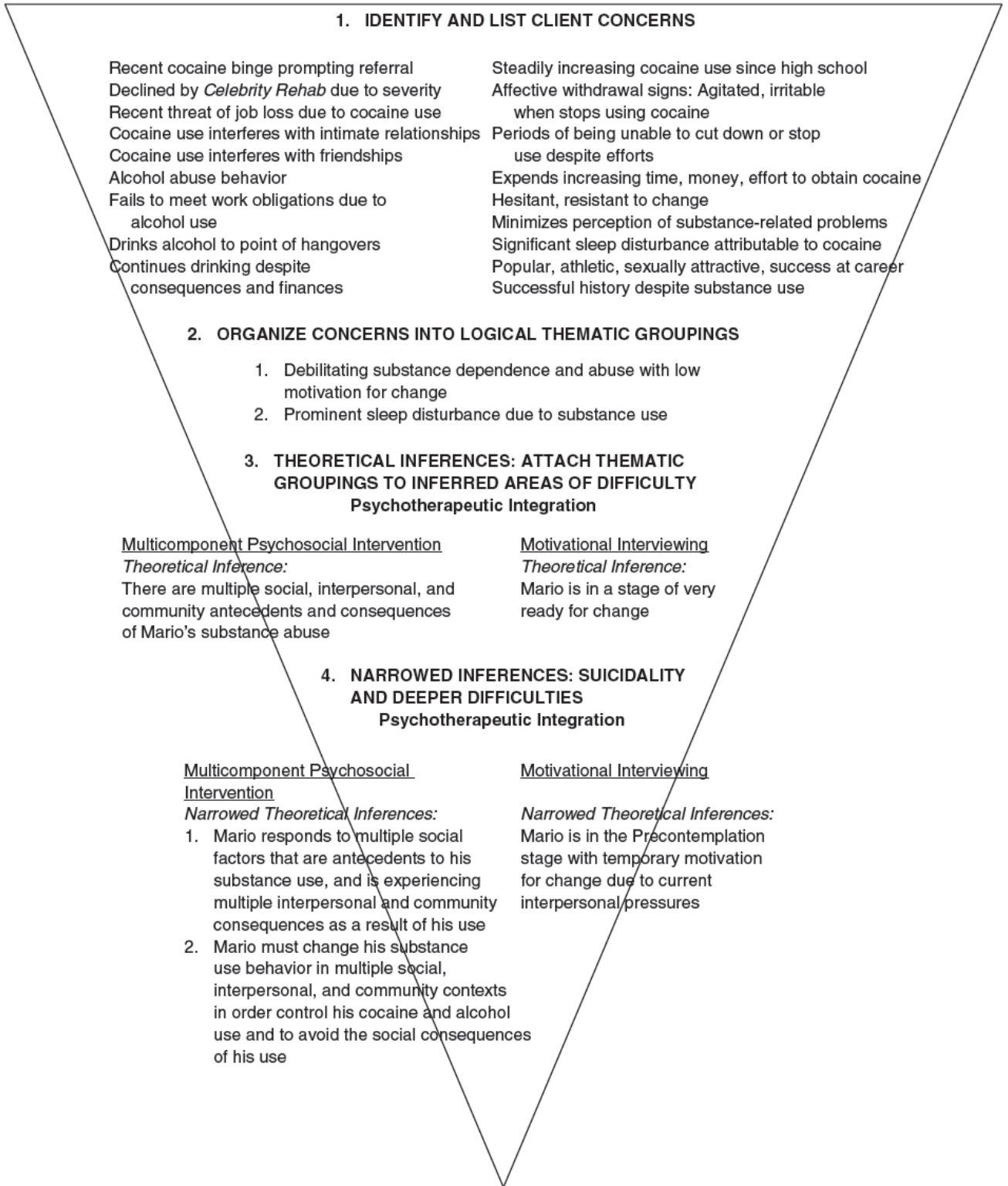
When forming a case conceptualization, the clinician applies a purist counseling theory, an integration of two or more theories, an eclectic mix of theories, or a solution-focused combination of tactics to his or her understanding of the client. In this case, Mario's counselor and the intake team based the conceptualization on psychotherapeutic integration of two theories (Corey, 2009). Psychotherapists very commonly integrate more than one theoretical approach in order to form a conceptualization and treatment plan that will be as efficient and effective as possible for meeting the client's needs (Dattilo & Norcross, 2006; Norcross & Beutler, 2008). In other words, counselors using the psychotherapeutic integration method attempt to flexibly tailor their clinical efforts to "the unique needs and contexts of the individual client" (Norcross & Beutler, 2008, p. 485). Like other counselors using integration, Mario's clinician chose this method because he had not found one individual theory that was comprehensive enough, by itself, to address all of the "complexities," "range of client types," and "specific problems" seen among his everyday caseload (Corey, 2009, p. 450).

Specifically, Mario's counselor selected an integration of (a) the Multicomponent Psychosocial Intervention Theory and (b) Motivational Interviewing. He selected this approach based on the client's

presentation of long-standing cocaine use with physiological consequences such as sleep disruption and long-standing alcohol use patterns. Multicomponent Psychosocial Intervention often is indicated when a combination of symptoms will be targeted via residential and community-based treatment, group therapy and self-help groups, as well as family therapy (Crits-Christoph et al., 1999; Higgins et al., 1993; Higgins & Silverman, 1999; Humpreys & Moos, 2007; Moos & Timko, 2008; Saatcioglu, Erim, & Cakmak, 2006; Stanton & Shadish, 1997), whereas an integrated approach emphasizing Motivational Interviewing is indicated for addressing the personal dynamics related to changing substance using behaviors and choices (Baer & Peterson, 2002; Miller & Rollnick, 2002). Mario's counselor is comfortable theoretically integrating these approaches, and it is the model commonly employed at the Beverly Hills center he selected for Mario.

The counselor used the Inverted Pyramid Method of case conceptualization because this method is especially designed to help clinicians more easily form their conceptual pictures of their clients' needs (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997). The method has four steps: Problem Identification; Thematic Groupings; Theoretical Inferences; and Narrowed Inferences. The counselor's clinical thinking can be seen in the figure below.

Mario's Inverted Pyramid Case Conceptualization Summary: Psychotherapeutic Integration of Multicomponent Psychosocial Intervention and Motivational Interviewing



Step 1: Problem Identification. The first step is Problem Identification. Aspects of the presenting problem (thoughts, feelings, behaviors, physiological features), additional areas of concern besides the presenting concern, family and developmental history, in-session observations, clinical inquiries (medical problems, medications, past counseling, substance use, suicidality), and psychological assessments (problem checklists, personality inventories, mental status exam, specific clinical measures) all may contribute information at Step 1. The counselor “casts a wide net” in order to build Step 1 as exhaustively as possible (Neukrug & Schwitzer, 2006, p. 202). As can be seen in the figure, the counselor and the evaluation team identified: Mario’s cocaine use symptoms, factors, and consequences; Mario’s alcohol use symptoms, factors, and consequences; immediate social concerns (threat of job loss, etc.); information about his history of use; his sleep symptoms; as well as strengths, accomplishments, and areas of successful adjustment. The problem description in Step 1 attempted to go beyond just the current events leading to Mario’s referral in order to be fully descriptive.

Step 2: Thematic Groupings. The second step is Thematic Groupings. The clinician organizes all of the exhaustive client information found in Step 1 into just a few intuitive-logical clinical groups, categories, or themes, on the basis of sensible common denominators (Neukrug & Schwitzer, 2006). Four different ways of forming the Step 2 theme groups can be used: Descriptive-Diagnosis Approach, Clinical Targets Approach, Areas of Dysfunction Approach, and Intrapsychic Approach. As can be seen in the figure, Mario’s counselor selected the Areas of Dysfunction Approach. This approach sorts together all of the Step 1 information into “areas of dysfunction according to important life situations, life themes, or life roles and skills” (Neukrug & Schwitzer, 2006, p. 205).

The counselor grouped together (a) all of Mario’s substance use behaviors, consequences, and motivational factors associated with both cocaine and alcohol into the theme “Debilitating substance dependence and abuse with low motivation for change”; and (b) Mario’s single concern pertaining to sleep into the stand-alone theme “Prominent sleep disturbance due to substance use.” His conceptual work at Step 2 gave the counselor a way to begin understanding and explaining the client’s many concerns as a narrower list of just two, clear, meaningful areas of negative functioning. As a substance-abuse counseling specialist, he based his

groupings on the literature suggesting that (a) clients and patients experiencing ongoing use of more than one substance see better outcomes when their concerns are conceptualized and treated together, as a polysubstance abuse problem, rather than as individual problems, and (b) clients with substance use problems and an additional mental health concern respond better when the additional mental health problem also is addressed (Project MATCH Research Group, 1997).

So far, at Steps 1 and 2, the counselor has used his clinical assessment skills and clinical judgment to begin meaningfully understanding Mario Alito's needs. Now, at Steps 3 and 4, he applies the theoretical approach he has selected. He begins making theoretical inferences to interpret and explain the processes or roots underlying Mario Alito's concerns as they are seen in Steps 1 and 2.

Step 3: Theoretical Inferences. At Step 3, concepts from the counselor's theoretical integration of two approaches—Multicomponent Psychosocial Intervention and Motivational Interviewing—are applied to explain the experiences surrounding, and the mechanisms maintaining, Mario's problematic substance use and its consequences. The counselor tentatively matches the theme groups in Step 2 with this theoretical approach. In other words, the symptom constellations in Step 2, which were distilled from the symptoms in Step 1, now are combined using theory to show what are believed to be the underlying causes or psychological etiology of Mario Alito's current needs (Neukrug & Schwitzer, 2006; Schwitzer, 2006, 2007).

First, Multicomponent Psychosocial Intervention Therapy was applied primarily to Mario's abuse and dependence behaviors. According to the model, there are interpersonal and community antecedents, and social consequences, of substance use; consequently, these social factors are necessary to understand a person's substance use behaviors and then target treatment (National Institute on Drug Abuse, 2008). Along these lines, the counselor inferred that there are multiple social, interpersonal, and community antecedents and consequences of Mario's substance use.

Second, Motivational Interviewing was applied primarily to Mario's intrapersonal experience of his use, especially as it related to his motivation for change. According to the model, individuals exist and may move through a series of predictable stages of change, including Precontemplation, Contemplation, Preparation,

Action, and Maintenance (Prochaska, Norcross, & DiClemente, 1994). Conceptually, understanding where a client exists in the process of contemplating and enacting change provides a guide to treatment planning using the nondirective social influence methods of Motivational Interviewing (Markland, Ryan, Tobin, & Rollnick, 2005; Miller & Rollnick, 2002). Along these lines, the counselor inferred that Mario is in a stage of very low readiness for change.

Step 4: Narrowed Inferences. At Step 4, the clinician's selected theory continues to be used to address still-deeper issues when they exist (Schwitzer, 2006, 2007). At this step, "still-deeper, more encompassing, or more central, causal themes" are formed (Neukrug & Schwitzer, 2006, p. 207). Mario's counselor continued to use psychotherapeutic integration of two approaches.

First, continuing to apply Multicomponent Psychosocial Intervention concepts at Step 4, Mario's counselor presented a pair of narrowed theoretical inferences, which he believed to be most explanatory and causal regarding Mario's problematic substance use: (a) Mario responds to multiple social factors that are antecedents to his substance use and is experiencing multiple interpersonal and community consequences as a result of his use; and, correspondingly, (b) Mario must change his substance-use behavior in multiple social, interpersonal, and community contexts in order to control his cocaine and alcohol use and to avoid the social consequences of his use. Second, continuing to apply Motivational Interviewing, the counselor presented another, complementary, narrowed theoretical inference: Mario is in the Precontemplation stage with temporary motivation for change due to current interpersonal pressures (Prochaska et al., 1994). When all four steps are completed, the client information in Step 1 leads to logical-intuitive groupings on the basis of common denominators in Step 2, the groupings then are explained using theory at Step 3, and then, finally, at Step 4, further deeper explanations are made. From start to finish, the thoughts, feelings, behaviors, and physiological features in the topmost portions are connected on down the pyramid into deepest dynamics.

Treatment Planning

At this point, Mario's clinician at the Beverly Hills Drug Rehabilitation Center has collected all available information about the problems that have been of concern to him and the treatment team that performed Mario's assessment. Based upon this information, the counselor developed a *DSM-5* diagnosis and then, using the "inverted pyramid" (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997), formulated a working clinical *explanation* of Mario's difficulties and their etiology that we called the *case conceptualization*. This, in turn, guides us to the next critical step in our clinical work, called the *treatment plan*, the primary purpose of which is to map out a logical and goal-oriented strategy for making positive changes in the client's life. In essence, the treatment plan is a road map "for reducing or eliminating disruptive symptoms that are impeding the client's ability to reach positive mental health outcomes" (Neukrug & Schwitzer, 2006, p. 225). As such, it is the cornerstone of our work with not only Mario, but with all clients who present with disturbing and disruptive symptoms and/or personality patterns (Jongsma et al., 2003a, 2003b; Jongsma & Peterson, 2006; Seligman, 1993, 1998, 2004).

A comprehensive treatment plan must integrate all of the information from the biopsychosocial interview, diagnosis, and case conceptualization into a coherent plan of action. This *plan* comprises four main components, which include (1) a behavioral definition of the problem(s), (2) the selection of achievable goals, (3) the determination of treatment modes, and (4) the documentation of how change will be measured. The *behavioral definition of the problem(s)* consolidates the results of the case conceptualization into a concise hierarchical list of problems and concerns that will be the focus of treatment. The *selection of achievable goals* refers to assessing and prioritizing the client's concerns into a *hierarchy of urgency* that also takes into account the client's motivation for change, level of dysfunction, and real-world influences on his or her problems. The *determination of treatment modes* refers to selection of the specific interventions, which are matched to the uniqueness of the client and to his or her goals and clearly tied to a particular theoretical orientation (Neukrug & Schwitzer, 2006). Finally, the clinician must establish how change will be measured, based upon a number of factors including client records and self-report of change, in-session observations by the clinician, clinician

ratings, results of standardized evaluations such as the Beck Depression Inventory-II (Beck & Steer, 1990) or a family functioning questionnaire, pre-post treatment comparisons, and reports by other treating professionals.

The four-step method discussed above can be seen in the text and is outlined below for the case of Mario Alito, followed by his specific treatment plan.

Step 1: Behavioral Definition of Problems. The first step in treatment planning is to carefully review the case conceptualization, paying particular attention to the results of Step 2 (Thematic Groupings), Step 3 (Theoretical Inferences), and Step 4 (Narrowed Inferences). The identified clinical themes reflect the core areas of concern and distress for the client, while the theoretical and narrowed inferences offer clinical speculation as to their origins. In the case of Mario, there is one primary and overarching area of concern. “Debilitating substance abuse with low motivation for change and sleep disturbance” refers to his steadily increasing cocaine and alcohol use since high school; continued drinking and cocaine use despite consequences; failure to meet work, family and relationship obligations when hung-over from alcohol or coming down from a cocaine binge; expending increasing amounts of time and money to obtain cocaine; minimized perception of substance-abuse problem with heightened resistance to change despite efforts; and significant sleep disturbance directly attributable to cocaine use and affective withdrawal signs, including agitation and irritability upon cocaine cessation. These symptoms and stresses are consistent with the diagnosis of Opioid Use Disorder; Cocaine-Induced Sleep Disorder, With Onset During Intoxication, Insomnia Type; Alcohol Use Disorder (APA, 2013; Gordek & Folsom, 2006; Grant et al., 2006; Inaba & Cohen, 2000; Jaffe, Rawson, & Ling, 2005; NIDA, 2008; Substance Abuse and Mental Health Services Organization, 2006).

Step 2: Identify and Articulate Goals for Change. The second step is the selection of achievable goals, which is based upon a number of factors, including the most pressing or urgent behavioral, emotional, and interpersonal concerns and symptoms as identified by the client and clinician, the willingness and ability of the client to work on those particular goals, and the realistic (real-world) achievability of those goals (Neukrug & Schwitzer, 2006). At this stage of treatment planning, it is important to recognize that not all of the client’s problems can

be addressed at once, so we focus initially on those that cause the greatest distress and impairment. New goals can be created as old ones are achieved.

In the case of Mario, the goals flow directly from his primary problem, “debilitating substance abuse with low motivation for change and sleep disturbance.” This complex, long-standing, and multidimensional problem requires that we design an intervention that is equally multidimensional so as to address all of the components of his substance-abuse problem. Based upon the assumption that Mario’s long-standing abuse of drugs and alcohol originated and evolved within a social context, it follows that there have been, and continue to be, a number of intrapersonal, interpersonal, and community factors that shape, reinforce, and maintain his behavior. Some of these may include his faulty cognitions around substance abuse, the maladaptive behavioral pattern that has developed through which he acquires and uses cocaine and alcohol, the adverse physical and physiological effects on him of these substances (including sleep problems), drug/alcohol-based and drug/alcohol-centered casual and intimate relationships, the reciprocal impact of career and celebrity status on his substance use, the perception of himself as a high-power and “untouchable” celebrity, and the impact of his numerous altercations, arrests, and failed rehabilitative efforts on both his self-image and the image of him in the public eye. This complex array of etiological and maintaining factors requires that we help Mario accept the fact of his chemical dependence and the destructive effect it has had in all areas of his life, help him withdraw from cocaine and alcohol and stabilize him physically and emotionally, establish and maintain total abstinence while increasing his knowledge of the addictive process and lifestyle, acquire the necessary intrapersonal and interpersonal coping skills to maintain long-term sobriety, develop an understanding of his personal pattern of relapse by identifying internal, interpersonal, and community triggers for relapse, and achieve a high quality of life, absent substance abuse. Additionally, given that Mario’s substance abuse is both long-standing and pervasive, it is important, if we are to help him achieve the above goals, to assess his motivation for change. We know that he is in a stage of “very low readiness for change,” so we will need to clarify obstacles to motivation and then help him strengthen his resolve and commitment to attain and maintain sobriety.

Step 3: Describe Therapeutic Interventions. This is perhaps the most critical step in the treatment planning process because the clinician must now integrate information from a number of sources, including the case conceptualization, the delineation of the client's problems and goals, and the treatment literature, paying particular attention to *empirically supported treatment* (EST) and *evidence-based practice* (EBP). In essence, the clinician must align his or her treatment approach with scientific evidence from the fields of counseling and psychotherapy. Wampold (2001) identifies two types of evidence-based counseling research: studies that demonstrate "absolute efficacy," that is, the fact that counseling and psychotherapy work, and those that demonstrate "relative efficacy," that is, the fact that certain theoretical/technical approaches work best for certain clients with particular problems (Psychoanalysis, Gestalt Therapy, Cognitive Behavior Therapy, Brief Solution-Focused Therapy, Cognitive Therapy, Dialectical Behavior Therapy, Person-Centered Therapy, Expressive/Creative Therapies, Interpersonal Therapy, and Feminist Therapy); and when delivered through specific treatment modalities (individual, group, and family counseling).

In the case of Mario, we have decided to use a two-pronged "integrated" approach comprised of Multicomponent Psychosocial Intervention and Motivational Interviewing. Multicomponent Psychosocial Intervention relies on a combination of techniques, modalities, and therapeutic venues to address the complex array of physiological, psychological (cognitive, behavioral, and emotional), interpersonal, and community factors that are related to, reinforce, and maintain substance abuse. These include Cognitive Behavior Therapy, family therapy, and psychoeducation delivered in a combination of outpatient and residential individual and group formats (Anton, O'Malley, & Ciraulo, 2006; Crits-Christoph et al., 1999; NIDA, 2008). Techniques that we will sequentially use with Mario as he moves from residential to outpatient counseling include referral for a medical examination of substance-related damage and monitoring during period of acute withdrawal; individual and group substance abuse psychoeducation; regular attendance in Narcotics Anonymous (NA); family counseling to identify the role members play in maintaining his substance abuse; identify physiological, emotional, and interpersonal triggers for substance use; identify and refute irrational thoughts related to his self-image as well as to substance abuse and celebrity; develop nonsubstance-related self-regulation/coping skills,

including deep breathing, muscle relaxation, assertiveness, self-affirmation, and mindfulness. Upon discharge, Mario will continue to receive group counseling at the center supplemented with individual and family counseling in the community. Techniques, in addition to those selected from his inpatient stay, will include assignment of a sponsor for abstinence support, development of a list of ways that sobriety could positively impact his life, plan social and recreational activities that are not associated with substance use, bibliotherapy for substance-abuse recovery, establishment of a mechanism for random drug screening, development of hierarchy of routines and activities to avoid relapse triggers, maintaining regular contact with sponsor and NA attendance upon discharge, assisting him in identifying and avoiding situations and people associated with substance use and psychiatric referral for possible psychopharmacotherapy (anxiety/depression).

We will also use Motivational Interviewing (MI), which asserts that the very notion of the “unmotivated client,” Mario in this case, is largely a myth. According to MI (Markland et al., 2005; Miller & Rollnick, 2002), “The client is viewed as an individual who waxes and wanes in his or her motivation, and one who can become motivated under the right circumstances” (Neukrug, 2011, p. 472). MI’s basic tenets are in line with “self determination theory [SDT]” (Markland et al., 2005), which advocates competence, autonomy, and relatedness, and suggests that motivation is multidimensional, dynamic and fluid, modifiable and a key to change, and is in turn affected by the clinician’s style and capacity to elicit and enhance motivational states. The clinician’s role is to identify the “stage” or readiness for change that the client is in (precontemplation, contemplation, preparation, action, and maintenance) and to then selectively use both directive (cognitive behavioral) and nondirective (open-ended questions, affirmations, reflective listening and summarizing [OARS], empathy and affirmation) skills to help the client move forward in his or her commitment to change. This technique, albeit relatively new, has been found to be effective in the treatment of a number of behavioral problems, including substance abuse and other “addictive” disorders (Arkowitz & Miller, 2008; Carrol et al., 2006). It is particularly suited for Mario, whose motivation has historically been erratic and undermined by a myriad of psychosocial and cognitive factors and who is beginning to understand the destructive effects of substance abuse on all facets of his life. The specific techniques that will be used with him are designed to enhance his competence,

autonomy, and relatedness and include open-ended questions around his drug use, perceptions of himself and goals, genuine and congruent affirmations highlighting his strengths, reflective and empathetic listening to his concerns and motivational obstacles, “rolling with his resistance” rather than directly confronting and challenging it, highlighting and summarizing the discrepancies in his narrative that maintain his substance use and undermine his motivation, and exploring options.

Step 4: Provide Outcome Measures of Change. This last step in treatment planning requires that we specify how change will be measured and indicate the extent to which progress has been made toward realizing these goals (Neukrug & Schwitzer, 2006). The counselor has considerable flexibility in this phase and may choose from a number of objective domains (psychological tests and measures of self-esteem, depression, psychosis, interpersonal relationship, anxiety, etc.), quasi-objective measures (pre-post clinician, client and psychiatric ratings), and subjective ratings (client self-report, clinician’s in-session observations). In Mario’s case, we have implemented a number of these, including client self-reported alcohol and cocaine abstinence, a pre-post improved measure on the Alcohol Use Inventory (Horn, Wanberg, & Foster, 1990), 6–12 month substance-free urine tests, and client self-reported and clinician-observed improvement in motivation to remain abstinent.

The completed treatment plan is now developed through which the counselor and Mario will work through his substance use problem. The treatment plan appears below and is summarized in the table below.

TREATMENT PLAN

Client: Mario Alito

Service Provider: Beverly Hills Drug Rehabilitation Center

BEHAVIORAL DEFINITION OF PROBLEMS:

1. Debilitating substance abuse—Steadily increasing cocaine and alcohol use since high school, continued drinking and cocaine use despite consequences, failure to meet work, family, and relationship obligations when hung over from alcohol or coming down from a cocaine binge, expending increasing amounts of time and money to obtain cocaine, minimized perception of substance abuse problem with

heightened resistance to change despite efforts, significant sleep disturbance directly attributable to cocaine use, and affective withdrawal signs, including agitation and irritability upon cocaine cessation.

GOALS FOR CHANGE:

1. Debilitating substance abuse

- Accept the fact of chemical dependence and its destructive effect
- Withdraw from cocaine and alcohol and stabilize physically, behaviorally, and emotionally
- Establish and maintain total abstinence while increasing knowledge of the addictive process and lifestyle
- Clarify obstacles to change motivation
- Strengthen his motivation, resolve, and commitment to attain and maintain sobriety
- Acquire the necessary intrapersonal and interpersonal coping skills to maintain long-term sobriety
- Develop an understanding of personal pattern of relapse by identifying internal, interpersonal, and community triggers for relapse
- Achieve a high quality of life absent the use of substances

THERAPEUTIC INTERVENTIONS:

A moderate-term course of individual Multicomponent Psychosocial Intervention and Motivational Interviewing (6–9 months)

1. Debilitating substance dependence and abuse

Inpatient/Residential

- Referral for a medical examination of substance-related damage and monitoring during period of acute withdrawal
- Individual and group substance-abuse psychoeducation
- Regular attendance in Narcotics Anonymous (NA)
- Family counseling to identify the role members play in maintaining substance abuse

- Identify physiological, emotional, and interpersonal triggers for substance use
 - Identify and refute irrational thoughts related to self-image as well as to substance abuse and celebrity
 - Develop non-substance-related self-regulation/coping skills, including deep breathing, muscle relaxation, assertiveness, self-affirmation, and mindfulness
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Outpatient

- Assignment of a sponsor for abstinence support
 - Development of a list of ways that sobriety could positively impact life
 - Plan social and recreational activities not associated with substance use
 - Bibliotherapy for substance abuse recovery
 - Establishment of a mechanism for random drug screening
 - Development of hierarchy of routines and activities to avoid relapse triggers
 - Maintain regular contact with sponsor
 - NA attendance
 - Assist in identifying and avoiding situations and people associated with substance use
 - Psychiatric referral for possible psychopharmacotherapy (anxiety/depression)
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Motivational Interviewing Techniques

- Open-ended questions around drug use, self-perceptions, and goals
- Genuine and congruent affirmations highlighting strengths
- Reflective and empathetic listening to concerns and motivational obstacles
- “Rolling with resistance” rather than directly confronting and challenging it
- Highlighting and summarizing discrepancies in narrative that maintain substance use and undermine motivation

- Exploration of options

OUTCOME MEASURES OF CHANGE:

The immediate cessation of substance use and establishment and maintenance of total abstinence and long-term adaptive functioning as measured by:

- Client self-reported alcohol and cocaine abstinence
 - Pre-post improved measure on the Alcohol Use Inventory
 - 12 month arrest-free police record
 - 6–12 month substance-free urine tests
 - Client self-report and clinician observation of improved quality of life and positive attitude and motivation to remain substance-free
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Mario’s Treatment Plan Summary: Psychotherapeutic Integration of Multicomponent Psychosocial Intervention and Motivational Interviewing

<i>Goals for Change</i>	<i>Therapeutic Interventions</i>	<i>Outcome Measures of Change</i>
<p><u>Debilitating substance abuse</u></p> <p>Accept the fact of chemical dependence and its destructive effects</p> <p>Withdraw from cocaine and alcohol and stabilize physically, behaviorally, and emotionally</p> <p>Establish and maintain total abstinence while increasing knowledge of the addictive process and lifestyle</p> <p>Clarify obstacles to change motivation</p> <p>Strengthen his motivation, resolve, and commitment to attain and maintain sobriety</p> <p>Acquire the necessary intrapersonal and interpersonal coping skills to maintain long-term sobriety</p>	<p><u>Debilitating substance abuse</u></p> <p><i>Inpatient/Residential</i></p> <p>Referral for a medical examination of substance-related damage and monitoring during period of acute withdrawal</p> <p>Individual and group substance-abuse psychoeducation</p> <p>Regular attendance in Narcotics Anonymous (NA)</p> <p>Family counseling to identify the role members play in maintaining substance abuse</p> <p>Identify physiological, emotional, and interpersonal triggers for substance use</p> <p>Identify and refute irrational thoughts related to self-image as well as to substance abuse and celebrity</p> <p>Develop nonsubstance-related self-regulation/coping skills, including deep breathing, muscle relaxation, assertiveness,</p>	<p><u>The immediate cessation of substance use and establishment and maintenance of total abstinence and long-term adaptive functioning as measured by:</u></p> <p>Client self-reported alcohol and cocaine abstinence</p> <p>Pre-post improved measure on the Alcohol Use Inventory</p> <p>12-month arrest-free police record</p> <p>6- to 12-month substance-free urine tests</p> <p>Client self-report and clinician observation of improved quality of life and positive attitude and motivation to remain substance-free</p>

<p>Develop an understanding of personal pattern of relapse by identifying internal, interpersonal, and community triggers for relapse</p> <p>Achieve a high quality of life absent the use of substances</p>	<p>self-affirmation, and mindfulness</p> <p><i>Outpatient</i></p> <p>Assignment of a sponsor for abstinence support</p> <p>Development of a list of ways that sobriety could positively impact life</p> <p>Plan social and recreational activities not associated with substance use</p> <p>Bibliotherapy for substance-abuse recovery</p> <p>Establishment of a mechanism for random drug screening</p> <p>Development of hierarchy of routines and activities to avoid relapse triggers</p> <p>Maintain regular contact with sponsor</p> <p>NA attendance</p> <p>Assist in identifying and avoiding situations and people associated with substance use</p> <p>Psychiatric referral for possible psychopharmacotherapy (anxiety/depression)</p> <p><i>Motivational Interviewing Techniques</i></p> <p>Open-ended questions around drug use, self-perceptions, and goals</p> <p>Genuine and congruent affirmations highlighting strengths</p> <p>Reflective and empathetic listening to concerns and motivational obstacles</p> <p>“Rolling with resistance” rather than directly confronting and challenging it</p> <p>Highlighting and summarizing discrepancies in narrative that maintain substance use and undermine motivation</p> <p>Exploration of options</p>	
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