PSYC1022: The Psychology of Addiction

Topic 13: Behavioural interventions (I)

Dr. Helena Pacitti

Outline:

- Relapse rates
- Project MATCH
  - Twelve-step facilitation
  - Cognitive behavioural therapy
  - Motivational enhancement therapy
- Systems level analysis

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Relapse rates

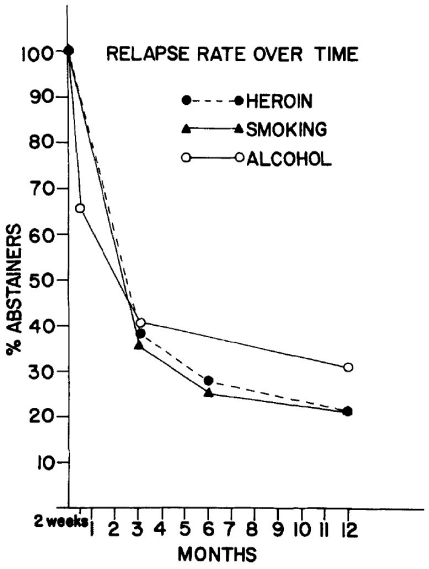
Those who enter treatment often have a comorbid dysregulation (psychiatric illness, cognitive impairments & impulsivity).

Hunt (1971): abstinence rates achieved by treatment

- number who remain abstinent falls to 40% by 3 months & 30% by 12 months.
- 3 groups differ in their primary drug of dependence, yet abstinence rates are comparable.

Hughes (2004): Similar relapse rates can be seen in self-quitters

- suggests a common relapse process operates in all quit attempts (Kirshenbaum et al. 2009)



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Project MATCH

Randomised control trial (RCT): alcohol dependent patients randomly allocated to one of three behavioural treatments: (1) Twelve-Step Facilitation Therapy, (2) Cognitive-Behavioural Coping Skills Therapy & (3) Motivational Enhancement Therapy.

- Each treatment was delivered over a 12-week period by trained therapists.
- Stringent attempts were made to standardise delivery of the interventions provided across multiple inpatient & outpatient facilities (experimental control).

Project MATCH Supported by NIAAA

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Twelve-step Facilitation (TSF)

A brief, structured approach to facilitating recovery from addiction. Based on the behavioural, spiritual & cognitive principles of 12-step fellowships such as Alcoholics Anonymous (AA) & Narcotics Anonymous (NA).

Principles: acknowledging that willpower alone cannot achieve sustained sobriety, surrender to the group conscience must replace self-centeredness & long-term recovery consists of a process of spiritual renewal.

Goals:

1. acceptance of the need for abstinence from alcohol & other drug use
2. surrender, or the willingness to participate actively in 12-step fellowships as a means of sustaining sobriety.

Therapist: assessment, advocates abstinence, explains 12-step concepts & actively supports initial involvement & ongoing participation in AA/NA. Also discusses specific readings from the AA/NA literature with the client, aids the client in using AA/NA resources in crisis times & presents more advanced concepts such as “moral inventories”.

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A.A. 12 Steps

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory, and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

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TSF Objectives

Acceptance: of their alcoholism; cannot control their drinking; abstinence is the only option.

Surrender: accept loss of control & have faith that a Higher Power can help them; AA path.

Cognition: understand how drinking has affected thinking; denial & how it contributes to continued drinking & resistance to acceptance; connection between alcohol abuse & negative consequences.

Emotion: understand AA view of emotions & how certain emotional states lead to drinking; how to deal with emotions to minimize the risk of drinking.

Behaviour: understand how alcoholism has affected their lives & how old habits supported continued drinking; to turn to AA in order to change; “get active” in AA.

Social: regular AA meetings/activities; obtain & develop relationship with sponsor; access AA when urges or relapse occur; re-evaluate relationships with “enablers”/alcoholics.

Spiritual: hope; believe & trust in a power greater than own willpower; acknowledge character defects & harm done to others.

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TSF Core Topics

Concepts are covered across 12 sessions. 5 core topics (sessions 1-4 & 10).

1. **Program Introduction:** AA principles, client history, negative consequences, tolerance, loss of control, diagnosis, TSF overview, schedule of AA meetings, AA manual, AA meeting attendance & reflection journal, reactions to readings/tasks, "slips", cravings & what was done about them.
2. **Acceptance:** review journal, introduce & discuss Step 1 of AA key concepts.
3. **Surrender:** review journal, introduce & discuss Steps 2 & 3.
4. **Getting active:** review journal, introduce & discuss `getting active' in AA.
10. **Termination:** helping the client evaluate the treatment & establish goals.

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TSF Elective Topics

Electives are covered in sessions 5-9:

The Genogram: reinforce concept of alcoholism as a disease that can be traced across generations.

Enabling: any behaviour by others that allow or have allowed the client to continue drinking or avoid/minimize negative consequences related to drinking. Acknowledge enabling & actively resist it.

People, Places & Things: review & address some of the practicalities of staying sober (spending time with friends who drink, parties, changing habits, etc.). Replace old with new sobriety-associated habits.

HALT: identify emotions which are most often associated with slips.

Moral Inventories: alcoholism is an illness of the spirit in the sense that alcoholics are driven by their disease to behave in ways that compromise their personal ethics & values. This undermines their self-esteem, promotes alienation & makes finding faith & reaching out to others more difficult.

Sober Living: attention to the matter of changing habits in the interest of recovery.

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Cognitive-behavioural therapy (CBT)

Therapists teach clients interpersonal & self-management skills. To develop these skills, clients must identify high-risk situations that may increase the likelihood of renewed drinking.

- high-risk situations include precipitants of drinking that are external to the individual as well as internal events such as cognitions & emotions.
- having identified situations that represent a high risk for relapse to drinking, clients must develop skills to cope with them.

Manual contains material for 22 sessions

- client receives 12 sessions (8 core, 4 elective)

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CBT Core Topics

Sessions 1-7 & 12

1. **Introduction to Coping Skills Training**: therapeutic relationship, client history, assessment of high-risk situations, client's commitments to treatment.
2. **Coping With Cravings & Urges to Drink:** triggers & avoidance/reduce exposure, time-limited nature of craving, coping strategies, urge surfing, craving plan & record.
3. **Managing Thoughts About Alcohol & Drinking:** awareness of states of mind that elicit relapse.
4. **Problem Solving:** examine triggers & establish coping skills. Role play crisis events & actions to deal with them.
5. **Drink Refusal Skills:** List drinking locations & social situations to enable the client to anticipate high-risk settings/social pressure. Identify high-risk people & situations to avoid. Role play scenarios where therapist models effective ways to handle situations.
6. **Planning for Emergencies & Coping With a Lapse:** discussion of relapse crisis & plans of action to cope.
7. **Seemingly Irrelevant Decisions:** discuss seemingly irrelevant thoughts, behaviours & decisions that may culminate in a high-risk situation. Encouragement to articulate & think through all decisions in order to avoid rationalizations/minimizations of risk. Attention to decision making process to interrupt chain of decisions to relapse.

12. **Termination:** summary, emergency plan, further treatment options.

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CBT Electives

Sessions 8-11:

- Starting Conversations
- Nonverbal Communication
- Introduction to Assertiveness
- Receiving Criticism
- Awareness of Anger
- Anger Management
- Awareness of Negative Thinking
- Managing Negative Thinking
- Increasing Pleasant Activities
- Managing Negative Moods & Depression
- Enhancing Social Support Networks
- Job-Seeking Skills
- Couples/Family Involvement I
- Couples/Family Involvement II.

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Motivational enhancement therapy (MET)

Based on principles of motivational psychology. Designed to produce rapid, internally motivated change. Employs motivational strategies to mobilize the client's own resources.

Consists of an initial extensive assessment (history & battery of cognitive tests). Treatment occurs over 4 sessions spread across 12 weeks. Whenever possible, the client's spouse or significant other is included in the first two of these four sessions.

1. structured feedback from initial assessment (problems associated with drinking, consumption & related symptoms, decisional considerations & future plans). Building client motivation to initiate or continue change.

2. Continued motivation enhancement, working toward consolidating commitment to change.

3 & 4. therapist continues to monitor & encourage progress.

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MET

Rationale: few differences in outcome between longer, more intensive alcohol treatment programs & shorter, less intensive alternative approaches.

- Are all equally ineffective?
  - Significant differences among alcohol treatment approaches are found in nearly half of clinical trials & relatively brief treatments have been shown in numerous studies to be more effective than no intervention.
- Treatments contain a common core of ingredients which evoke change & additional components of more extensive approaches may be unnecessary in many cases.

Six elements believed to be active to induce change (FRAMES):

1. FEEDBACK of personal risk or impairment
2. Emphasis on personal RESPONSIBILITY for change
3. Clear ADVICE to change
4. A MENU of alternative change options
5. Therapist EMPATHY
6. Facilitation of client SELF-EFFICACY or optimism

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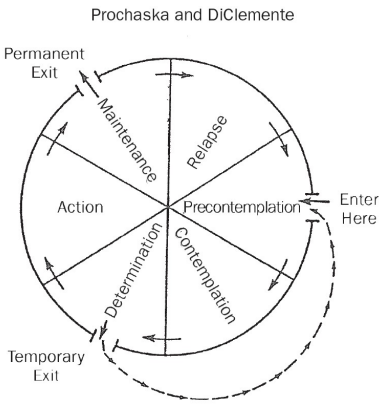
MET



Prochaska & DiClemente (1986): Transtheoretical perspective posits that individuals move through a series of 6 stages of change as they progress in modifying problem behaviours. Each stage requires certain tasks to be accomplished & certain processes to be used in order to achieve change.

1. **Precontemplation:** people who are not considering change in their problem behaviour
2. **Contemplation:** individuals' beginning to consider both that they have a problem & the feasibility & costs of changing that behaviour.
3. **Determination:** the decision is made to take action & change.
4. **Action:** begin to modify the problem behaviour (normally continues for 3–6 months)
5. **Maintenance:** after successfully negotiating the action stage, individuals move to maintenance (sustained change)
6. **Relapse:** maintenance fails & the individual begins another cycle.

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MET: Phase 1

Building motivation for change: focuses on developing clients' motivation to make a change in their drinking. Five strategies to achieve this:

1. **Eliciting Self-Motivational Statements:** facilitates client talking themselves into change.
2. **Listening With Empathy:** therapist listens carefully to what the client is saying, then reflects it back to the client, often in a slightly modified or reframed form. Acknowledgment of the client's expressed or implicit feeling state may also be included.
3. **Affirming the Client:** therapist affirms, compliments & reinforces the client.
4. **Handling Resistance:** Client resistance during treatment is affected by the therapist's own style. How the therapist responds to resistant behaviours is one of the defining characteristics of MET (e.g. never meet resistance head on via arguing back).
5. **Reframing:** a strategy whereby therapists invite clients to examine their perceptions in a new light or a reorganized form. New meaning is given to what has been said or problematic thoughts.

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MET: Phase 2

Strengthening Commitment To Change: this is achieved through several stages

1. **Recognizing Change Readiness:** knowing when to begin moving toward a commitment to action. Signs include: client stops resisting, asks fewer questions, more settled, self-motivational statements indicating openness to change & begins imagining how life might be after a change.
2. **Discussing a Plan:** shift for the therapist from focusing on reasons for change to negotiating a plan for change. Clients may initiate this by stating a need or desire to change or by asking what they could do.
3. **Communicating Free Choice:** An important & consistent message is the client's responsibility & freedom of choice.
4. **The Change Plan Worksheet (CPW):** is to be used during session 2 to help in specifying the client's action plan. This requires statements about: The changes I want to make are . . .; The most important reasons why I want to make these changes are . . .; The steps I plan to take in changing are . . .; The ways other people can help me are . . .; I will know that my plan is working if . . .; Some things that could interfere with my plan are . . .

Session 3 and 4: Review progress, renew motivation & commitment.

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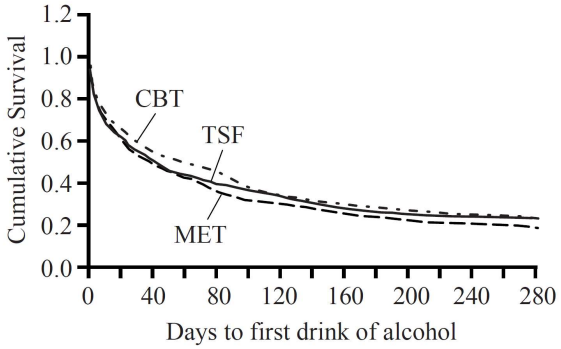
Project MATCH Results

Babor (2008): all three groups showed reductions in alcohol consumption by the end of treatment relative to baseline. There were no significant differences between the three treatments.

- TSF, CBT & MET showed exactly the same relapse curves over time
  - ~20% of each group remained abstinent after 280 days following treatment.



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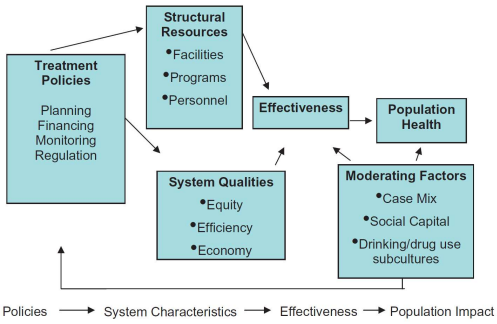
Systems level analysis

Babor et al. (2008): because behavioural treatments with different qualities do not appear to produce different effects on abstinence, nor have markedly different therapeutic efficacy for different groups of subjects, it appears these treatments are having a non-specific effect to produce their effect on abstinence.



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