Counseling methods used in substance abuse treatment

ASSIGN BUSTER

Therapy techniques have become increasingly important methods in the treatment of people with various forms of substance abuse (“ SA”) issues. Particularly in an age of managed care 1 , the pressure to provide quick but intensive solutions to them is intense. Fortunately, there are several schools of counseling whose techniques are amenable to these requirements. While the specifics of interventions and therapies will depend on conditions such as the substance(s) used, the severity of the problem(s) being addressed, and the desired short and long term outcomes, the techniques can be used individually or in a more eclectic combination.

Studies which will be examined here show brief treatment can be effective for a range of problems. One of their primary advantages is that since they are less costly, more people can be reached with fixed governmental financial resources. In addition, the methods can be tailored to the specific needs of an individual client.

The term “ brief therapy” as discussed herein consists of several treatment approaches derived from a number of theoretical schools. They have been selected for use in the treatment world for a variety of reasons. This paper does not intend to be an exhaustive cataloging of them. In fact it will examine only the three most commonly used of the eight discovered in a search of the primary U. S. database of substance abuse treatment methodologies (SAMHSA, 2010) that the author has personal experience with. The three are supported by significant research, while others, such as Existential Therapy, have not been, and in fact some schools of treatment may by their nature not be subject to such scrutiny.

The counseling methods found are:

Cognitive-Behavioral Therapy

Strategic Therapy

Interactional Therapy

Humanistic Therapy

Existential Therapy

Brief Psychodynamic Therapy

Brief Family Therapy

Time-Limited Group Therapy

Brief Therapy Defined

Brief therapy is a process that uses rapid assessment (sometimes as little as five minutes; more generally an hour or two), immediate client engagement (sometimes forced by courts and other law enforcement agencies but in all cases dependent upon the skill of the clinician (CSAT, 1998) and the proper assessment of client eligibility in the first place), and laser-like focused training in ways of implementing change. The duration of brief therapies found ranges from one to more than three dozen sessions, with typical numbers of visits of between six and twelve (Heather, 1994).

Research concerning relative effectiveness of brief versus longer term therapies for a variety of presenting complaints is mixed. However, there is

evidence suggesting that brief therapies are often as effective as lengthier treatments for properly-selected groups of clients.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) derives, in part, from both behavioral and cognitive theories. While sharing a number of concepts and methods in common, CBT is also distinct in many ways from these other therapies (Carroll, 1998).

CBT uses the teaching of new learning processes to help individuals reduce their drug use. It works by helping clients recognize risky situations in which they are likely to use, find ways of avoiding those situations, and cope more effectively with them if they cannot avoid them. It also teaches them to addresses their inner feelings and outward behaviors related to their substance abuse (Carroll, 1998).

To achieve these goals, cognitive-behavioral SA therapists use three basic methods: (1) functional analysis, (2) coping skills training, and (3) relapse prevention (Rotgers, 1996).

Functional Analysis

This analysis attempts to identify the precursors and outcomes of substance abuse which serve as triggers. Precursors can come from emotional, social, cognitive, situational, environmental, and physiological domains (Miller, 1980). The functional analysis should also focus on the quantity, breadth and effectiveness of the client's coping skills. While a major weight in CBT is on recognizing and fixing deficiencies in coping skills, the therapist also

analyzes the client’s strengths and adaptive skills (DeNelsky and Boat, 1986).

Coping Skills Training

A major component in cognitive-behavioral therapy is the development of appropriate coping skills. Deficits in coping skills among substance abusers may be the result of a number of possible factors (Carroll, 1998). They may have never developed these skills, possibly because the early onset of substance abuse and/or early family dysfunction impaired the development of age-appropriate skills. Or, earlier developed healthy coping skills may have been diminished by the actual use of substances as the client’s main method of coping with life. Also, some clients continue to use skills that were suitable to an earlier age but are no longer apt or useful. Others clients may have some good coping skills but for some reason are blocked from using them. However these defects originated, one of the main goals of CBT is to help the individual cultivate and use coping skills that can handle high-risk situations without having to return to their learned coping skill: more drug use.

Relapse Prevention

The third part of CBT is relapse prevention. While one can find many theories of relapse (Donovan and Marlatt, 1993), the most common one cited is that of Annis and Davis (1989). Relapse prevention relies a thorough initial functional analyses, identification of triggers (people, places and things), and coping skills, but adds more training in which the therapist deals directly with the thinking involved in relapse process and works on getting the individual to be more effective in coping with that thinking.

The two main advantages of CBT are a) that it is generally brief in length and b) flexible in implementation. CBT is usually done in 12 sessions over 12 weeks (Carroll, 1998). Sessions include basic ones that deal with substance-related issues (cravings, saying “ no” to offered substances, crisis planning) and general problem-resolution skills as well as more specialized topics that are more general (usually social and communication skills) based on the individual assessment. For example, a 12-session CBT for cocaine use has shown that this length of treatment is enough to develop and maintain cocaine abstinence, (Carroll, 1998). Unfortunately, however, not all clients will significantly improve in that number of sessions. If that occurs, the initial CBT experience can still form the foundation of a more thorough treatment plan.

Brief Psychodynamic Therapy

Psychodynamic therapy (“ PT”) attempts to treat the unconscious thoughts that result in the behavior the client presents at assessment. The goals of psychodynamic therapy are self-awareness and seeing the influence of the past on the present. In its brief form, this approach teaches the client to view unresolved conflicts and behaviors that have grown out of previous dysfunctional relationships and behaviors and that show up in the need and desire to use substances.

Many different methodologies of brief psychodynamic psychotherapy have developed from psychoanalytic theory and have been used clinically to treat many disorders. A reasonable body of research supports the use of these methodologies (Crits-Christoph and Barber, 1991).

Short-term PT generally has been seen to be the most effective when used as part of a more comprehensive treatment program that includes such aversive tools as urine screening, psycho-education and some of the newer psychopharmacological treatments.

Brief PT also seems to be more effective after a period of abstinence has been achieved. It may also be more useful with people of only moderate severity in their abuse. Regardless, the therapist must be well-versed in SA pharmacology, the subcultures of substance abuse, and 12-Step programs.

Ten major approaches to short-term psychodynamic psychotherapy were discovered in a search of the SAMHSA database (SAMHSA, 2010; Crits-Christoph and Barber, 1991). They are:

Mann's Time-Limited Psychotherapy (TLP)

Sifneos' Short-Term Anxiety-Provoking Psychotherapy (STAPP)

Davanloo's Intensive Short-Term Dynamic Psychotherapy (ISTDP)

SE Psychoanalytic Psychotherapy

The Vanderbilt Approach to Time-Limited Dynamic Psychotherapy (TLDP)

Short-Term Dynamic Therapy of Stress Response Syndromes

Brief Adaptive Psychotherapy (BAP)

Dynamic Supportive Psychotherapy

A Self-Psychological Approach

Interpersonal Psychotherapy (IPT)

While these approaches differ in some or many ways depending on the extent to which they use supportive versus challenging techniques, focus on short-term or long-term problems, have a goal of managing symptoms or undertaking more fundamental personality change, or are inward or outward directed, they all adhere to some of the basic tenets of psychotherapy: the value of the therapeutic alliance, working with defense mechanisms and resistance, and transference,

This list is not exhaustive; numerous others, perhaps less well known, or modifications to them are not considered here. Many of these approaches have developed from clinical experience and are thus based on more anecdotal evidence, and some have been researched minimally, if at all.

The number one factor that seems to determine a successful outcome of PT is the therapeutic alliance that develops (Luborsky et al., 1985). This seems to be true independent of the specific school of therapy. Psychodynamic therapy has always viewed the relationship as crucial and the means by which change occurs. Of all the brief techniques mentioned, PT places the greatest emphasis on the therapeutic relationship and provides the most detailed and thorough description of how to build and maintain this relationship.

Another critical underlying concept of psychodynamic theory — and one that can be of great benefit to all therapists — is the concept of insight. Psychodynamic approaches regard insight as a most valuable kind of self-knowledge, particularly with respect to past conflicts and present world-

views and the insight into repressed feelings. Insight can arrive quickly or slowly, but the goal of brief PT is to streamline the process. Luborsky et al. give an example of a client who feels depressed and angry and then drinks who then realizes that his anger toward his father that he thinks lead him to use is stimulated by another abusive person in his life, perhaps at work. This learned insight then gives the client the opportunity to interrupt the behavior.

Brief Group Therapy

Group psychotherapy is the most common mode of treatment of substance abuse disorders. It is different from other types of group therapy, such as family therapy, in that groups tend to be a) open-ended and b) formed with people who are generally strangers to each other.

The lessons learned in the group are then practiced in the client’s external social network. The client then returns to the group to describe his/her success/failure and the group processes this.

Group therapy is cited as standard SA treatment for a number of reasons. In actual practice, groups let the client see how their disease has progressed in themselves and in the members of their social network. It lets them experience their own success and the successes of other group members in an environment of mutual support and hope. The curative factors associated with group psychotherapy, defined by Irvin Yalom, the elder statesman of group therapy, specifically address the issues of hope, universality and insight seen through others, and a number of other issues specific to the SA clients (Yalom, 1995). In addition, Alcoholics Anonymous (AA) and many

other 12-Step groups have long recognized the importance of how the fellowship of a group can end the deep and painful isolation associated with substance abuse. At the same time, such groups foster a level of connectedness with those who have a common purpose which is to drastically and permanently alter their lives. From this angle, brief psychotherapy groups offer significant opportunity to maximize the efforts of the client and the therapist.

Research shows that most clients improve through group therapy in a brief amount of time – typically 8 to 12 weeks (Garvin et al., 1976). Garvin's research suggests that brief group therapy can approach that of longer term therapy in fostering change, if that therapy is more goal-oriented, more structured and more directive than long-term group therapy.

SAMHSA identifies seven methods of group therapy (SAMHSA, 2010):

Brief cognitive group therapy

Cognitive-behavioral group therapy

Strategic/interactional therapy

Brief group humanistic and existential therapies

Group psychodynamic therapy

Modified dynamic group therapy (MDGT)

Modified interactional group process (MIGP)

The preferred time for brief group therapy is no more than 2 sessions per week (except in residential treatment where it usually occurs daily). Sessions are typically 1½ to 2 hours in length.

Given the much shorter residential course of treatment that generally occurs under managed care, one can question the use of a process-intensive group and suggest that psycho-educational groups be used instead. However, even though today's client may not spend more than three to five days in detox on an inpatient unit, much work can be done by the client in this brief time. As mentioned before, directive educational groups are an additional necessity but are not generally sufficient by themselves. Groups with expert, active facilitation, but which still adhere to a formal, can quickly build cohesion and act as powerful tools for clients to move on to their next level of treatment.

Group therapy is usually most effective if members have been able to develop their roles in the group, to perform in these roles, and to learn from the feedback they receive. Groups usually need time to define themselves, develop cohesion, and become a safe environment for the members. Of course, with any treatment, members have to have cleansed their bodies and minds of the most drastic serious effects of their recent use before gaining much benefit from the group. Because of this, the time frame of the member's participation in the group must address his or her own therapeutic goals as well as any externally-imposed limit.

Modified Interactional Group Process

Brief therapy based on the Modified Interactional Group Process (“ MIGP”) is a combination of the work of several theorists, primarily Irvin Yalom (Yalom, 1995). MIGP differs significantly from psycho-educational groups used in treatment. While both types of groups offer learning experience required for a newly-sober client, combining one with the other has the most clinical effect. The psycho-educational group is more directive, with the therapist as the main figure. Even with this, however, the dynamism of the process itself, even in a psycho-educational format, enables clients to make connections and build relationships that will support their recovery.

The features that make MIGP different other group processes are the greater activity of the leader and his or her creation of a safe environment that allows group members to examine inter-personal relationship issues without excessive emotional reticence. This feeling of safety is greatly enhanced by the therapist’s enforcement of adherence to group rules and norms over the course of the group’s life. The critical importance of confidentiality, the group’s acting in a responsible, adult fashion, and the need for self-disclosure must all be supported by the therapist. Beginning and ending on time, making sure each member has a place in the group, and addressing absences set examples of boundaries the members may not have previously experienced in their chaotic, dysfunctional lives and contribute to the development of a safe therapeutic environment.

By doing this, the leader trains the clients to realize that they, not he or she, the primary agents of change. The group becomes a safe place to give and to receive support. And although traditionally SA were once significantly

confrontational, MIGP is less threatening and far more supportive. Yalom bases this on the belief that denial and other defense mechanisms become more fixed when a person is attacked. Consequently, group members are encouraged to support one another and look for areas of commonality rather than use more shame-based interactive styles that attempt to “ break through denial.”

Conclusion

There are many counseling techniques available for substance abuse treatment. Some have been rigorously studied and others rely more on anecdotal reports. Some are based on well-researched and time-established theories of personality and behavior and others are new. This paper has not been an attempt to exhaustively catalog all of them but rather to assess some of the most popular and, in this day of managed care and limited governmental budgets, most cost-effective means of providing some meaningful treatment to a larger population than can be served by what is still the gold standard to substance treatment: 30-90 days of residential treatment followed by 3-6 months of weekly aftercare groups.

Brief Psychodynamic Therapy

(Crits-Christoph and Barber, 1991)

Therapy (Theorist)

Length of Treatment

Focus

Major Techniques

Time-Limited Psychotherapy (Mann)

12 sessions

Central issue related to conflict about loss (lifelong source of pain, attempts to master it, and conclusions drawn from it regarding the client's self-image)

Formulation, presentation, and interpretations of the central issue

Interpretation around earlier losses

Termination

Short-Term Anxiety-Provoking Psychotherapy (Nielsen and Barth)

Usually 12 to 15 sessions

Unresolved conflict defined during the evaluation

Early transference interpretation

Confrontation/clarification/interpretations

Intensive Short-Term Dynamic Psychotherapy (Laikin, Winston, and McCullough)

5 to 30 sessions; up to 40 sessions for severe personality disorders

Experiencing and linking interpersonal conflicts with impulses, feelings, defenses, and anxiety

Relentless confrontation of defenses

Early transference interpretation

Analysis of character defenses

SE Therapy (Luborsky and Mark)

16 for major depression, 36 for cocaine dependence

Focus on the core conflictual relationship theme

Supportive: creating therapeutic alliance through sympathetic listening

Expressive: formulating and interpreting the CCRT; relating symptoms to the CCRT and explaining them as coping attempts

Vanderbilt Time-Limited Dynamic Psychotherapy (Binder and Strupp)

25 to 30 sessions

Change in interpersonal functioning, especially change in cyclical maladaptive patterns

Transference analysis within an interpersonal framework

Recognition, interpretation of the cyclical maladaptive pattern and fantasies associated with it

Brief Adaptive Psychotherapy (Pollack, Flegenheimer, and Winston)

Up to 40 sessions

Maladaptive and inflexible personality traits and emotions and cognitive functioning, especially in the interpersonal domain

Maintenance of focus

Interpretation of the transference

Recognition, challenge, interpretations, and resolution of early resistance

High level of therapist activity

Dynamic Supportive Psychotherapy (Pinsker, Rosenthal, and McCullough)

Up to 40 sessions

Increase self-esteem, adaptive skills, and ego functions

Self-esteem boosters: reassurance, praise, encouragement

Reduction of anxiety

Respect adaptive defenses, challenge maladaptive ones

Clarifications, reflections, interpretations

Rationalizations, reframing, advice

Modeling, anticipation, and rehearsal

Self Psychology (Baker)

12 to 30 sessions, not rigidly adhered to

Change intra-psychic patterns. Incorporate more diverse representations of others and changes in information processing

Analysis of the mirroring, idealizing, and merger transferences

Supportive, empathic

Interpersonal Psychotherapy (Klerman)

Time limited; for substance abuse, the trials have been 3 and 6 months

Eliminating or reducing the primary symptom; improvement in handling current interpersonal problem areas, particularly those associated with substance abuse

Exploration, clarification, encouragement of affect, analysis of communication, use of the therapeutic relationship and behavior-change techniques