PATIENT INTERVENTIONS: MUTUAL HELP, PSYCHOTHERAPY, AND SOCIAL SUPPORT

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The ASAM Review Course of Addiction Medicine

July 2022

Financial Disclosures

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Medical Director - Georgia Professionals Health Program, Inc: Salary

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DynamiCare Health, Inc: Stock

A Very Brief Introduction

- Recovery Support Services
- Relapse Prevention Training
- Twelve-step Support Systems
- Recovery Coaching
- Contingency Management
- Affect Recognition & Regulation – DBT
- Addressing Trauma - EMDR
- Recovery-based Partner Therapy

Recovery Support Services

Recovery Support Services[1]

- Translation and Transportation
- Housing & Family
- Parenting & Childcare
- Cultural and Gender Discrimination
- Employment
- Financial and Legal
- Schooling and Training

[1] Laudet, A. B. and K. Humphreys (2013). "Promoting recovery in an evolving policy context: what do we know and what do we need to know about recovery support services?" J Subst Abuse Treat **45(1): 126-133**

Relapse Prevention Training

Principles of Relapse Prevention Training

- Relapse prevention provides definitive skills that can be taught and practiced.
- Research has validated two specific techniques
  - Cognitive Behavioral Approach[1]
  - Mindfulness-based Approach[2]
- Both arose from the University of Washington, G. Alan Marlatt's group.

[1] Marlatt, A., & Donovan, D. (2007). *Relapse Prevention, Maintenance Strategies in the Treatment of Addictive Behaviors (Second ed.): Guilford Press.*
[2] Bowen, S., Chawla, N., & Marlatt, G. A. (2011). *Mindfulness-based relapse prevention for addictive behaviors : a clinician's guide. New York: Guilford Press.*

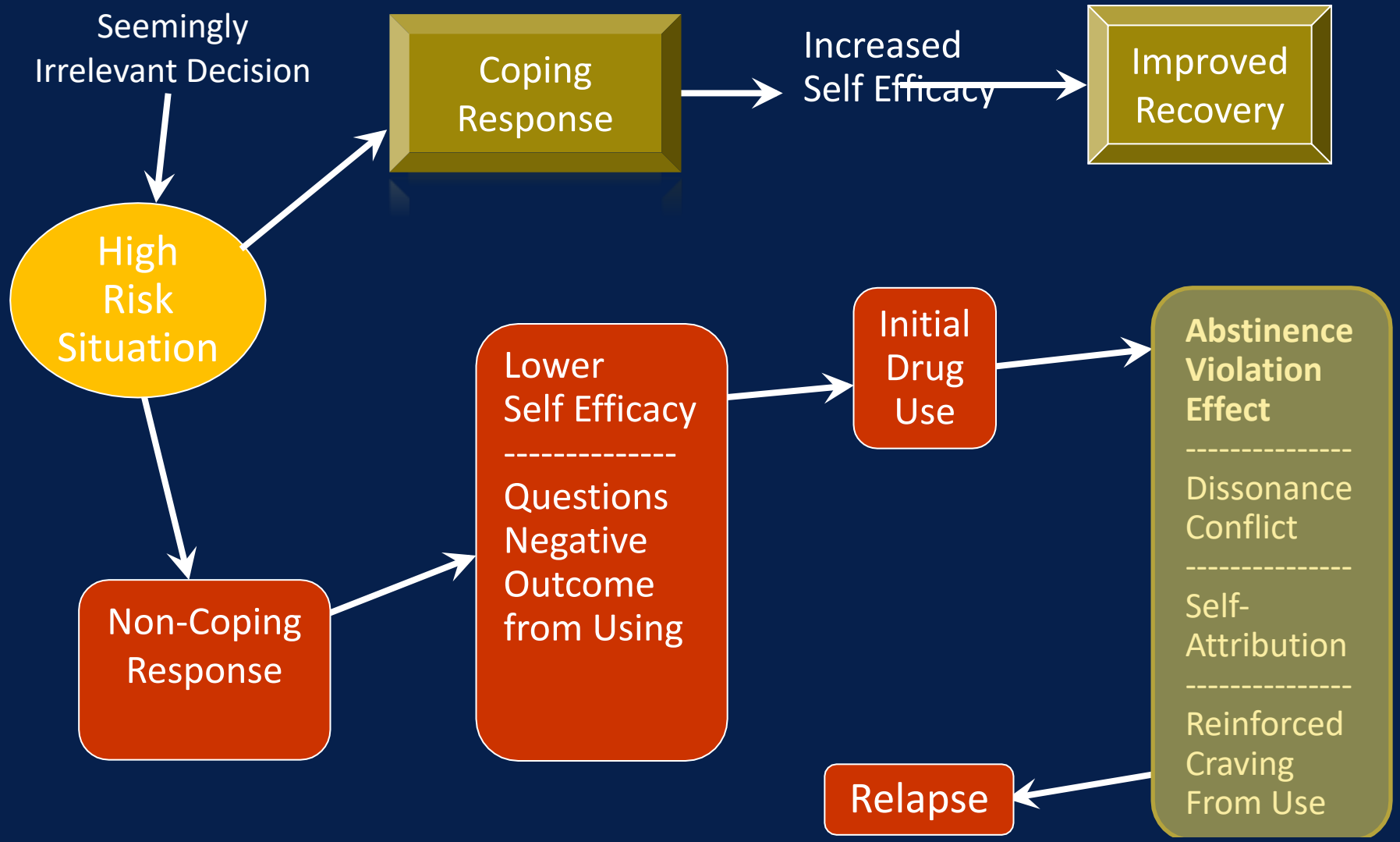
Recognizing Cravings

- Cravings are a normal part of the human experience.
- Addiction disorders simply grab onto this process. In addiction recovery, they can be quite intense and/or persistent.
- The strength, frequency, and duration of cravings vary from person to person and from time to time and are not necessarily predictors of relapse.
- Cravings may never completely disappear.
- Learning to manage cravings, then, is a central part of successful remission.

Types of Cravings

- Environmental cues (e.g., seeing a drug, smelling tobacco smoke, hearing addiction-related music).
- Visceral events (body sensations, taste, or smell)
- Emotional events (a feeling that the alcoholic “used to drink over”)
- Memory tapes (scenes that play in the mind, especially those with strong visual “tapes”).

Process Model of Relapse



1 Modified from Marlatt, A., & Donovan, D. (2007). *Relapse Prevention, Maintenance Strategies in the Treatment of Addictive Behaviors (Second ed.):* Guilford Press.

Essential Elements of the Process Model

- Collating a list of High-Risk Situations and clues for when they may occur is important for remission.
- Considering the best coping response for the most likely HRSs ahead of time is powerful medicine.
- Negative self talk (self-attribution) is counterproductive.
- Enacting coping responses decreases the probability of future relapse.

Mindfulness Model of Relapse Prevention

- Teaches Mindfulness - a mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations.
- Meditation reduces impulsivity and teaches a calming self-awareness of one's current state.
- MBRP teaches patients to focus on increasing awareness, decreasing judgment, and shifting from "reacting" to "skillful responding."[1]

[1] Bowen, S., Chawla, N., Collins, S. E., Witkiewitz, K., Hsu, S., Grow, J. Marlatt, A. (2009). Mindfulness-Based Relapse Prevention for Substance Use Disorders: A Pilot Efficacy Trial. *Substance Abuse, 30(4), 295-305.*

Twelve Step Support Systems

Mutual or Peer Support Groups

Twelve-step programs:

- Alcoholics Anonymous / Narcotics Anonymous / Cocaine Anonymous / Crystal Meth Anonymous / Nicotine Anonymous
- Al Anon / Nar Anon
- ACOA (Adult Children of Alcoholics)

Other national support groups:

- Smart Recovery
- Women for Sobriety
- Refuge Recovery

Local, religiously affiliated and/or less formalized programs

- Celebrate Recovery & Church groups
- Continuing care groups at a treatment center

Alcoholics Anonymous

- AA helps individuals recover through common process mechanisms associated with enhancing self-efficacy, coping skills, and motivation, and by facilitating adaptive social network changes.[1]
- Focuses individual on long-term goals and provides a holding place for that patience.
- Teaches relapse prevention skills.
- Normalizes the experience of loss of control, slippage of moral values, and substance-induced trauma.
- Sets discontinuation of abusable substances as the primary goal.
- Provides a path for reconciliation of the past.
- Provides a social network that is (relatively) free of substance use.

[1] Kelly, J. F., Magill, M., & Stout, R. L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addiction Research & Theory, 17(3), 236-259.*

Why Won't My Patients go to AA?

- A focus on spiritual principals and, by some, religious tenets.
- Spiritual references often turn off the agnostic or atheist if they do not mesh with spiritual beliefs of other members.
- Many patients with addiction disorders suffer from varying levels of social phobia.
- Newcomers find the format unusual, look for hierarchical structures where none exist.
- Most patients are not naturally drawn to AA, as its values and system is antithetical to the mindset and worldview that their illness has induced previously.

Why do Patients Dislike AA?

How patients approach their issues and situation:	What AA teaches:
Focus on short-term goals	Focus on long-term goals
Quick fix	Gradual change
I'm different	We are all the same
Pleasure (or relief from pain) is paramount	Pain helps you grow
I can do this	We can do this
Fight harder	The solution emerges when you admit defeat.
My problems will improve if external things get better.	Problems will only improve when you approach the world in a different manner.
Substances are the problem	I am the problem

What do Patients Like in AA?

- Listening to stories of hope and transformation
- Not being forced to talk
- No obligatory dues or fees
- Ease of access: many cities have hundreds or even thousands of meetings throughout the day.
- A sense of warmth and belonging
- Acceptance and often unconditional love
- Coffee & cigarettes

Core Concepts of AA

- Proper implementation requires familiarity with the core concept and terms
  - Acceptance of the illness; working through “denial” and accepting “powerlessness”
  - Mentoring: Obtaining a sponsor who provides support and helps the individual understand the process.
  - Attendance at meetings must be frequent at first (“like old fashioned antibiotics, effective but has to be taken often for it to work”)
  - Spirituality: Surrender to “higher power” of ones own choosing (often the group in its wisdom is that power)
- Explore what is helpful and what, at first, is not

Twelve-Step Facilitation

- Handoff can be cold, warm or with training.
  - Cold: “You should go to an AA meeting, look it up online.”
  - Warm: “ I know of a meeting at 8 pm on Pine St every weeknight. Would you consider going there twice between now and when we next meet?”
  - Manualized: “We are going to walk through a manual that teaches you how to use 12-Step programs to support your recovery. I will help you find a meeting locally. Then you can go to a meeting and report back next week and we will discuss what happened.”
- Handoff with training is best implemented using a structured process and can be manual-driven.
  - Manual developed for project MATCH available through NIAAA[1]
  - MAAZE - Making Alcoholics Anonymous Easier[2]

[1] Nowinski, J., et al. (1995). *Twelve Step Facilitation Therapy Manual*. Rockville, Maryland, U.S. Department of Health and Human Services

[2] Kaskutas, L. A., et al. (2009). "Effectiveness of Making Alcoholics Anonymous Easier: a group format 12-step facilitation approach." *J Subst Abuse Treat* 37(3): 228-239.

The 2020 Cochrane Review

- March 2020 Cochrane Review (authors Kelly, Humphreys & Ferri)
- 27 Studies, 10,566 participants, 21 RCT or quasi-RCT
- Compared MET & CBT with twelve step programs and twelve step facilitation.
- Concluded that AA/TSF:
  - Usually produced **higher** rates of continuous abstinence than the other established treatments investigated.
  - May be superior to other treatments for increasing the percentage of days of abstinence, particularly in the longer-term.

[1] Kelly, John F., Keith Humphreys, and Marica Ferri. "Alcoholics Anonymous and other 12-step programs for alcohol use disorder." Cochrane Database of Systematic Reviews (2020).

The 2020 Cochrane Review[1]

- Concluded that AA/TSF:
  - Performs as well as other treatments for reducing the intensity of alcohol consumption.
  - Four of the five economics studies found substantial cost-saving benefits for AA/TSF, these interventions reduce healthcare costs substantially.
- This is a clear evidence base for this modality for those with alcohol use disorder.
- Kelly stated, “It’s the closest thing in public health we have to a free lunch.”
- In addiction medicine, the term “Evidence-based medicine” has become conflated with MAT. Everyone should add AA to the category of Evidence-based medicine for AUD.

[1] Kelly, John F., Keith Humphreys, and Marica Ferri. "Alcoholics Anonymous and other 12-step programs for alcohol use disorder." Cochrane Database of Systematic Reviews 3 (2020).

Outcomes Using ROSC in OUD

- Benefits of active referral to twelve step programs in opioid use disorder less clear.
- One large recent review of ~21,000 patients provided three types of care[1]
  - Medication management (MM) only
  - Limited psychosocial (LP) therapy
  - Recovery-oriented, 12-step orientation (RO)
- Urine drug tests negative for opioids at the time of the second buprenorphine prescription were 34% for MM, 56% for LP, and 62% for RO ($P < .001$)

[1] Galanter, M., et al. (2020). "Buprenorphine Treatment for Opioid Use Disorder in Community-Based Settings: Outcome Related to Intensity of Services and Urine Drug Test Results." *American Journal on Addictions*

Recovery Coaching

Recovery Coaching

- Recovery Coaching is provided by a paraprofessional and designed to sustain connection and help with day-to-day choices and actions.
- A Recovery Coach is a non-judgmental individual who encourages self-reflection and promotes actions that promote or endorse remission behaviors and recovery.
- RCs can work with individuals who are actively using and those in early remission.
- Recovery coaches do not offer primary treatment for addiction, do not diagnose, and are not associated with any particular method or means of recovery.
- Services provided include strengths-based support (as opposed to disease-focused assistance).

Recovery Coaching

- Recovery coaching is ad hoc, often conducted via telephone or via electronic communication.
- May be linked with Contingency Management, urine drug screening and social services.
- Limited research[1] shows:
  - Improved relationships with providers and social supports
  - Increased satisfaction with the treatment overall
  - Reduced rates of relapse
  - Increased retention in treatment

[1] Reif, S., et al. (2014). "Peer recovery support for individuals with substance use disorders: Assessing the evidence." *Psychiatric Services* **65(7): 853-861.**

Contingency Management

Contingency Management

- Contingency Management (CM) is a treatment tool that is:
  - Among the most thoroughly researched behavioral approach to SUD treatment (>100 RCTs and multiple meta-analyses).
  - Among the most effective clinical approaches.
  - Cost-effective
  - Can be used with patients across the change spectrum (from decreasing use to attaining and maintaining remission.
  - Increases compliance with medications that treat addiction.

And yet, it is *rarely* utilized.

Contingency Management

- Is based upon operant conditioning or behavioral economics
- Breaks down the recovery process into a series of goals that are:
  - Concrete
  - Attainable
  - Realizable
- This sidesteps the hopelessness of many individuals with addiction diseases
- Subtly and subconsciously establishes priorities for recovery by:
  - Rewarding critical recovery behaviors
  - Prioritizes critical behaviors through reward intensity
- Important elements are:
  - Pro-remission or recovery behaviors are reinforced in close temporal proximity to the event.
  - Monetary reinforcers are the most simple and universal rewards, but other reinforcers (e.g., food vouchers) work in some situations.

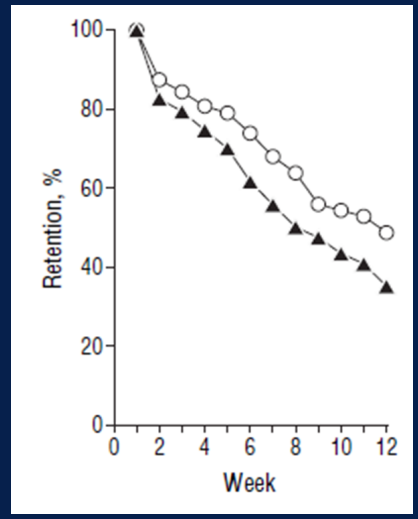
Contingency Management

- Rewards should be:
  - Immediate - immediate rewards are twice as effective as delayed rewards.[1]
  - Tangible - and matched to participant needs.
  - Intermittent - e.g., pulling a ticket from a punch bowl that may contain a prize of varying values are just as effective as constant reinforcement but is more cost effective.
  - Valuable - low value rewards are half as effective as high-value rewards.[1]
- Importantly, CM does not increase gambling.[2]

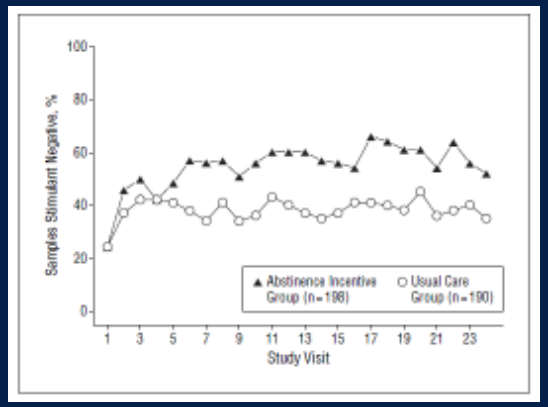
[1] Lussier, J. P., et al. (2006). "A meta-analysis of voucher-based reinforcement therapy for substance use disorders." *Addiction* **101(2): 192-203.**
[2] Petry, N. M., et al. (2006). "Prize-based contingency management does not increase gambling." *Drug Alcohol Depend.* **83(3): 269-273.**

Examples of Efficacy in Different Venues

- 800 cocaine/methamphetamine-using patients across 14 clinics
- Prize-based CM, in a 12-week study
- Psychosocial clinics: $70/month/patient
  - Retention: 49% (CM) vs. 35% (Control)
  - Mean consecutive weeks abstinent: 4.4 vs 2.6
- Methadone clinics: $40/month/patient
  - 24% of patients reached cocaine abstinence in CM group, versus 9% in controls.
  - Mean consecutive abstinent period: 2.8 weeks in CM group versus 1.2 weeks in controls.



Petry, et al. 2005



Sindelar, et al. 2006

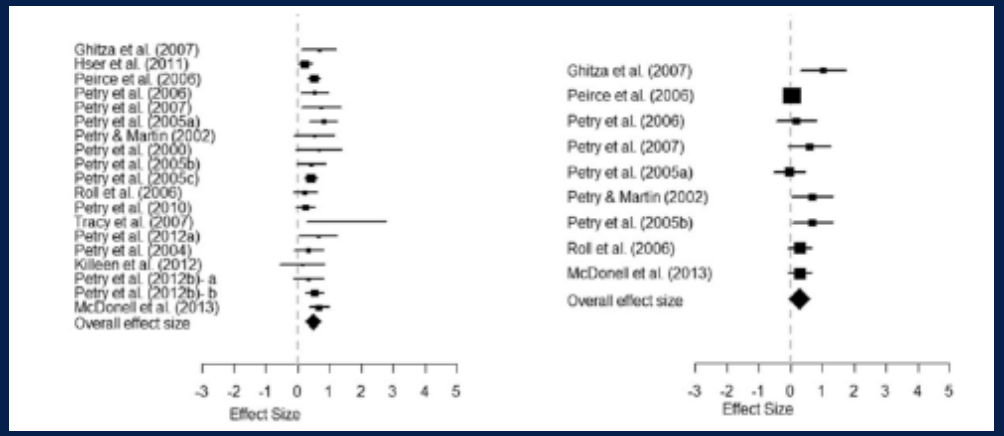
Petry, N. M., Peirce, J. M., Stitzer, M. L., & et al. (2005). Effect of prize-based incentives on outcomes in stimulant abusers in outpatient psychosocial treatment programs: A national drug abuse treatment clinical trials network study. *Arch Gen Psychiatry, 62(10), 1148-1156.*

Sindelar, J. L., Olmstead, T. A., & Peirce, J. M. (2007). Cost-effectiveness of prize-based contingency management in methadone maintenance treatment programs. *Addiction, 102(9), 1463-1471.*

Limitations of CM

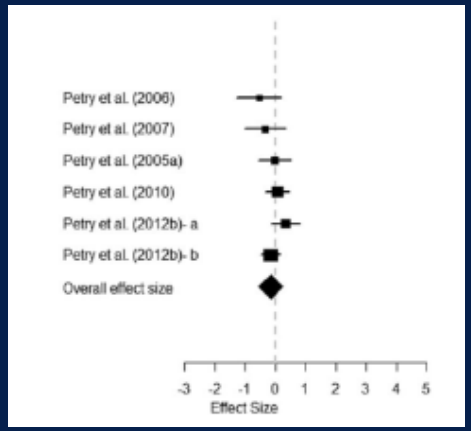
- Research studies reported a cost of about $100 per month per patient in prizes (Petry, 2013)
- Studies were mostly 3-month trials
- Effects dissipate after 6 months (Benishek 2014).
  - Possibly CM shapes, but does not transform behavior

End-of-Treatment



Short-term Follow-up

6-mo. Post-Treatment



Implementing Contingency Management

- Staff may have concerns about “paying patients to do the right thing.”
  - This is overcome by pragmatic discussions. Motivation is a scarce commodity for many patients!
- The logistics are complex
  - Setting up measurable, concrete goals
  - Recording responses
  - Tracing and dispensing rewards
- The easiest method of implementation comes from technology.

Affect Regulation and Recognition

Affect Regulation and Recognition

- Many individuals have difficulties with either:
  - Recognizing and understanding feeling states
  - Responding in a productive manner to those feelings
- Addiction entraps and induces strong emotions and difficulties handling emotions trigger relapse and continued use.
- Therapy in emotions management is helpful in preventing relapse in such individuals.[1]
- Alexithymia (the inability to recognize and name feeling states) plays a role in a different population of those with substance use disorders.[2]

[1] Hsu, S. H., Collins, S. E., & Marlatt, G. A. (2013). Examining psychometric properties of distress tolerance and its moderation of mindfulness-based relapse prevention effects on alcohol and other drug use outcomes. *Addict Behav, 38(3), 1852-1858.*

[2] Morie, K. P., Yip, S. W., Nich, C., Hunkele, K., Carroll, K. M., & Potenza, M. N. (2016). Alexithymia and addiction: a review and preliminary data suggesting neurobiological links to reward/loss processing. *Current addiction reports, 3(2), 239-248.*

Dialectic Behavioral Therapy

- The best studied, evidence-based technique is Dialectic Behavioral Therapy (DBT). [1]
- Four basic skills in DBT, commonly taught in a class setting:
  - Emotion regulation
  - Mindfulness
  - Interpersonal effectiveness
  - Distress tolerance
- DBT combines cognitive-behavioral and mindfulness techniques to emotional regulation.
- Helpful in patients with problems in emotional regulation, including those with borderline personality disorder.

[1] McClintock, Andrew S., and Marianne Marcus. "Mindfulness-based approaches in addiction treatment." *Textbook of Addiction Treatment* (2021): 391-400.

Partner Therapy

Partner / Couples Therapy

- Several partner therapies have been studied and shown to be effective in increasing remission.[1]
- Important to explore the partner's relationship to substances as well as others in the home.
- Encourage reasonable accommodations by the partner to support remission. The partner's definition of "reasonable" is important!
- Remission is problematic when the identified patient is on the downside of a significant power differential.

[1] Powers, M. B., Vedel, E., & Emmelkamp, P. M. (2008). Behavioral couples therapy (BCT) for alcohol and drug use disorders: A meta-analysis. *Clin Psychol Rev, 28(6), 952-962.*

Trauma Symptom Abatement - EMDR

Trauma & Addiction

- Physical, emotional, sexual, or religious trauma co-migrates with addiction disorders (incidence of addition higher in traumatized populations).[1]
- …with a suggestion that trauma especially childhood trauma contributes to the development of addiction disorders.
- Addiction often traumatizes its victim. Random flashbacks of intense addiction-related memories may trigger relapse.

[1] Khoury, L., Tang, Y. L., Bradley, B., Cubells, J. F., & Ressler, K. J. (2010). Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population. *Depress Anxiety, 27(12), 1077-1086.*

Eye Movement Desensitization and Reprocessing (EMDR)

- Developed in 1987, the therapist gently guides the patient to briefly focus on the trauma memory.
- …while simultaneously engaging eye movements and/or other forms of rhythmic left-right stimulation.
- The process is highly structured and repeatable with multiple sessions that
  - Gather the history
  - Qualify the target memory
  - Process the memory to an adaptive resolution
  - Evaluate the outcome

Eye Movement Desensitization and Reprocessing (EMDR)

- Individuals with a trauma history often begin using substances to manage flashbacks and emotional unrest produced by their trauma.
- Trauma victims abuse alcohol, sedatives and dissociatives but, paradoxically use stimulants and cocaine.
- EMDR may be helpful in disengaging and disaffecting addiction-related memories.[1]
- EMDR and other interventions reduce trauma flashbacks and thus the substance use triggered by their recall.
- This in turn improves the prognosis of the addiction disorder.
- Other trauma-resolution techniques may also prove helpful.

[1] Hase, M., Schallmayer, S., & Sack, M. (2008). EMDR reprocessing of the addiction memory: Pretreatment, posttreatment, and 1-month follow-up. *Journal of EMDR Practice and Research, 2(3), 170-179.*

Conclusions

- A wide variety of psychosocial interventions are available to assist in recovery from substance use disorders.
- Careful assessment is the first and most important step in matching treatment to a particular individual's issues.
- Not addressing psychosocial issues leads to a worse prognosis and is bad medicine.
- Engaging patients with all psychosocial interventions requires an approach based upon compassion and concern.
- Physicians should have a basic understanding of the many types of therapeutic interventions in order to help patients engage in them when indicated.