

Chapter 6. Psychosocial interventions for alcohol use disorders

6. Psychosocial interventions for alcohol use disorders

This chapter describes, and provides the rationale for, the most widely used, empirically supported psychosocial approaches employed to treat alcohol problems. It also presents a general framework to guide choice of psychosocial treatment with recommendations for strategies that are expected to increase treatment effectiveness.

Overview of psychosocial interventions

Psychosocial interventions or treatment encompass a wide range of non-pharmacological approaches commonly used to treat alcohol and other drug use disorders.

These interventions generally focus on the individual (their beliefs, feelings and behaviour), their social context, including family, community and cultural factors and the interaction between these two domains.

Psychosocial interventions encompass:

- **treatment content** (that is, the skills, strategies and theoretical orientation of treatment)
- **treatment process** (that is, the interaction between the clinician and patient, which includes the strength of engagement, interpersonal interactions and ability to work on shared treatment goals).

Psychosocial treatment researchers increasingly support the view that effective treatment outcome requires sound integration of treatment content and process.

Many psychosocial interventions derive from social learning theory. They share the basic tenet that, although biological and genetic factors play a significant role in the aetiology of substance use disorders, problematic patterns of alcohol and other drug use are learned in a social environment and can, therefore, be replaced by new, more adaptive learned behaviour.

Effective psychosocial interventions help patients address their drinking problems by engaging their motivation and other resources and effecting cognitive, behavioural and social changes with respect to drinking. Where alcohol and other substance use are conceptualised as maladaptive attempts to cope with stress, distress or other negative emotional states, psychosocial interventions can be particularly useful in teaching more functional coping skills.

The most widely used psychosocial approaches that have received consistent empirical support are:

- brief interventions (see Chapter 4)
- motivational approaches
- various forms of cognitive behavioural therapy, including coping skills training, behavioural self-management (controlled drinking), relapse prevention and behavioural couples therapy.

A psychosocial intervention can be used as a stand-alone treatment, or in conjunction with pharmacotherapy. Consistent evidence shows that people who receive these interventions benefit substantially, and at follow-up show clinically significant reductions in their alcohol consumption, increases in number of days abstinent, and improvements in overall functioning.

When to use psychosocial interventions

Psychosocial interventions are used to engage a person's interest and commitment to change and to teach the requisite skills to maintain that change. They can be used by a range of health workers in a variety of treatment settings. They can be implemented individually or in groups. Some clinicians prefer to use motivational strategies in the early stages of therapy, to increase preparation for change, supplementing with more cognitive behavioural or other specialised therapy as appropriate. Clinicians who use these approaches **must** be appropriately trained and competent in their application.

Psychosocial interventions vary in intensity, from brief to intensive and specialised (for example, cognitive behavioural therapy, couples therapy). Brief interventions are most suited for non-dependent drinkers (see Chapter 4). More intensive psychosocial interventions, described in this chapter, are appropriate for people with more established alcohol problems for whom brief interventions are not sufficient.

In general, low intensity psychosocial interventions are indicated for people with low dependence, increasing the level of intensity for those with more severe dependence and co-existing mental health concerns. A model – a stepped care approach – to help clinicians make decisions about appropriate interventions is presented below.

Choosing psychosocial interventions: a stepped care approach

The choice of intervention for alcohol use disorder, whether psychosocial or pharmacological, will depend on the patient's presentation and needs, and available resources. People presenting to alcohol and other drug clinics may have different treatment needs from those presenting to primary care settings.

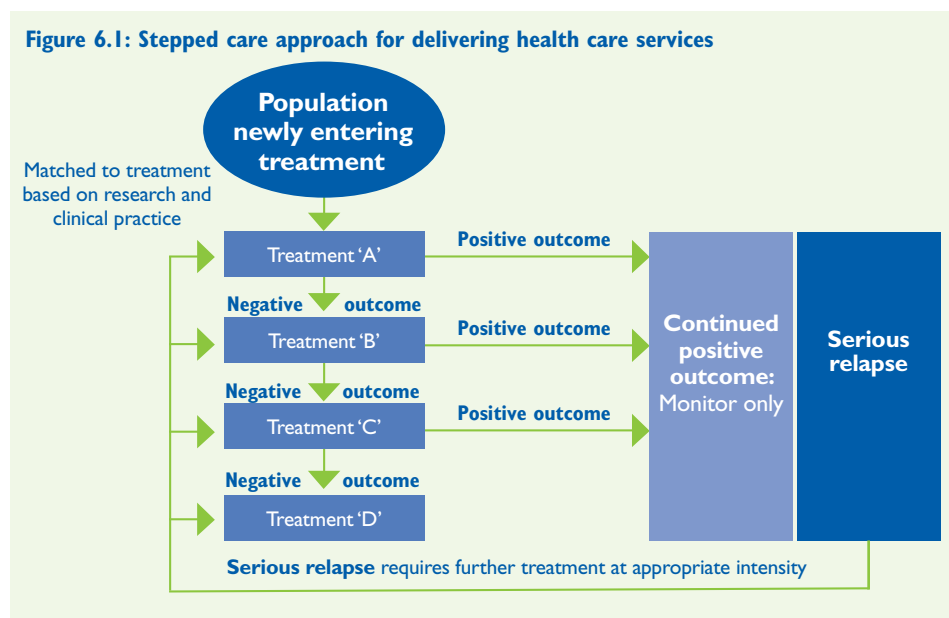
Principles of treatment selection and care planning are described in Chapter 3. Important components of treatment interventions for problem drinkers includes:

- assessment and feedback
- goal setting: abstinence, moderation and reduced drinking
- case formulation and treatment plan
- therapeutic alliance, engagement and retention in treatment
- relapse prevention
- follow-up and aftercare.

Basic counselling 'micro-skills', including warmth, empathy and optimism, and strong interpersonal skills are associated with better retention in treatment and indirectly with better treatment retention. Central to provision of any counselling intervention is a strong bond and therapeutic alliance between the patient and clinician.

Within this context, a stepped care model is proposed as a practical approach to implementing interventions. The main components of stepped care include thorough assessment, monitoring, implementation of a treatment plan based upon patient presentation and goals, regular review of progress and re-evaluation in the absence of a positive response to treatment.

Derived from other areas of health care, stepped care stipulates that patients should be offered the least restrictive intervention appropriate to their presentation. In primary care settings, this might be a brief intervention of education and advice. In treatment settings, the least restrictive intervention might be outpatient psychosocial treatment. The model (see Figure 6.1) suggests that, should the first intervention prove insufficiently beneficial to the patient, the next level of intensity of treatment may be offered. This could take the form of more intensive psychological treatment, such as cognitive behavioural therapy or pharmacotherapy, or a combination of both. Residential treatment, in the stepped care model, would be viewed as more intensive and restrictive and to be pursued only when other less restrictive interventions have proven ineffective or the individual presentation clearly requires this level of intensity of treatment.



Source: Sobell, MB & Sobell, LC 2000, 'Stepped care as a heuristic approach to the treatment of alcohol problems', *Journal of Consulting and Clinical Psychology*, vol. 68, no. 4, pp. 573–79.

According to the stepped care model, determining the level of intervention the individual needs is based on a thorough assessment and sound clinical judgement (See Chapter 3). The appropriate level of intensity of treatment is commenced and the patient's progress is monitored and reviewed. The patient's response to treatment determines the next step, which could be either continued monitoring of progress or, in the absence of clear benefit, stepped up intensity of treatment.

While limited evidence supports application of the stepped care approach, it has sound 'face validity' in selecting treatment approaches and is an efficient use of resources. At present, there is limited evidence to support 'patient-treatment' matching based upon patient characteristics. The stepped care model is proposed here as an adjunct to decision-making and does not replace clinical judgement and expert advice. The decision-making process is described in the clinical vignette 'Case scenario: Stepped care approach to selecting psychosocial interventions' (see box).

CASE SCENARIO: STEPPED CARE APPROACH TO SELECTING PSYCHOSOCIAL INTERVENTIONS

John, a 45-year-old man, presents to his general practitioner complaining of feeling tired most Mondays (with occasional absenteeism), and with a background of high blood pressure. On questioning, he admits to drinking between four and six 375 ml cans of full strength beer (6 to 10 standard drinks) most days and more on weekends (often 12 cans per day) when he goes out with friends. He has no history of treatment for his drinking or for other mental health concerns, and does not describe alcohol withdrawal symptoms. The general practitioner explains that his alcohol use may be contributing to his high blood pressure, and mild 'hangovers' experienced on Monday mornings. She advises him to cut down (brief intervention). At his next appointment one month later, John reports no change in his drinking. She suggests a course of naltrexone, which he commences but ceases after two days.

His general practitioner refers him to the Community Health Centre for counselling. John attends his appointment at the clinic where he is assessed and is offered a few sessions of motivational interviewing and a controlled drinking program with the drug and alcohol worker. John engages well with his counsellor, improves temporarily (drinking two cans per day) but then, after attending a social function, relapses and seems unable to resume moderation. During their discussion of his relapse, the counsellor points out a pattern of excessive alcohol use in social situations. She refers him to the clinic's psychologist for assessment of his social anxiety and for cognitive behavioural therapy. After completing 10 sessions of cognitive behavioural therapy for excessive alcohol use and social anxiety, John looks better and claims to feel better. His drinking is down to two to three cans two to three times per week; he monitors and paces his drinking; he knows how to plan for and manage risky social situations and has learned other ways of coping with his social anxiety. Apart from several telephone calls for follow-up to discuss his progress, John needs no further treatment. His blood pressure had returned to normal, and he now no longer misses work on Mondays.

John had low alcohol dependence and social anxiety but no other serious co-existing problems. The brief intervention was stepped up when it was apparent that he needed more intensive treatment (motivational interviewing and controlled drinking program, followed by cognitive behavioural therapy addressing coping skills and social anxiety). A person who presents with severe alcohol dependence and poor mental health, on the other hand, would clearly need more intensive treatment, perhaps treatment for alcohol withdrawal and monitoring of mental health concerns followed by more intensive psychosocial and medication approaches.

Recommendation	Strength of recommendation	Level of evidence
6.1 A stepped care approach is recommended as a framework for selecting psychosocial interventions, incorporating assessment, monitoring, implementation of a treatment plan, regular review of progress, and increasing intervention intensity in the absence of a positive response to treatment.	D	IV

Motivational interviewing

Motivational interviewing is a style of counselling that focuses on helping the individual explore and resolve ambivalence about change. The patient's own reasons for change are elicited and used to motivate movement towards action and behaviour change. Motivational interviewing is directive in that it guides the person towards resolution of ambivalence and towards change. The term 'interviewing' was chosen to reflect the therapist's enquiring, non-confrontational approach. The therapist is not viewed as an expert but rather as a facilitator.

Motivational interviewing and its derived manual-guided motivation enhancement therapy are effective, empirically supported psychosocial interventions. They can be used as a first-line or stand-alone treatment, or as an adjunct to other psychosocial or pharmacological treatment modalities, and aim to address patient ambivalence to changing their drinking or other behaviours. The principles underpinning motivational interviewing are:

- **collaboration** – the therapist and patient pursue change together; there is no coercion, rather facilitation of exploration and discovery
- **evocation** – the patient is believed to possess the intrinsic goals and resources for change, which the therapist elicits
- **autonomy** – the therapist respects the patient's right and capacity for self-direction and facilitates informed choice.

The guiding concepts of motivational interviewing are:

- **Express empathy**

In expressing empathy, the therapist listens non-judgmentally and conveys acceptance of the patient. Reluctance to change problematic behaviour is viewed as an understandable and normal part of human experience. The basic premises are that acceptance facilitates change, skilful reflective listening is fundamental, and ambivalence is normal.

- **Develop discrepancy**

Discrepancy and tension is created empathically between the patient's present behaviour and their broader goals and values. This requires an exploration and understanding of the patient's goals and values as well as an understanding of their current concerns. A discrepancy between these two sets of circumstances will reflect the importance of change to the patient. If change is important, then eliciting reasons for change should not be difficult. If change is not important to the patient, behaviour change may be difficult to achieve and maintain.

- **Roll with resistance**

Resistance in motivational interviewing is viewed as an interpersonal phenomenon between patient and therapist. The therapist avoids argument. A resistant response from the patient is a sign that the therapist's style may be too confronting or insistent and that a different approach is needed. Engagement with resistance is expected to increase resistance. New perspectives are invited but not imposed. The patient is viewed as the source of new answers and solutions. The therapist's role is to facilitate exploration of options.

- **Support self-efficacy**

Self-efficacy refers to a person's belief in their ability to carry out and succeed with a specific task. Self-efficacy is a key element in motivation for change and is a reasonable predictor of change. A therapist's own expectations about a patient's likelihood of change can have a powerful effect on the outcome.

Recommendation	Strength of recommendation	Level of evidence
6.2 Motivational interviewing approaches can be used as a first-line or stand-alone treatment, or as an adjunct to other treatment modalities in addressing patient's ambivalence to change their drinking or other behaviours.	A	1a

Cognitive behavioural interventions

Cognitive behavioural interventions are empirically supported and comprise a range of approaches broadly based on learning principles and the idea that cognitive processes influence behaviour. The most prominent of these approaches are:

- behavioural self-management or self-control: controlled drinking programs
- coping skills training
- cue exposure
- behavioural couples therapy.

Behavioural self-management or self-control: Controlled drinking programs

Identifying and agreeing upon treatment goals is an important process for many patients (see also Chapter 3). For patients with no or low levels of alcohol dependence, and who are not experiencing significant or irreversible alcohol-related harms, a goal of moderation may be achievable. Consumption within current NHMRC guidelines can be recommended either immediately or as a medium-term target.

For patients with severe alcohol dependence, and/or those presenting with associated problems such as organ damage, cognitive impairment and co-existing mental health problems, the most realistic drinking goal is likely to be abstinence. For many such patients, achieving abstinence is associated with a risk of alcohol withdrawal syndrome. If so, this should be managed before longer-term abstinence or reduced drinking can be achieved (see Chapter 5). Limited evidence indicates that people with moderate to severe dependence can successfully moderate their alcohol use in the immediate term, and a period of abstinence (at least 3 to 6 months) is generally recommended before attempting controlled drinking programs. See Chapter 3 for treatment planning and how to work with patients who identify unrealistic treatment goals.

The behavioural self-management approach (also called controlled drinking programs) teaches people to reduce their alcohol consumption, and is suitable for people at the less severe end of the dependence spectrum. Behavioural self-management includes:

- goal setting
 - setting the number of drinks to be consumed per day or week
 - setting the circumstances in which drinking will occur
- self-monitoring of daily drinking, including
 - time, place, and people with whom they drink
 - number of drinks consumed
 - how they felt at the time

- controlling the rate of drinking
 - timing each drink and spacing drinks
 - alternating between alcoholic and non-alcoholic drinks
 - eating during sessions
- identifying problematic drinking situations and triggers to drinking.

Various self-help booklets and resources are available to help patients attempting controlled drinking programs (see Appendix 5).

Recommendation	Strength of recommendation	Level of evidence
6.3 Behavioural self-management (controlled drinking program) can be recommended as a treatment strategy for people with no or low level dependence and for when patient and clinician agree that moderation is an appropriate goal.	A	Ib

Coping skills training

Coping skills training is one of the best-established and empirically supported interventions for alcohol use disorder. Skills training assumes that developing effective coping skills can help people deal with stressful social situations that are linked to their alcohol use.

Examples of coping skills include assertiveness, communication, drink refusal, problem solving, anger management and coping with urges. Skills training is most beneficial to people who appear to lack the relevant skills to achieve and maintain abstinence; it is generally delivered by therapists with specific training in this approach.

Recommendation	Strength of recommendation	Level of evidence
6.4 Coping skills training is recommended for people who appear to lack the relevant skills to achieve and remain abstinent.	A	Ib

Cue exposure

Cue exposure is an empirically supported treatment method that derives from learning theory. It assumes that people, places or events that regularly precede drinking become associated with the pleasant effects of alcohol, and alcohol consumption becomes a conditioned response to these cues.

Cue exposure can be applied with a treatment goal of either abstinence or moderation with moderately good results. The goal of cue exposure is to decrease the likelihood of a relapse to drinking by either decreasing the strength of the association between alcohol-related cues and the urge to drink, or increasing the use and effectiveness of coping skills when confronted with alcohol-related cues in daily life.

Cue exposure therapy usually consists of six to 12 sessions, each of 50 to 90 minutes duration. Sessions can be run daily or less frequently. Cue exposure is a specialist treatment intervention and should only be offered by qualified professionals.

Recommendation	Strength of recommendation	Level of evidence
6.5 Cue exposure in conjunction with other psychosocial interventions can be an effective intervention for treating alcohol dependence.	A	Ib

Behavioural couples therapy

Alcohol problems have a far-reaching effect on partners and families. Little systematic information is available on effective family therapy approaches, that is, approaches that involve the entire family in treatment. However, therapy with couples or partners – especially behaviourally oriented therapy – has received considerable empirical support and has been shown to be more effective than individual treatment. Therapy with problem drinkers and their partners can be conducted in several ways, namely:

- The first approach – therapy with the partner of a problem drinker – can focus on improving the partner's coping skills and increasing the problem drinker's readiness for treatment. In this approach, the partner is taught specific skills to reduce conflict over drinking, reinforce reduced consumption or abstinence, and encourage attendance for treatment.
- The second and more specialised approach – behavioural couples therapy – focuses on both individuals and their communication and social context. It teaches the drinker self-management skills and the partner, coping skills. It teaches communication and problem solving skills to reduce conflict and ways of consolidating social support for changes in alcohol use.
- The third approach is also a behaviourally based couples (marital) therapy but includes use of alcohol pharmacotherapy, usually disulfiram. It involves both partners in treatment, focuses on improving the relationship, resolving conflict and problems, and introduces spouse-supervised disulfiram use. This approach has been shown to improve drinking outcomes and maintain marital stability and satisfaction.

Clinicians interested in delivering couples therapy should be appropriately trained to deliver this specialised intervention. Work with couples can be very challenging especially when problems are longstanding and conflict is well established.

Recommendation	Strength of recommendation	Level of evidence
6.6 Behavioural couples therapy, which focuses on drinking behaviour as the problem, can improve drinking outcomes following treatment and should be delivered by an appropriately trained clinician.	A	1a

Other counselling strategies

Contingency management is a strategy that uses positive reinforcement to improve treatment outcomes by providing incentives to encourage behavioural changes. Withholding incentives when desirable behaviour is not maintained (that is, negative reinforcement) may also be used. While evidence has shown that contingency management is effective in research settings, it has not been routinely translated into clinical practice largely due to resourcing problems.

A number of other approaches are being increasingly used in counselling settings, including for patients with alcohol problems. Examples include:

- solution-focused approaches (such as solution-focus brief therapy)
- mindfulness-based stress reduction
- psychodynamic therapy
- narrative therapy.

These counselling approaches are not supported by a strong evidence base so are not yet widely recommended.

Relapse prevention strategies

Relapse is a common problem in alcohol treatment. Most dependent drinkers relapse to problematic drinking within the first few months (often weeks) of treatment. This is consistent with the chronic relapsing–remitting nature of alcohol dependence, and should be addressed in treatment planning, rather than seen as a failure of treatment.

Specific situations or mood states are often associated with relapse, including:

- negative emotional states (frustration, anger, anxiety, depression or anger)
- interpersonal conflict (relationships with partner, work colleagues, friends)
- direct or indirect social pressure to drink.

Relapse prevention is not so much a specific intervention but rather a set of strategies that aim to help the patient maintain treatment gains. Such strategies may include a number of cognitive and behavioural approaches that help prevent lapses becoming relapses, such as:

- learning to identify situations that have been associated with excessive drinking and to use appropriate cognitive and behavioural strategies to cope effectively
- constructively appraising lapses, thereby reducing fear of failure, guilt, shame and hopelessness and preventing a lapse from becoming a relapse
- learning, through careful forward planning, to avoid unnecessary risk and deal positively and confidently with inevitable risk.

All moderately and severely alcohol dependent patients should be offered the opportunity to learn relapse-prevention strategies. These are best discussed after acute withdrawal symptoms have subsided. Relapse prevention addresses itself to maintaining change and to developing self-efficacy and coping skills.

Relapse prevention may also incorporate medications for reducing alcohol use (such as naltrexone, disulfiram, acamprosate) and/or address concomitant conditions linked to relapse (such as anxiety, depression, sleep disorder, chronic pain).

Recommendation	Strength of recommendation	Level of evidence
6.7 Psychosocial relapse prevention strategies are recommended for use with all moderately to severely alcohol-dependent patients.	A	Ib
6.8 Psychosocial relapse prevention strategies are best delivered as soon as acute withdrawal symptoms have subsided.	C	III

Residential rehabilitation programs

Residential rehabilitation programs (sometimes called therapeutic communities) are usually long-term programs where people live and work in a community of other substance users, ex-users and professional staff. Programs can last anywhere between 1 and 24 months (or more). The aim of residential rehabilitation programs is to help people develop the skills and attitudes to make long-term changes towards an alcohol- and drug-free lifestyle. Programs usually include activities such as employment, education and skills training, life skills training (such as budgeting and cooking), counselling, group work, relapse prevention, and a 're-entry' phase where people are helped return to their community. Some programs are based on

12-step Alcoholics Anonymous (AA) approaches (see Chapter 8). An extended period of abstinence can be beneficial in reversing cognitive and physical harm arising from chronic heavy alcohol use.

Residential rehabilitation programs can be effective for people needing structured long-term support, and are more attractive to those with moderate to severe dependence, and limited social supports.

Recommendation	Strength of recommendation	Level of evidence
6.9 Residential rehabilitation programs can be effective for patients with moderate to severe dependence who need structured residential treatment settings.	D	IV