

IV. TREATMENT OF ALCOHOL-RELATED DISORDERS A. OVERVIEW The focus of this section is on the treatment of patients with alcohol dependence or abuse. However, treatment of these disorders may be complicated by episodes of intoxication and withdrawal, the treatment of which is discussed in Sections IV.C.1 and IV.C.2. Alcohol use disorders are common. In the National Epidemiologic Survey on Alcohol and Related Conditions, the 12-month prevalences were 4.65% for alcohol abuse and 3.61% for alcohol dependence (23), with corresponding 12-month prevalences in the National Comorbidity Study of 3.1% and 1.3%, respectively (946), and prevalences of lifetime disorder that were about five times the 12-month prevalences (947). The course of alcohol use disorders is variable and frequently characterized by periods of remission and relapse. The first episode of alcohol intoxication is likely to occur in the midteens, and the age at onset of alcohol dependence peaks at ages 18–25 years (947, 948). The first evidence of withdrawal, if it occurs, is not likely to appear until many other aspects of dependence have developed. Although some individuals with alcohol dependence achieve longterm sobriety without active treatment, others need treatment to stop the cycles of remission and relapse (949). The relation of alcohol dependence to alcohol abuse is also variable. In one study (950), only 30% of male subjects with alcohol abuse at baseline met criteria for alcohol dependence 4 years later; the other 70% either continued to meet criteria for alcohol abuse or saw their alcohol problems remit entirely. The long-term goals of treatment for patients with an alcohol use disorder are identical to those for patients with any type of substance use disorder and include abstinence (or reduction in use and effects), relapse prevention, and rehabilitation. There is some controversy in the literature, however, regarding the possible benefits of striving for a reduction in alcohol intake, as opposed to total abstinence, for those who are unlikely to achieve the latter. A comprehensive review of the issue (951) concluded that a lower severity of pretreatment alcohol dependence and an individual's belief that he or she could control his or her drinking were associated with the individual's achieving controlled drinking after treatment. Interventions aimed at achieving moderate drinking have also been used with patients in the early stages of alcohol abuse (952, 953). Controlled drinking may be an acceptable outcome of treatment for a select group of patients when it is accompanied by substantial improvements in morbidity and psychosocial functioning. However, abstinence is the optimal goal that achieves the best long-term overall functioning (9). Numerous studies (43, 954, 955) have documented positive outcomes among individuals who receive treatment for alcohol dependence; approximately 70% of all such patients manifest a reduction in the number of drinking days and improved health status within 6 months (43). Copyright 2010, American Psychiatric Association. APA makes this practice guideline freely available to promote its dissemination and use; however, copyright protections are enforced in full. No part of this guideline may be reproduced except as permitted under Sections 107 and 108 of U.S. Copyright Act. For permission for reuse, visit APPI Permissions & Licensing Center at <http://www.appi.org/CustomerService/Pages/Permissions.aspx>. 90

APA Practice Guidelines The majority of patients who are treated for an alcohol use disorder have at least one relapse episode during the first year after treatment. However, there is considerable evidence to show that most individuals with an alcohol use disorder drink less frequently and consume less alcohol after receiving treatment compared with before treatment (956–959). For example, patients typically report drinking heavily on 75% of the days during a 3-month period before treatment, whereas during posttreatment follow-ups, they report being abstinent on 70%–90% of the days and engage in heavy drinking on 5%–10% of the

days (231). Treatment has also been shown to bring about improvements in family functioning, marital satisfaction, and psychiatric impairments (43, 290, 960–963). Although improvements after treatment for alcohol dependence are at least in part attributable to nontreatment factors such as patient motivation (964), it is generally accepted that treatment does make a difference, at least in the short run.

B. TREATMENT SETTINGS The choice of treatment setting for an alcohol-dependent individual will be determined by the results of the initial medical and psychiatric evaluation (see also Section II.C). In addition, the optimal treatment setting and subsequent treatment outcome are likely to vary depending on the characteristics of the individual patient (965, 966). Patients with alcohol withdrawal must be detoxified in a setting that provides for frequent clinical assessment and the provision of any necessary treatments (967). Some outpatient settings can accommodate these requirements and may be appropriate for patients deemed to be at low risk for a complicated withdrawal syndrome, with medical detoxification being accomplished using the medications described below (see Section IV.C.3). Postdetoxification treatment can also be successfully conducted outside of the hospital (e.g., in outpatient, day hospital, or partial hospitalization settings) for most patients with alcohol dependence or abuse (51, 956, 967). Intensive outpatient care involving frequent visits or conducted in a day hospital is generally preferable for the early phase of treatment. It is usually preferred that a significant other be available for travel to and from the treatment site, medication monitoring, symptom evaluation, support for abstinence, and communication with a responsible health care professional on behalf of the alcoholic patient. Relapse prevention medications should always be considered after detoxification. Currently available medications are naltrexone, disulfiram, and acamprosate (see Sections IV.C.3.a–c). Patients who are unlikely to benefit from less intensive and less restrictive alternatives may need to be hospitalized at times during their treatment. In particular, those who have a history of withdrawal seizures or delirium tremens, whose documented history of very heavy alcohol use and high tolerance places them at risk for a complicated withdrawal syndrome, who are concurrently abusing other substances, who have a severe comorbid general medical or psychiatric disorder, or who repeatedly fail to cooperate with or benefit from outpatient detoxification are more likely to require a residential or hospital setting that can safely provide the necessary care. Patients in severe withdrawal (i.e., delirium tremens) always require treatment in a hospital setting. Patients who fail to achieve abstinence or who relapse frequently should also be given a trial of inpatient care. Under some circumstances, psychiatrically or socially unstable individuals may similarly benefit from the stabilization provided by a residential treatment setting. Inpatient care should include medical detoxification and a program of rehabilitation. Although many inpatient and residential treatment programs have been traditionally organized around a treatment length of 28 days, empirical studies have not yet identified a specific optimal length of stay for the treatment of patients with an alcohol use disorder. Moreover, 28 days is a brief period in the natural history of a chronic disease. Copyright 2010, American Psychiatric Association. APA makes this practice guideline freely available to promote its dissemination and use; however, copyright protections are enforced in full. No part of this guideline may be reproduced except as permitted under Sections 107 and 108 of U.S. Copyright Act. For permission for reuse, visit APPI Permissions & Licensing Center at <http://www.appi.org/CustomerService/Pages/Permissions.aspx>.

Treatment of Patients With Substance Use Disorders 91 Regardless of whether treatment for an alcohol use disorder begins in an inpatient or outpatient setting, the pivotal factor in successful treatment is engaging the patient in long-term outpatient relapse prevention with a duration measured in years rather than days. Patients should also be encouraged to participate in 12-step or other self-help group programs during outpatient rehabilitation.

C. SOMATIC TREATMENTS 1. Treating intoxication states In

general, the acutely intoxicated patient requires reassurance and maintenance in a safe and monitored environment in which efforts are made to decrease external stimulation and provide orientation and reality testing. Adequate hydration and nutrition are also essential. Clinical assessment should follow the general guidelines described in Section II.B, giving particular emphasis to the patient's general medical and mental status, substance use history, and any associated social problems. Patients presenting with signs of intoxication should also be assessed for the possibility of recent use of other substances that could complicate their clinical course. Patients with a history of prolonged or heavy drinking or a history of withdrawal symptoms are at particular risk for medically complicated withdrawal syndromes and may require hospitalization.

2. Treating withdrawal syndromes The treatment of alcohol withdrawal has two major goals: 1) help the patient achieve detoxification in a manner that is as safe and comfortable as possible and 2) enhance the patient's motivation for abstinence and recovery (968). According to DSM-IV-TR, the syndrome of mild to moderate alcohol withdrawal generally occurs within the first several hours after the cessation or reduction of heavy, prolonged ingestion of alcohol. It includes signs and symptoms such as gastrointestinal distress, anxiety, irritability, elevated blood pressure, tachycardia, and autonomic hyperactivity. The syndrome of severe alcohol withdrawal, including delirium tremens, occurs especially within the first several days after cessation or reduction of heavy, prolonged ingestion of alcohol; the syndrome includes signs and symptoms such as clouding of consciousness, difficulty in sustaining attention, disorientation, generalized tonic-clonic seizures (grand mal) seizures, respiratory alkalosis, and fever (969–971). As described in DSM-IV-TR and elsewhere (972, 973), 100 mg/day). Hepatotoxicity resulting from an interaction between nonsteroidal anti-inflammatory drugs (NSAIDs) and high-dose naltrexone has also been described (1047); clinicians should use high doses of naltrexone cautiously and warn patients accordingly. In addition, because naltrexone is an opioid antagonist, it would be inappropriate for patients requiring opioid analgesics. The Copyright 2010, American Psychiatric Association. APA makes this practice guideline freely available to promote its dissemination and use; however, copyright protections are enforced in full. No part of this guideline may be reproduced except as permitted under Sections 107 and 108 of U.S. Copyright Act. For permission for reuse, visit APPI Permissions & Licensing Center at <http://www.appi.org/CustomerService/Pages/Permissions.aspx>.

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95 naltrexone-treated patient should carry a card explaining these issues and provide it to health care personnel in an emergency.

b) Disulfiram Treatment with the aversive agent disulfiram (usually 250 mg/day, range 125–500 mg/day) is aimed at motivating abstinent alcoholic individuals to resist alcohol consumption. When aldehyde dehydrogenase is inhibited by disulfiram (151), alcohol consumption causes toxic levels of acetaldehyde to accumulate, which in turn is associated with a host of unpleasant and potentially dangerous signs and symptoms, including a sensation of heat in the face and neck, headache, flushing, nausea, vomiting, hypotension, and anxiety (148–150). Chest pain, seizures, liver dysfunction, respiratory depression, cardiac arrhythmias, myocardial infarction, and death have also been reported. The purpose of disulfiram is not to make the patient ill but to prevent a patient from drinking impulsively because he or she knows that illness will result from drinking while he or she is taking disulfiram. However, disulfiram is only effective to the degree that an alcohol-using individual adheres to taking it as prescribed. Methods to improve adherence include behavioral contracting between an alcohol-dependent individual and his or her spouse and other forms of monitored administration with set contingencies. Controlled trials have not demonstrated any advantage of disulfiram over placebo in achieving total abstinence, delaying relapse, or improving employment status or social stability (1048, 1049), and a meta-analysis showed only some diminution in drinking with

disulfiram (1036). However, a large VA multisite cooperative study did find that patients receiving 250 mg of disulfiram reported significantly fewer drinking days than those who either received no disulfiram or 1 mg of disulfiram (150). Moreover, some clinicians believe that this medication, when combined with other therapeutic interventions, has some benefit for selected individuals who remain employed and socially stable (150, 1048, 1050–1052). Patients who are intelligent, motivated, and not impulsive and whose drinking is often triggered by unanticipated internal or external cues that increase alcohol craving are the best candidates for disulfiram treatment. Treatment effectiveness is enhanced when adherence is encouraged through frequent behavioral monitoring (e.g., breath tests), group support for remaining abstinent (e.g., group therapy, AA) (1053), contingency contracting, or, where feasible, supervised administration of disulfiram (1054, 1055). Disulfiram should never be used without the patient's knowledge and consent; understanding and explaining disulfiram's toxic or potentially lethal effects to patients is a prerequisite for its use (1056–1058). Patients taking disulfiram must be advised to avoid all forms of ethanol (including, for example, that found in some cough syrups). Disulfiram requires hepatic metabolism to convert it into an active medication. A metabolite of disulfiram is an inhibitor of CYP 450 3A4 (1059) and can interfere with the metabolism of a variety of psychotropic and other medications that are substrates for CYP 450 3A4. In addition to its aversive effects after the ingestion of alcohol, disulfiram can cause a variety of adverse effects that are rare but potentially severe, including neuropathies and hepatotoxicity. Thus, it should be used cautiously in patients with moderate to severe hepatic dysfunction, peripheral neuropathies, renal failure, and cardiac disease (1048). A patient who is impulsive, has poor judgment, or has a severe co-occurring psychiatric disorder (e.g., schizophrenia, bipolar disorder) that makes him or her unreliable or self-destructive (149, 1060) may also be a poor candidate for disulfiram treatment. Moreover, disulfiram is eliminated from the body slowly. Ingesting alcohol even 1–2 weeks after the last dose of disulfiram could cause an alcohol-disulfiram reaction (1061).

c) Acamprosate In 2004 the FDA approved a new medication, acamprosate, for the treatment of alcohol dependence. The approval was based primarily on data derived from studies done in Europe (reviewed in 1062, 1063). Although the neuropharmacological action of acamprosate is not Copyright 2010, American Psychiatric Association. APA makes this practice guideline freely available to promote its dissemination and use; however, copyright protections are enforced in full. No part of this guideline may be reproduced except as permitted under Sections 107 and 108 of U.S. Copyright Act. For permission for reuse, visit APPI Permissions & Licensing Center at <http://www.appi.org/CustomerService/Pages/Permissions.aspx>. 96 APA Practice Guidelines completely known, researchers do know that it is an amino acid derivative of taurine that is thought to work at brain glutamate receptor sites and stabilize glutamatergic function (155). As such, it has been hypothesized that it might normalize an aberrant glutamate system present during early abstinence that may be the basis of protracted withdrawal and early abstinence craving (1064). Studies in Europe have evaluated patients who have generally started on the medication while in a hospitalized setting and who were abstinent for at least 7–10 days before taking the medication; the results of those studies showed that an increased number of patients maintain abstinence. Those who relapsed had more abstinent time before their first drinking day and also more overall abstinent days during a year or more of treatment (1062, 1063, 1065, 1066). In contrast, a multisite trial completed in the United States did not find acamprosate to be effective in a primary intent-to-treat analysis but did find that when subjects' motivation to maintain abstinence and adhere to medication treatment was taken into account, acamprosate was more effective than placebo in increasing the number of abstinent days (1067). The U.S. trial included outpatients who had a varied number of abstinent days prior to medication initiation,

but, in general, the overall pretreatment abstinent time was much shorter than that in the European trials. Also, subjects in the U.S. trial received a standardized medical management type of counseling, whereas the European studies generally used varied traditional psychosocial alcohol treatment approaches focusing on the maintenance of abstinence. It would appear that, although not specifically studied, a number of days (perhaps 7 or more) of abstinence prior to starting acamprosate might be needed for acamprosate to be most effective. There is also some evidence that acamprosate and naltrexone can be given together, but the benefit of doing so has not been clearly established (954, 1068). The COMBINE Study, a multisite trial supported by the National Institute on Alcohol Abuse and Alcoholism is in the process of further assessing the efficacy of acamprosate alone and in combination with naltrexone with and without a specialist-delivered behavioral intervention (1069, 1070). Acamprosate has also been studied in combination with disulfiram and has shown an apparent improvement in efficacy (1071). At a dosage of two 333-mg pills t.i.d. (total dose of 1,998 mg), which is an approved dose in the United States, acamprosate is well tolerated, with generally self-limited and symptomatically treated diarrhea being the main adverse effect. Because acamprosate is excreted by the kidneys and not metabolized by the liver, caution must be taken with patients who have renal impairment (1072). However, liver disease should not affect its metabolism or blood level concentrations. Acamprosate has minimal if any negative interaction with alcohol so that it is expected to be generally safe in active or relapsed drinkers. d) Medications acting on the serotonin system SSRIs have been used in the treatment of alcoholism to directly affect alcohol consumption, with the goal of reducing drinking or promoting abstinence. SSRIs also may reduce psychiatric symptoms or syndromes (e.g., anxiety, depression) that might influence drinking behavior. In addition to evidence that serotonin modulates the behavioral effects of alcohol (479, 1073–1075), several randomized, double-blind, placebo-controlled human studies with nondepressed heavy drinkers found that SSRIs reduce short-term alcohol consumption by 15%–20% (1076, 1077). However, subsequent studies in patients diagnosed with alcohol dependence have been less consistent (1078–1080) and suggest that SSRIs may worsen drinking behaviors in some individuals. The use of SSRIs in the treatment of alcohol dependence is similar to their use in other disorders (430), although gastrointestinal side effects may be more prominent in alcohol users. TCAs also have nonselective effects on serotonin reuptake and have been used to treat depression associated with alcohol use disorders with equivocal results (138). However, two studies showed improved mood and reduced alcohol consumption in open (428) and double-blind, placebo-controlled trials (1081) with desipramine. Subsequent randomized, double-blind, Copyright 2010, American Psychiatric Association. APA makes this practice guideline freely available to promote its dissemination and use; however, copyright protections are enforced in full. No part of this guideline may be reproduced except as permitted under Sections 107 and 108 of U.S. Copyright Act. For permission for reuse, visit APPI Permissions & Licensing Center at <http://www.appi.org/CustomerService/Pages/Permissions.aspx>. Treatment of Patients With Substance Use Disorders 97 controlled trials with desipramine (438) and imipramine (437), as well as a recent meta-analysis (425), concluded that TCAs may offer modest benefits in treating patients with alcohol use disorders and depression but not those with alcohol use disorders in the absence of depression. Based on animal studies (1082, 1083) and early clinical laboratory findings (1084), the selective serotonin-3 receptor antagonist ondansetron was thought to have effects on alcohol reward and thereby reduce alcohol consumption and promote abstinence. Although patients with early-onset alcoholism and lower levels of drinking showed some benefit with low-dose ondansetron (1085, 1086), other patient subgroups did not demonstrate a response. Replication studies have yet to be conducted,

and ondansetron is not approved by the FDA for alcoholism treatment. (Dosing, side effects, and implementation of treatment with ondansetron are discussed in greater detail in Section IX.B.3.d.) e) Lithium The use of lithium to treat patients with an alcohol use disorder not comorbid with bipolar disorder was supported by some early anecdotal reports and by a small double-blind, placebocontrolled study (1087). However, a large VA collaborative study (1088) showed no benefits of lithium over placebo for patients with or without depressive symptoms. A more recent metaanalysis also showed no efficacy for lithium in treating alcohol use disorders (1036). Consequently, lithium is not recommended as a primary treatment in patients who do not have cooccurring bipolar disorder.

D. PSYCHOSOCIAL TREATMENTS A variety of psychosocial treatments have been used in the treatment of alcohol use disorders (1089), and the efficacy of specific psychotherapies for these disorders has been reviewed by a number of authors (79, 956, 1090, 1091). The sections that follow provide an overview of the use of CBT, behavioral therapies, psychodynamic therapies, IPT, self-help groups, brief interventions, marital and family therapy, and aftercare in the treatment of alcohol use disorders.

1. Cognitive-behavioral therapies CBT and relapse prevention therapies aimed at improving self-control and social skills have been consistently found to reduce drinking (79, 1090, 1092–1094); such cognitive-behavioral therapies, as well as MET and TSF, are therefore recommended for use in individuals with an alcohol use disorder. Cognitive-behavioral stress management interventions and behavioral self-control training (consisting of cognitive and behavioral strategies, including self-monitoring, goal setting, rewards for goal attainment, functional analysis of drinking situations, and the learning of alternative coping skills) produced better outcomes than control treatments in about half of the studies (79, 1090, 1095–1097). Better outcomes during follow-up also seem to occur in individuals who show increased coping responses or “self-efficacy” at the end of treatment (184, 1098–1100) and in those who use problem solving or mastery rather than relying on avoidance of high-risk situations as a coping strategy (43, 265, 959, 1101). In contrast, cognitive therapy interventions that are focused on identifying and modifying maladaptive thoughts but that do not include a behavioral component are not as effective. In group settings, CBT approaches are similarly effective, although treatment benefits may vary with patient characteristics (1102–1104). Finally, most studies show efficacy for social skills training, which focuses on learning skills for forming and maintaining interpersonal relationships, being assertive, and refusing alcohol (79). MET and motivational interviewing are typically brief therapies that last one to four sessions and are aimed at maximizing the patient’s intrinsic desire to change or enhancing a patient’s adherence to more intensive or extended treatment. Motivational approaches have been found to be efficacious in most studies (reviewed by Dunn et al. [1105] and Miller and Wilbourne [79]), including the findings from Project MATCH (43, 90, 265, 1106) in which four

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MET sessions given as a stand-alone treatment either initially or as part of posthospitalization care were comparable to 12 sessions of CBT or TSF, with benefits of treatment persisting through 3 years of follow-up.

2. Behavioral therapies Individual behavioral therapy, particularly involving positive reinforcements for targeted behaviors, has been found to be effective for patients with an alcohol use disorder (191, 956, 1090) and is also a recommended treatment approach. Also effective are behavioral contracting (79) and the community reinforcement approach (190, 1107, 1108), which uses behavioral principles and usually includes conjoint therapy, training in job finding, counseling focused on alcohol-free social

and recreational activities, monitoring of disulfiram use, and an alcohol-free social club. When compared with usual outpatient treatment or disulfiram plus a behavioral adherence program, community reinforcement led to significantly better patient outcomes (190, 1108). Community reinforcement also has documented effectiveness in combination with marital therapy (690). Compared with positive reward approaches, aversive therapies have been less successful (79). Relaxation training, although widely studied, has been ineffective in virtually all controlled trials (79).

3. Psychodynamic and interpersonal therapies There are insufficient studies of adequate research design regarding the use of group or individual psychodynamically oriented psychotherapies for the treatment of individuals with an alcohol use disorder (79, 1090). It is difficult to draw conclusions in this area because of the paucity of well-controlled and designed studies, and the small extant literature is limited by poor research design and short duration of studies. However, there is some clinical consensus that such treatment is particularly helpful when other psychiatric disorders or interpersonal issues are present and when combined with other psychosocial or biological interventions. There are large numbers of patients in this type of treatment, and clinical consensus suggests the therapy is effective in at least some of these patients (956, 1090). In addition to addressing alcohol abuse or dependence, treatment goals often include stabilization of the patient's social and interpersonal life, disorganization of which may both accompany and perpetuate the alcohol use disorder.

4. Brief therapies Brief interventions are generally delivered over one to three sessions and include an abbreviated assessment of drinking severity and related problems as well as the provision of motivational feedback and advice. Typically studied in general medical or school-based settings and in nontreatment-seeking heavy drinkers, brief therapies have been shown to be effective in reducing alcohol use and improving general health and social functioning (79, 275, 1109). In these subgroups of patients, the efficacy of brief therapies is often comparable with that of longer, more intense treatment; even very brief interventions (i.e., a few hours) may have some positive effect (1110, 1111).

5. Self-help groups and 12-step-oriented treatments The effectiveness of AA, per se, has not been evaluated in randomized studies. However, other sources of information provide growing support for the utility of AA and 12-step-oriented treatments (259, 261, 956, 958, 959) as well as the efficacy of professional therapies such as TSF that are aimed at motivating patients to participate in AA (43, 219, 265, 267, 269). In addition, a large number of studies have documented that greater AA participation is associated with greater rates of abstinence from alcohol (1112) as well as with better drinking outcomes.

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Treatment of Patients With Substance Use Disorders 99 (260–266, 289, 1113, 1114). Thus, most patients should be encouraged to attend at least several AA meetings to ascertain the appropriateness and utility of AA in helping them remain alcohol free. Individual patient needs and concerns should, however, be taken into consideration when making this recommendation. As a spiritual but nonreligious program requiring belief in something beyond oneself (268), AA provides tools for its participants to maintain sobriety, including the 12 steps, group identification, and mutual help. More specifically, “AA is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking” (253). Al-Anon (friends and family), Alateen (teenage children of alcoholic individuals), and Adult Children of Alcoholics (those who grew up in alcoholic or otherwise dysfunctional

homes) help family members and friends of alcoholic individuals focus on the need to avoid enabling behaviors and care for oneself whether a loved one is drinking or not. Other mutual help programs include Women for Sobriety, Rational Recovery, Double Trouble (for patients with alcohol dependence comorbid with other psychiatric disorders), and Mentally Ill Chemical/Substance Abusers. Patients may be more likely to benefit from AA groups composed of individuals with similar personal characteristics, such as age, sex, or cultural and occupational status. Evidence from smallscale trials on patient-to-program matching suggests that patients with a greater severity of drinking problems, an affective rather than cognitive focus, a concern about purpose and meaning in life, better interpersonal skills, and a high need for affiliation are good candidates for AA (254, 1115). In the landmark Project MATCH study (43), TSF-based aftercare was more effective than that using CBT for outpatients who did not show psychiatric symptoms and was of comparable efficacy for those with psychiatric symptoms. At 1-year follow-up, patients rated as high in seeking meaning of life fared better with TSF compared with MET and CBT, and patients with high social support for abstinence had better drinking outcomes at 1- and 3-year follow-up. Although official AA policy encourages members to adhere to medical treatment, many individual members interpret the ethos of coping without the use of drugs to mean that recovering individuals should also forgo psychiatric medications (1116). Consequently, patients with a co-occurring psychiatric disorder requiring medication should be encouraged to attend dualdiagnosis AA groups or those in which regular attendees do not oppose medically prescribed psychotropic treatment.

6. Marital and family therapies For patients who are married or living with family members, such relationships can be an important factor in the posttreatment environment (1090, 1117). Thus, it is not surprising that therapies aimed at enhancing marital or family relationships can be effective in the treatment of alcohol use disorders. In particular, behavioral marital therapy has demonstrated efficacy and cost-effectiveness (79, 225, 236, 238, 690, 961, 1118, 1119). Marital approaches for which there is significant support are Al-Anon facilitation and disulfiram contracting (168, 248); other approaches to marital therapy have shown lesser degrees of efficacy (79).

7. Self-guided therapies Strong evidence is available to support the efficacy of self-monitoring of drinking patterns, guided by pamphlets provided by practitioners (79). Such approaches have typically been evaluated in general populations of primary care patients or with heavy drinkers who do not meet full criteria for alcohol dependence. Patients presenting to specialized substance use disorder treatment settings have generally experienced multiple failures at self-treatment and are poorer candidates for this approach.

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8. Aftercare A patient's involvement in aftercare after completing inpatient treatment for an alcohol use disorder is an important predictor of outcome (264, 1120, 1121). The lowest rates of relapse have been noted in those completing an aftercare program (1121, 1122), with some evidence that completion rates vary with therapists' efforts to maintain patients in the aftercare program (1122). Although the number of trials on specific aftercare approaches is limited, there is evidence for efficacy for TSF (43, 265), MET (43, 265), CBT administered alone (43, 265) or with coping skills training (223, 1102, 1103), a version of behavioral marital therapy that includes relapse prevention techniques (1118, 1119), insight-oriented interactional group therapy (223, 1102, 1103), and nurse visits delivered over a 12-month period (1123).