

Psychosocial Interventions for Substance Use Disorders

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Overview

- Motivational Interviewing
- Cognitive Behavioral Therapy (CBT) and Relapse Prevention (RP)
- Contingency Management
- Matrix Model

Case I: Jane

- 20 y.o. WF college student with no prior psychiatric or medical history who began using methamphetamine at weekend parties 9 months ago.
- 6 months ago, increased use to 4-5 days/wk to improve concentration, increase productivity with coursework, and facilitate weight loss.
- Quit job at school cafeteria after developing paranoia and AH 3 months ago.
- Experienced fatigue, hypersomnia and increased appetite between uses.
- Stopped use three weeks ago after return home for summer vacation.

Case I: Jane (cont'd)

- Since then, has experienced low mood, diminished energy, irritability, and residual suspiciousness.
- Brought in by parents to primary care office for evaluation, noting concerns about social isolation, distractibility, lack of motivation to work, and refusal to return to school in the fall.
- On interview, pt thinks she may have medical illness, but also uncertain if meth use during final exams possibly contributed to sx's.

Case II: Alex

- 45 y.o. AAM employed in entertainment industry with reported history of Bipolar D/O, methamphetamine and alcohol dependence.
- Recent two months of sobriety in 3-day/wk outpatient drug treatment program.
- Did not attend groups for two weeks, then presented to outpatient appointment complaining of irritable mood, insomnia, “racing thoughts”, and intermittent AH of whispers.
- Appeared anxious and restless at appointment, and reported seeing “brief white shadows.”

Case II: Alex (cont'd)

- Had visible excoriations on face; described episodes of picking due to sensations of “pebbles” under his skin.
- Expressed concern that symptoms were distressing and might be related to bipolar illness.
- Reported history of prior psychiatric admissions, suicide attempt three years ago by medication overdose, and history of prior treatment with lamictal and depakote.
- No significant medical history, no current medications.
- On further questioning, admitted to relapse on methamphetamine and alcohol 10 days ago.

Motivational Interviewing: Definition

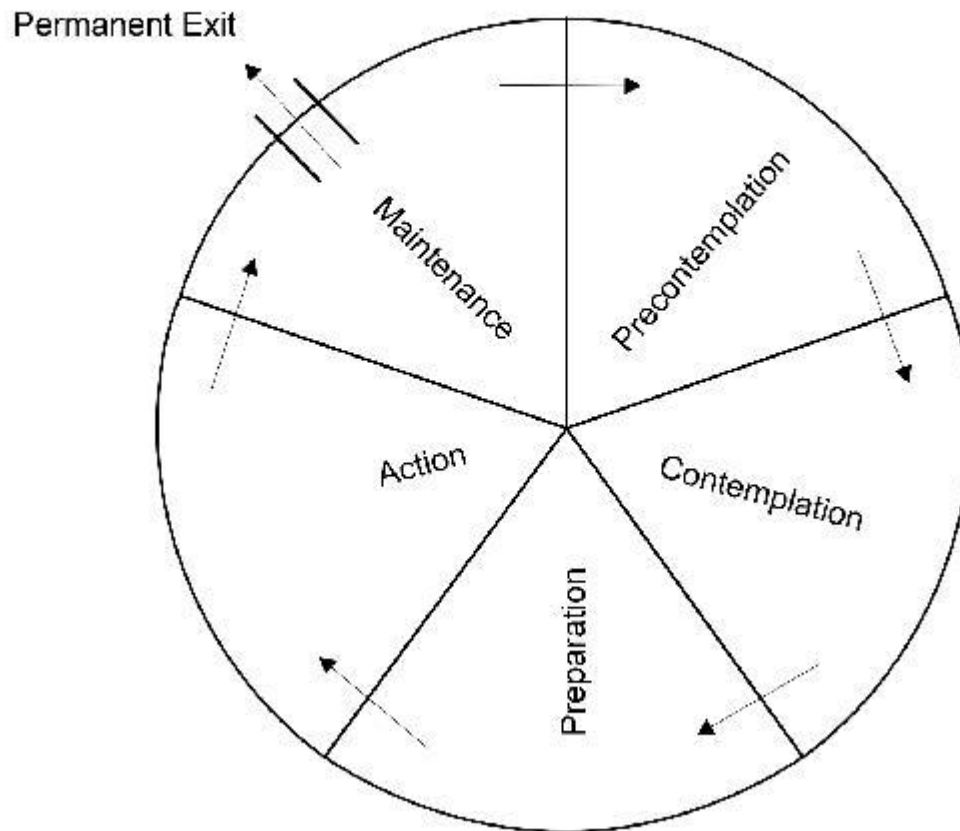
Motivational interviewing is a client-centered style of interaction aimed at helping people explore their ambivalence about their substance use and begin to make positive behavioral and psychological changes.

Transtheoretical Change Model (Prochaska and DiClemente, 1984)

- Change process involves a sequence of stages involving thinking about, initiating, and maintaining behaviors:
 1. Precontemplation
 2. Contemplation
 3. Action
 4. Preparation
 5. Maintenance
- Change process is cyclical, and individuals vary in terms of rate and nature of changes.
- Knowledge of a patient's stage of change can guide intervention strategies.

Transtheoretical Change Model

Figure 1-2
Five Stages of Change



Motivational Interviewing and Ambivalence

Assumptions:

- Ambivalence is normal and relevant to recovery.
- Ambivalence can be resolved by tailoring the intervention to the individual.
- Therapist's relationship with the patient is collaborative in nature.
- Confrontation can present a barrier to eliciting behavior change.

Stage-Specific Motivational Conflicts

Stage of Change	Client Conflict
Precontemplation	I think meth gives me the energy I need to get things done, but I hope that by agreeing to talk about it, my partner will feel reassured.
Contemplation	I can picture how quitting meth could help my depression, but I can't imagine living without it.
Preparation	I'm feeling good about starting treatment, but I'm wondering if I have the discipline to show up at 9am.
Action	Staying clean for the past few weeks has helped me to feel better, but I would love to use meth occasionally, like on a Saturday night.
Maintenance	These recent months of abstinence have made me feel that I am progressing towards recovery, but I'm still wondering whether total abstinence is really necessary.

Five Principles of Motivational Interviewing

1. Express empathy through reflective listening.
2. Develop discrepancy between patients' goals or values and their current behaviors.
3. Avoid argument and direct confrontation.
4. Adjust to client resistance.
5. Support self-efficacy and optimism.

Principle I: Express Empathy

Key elements of an empathic style (SAMHSA, 2005)

- Respect and acceptance of patients and their feelings
- Nonjudgmental and collaborative
- “Knowledgeable consultant” role
- Listen, don’t tell
- Persuasive, yet allowing the patient to make the decision

Principle II: Develop Discrepancy

Objective: to develop discrepancy between current behavior and hopes for the future.

- Raise patients' awareness of negative personal, familial, or community consequences of substance use.
- How are personal goals (e.g., physical health, mental health, marital satisfaction) undermined by substance use?
- Amplify and focus on this discrepancy until the patient can articulate arguments for change.

Principle III: Avoid Argument

- Arguments may precipitate resistance to change
- Defending or proving a point may breed defensiveness
- Labeling (e.g., “alcoholic”) is unnecessary
- The goal is to facilitate the patient’s own statement of an argument to change behavior

Principle IV: Roll With Resistance

- Resistance is a signal to listen more carefully or change therapeutic approach
- Recognizing resistance
 - 4 types (*Miller and Rollnick, 1991*):
 1. Arguing (e.g., challenging, discounting, hostility)
 2. Interrupting (e.g., talking over, cutting off)
 3. Denying (e.g., blaming, disagreeing, minimizing, unwillingness to change)
 4. Ignoring (e.g., inattention, sidetracking)

Principle V: Support Self-Efficacy

- Elicit hope and optimism about the patient's ability to achieve behavior change.
- Discuss treatment or change options, even if they have dropped out of other programs or relapsed.
- Provide examples of how individuals in similar situations have successfully changed behavior.
- Patient is responsible for choosing and executing a plan of change.
- “One day at a time”

Motivational Techniques

- **Questions to Evoke Self-Motivational Statements**
 - **Problem Recognition**
 - What difficulties have you had in relation to your drug use?
 - How has your use of meth stopped you from doing what you want to do?
 - **Concern**
 - What worries you about your drug use? What can you imagine happening to you?
 - What do you think will happen if you don't make a change?
 - **Intention to Change**
 - What makes you think that you may need to make a change?
 - If you were 100% successful and things worked out exactly as you would like, what would be different?
 - **Optimism**
 - What encourages you that you can change if you want to?

SAMHSA (1999)

Evidence Basis for M.I.

- Efficacy of Motivational Interviewing (M.I.) has been most widely studied in alcohol abusing and dependent populations: at least 32 trials
- M.I. effectively improves treatment adherence and drinking outcomes (Brown & Miller, 1993; Hettema, Steele & Miller, 2005)
- M.I. is viewed increasingly as being most effective when combined with other standard psychosocial interventions (Rohsenow et al., 2004)
- Recent studies demonstrate incremental efficacy of combined cognitive-behavioral + M.I. interventions among drug users (McKee et al., 2007; MTP Research Group, 2004)

Summary

- Understanding a substance user's level of motivation can guide a clinician's first intervention.
- Goal is to enhance motivation to change behavior and elicit self-motivational statements using a supportive, non-confrontational style.
- This can be accomplished in 5-10 minutes once diagnostic information has been acquired.
- The 5 principles of M.I. are:
 1. Express empathy
 2. Develop discrepancy
 3. Avoid argument
 4. Roll with resistance
 5. Support self-efficacy

Cognitive Behavioral Therapy & Relapse Prevention

Principles of CBT

- CBT is used to teach, encourage, and support individuals about how to reduce / stop their harmful drug use.
- CBT provides skills that are valuable in assisting people to achieve initial abstinence from drugs (or to reduce their drug use).
- CBT also provides skills to help people sustain abstinence (relapse prevention).

Principles of Relapse Prevention

Relapse Prevention (RP) is a cognitive-behavioral treatment (CBT) with two main goals:

1. To prevent the occurrence of initial “slips” or lapses after a commitment to change has been made; and
2. To prevent any lapse that does occur from escalating into a full-blown “relapse.”

Because of the common elements of RP and CBT, I will refer to all of the material in this portion of the session as CBT

Features of CBT

- CBT is
 - Short-term
 - Structured
 - Goal-oriented
 - Present focused
- CBT can be adapted to a wide range of clients as well as a variety of settings (inpatient, outpatient) and formats (group, individual).

Behavioral CBT Concepts

In the early stages of CBT treatment, strategies emphasize behavior change, and include:

- Setting a schedule to promote engagement in behaviors that are inconsistent with substance use
- Recognizing and avoiding “high risk” situations
- Facilitating positive coping skills

Cognitive CBT Concepts

As CBT treatment continues into later phases of recovery, more emphasis is given to the “cognitive” part of CBT. This includes:

- Psychoeducation regarding addiction
- Teaching clients about triggers and cravings
- Teaching clients cognitive skills (e.g., “thought stopping” and “urge surfing”)
- Identifying “red flag thoughts”

Individualizing CBT

- CBT programs are individualized by learning details about the person's drug use behaviors.
- It is critical to know how the drug use is connected with other aspects of a person's life. These details are critical to creating an appropriate treatment plan.

The 5 Ws

- The time periods when the client uses drugs
- The places where the client uses and buys drugs
- The external cues and internal emotional states that can trigger drug craving (why)
- The people with whom the client uses drugs or the people from whom she or he buys drugs
- The effects the client receives from the drugs — the psychological and physical benefits (what happened)

“Triggers”

- A “trigger” is a something that has been associated with substance use in the past
- Triggers can include people, places, things, time periods, emotional states
- Triggers can stimulate thoughts of substance use and craving for drugs

External Triggers

- People: drug dealers, drug-using friends
- Places: bars, parties, drug user's house, parts of town where drugs are used
- Things: drugs, drug paraphernalia, money, alcohol, movies with drug use
- Time periods: paydays, holidays, periods of idle time, after work, periods of stress

Internal Triggers

- Anxiety
- Anger
- Frustration
- Sexual arousal
- Excitement
- Boredom
- Fatigue
- Happiness

Understanding Craving

Craving (definition)

- To have an intense desire for
- To need urgently; require

Many people describe craving as similar to a hunger for food or thirst for water. There are cognitive, emotional, and physiological components to it.

Individual Differences in Cravings

Cravings or urges are experienced in a variety of ways by different individuals.

For some, the experience is primarily **somatic**.

For example, “I just get a feeling in my stomach” or “My heart races” or “I start smelling it.”

For others, craving is experienced more

cognitively. For example, “I need it now” or “I can’t get it out of my head” or “It calls me.”

Coping With Cravings

Coping with Craving:

1. Engage in non-drug-related activity
2. Talk about craving
3. “Surf” the craving
4. Thought stopping
5. Self-talk
6. Contact a drug-free friend or counsellor
7. Pray

Summary

- Behavioral strategies in CBT include scheduling and avoiding high risk situations.
- Cognitive strategies include recognizing triggers and cravings, thought stopping, recognizing “red flag thoughts,” and analysis of the chain of events that result in a “slip” or “lapse.”
- Optimally, CBT strategies can be used while practicing a style of interaction that is consistent with M.I.

Contingency Management

Contingency Management

■ Basic Assumptions

- Drug and alcohol use behavior can be controlled using operant reinforcement procedures
- Vouchers can be used for money or goods
- Vouchers should be redeemed for items incompatible with drug use
- Escalating the value of the voucher for consecutive weeks of abstinence promotes better performance
- Counseling/therapy may or may not be required in conjunction with CM procedure

Behavior can be modified by:



Rewards

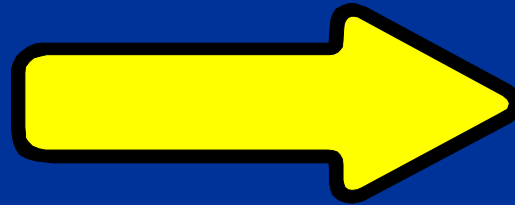


Punishment

It is the CONTINGENCY
that matters.....



BEHAVIOR



REWARD,
PUNISHER

*Learning occurs best when the
behavior is followed **immediately**
by the consequence.*

Contingency Management

■ Key concepts

- Behavior to be modified must be objectively measured
- Behavior to be modified (e.g., urine test results) must be monitored frequently
- Reinforcement must be immediate
- Penalties for unsuccessful behavior (e.g., positive urine test) can reduce voucher amount
- Vouchers may be applied to a wide range of prosocial alternative behaviors

CM has been used to treat a number of types of drug abuse

Opioids

Benzodiazepines

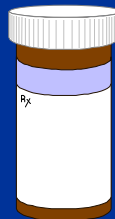
Marijuana

Methamphetamine

Nicotine (tobacco smoking)

Alcohol

Cocaine



Why CM?

- It has proven effective for treating every type of substance use disorder to which it has been applied (e.g., Higgins & Silverman, 1999)
- It is one of the most effective treatments for cocaine abuse (e.g., Rawson, R.A. McCann, M.J, Huber, A. Shoptaw, S., Farabee, D. Reiber, C. and Ling, W., 2002)
- A recent meta-analysis reports that CM results in a successful treatment episode **61%** of the time while other treatments with which it has been compared result in a successful treatment episode **39%** of the time (Prendergast, Podus, Finney, Greenwell & Roll, 2006)

Conclusions

- CM appears to increase the abstinence rates when combined with psychosocial treatments
- Suggests CM should be an integral part of methamphetamine use disorder treatment modalities

Matrix Model of Outpatient Therapy

- Structured intensive outpatient approach delivered over a 16 week period, with ongoing aftercare.
- Positive reinforcement via verbal praise, group support, and encouragement used extensively to promote treatment engagement and retention.
- Urine testing to monitor substance use and reinforce abstinence
- Self-help meeting attendance encouraged
- Integrates cognitive, behavioral, motivational, and 12-step techniques

The Matrix Model

<i>Monday</i>	<i>Wednesday</i>	<i>Friday</i>
Early Recovery Skills Weeks 1-4	Family/education Weeks 1-12	Early Recovery Skills Weeks 1-4
Relapse Prevention Weeks 1-16	Social Support Weeks 13-16	Relapse Prevention Weeks 1-16

❖ Urine or breath alcohol tests once per week, weeks 1-16

Matrix Model of Outpatient Therapy

- In the largest psychosocial clinical trial of methamphetamine dependent adults to date, the Matrix Model was compared to Treatment As Usual (TAU) across 8 sites in the U.S. (N=978) (Rawson et al., 2004)
- In the overall sample, and in the majority of sites, those who were assigned to Matrix treatment attended more clinical sessions, stayed in treatment longer, provided more MA-free urine samples during the treatment period, and had longer periods of MA abstinence than those assigned to receive TAU.
- At post-treatment follow-up (6 months and 1 year), the superiority of the Matrix approach over TAU was not maintained.
- Nevertheless, the in-treatment benefit is an important demonstration of empirical support for this psychosocial treatment approach.

Summary: Behavioral and Psychosocial Treatments for Stimulant Dependence

- There are effective treatments for alcohol and drug dependence.
- There is empirical evidence with randomized controlled clinical trials that support:
 - Motivational Interviewing
 - Cognitive Behavioral Therapy
 - Contingency Management
 - Matrix Model

Thank you!

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