Substance use disorders: Psychosocial management

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INTRODUCTION

This topic reviews individual and group psychotherapies for substance use disorders (SUDs) that have shown evidence of efficacy in clinical trials, as well as widely used psychotherapeutic interventions, such as addiction counseling, that have not been well tested in clinical trials.

Along with cognitive-behavioral therapy (CBT) for SUDs, several psychotherapies combine CBT-based principles and techniques with other components to address a wider variety of issues in recovery. Behavioral couples therapy was developed to treat SUD patients conjointly with committed partners who do not use substances. Twelve-step facilitation and similar interventions are designed to encourage patients to initiate and sustain participation in mutual help groups. Behavioral medical management provides monitoring of compliance with medication and side effects, along with brief counseling on how to reduce substance use, as well as encouragement to attend community mutual help groups.

Psychotherapies for SUDs are reviewed here. Other psychosocial interventions for SUDs, including screening and brief intervention, mutual help groups, physician health programs, integrated therapies for dual diagnoses, and models enhancing the delivery of SUD care, such as continuing care, are reviewed separately.

- (See "Screening for unhealthy use of alcohol and other drugs in primary care".)
- (See "Brief intervention for unhealthy alcohol and other drug use: Efficacy, adverse effects, and administration".)

- (See "Substance use disorders in physicians: Assessment and treatment", section on 'Physician health programs'.)
- (See "Treatment of co-occurring anxiety-related disorders and substance use disorders in adults".)
- (See "Continuing care for addiction: Components and efficacy".)
- (See "Continuing care for addiction: Implementation".)
- (See "Alcohol use disorder: Psychosocial management", section on 'Mutual help groups'.)

Psychosocial treatments for specific SUDs (opioid, alcohol, stimulant, cannabis, and benzodiazepine use disorders), including psychotherapies, are reviewed separately. (See "Opioid use disorder: Psychosocial management" and "Alcohol use disorder: Psychosocial management" and "Cannabis use disorder: Clinical features, screening, diagnosis, and treatment" and "Stimulant use disorder: Psychosocial management" and "Benzodiazepine use disorder", section on 'Psychosocial augmentation'.)

COGNITIVE-BEHAVIORAL THERAPY

Cognitive behavioral therapy (CBT) seeks to help patients with SUD to modify biased cognitions and attributions related to substance use and alter behaviors that increase vulnerability to substance use [1,2]. Goals include helping patients to have a better understanding of their risk factors for use, more accurate attributions and cognitions, increased self-efficacy (ie, belief in one's ability to address problems), and more effective coping responses.

The first task is to identify such cognitions and behaviors and help the patient learn to recognize them and to anticipate when they are likely to occur. The second task is to expand the patient's repertoire of effective coping responses. Other topics that are typically addressed include shoring up motivation, drink/drug refusal skills and assertiveness, communication skills, receiving criticism, giving and receiving compliments, coping with anger and depression, dealing with interpersonal problems, increasing pleasant activities, and managing stress. Cognitive factors that increase risk for relapse, such as attributional and attentional biases, are identified and addressed.

As an example, a tendency to believe that relapses are always caused by external factors over which one has no control, such as the behavior of others (ie, persistent external attributions), increases risk for relapse. Attentional bias refers to a tendency to notice and orient toward cues associated with substance use (eg, ads for liquor) more quickly than in individuals without an SUD.

Patients are usually given homework assignments to complete between sessions. At first, such assignments are generally focused on self-monitoring of substance use and related factors, such as craving and exposure to risky situations. As the therapy progresses, homework often involves rehearsing of coping responses that have been identified in sessions.

CBT may be more appealing to individuals who do not favor the 12-step program's emphasis on spirituality and group process. Participation in CBT for SUD generally requires participants to have sufficiently intact cognitive functioning to support engagement in treatment sessions and homework assignments. Examining cognitive bias and distortions and participating in exercises designed to increase coping skills may be difficult for individuals with significant cognitive deficits.

Theoretical foundation — CBT is primarily based on social learning theory [2-4]. According to this theoretical perspective, problematic substance use is considered largely a learned behavior (although some people are seen as more susceptible to SUD due to their genetic makeup and other biological factors). Individuals are likely to engage in problematic substance use, including relapse, when they encounter high-risk situations.

These situations lead to stressful internal states or external circumstances that have been associated with past substance use by the individual and typically stimulate craving. Although some situations are high risk for most individuals (eg, negative affect, interpersonal conflict), there is a fair amount of variation across individuals in which situations are most risky.

When a high-risk situation is encountered and increases stress or stimulates craving, the likelihood that alcohol or drug use occurs is determined by a combination of motivation, attributions and other cognitions, self-efficacy, and coping ability [3,5]. Individuals are more likely to drink or use drugs if their motivation for behavior change or self-efficacy for mounting a coping behavior is low, or if their coping abilities for that situation are poor. Biased cognitions and attributions that impair judgment and undermine coping efforts can also contribute to increased risk for substance use or relapse. As examples:

- Someone with an external locus of control (ie, a belief that his behavior is strongly influenced or even caused by other people) might have particular difficulty in refusing offers of alcohol or drugs.
- Someone who believes that any use of alcohol or drugs will lead to a full-blown relapse may be more likely to use heavily after a slip.
- Someone with an attentional bias will be more likely to notice substance use-related cues in the environment, such as drug use activity and advertisements for alcohol.

Components — Components of CBT for SUD generally include a combination of:

- Psychoeducation – Information on the factors that cause and sustain SUDs and how they can be addressed with CBT.
- Functional analysis – A functional analysis is a careful and detailed reconstruction of a recent episode of a patient's substance use. The functional analysis is used to determine the internal states and external circumstances that preceded the onset of alcohol or drug use in that episode (ie, the antecedents), factors that influenced the course and termination of the episode, and the consequences of the episode. Through an analysis of several episodes of use, the therapist and patient strive to develop an understanding of the patient's particular set of risky internal states and situations.
- Developing coping skills that help patients manage emotions without drugs. As an example, a patient who is likely to relapse when feeling depressed learns to use a combination of exercise and contact with supportive friends to reduce urges to use when depressed.
- Enhancing drug refusal and problem-solving skills.
- Enhancing interpersonal functioning (eg, a person with poor assertiveness skills learns how to respond effectively to offers of alcohol or drugs).
- Increasing recovery-focused activities. Examples include active participation in mutual help organizations, improving employment status, involvement in service activities that provide a sense of meaning and purpose, and engagement in activities that improve mood and increase pleasure.

Efficacy

Face-to-face CBT — Meta-analyses have generally concluded that cognitive-behavioral therapy (CBT) produces small positive effects on substance use outcomes in comparison with other interventions [6-9]. A 2009 meta-analytic review of 53 trials of CBT for alcohol or illicit drug use disorders (from 1980 to 2006) with a range of comparison conditions found an overall small positive effect [9]. Substance use outcomes varied widely across trials. As an estimate of the size of the observed effect, averaged across all trials, 58 percent of patients who received CBT had better substance use outcomes compared with patients who received an alternative intervention or control.

Moderator analyses found that the positive effects of CBT were larger in studies of treatment for cannabis use disorders, compared with those for alcohol, stimulant, opioid, or polydrug use

disorders. Studies with no treatment control conditions yielded large effects, whereas those with active control conditions (eg, treatment as usual, interpersonal therapy, or 12-step facilitation) produced only small effects.

As an example, a clinical trial randomly assigned 89 men with alcohol use disorders (88 percent with DSM-IV alcohol dependence) to receive motivational interviewing plus CBT (12 sessions) or to motivational interviewing only (4 sessions) [10]. No differences in the primary alcohol use outcome, drinks per day, were seen between the motivational interviewing plus CBT and motivational interviewing only during the treatment phase or a 12-month follow-up. Both conditions improved to the same degree from baseline to follow-up.

Computer-assisted CBT — A computer-assisted version of CBT (computer-based training for CBT or "CBT4CBT") has been developed and preliminarily tested [11]. The program consists of six modules, which are based on a well-regarded CBT manual [1]. Each module uses a multimedia format; as an example, one includes video depicting actors in a realistic situation placing them at high risk for substance use. Appropriate coping behaviors for the situations are explained and depicted in a subsequent video. These lessons are followed by learning assessments and guides for homework assignments.

Two clinical trials comparing CBT4CBT plus standard care found efficacy for some outcomes compared with standard care alone [11,12]. As an example, a clinical trial randomly assigned 77 individuals with DSM-IV substance dependence upon their entry into outpatient treatment in a community program to receive standard care or standard care plus biweekly access to computer-based training in CBT [11]. During the eight-week treatment period, participants in the CBT4CBT condition submitted fewer urine drug screens that were positive for any type of drug than those in standard care (2.2 versus 4.3).

Administration — CBT can be provided in either individual or group formats; most trials have studied the individual format version. CBT has usually been provided over 12 sessions in clinical trials with a range of 8 to 24 sessions.

Training for clinicians to provide CBT for SUDs usually requires three- to seven-day trainings in person, followed by remote supervision that makes use of audiotapes of sessions.

Multiple manuals provide detailed information for clinicians on how to deliver evidence-based versions of CBT [1,2,4].

CBT-BASED THERAPIES

Other interventions incorporate cognitive-behavioral therapy (CBT) components and principles but differ from CBT. These differences are relatively small in coping skills training [4] and relapse prevention [3]. Relapse prevention, for example, focuses to a greater extent on reducing the likelihood and severity of relapses in those who had initially achieved abstinence, while CBT is generally used to both initiate and sustain reductions in use or abstinence.

The community reinforcement approach (CRA) [13,14] and combined behavioral intervention (CBI) [15] include a variety of other components to address a wider variety of issues in recovery in addition to CBT principles and components. (See 'Community reinforcement approach' below and 'Combined behavioral intervention' below.)

Both interventions are provided in 12 to 24 sessions, which are typically individual. However, both CRA and CBI can include a few couples sessions if the patient is in a committed relationship with someone who does not have an SUD and is willing to participate. Manuals describing how to provide each of these interventions are available [13-15].

A notable difference between mindfulness-based relapse prevention, on one hand, and CBT, is the emphasis on being able to tolerate negative affect and craving, rather than quickly engaging in coping behaviors designed to eliminate or counteract such feelings. Although most of these interventions are usually delivered via individual sessions, mindfulness-oriented relapse prevention [16] is delivered in a group format. (See 'Mindfulness-based relapse prevention' below and 'Acceptance and commitment therapy' below.)

Community reinforcement approach — Community reinforcement approach (CRA) aims to make abstinence more rewarding than continued use [13,14,17,18]. CRA consists of CBT-based intervention components, counseling focused on developing new recreational activities and healthy social networks, employment counseling, assistance accessing social service, and couples counseling for patients with partners. Some versions have included a social club, which hosts sober parties and other activities on weekends, and substance-specific pharmacotherapy. Contingency management, an intervention reviewed separately, is sometimes incorporated into the program to reinforce abstinence. (See "Substance use disorders: Principles, components, and monitoring during treatment with contingency management" and "Substance use disorders: Training, implementation, and efficacy of treatment with contingency management".)

Social services — Psychotherapy is provided in tandem with social services that help individuals to meet basic needs in the CRA, as it is in other multimodal, evidence-based interventions and in the general provision of mental health care. Social services can be a critical component to achieving treatment success. As examples:

- The stress of homelessness and associated challenges adhering to health care visits can benefit from attention to housing options.

- Patients with food insecurity and hunger will have difficulty focusing on cutting down or abstaining from alcohol. Such patients should be linked to nutrition resources.

Efficacy — A systematic review of four clinical trials (three of participants with DSM-IV alcohol dependence; one of DSM-IV opioid dependence) found that the CRA was more effective compared with usual care in reducing the number of substance use days; results were mixed for the duration of continuous abstinence [19]. As an example, a trial of 91 homeless patients with DSM-IV alcohol dependence at a large day shelter were randomly assigned to receive either the CRA or usual care [20]. At follow-up assessments over the subsequent year, patients assigned to the CRA experienced reduced alcohol consumption on multiple measures compared with usual care (eg, fewer drinking days per week [at six months, 0.98 versus 2.29 days; at nine months, 1.32 versus 2.89 days]).

The review found the combination of the CRA and contingency management to be more efficacious compared with the CRA alone.

Combined behavioral intervention — Combined behavioral intervention (CBI) combines elements of CBT with components from motivational interviewing and 12-step facilitation interventions [15]. When possible, a concerned significant other participates in the treatment process. CBI was developed based on the observations that patients with low motivation to change their substance use got little benefit out of CBT, that involvement with mutual help programs and participation of significant others were associated with better substance use outcomes, and that CBT and 12-step interventions were not necessarily incompatible. (See "Substance use disorders: Motivational interviewing".)

Only a single randomized clinical trial has been published evaluating the efficacy of CBI. The multisite COMBINE trial examined the effects of several medication and behavioral therapies alone and in combination for the treatment of DSM-IV alcohol dependence [21]. One thousand, three hundred, and eight-three patients with 4 to 21 days of abstinence were randomly assigned to receive one of four medication conditions (naltrexone, acamprosate, their combination, and double placebo). Patients in each of the four medication groups were also randomly assigned to receive a lower intensity medical management intervention or medical management plus CBI. The randomization included a ninth group which received CBI alone without pills.

The addition of CBI to medication-assisted treatment in the COMBINE trial did not reduce substance use. Across all medication treatment groups, patients assigned to receive CBI plus

medical management did not differ compared with patients assigned to medical management without CBI on two primary outcome measures (percent days abstinent, time to first heavy drinking day) at the end of treatment or at 12 months post-treatment.

Components of CBI have been shown to produce better SUD outcomes compared with existing treatment. A detailed manual is available to facilitate learning and implementation of the intervention [15].

Mindfulness-based relapse prevention — Mindfulness-based relapse prevention includes the teaching and practice of mindfulness meditation to increase awareness of thoughts, feelings, and the surrounding environment to help patients manage drug cravings and other negative emotional states without needing to use substances [22].

A 2017 meta-analysis of six clinical trials comparing a mindfulness-based intervention with an active control condition (eg, treatment as usual or alternative treatments) in patients with an SUD found small to moderate effects favoring mindfulness-based treatment on days of substance use and negative consequences of use [23]. A medium effect size favoring mindfulness-based treatment was seen for reducing opioid use.

Acceptance and commitment therapy — Acceptance and commitment therapy (ACT) emphasizes acceptance, for example, acceptance of aversive internal experiences, to increase cognitive flexibility and reduce experiential avoidance. ACT includes a mindfulness component as well.

The efficacy of ACT was examined in a meta-analysis of five trials comparing the intervention with active control conditions (eg, 12-step groups, treatment as usual, CBT). A small to medium positive effect (g = 0.42+) was seen favoring ACT on substance use outcomes [24].

COUPLES AND FAMILY THERAPIES

Addressing patients' problems in close relationships and/or bringing partners and family members into patients' SUD treatment can make important contributions to meeting SUD treatment goals. Various types of couples and family therapies are widely available; however, their components vary and their efficacy has not been rigorously tested. Behavioral couples therapy (BCT) is a specific, manualized couples intervention that has been tested in SUD patients and their partners.

Behavioral couples therapy — BCT is a conjoint intervention that incorporates some elements of cognitive-behavioral therapy to address problematic behaviors within committed

relationships that tend to sustain substance use and inhibit recovery [25]. BCT is intended for relationships between an individual with an SUD and a significant other who does not have an SUD.

Theoretical foundation — BCT is grounded in behavioral theories of reinforcement and learning [25,26]. In couples where one partner has an SUD, the nature of the interactions between partners can influence whether the partner with an SUD abstains or uses. As the SUD worsens, couples tend to stop reinforcing each other for positive behaviors and instead focus only on negative or problematic behaviors.

As an example, the significant other may berate the person with the SUD when that person drinks or uses drugs but fail to comment positively on a day of abstinence. The person with the SUD may not voice appreciation when the significant other does something pleasing or supportive but instead focuses on a time when he or she felt unjustly accused of alcohol or drug use by that person. As the relationship becomes less and less supportive and growth enhancing, substance use gets worse.

Principles and components — BCT is delivered in a series of conjoint sessions [25,26]. In the initial session, the identified patient and concerned significant other are instructed to keep daily logs in which information on perceived substance use, craving, and relationship satisfaction is recorded. Patients and significant others are taught to conduct functional analyses of any drinking or drug use episodes, and relapse prevention skills are learned and practiced. Behavioral contracting is included, which often addresses the patient's pledge to be abstinent that day and the significant other's commitment to offer help.

There is an emphasis on identifying and decreasing family members' behaviors that trigger or reward drinking. The significant other learns to reinforce positive behaviors by the identified patient, such as abstinent days, attending self-help meetings, or taking an antidrinking medication such as disulfiram or naltrexone, and to withdraw positive reinforcement when substance use occurs rather than express anger or make threats. The therapist also makes suggestions aimed at improving general relationship functioning (eg, identified patients and significant others are taught to notice and voice appreciation for the thoughtful or helpful things that the other person does for them).

Administration — BCT is typically provided to individual couples. In some models, a monthly couples group has also been added to the individual couples sessions. Sessions are generally provided weekly over 8 to 12 weeks. Manuals have been developed to guide BCT delivery [26,27]. Clinicians need training to deliver BCT properly, especially if they have limited or no experience treating couples.

Efficacy — Multiple clinical trials have found BCT to be efficacious in the treatment of patients with an alcohol use disorder compared with standard addictions treatment or when augmenting standard treatment [28-32]. Most earlier trials studied male patients with nonpatient female spouses; two more recent trials were with female patients and nonpatient male spouses [29,32].

As an example, a 2009 trial randomly assigned 102 women with alcohol use disorder to BCT with their male partners or to alcohol behavioral individual therapy. Both treatments were manual-guided, 20-session, abstinence-oriented CBT-based treatments. Follow-ups were done every three months for 18 months after baseline. BCT produced better outcomes on the two primary drinking outcomes (eg, percent days abstinent and percent days heavy drinking) across the 18-month follow-up than the individual CBT condition. For example, percent days heavy drinking in the individual condition hovered between 30 to 35 percent during the post-treatment follow-up, whereas it ranged from 12 to 20 percent in BCT.

Clinical trials comparing BCT with another type of couples-based treatment for SUD have found mixed results. Two trials found BCT led to superior drinking outcomes compared with interactional couples group therapy and with alcohol-focused spouse involvement [30,33]. Two other trials did not find a difference in drinking outcomes between BCT and family systems couples therapy or alcohol-focused spouse involvement [34,35].

MOTIVATIONAL INTERVIEWING

Motivational interviewing is a directive, patient-centered approach that aims to help people change problem behaviors and enhances intrinsic motivation to change by exploring and resolving ambivalence. Components and efficacy of motivational interviewing for reducing substance use are reviewed separately. (See "Substance use disorders: Motivational interviewing" and "Brief intervention for unhealthy alcohol and other drug use: Goals and components".)

Brief motivational counseling — Brief motivational counseling is a form of addiction counseling that incorporates principles and techniques from motivational interviewing. Each session lasts approximately 15 minutes and is typically delivered over two to three sessions, repeating as needed. This type of counseling was developed for patients with risky drinking or mild (but not moderate to severe) alcohol use disorder.

CONTINGENCY MANAGEMENT

Contingency management, which is used to augment another psychosocial or medication intervention, employs incentives to encourage treatment attendance and/or abstinence from alcohol/drug use. The theoretical foundation, components, and efficacy of contingency management are reviewed separately. (See "Substance use disorders: Principles, components, and monitoring during treatment with contingency management" and "Substance use disorders: Training, implementation, and efficacy of treatment with contingency management".)

ADDICTION COUNSELING

Addiction (or drug/alcohol) counseling is a widely used treatment for SUD in both individual and group formats. The content of counseling varies; however, it typically includes education and may also incorporate elements of cognitive, behavioral, insight-oriented, and/or supportive psychotherapies.

Counseling in many SUD treatment programs is based on the principles of 12-step programs like Alcoholics Anonymous. The sessions also focus on helping patients avoid situations where they are likely to encounter alcohol or drugs or triggers for their use, plan safe social activities, and continue attendance at mutual help groups between counseling sessions. In many cases, the counselors in these programs are in recovery themselves (ie, they have a history of an SUD and extensive experience maintaining abstinence).

Some addiction counseling approaches are based on alternatives to 12-step models; for example, some omit the concept of a higher power and, for patients treated for dual diagnoses, provide support for treatment of psychiatric disorders with psychotropic medications.

Addiction counseling, as delivered in “real world” settings, has not been tested in efficacy trials. Addiction counseling has often served as the treatment-as-usual “control” condition in many trials of structured psychosocial interventions for SUD. There are no meta-analyses or major reviews of addiction counseling. Outcomes of addiction counseling as the “treatment as usual” have varied considerably across trials, usually doing somewhat worse than or as well as the primary intervention studied; in a few trials, it has performed better than the comparison condition.

Individual drug counseling — Developed for a large multisite cocaine dependence treatment trial sponsored by the National Institute on Drug Abuse in the United States, “individual drug counseling” is a structured, manual-based form of addiction counseling [36]. (See 'Efficacy' below.)

Theoretical foundation — Individual drug counseling is based on many of the same theoretical beliefs as 12-step programs. Addiction is seen as a complex disease that negatively affects the mind, body, and spirit, and severely damages social relationships. The philosophy of this abstinence-oriented approach incorporates two important elements: endorsement of the disease model and the spiritual dimension of recovery. Individual drug counseling also focuses on developing coping responses and avoiding high-risk situations [36].

Principles and components — In the development of individual drug counseling, investigators sought to synthesize and standardize the key components of interventions addiction counselors typically provide in most public and private SUD treatment programs in the United States. These components include an emphasis on [36]:

- Abstinence as a treatment goal
- Adoption of 12-step beliefs
- Avoidance of people and situations associated with past use
- Careful planning of free time during the week and on weekends
- Focus on the present
- Emphasis on short-term behavioral goals directly related to addiction
- Participants in drug counseling are strongly encouraged to additionally participate in a mutual help group

Early sessions of drug counseling focus on addressing issues such as denial and ambivalence about adopting a goal of abstinence. The next sessions address issues related to early abstinence, such as avoiding people and places associated with substance use, structuring free time, coping with craving and high-risk situations, compulsive sexual behavior, withdrawal symptoms, and 12-step program participation.

Sessions in the second half of the intervention are focused on maintaining abstinence and enriching recovery. Topics include relapse prevention tools, having healthy relationships while in recovery, managing anger, development of a drug-free lifestyle with appropriate leisure activities and time for relaxation, addressing shame and guilt over prior behavior, identification and fulfillment of needs, employment and management of money, and working the more advanced steps of 12-step programs.

At or near the beginning of each session, counselors are instructed to ask how the patient has been doing since the last session and whether there has been any use of alcohol or other drugs. Counselors are encouraged to obtain frequent urine samples during individual drug counseling and discuss the results of the drug testing in each session. If the self-reports or toxicology tests indicate that the patient has used alcohol or other drugs, the patient and counselor discuss what precipitated the episode of use and develop alternative coping methods to avoid further use. In this way, individual drug counseling can resemble cognitive-behavioral therapy-based interventions. If the patient brings up other current problems that are related to addiction, the counselor and patient work together to identify ways of handling the problems that do not involve alcohol or drug use. (See 'Cognitive-behavioral therapy' above.)

National Institute on Drug Abuse's drug counseling intervention was designed to be tested and delivered in combination group counseling sessions. The intervention is provided via 36 individual sessions delivered over six months (two per week in the first 12 weeks, one per week in the second 12 weeks), with several booster sessions possible after that [36]. The group counseling component was provided weekly and was focused on educating patients about recovery, encouraging participation in 12-step programs, and providing a supportive group atmosphere for initiating abstinence and a new lifestyle. Manuals further describe the structure and content of the interventions [36,37].

Efficacy — A large clinical trial found that the combination of individual drug counseling and group counseling was more efficacious than group counseling alone or in conjunction with psychotherapies other than individual drug counseling. The trial randomly assigned 487 patients with DSM-IV cocaine dependence to receive one of four conditions: group drug counseling plus individual drug counseling, group drug counseling plus cognitive therapy, group drug counseling plus supportive-expressive psychodynamic therapy, or group drug counseling alone. The therapies were provided via 36 individual sessions and 24 group sessions over six months.

Compared with the two psychotherapies and with group drug counseling alone, individual drug counseling plus group drug counseling showed the greatest improvement on both primary outcome measures: the Addiction Severity Index-Drug Use Composite score and the number of days of cocaine use in the past month. As an example, at the six-month follow-up the rate of self-reported cocaine use in the prior month was lower for patients assigned to group drug counseling plus individual drug counseling compared with group counseling plus cognitive therapy, group drug counseling plus supportive-expressive psychodynamic therapy, and group counseling alone (40 versus 58 versus 50 versus 52 percent).

BEHAVIORAL MEDICAL MANAGEMENT

Patients who are treated with medication for an SUD but do not receive psychosocial treatment may benefit from the addition of behavioral medical management. Behavioral medical management, which is similar to medication management in scope, is a structured intervention developed to accompany the prescribing of medication for an individual with an SUD [38-40]. Further information is available at https://www.niaaa.nih.gov/sites/default/files/NIAAA-combined-behavioral-intervention-manual.pdf.

Components of the intervention include:

- Monitoring of adherence with medication and any side effects
- Monitoring of patients' alcohol and drug use, symptoms, and progress
- Education regarding SUD and its treatment
- Encouragement (but not requirement or expectation) to attend community mutual help groups

Efficacy — No clinical trials have directly compared the efficacy of medication for SUD in conjunction with and without behavioral medical management. Several trials have compared medication and behavioral medical management with medication and other psychosocial interventions, finding that both groups led to decreased substance use [41-43]. In our clinical experience, behavioral medical management can help SUD patients participate actively in treatment and decrease use.

FACILITATING MUTUAL HELP GROUP ENGAGEMENT

Many patients with SUDs do not sufficiently engage in mutual help groups, such as Alcoholics Anonymous (AA), despite clinician recommendations that they do so. Rates of initial engagement are low and participation decreases markedly over time [44]. Interventions to facilitate engagement in mutual help groups are reviewed here. (See "Alcohol use disorder: Psychosocial management" and "Alcohol use disorder: Psychosocial management", section on 'Mutual help groups'.)

Components — Interventions to increase participation in mutual help groups typically involve a combination of the following components:

- Education about the program
- Guidance in working on the first few steps of the program
- Active efforts to link patients to program participants
- Helping patients find appropriate meetings at an accessible location and time
- Most include a specific focus on:
  - Initiation.
  - Active participation – As examples, speaking at meetings, obtaining a sponsor, using the telephone to get support, and participating in social activities [45].
  - Sustained, regular attendance.

The interventions differ in some components and emphases:

- **Twelve-step facilitation** – Twelve-step facilitation is provided by a clinician using a manual [45] in an individual patient format. Clinicians with experience in treating addiction and knowledge of 12-step programs can generally learn to deliver this intervention via self-study of the manual.

  The intervention is delivered over 12 sessions, which begin by addressing engagement – the clinician actively encourages participation. Subsequent sessions aim to help participants complete the first five steps of the AA program. These sessions are structured: review of the past week, working on steps, homework, and recovery-oriented activity planning.

- **Enhanced referral** – Enhanced referral to 12-step intervention is delivered in three individual sessions consisting of [46]:
  - Contracting to attend mutual help meetings
  - Linkage with a peer to attend meetings
  - Attendance monitoring
  - Help in obtaining a temporary sponsor

- **Network support** – An adaptation of 12-step facilitation including many of its features, but adapted to stress changing one's broader social network to be more supportive of abstinence [47,48].

AA philosophy and a higher power are de-emphasized in favor of AA as a means to make new friends and increase involvement in enjoyable social activities that can make abstinence more reinforcing.

- **Stimulant abuser groups to engage in 12-step (STAGE-12)** – An adaptation of 12-step facilitation for stimulant drug users in three individual sessions and five 90-minute group sessions over eight weeks [49].

- **Making Alcoholics Anonymous Easier** – An intervention delivered by counselors who are members of 12-step groups [50]. Designed to overcome resistance to 12-step groups by changing participants' attitudes toward people in 12-step groups, addressing the perceived social desirability of participation, and increasing participants' ability to control and manage their experiences at the meetings.

Efficacy — Eight randomized clinical trials with an aggregate total of 2546 patients compared 12-step facilitation with other active interventions or treatment as usual, including cognitive-behavioral therapy (CBT) [51-54], motivational enhancement therapy [51], and the community reinforcement approach [55], and treatment as usual [56-58]. Findings were mixed, with the majority showing increased participation in the 12-step program and improved substance use outcomes.

As an example, a clinical trial, Project MATCH, randomly assigned 1726 patients with alcohol use disorder to 12-step facilitation, CBT, or motivational enhancement therapy [51]. The study included 952 individuals enrolled at the start of outpatient treatment and 774 enrolled at the start of aftercare. At 12 months post-treatment, there were no main effect differences among patients enrolled in the three treatments on the primary outcomes, percent days abstinent, and drinks per drinking day. In the outpatient arm, percent days abstinent was clustered around 85 percent in all three conditions across the 12-month follow-up, with around two drinks per drinking day in each condition at each follow-up. Outcomes in the aftercare arm followed the same pattern.

Findings for primary outcomes from other trials included:

- Twelve-step facilitation led to a greater percent of days abstinent and drinks per drinking day compared with CBT [59].

- Rates of abstinence rates from cocaine in patients with DSM-IV cocaine dependence treated with methadone were greater with 12-step facilitation compared with group counseling, as were rates of cocaine-negative urine tests [57].

- No differences were seen in maximum weeks of continuous cocaine abstinence or in proportion of cocaine-negative urine tests between 12-step facilitation and the community reinforcement approach [55].

Interventions for encouraging engagement in mutual help groups other than 12-step facilitation have each been supported by findings in a clinical trial: enhanced referral [46,60], network support [47], and STAGE-12 [49].

SUMMARY

- This topic reviews individual and group psychotherapies for substance use disorders (SUDs) that have shown evidence of efficacy in clinical trials, as well as widely used psychotherapeutic interventions such as addiction counseling that have not been well tested in clinical trials. (See 'Introduction' above.)

- Cognitive-behavioral therapy (CBT) seeks to help patients with SUDs to modify biased cognitions and attributions related to substance use and alter behaviors that increase vulnerability to substance use. CBT has been shown in randomized clinical trials to produce small positive effects on substance use outcomes in comparison with other interventions. (See 'Cognitive-behavioral therapy' above.)

- A number of interventions incorporate CBT components and principles but have a more specific focus (eg, relapse prevention) or include other components to address a wider variety of issues in recovery. One such intervention, the community reinforcement approach, has generally been found to be efficacious in clinical trials. (See 'CBT-based therapies' above.)

- Behavioral couples therapy (BCT) is a conjoint intervention that incorporates elements of CBT to address problematic behaviors within committed relationships that tend to sustain substance use and inhibit recovery. BCT is intended for relationships between an individual with an SUD and a significant other who does not abuse alcohol or drugs. Clinical trials have consistently shown BCT to be efficacious in comparison with other individual or group-focused treatment. (See 'Behavioral couples therapy' above.)

- Addiction (or drug/alcohol) counseling is a widely used treatment for SUD in both individual and group formats. The content of counseling varies, often including education and a 12-step orientation, and may incorporate elements of cognitive, behavioral, insight-oriented, and/or supportive psychotherapies. Commonly used forms of addiction

counseling have not been tested in randomized clinical trials. (See 'Addiction counseling' above.)

"Individual drug counseling" is a structured, manual-based intervention shown to reduce cocaine use when combined with group counseling in patients with DSM-IV cocaine dependence. (See 'Individual drug counseling' above.)

- Behavioral medical management (similar to medication management) is a structured, manualized, behavioral intervention developed to be provided in conjunction with medication for SUD, monitoring adherence, side effects, substance use, and providing education, encouragement, and other services. (See 'Behavioral medical management' above.)

- Twelve-step facilitation is the best studied of several interventions designed to increase participation in mutual help groups such as Alcoholics Anonymous. Clinical trials of 12-step facilitation found increased participation in 12-step programs; a majority of trials found that 12-step facilitation led to improved substance use outcomes. (See 'Facilitating mutual help group engagement' above.)

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