



Complete Summary

GUIDELINE TITLE

Brief interventions and brief therapies for substance abuse.

BIBLIOGRAPHIC SOURCE(S)

Treatment Improvement Protocol Series 34 Consensus Panel. Brief interventions and brief therapies for substance abuse. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1999. (Treatment improvement protocol (TIP) series; no. 34). [583 references]

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Substance use disorders

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Counseling
Treatment

CLINICAL SPECIALTY

Family Practice
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

- To link research to practice by providing counselors and therapists in the substance abuse treatment field with up-to-date information on the usefulness of these innovative and shorter forms of treatment for selected subpopulations of people with substance abuse disorders and those at risk of developing them.
- To present the historical background, outcomes research, rationale for use, and state-of-the-art practical methods and case scenarios for implementation of brief interventions and therapies for a range of problems related to substance abuse.

TARGET POPULATION

Clients with substance abuse problems ranging from at-risk to dependent use

INTERVENTIONS AND PRACTICES CONSIDERED

Brief Interventions

1. Components of effective brief intervention using the acronym FRAMES:
 - Feedback to the individual about personal risk or impairment.
 - Responsibility placed on the participant.
 - Advice to change given by the clinician.
 - Menu of alternative self-help or treatment options offered to the participant.
 - Empathic style used by the counselor.
2. Steps in brief intervention incorporating FRAMES
 - Introducing the issues in the context of the client's health.
 - Screening, evaluation, and assessment.
 - Providing feedback.
 - Talking about change and setting goals.
 - Summarizing and reaching closure.

Brief Therapies

1. Criteria for when to use brief therapy
2. Components of effective brief therapy
3. Screening and assessment
4. First session goals

5. Maintenance strategies, termination of therapy, and followup
6. Cognitive-behavioral therapy
7. Strategic/interactional therapies, including:
 - Ericksonian Therapy
 - Solution-Focused Brief Therapy
 - The MRI Therapeutic Model
 - Haley's Problem-Solving Therapy
8. Humanistic and existential therapies, including:
 - Client-Centered Therapy
 - Existential Therapy
 - Narrative Therapy
 - Gestalt Therapy
 - Transpersonal Therapy
9. Psychodynamic therapies, including:
 - Supportive-Expressive Therapy
 - 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)
10. Family therapy
11. Group therapy including:
 - Brief Cognitive Group Therapy
 - Cognitive-Behavioral Group Therapy
 - Strategic/Interactional Therapies
 - Brief Group Humanistic and Existential Therapies
 - Group Psychodynamic Therapy
 - Modified Dynamic Group Therapy
 - Modified Interactional Group Process

MAJOR OUTCOMES CONSIDERED

- Aftercare follow-up rates
- Aftercare compliance rates
- Alumni participation rates
- Discharge against medical advice rates
- Counselors' ratings of client involvement in substance abuse following treatment
- The number of complaints related to the brief intervention or therapy
- Client satisfaction surveys
- Follow-up phone calls
- Counselor-rating questions added to clinical chart
- Cost

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

All Treatment Improvement Protocols (TIPs) are produced after a major literature search followed by a meta-analysis by skilled professionals on the contractor's staff. Then the research-based evidence is combined with whatever field-based experience is shared at the consensus panel.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

After selecting a topic for a Treatment Improvement Protocol (TIP), the Center for Substance Abuse Treatment invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their

peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

In a study looking at the costs of brief interventions, Holder and colleagues evaluated the evidence of clinical effectiveness and the typical costs of various alcoholism treatment modalities and found brief motivational counseling among the most effective in terms of a combination of clinical and cost effectiveness. It ranked third among the six highest ranking approaches in terms of weighted effectiveness (based on a total of nine studies conducted between 1983 and 1990). Brief motivational counseling was also rated the least costly of the six most effective therapies—or most cost-effective of 33 evaluated modalities.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A large and diverse group of field experts closely reviewed the draft document

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The Consensus Panel's recommendations summarized below are based on both research and clinical experience. Those supported by scientific evidence are followed by (1); clinically based recommendations are marked (2).

Brief Interventions

Brief interventions are those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse, either by natural, client-directed means or by seeking additional substance abuse treatment.

A brief intervention, however, is only one of many tools available to clinicians. It is not a substitute for care for clients with a high level of dependency. It can, however, be used to engage clients who need specialized treatment in specific aspects of treatment programs, such as attending group therapy or Alcoholics Anonymous (AA) meetings.

- The Consensus Panel believes that brief interventions can be an effective addition to substance abuse treatment programs. These approaches can be

- particularly useful in treatment settings when they are used to address specific targeted client behaviors and issues in the treatment process that can be difficult to change using standard treatment approaches (2).
- Variations of brief interventions have been found to be effective both for motivating alcohol-dependent individuals to enter long-term alcohol treatment and for treating some alcohol-dependent persons (1).
 - The Consensus Panel recommends that programs use quality assurance improvement projects to determine whether the use of a brief intervention or therapy in specific treatment situations is enhancing treatment (2).
 - The Consensus Panel recommends that agencies allocate counselor training time and resources to these modalities. It anticipates that brief interventions will help agencies meet the increasing demands of the managed care industry and fill the gaps that have been left in client care (2).
 - Substance abuse treatment personnel should collaborate with other providers (e.g., primary care providers, employee assistance program, wellness clinic staff, etc.) in developing plans that include both brief interventions and more intensive care to help keep clients focused on treatment and recovery (2).

Goals of brief interventions

The basic goal of any brief intervention is to reduce the risk of harm that could result from continued use of substances. The specific goal for each individual client is determined by his consumption pattern, the consequences of his use, and the setting in which the brief intervention is delivered.

- Focusing on intermediate goals allows for more immediate success in the intervention and treatment process, whatever the long-term goals may be. Intermediate goals might include quitting one substance, decreasing frequency of use, or attending a meeting. Immediate successes are important to keep the client motivated (2).
- When conducting a brief intervention, the clinician should set aside the final treatment goal (e.g., accepting responsibility for one's own recovery) to focus on a single behavioral objective. Once this objective is established, a brief intervention can be used to help reach it (2).

Components of brief interventions

There are six elements that are critical for effective brief interventions (1). The acronym FRAMES was coined to summarize these six components:

- Feedback is given to the individual about personal risk or impairment.
- Responsibility for change is placed on the participant.
- Advice to change is given by the clinician.
- Menu of alternative self-help or treatment options is offered to the participant.
- Empathic style is used by the counselor.
- Self-efficacy or optimistic empowerment is engendered in the participant.

A brief intervention consists of five basic steps that incorporate FRAMES and remain consistent regardless of the number of sessions or the length of the intervention:

1. Introducing the issues in the context of the client's health.
2. Screening, evaluating, and assessing.
3. Providing feedback.
4. Talking about change and setting goals.
5. Summarizing and reaching closure.

Providers may not have to use all five of these components in any given session with a client. However, before eliminating steps in the brief intervention process there should be a well-defined reason for doing so (2).

Essential knowledge and skills for brief interventions

Providing effective brief interventions requires the clinician to possess certain knowledge, skills, and abilities. The following are four essential skills (2):

1. An overall attitude of understanding and acceptance
2. Counseling skills such as active listening and helping clients explore and resolve ambivalence
3. A focus on intermediate goals
4. A working knowledge of the stages-of-change through which a client moves when thinking about, beginning, and trying to maintain new behavior

Brief Therapies

Brief therapy is a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. The brief therapies presented in this Treatment Improvement Protocol should be seen as separate modalities of treatment, not episodic forms of long-term therapy.

Brief therapies usually feature more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from 1 to 40 sessions, with the typical therapy lasting between 6 and 20 sessions.

Brief therapies also differ from brief interventions in that their goal is to provide clients with tools to change basic attitudes and handle a variety of underlying problems. Brief therapy differs from longer term therapy in that it focuses more on the present, downplays psychic causality, emphasizes the effective use of therapeutic tools in a shorter time, and focuses on a specific behavioral change rather than large-scale or pervasive change.

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 certain populations.

- The best outcomes for brief therapy may depend on clinician skills, comprehensive assessments, and selective criteria for eligibility. Using selective criteria in prescribing brief therapy is critical, since many clients will not meet its eligibility requirements (2).
- Brief therapy for substance abuse treatment is a valuable approach, but it should not be considered a standard of care for all populations (1). The

Consensus Panel hopes that brief therapy will be adequately investigated in each case before managed care companies and third-party payors decide it is the only modality for which they will pay.

- Brief interventions and brief therapies are well suited for clients who may not be willing or able to expend the significant personal and financial resources necessary to complete more intensive, longer term treatments (2).
- Both research and clinical expertise indicate that individuals who are functioning in society but have patterns of excessive or abusive substance use are unlikely to respond positively to some forms of traditional treatment, but some of the briefer approaches to intervention and therapy can be extremely useful clinical tools in their treatment (1).

When to use brief therapy

Determining when to use a particular type of brief therapy is an important consideration for counselors and therapists. The Panel recommends that client needs and the suitability of brief therapy be evaluated on a case-by-case basis (2). Some criteria for considering the appropriateness of brief therapy for clients include:

- Dual diagnosis issues
- The range and severity of presenting problems
- The duration of substance dependence
- Availability of familial and community supports
- The level and type of influence from peers, family, and community
- Previous treatment or attempts at recovery
- The level of client motivation
- The clarity of the client's short- and long-term goals
- The client's belief in the value of brief therapy
- The numbers of clients needing treatment

The following criteria are derived from Panel members' clinical experience:

- Less severe substance dependence, as measured by an instrument like the Addiction Severity Index (ASI)
- Level of past trauma affecting the client's substance abuse
- Insufficient resources available for more prolonged therapy
- Limited amount of time available for treatment
- Presence of coexisting medical or mental health diagnoses
- Large numbers of clients needing treatment leading to waiting lists for specialized treatment

The Consensus Panel also notes that

- Planned brief therapy can be adapted as part of a course of serial or intermittent therapy. When doing this, the therapist conceives of long-term treatment as a number of shorter treatments, which require the client's problems to be addressed serially rather than concurrently (1).
- Brief therapies will be most effective with clients whose problems are of short duration and who have strong ties to family, work, and community. However, a number of other conditions, such as limited client resources, may also dictate the use of brief therapy (2).

- It is essential to learn the client's perceived obstacles to engaging in treatment as well as to identify any dysfunctional beliefs that could sabotage the engagement process. The critical factor in determining an individual's response is the client's self-perception and associated emotions (1).

Components of effective brief therapy

While there are a variety of different schools of brief therapy available to the clinician, all forms of brief therapy share some common characteristics (2):

- They are either problem focused or solution focused--they target the symptom, not its causes.
- They clearly define goals related to a specific change or behavior.
- They should be understandable to both client and clinician.
- They should produce immediate results.
- They can be easily influenced by the personality and counseling style of the therapist.
- They rely on rapid establishment of a strong working relationship between client and therapist.
- The therapeutic style is highly active, empathic, and sometimes directive.
- Responsibility for change is placed clearly on the client.
- Early in the process, the focus is to help the client enhance his self-efficacy and understand that change is possible.
- Termination is discussed from the beginning.
- Outcomes are measurable.

Screening and assessment

Screening and assessment are critical initial steps in brief therapy. Screening is a process in which clients are identified according to characteristics that indicate they are possibly abusing substances. Screening identifies the need for more in-depth assessment but is not an adequate substitute for complete assessment.

Assessment is a more extensive process that involves a broad analysis of the factors contributing to and maintaining a client's substance abuse, the severity of the problem, and the variety of consequences associated with it. Screening and assessment procedures for brief therapy do not differ significantly from those used for lengthier treatments.

- Clinicians can use a variety of brief assessment instruments, many of which are free. These instruments should be supplemented in the first session by a clinical assessment interview that covers current use patterns, history of substance use, consequences of substance abuse, coexisting psychiatric disorders, major medical problems and health status, education and employment status, support mechanisms, client strengths and situational advantages, and family history (2).
- The screening and assessment process should determine whether the client's substance abuse problem is suitable for a brief therapy approach (2).
- Assessment is critical not only before beginning brief therapy but also as an ongoing part of the process (2).
- Therapists who primarily provide brief therapy should be adept at determining early in the assessment process which client needs or goals are appropriate to

address. Related to this, and equally important, the therapist must establish relationships that facilitate the client's referral when her needs or goals cannot be met through brief therapy (2).

The first session

In the first session, the main goals for the therapist are to gain a broad understanding of the client's presenting problems, begin to establish rapport and an effective working relationship, and implement an initial intervention, however small.

1. Counselors should gather as much information as possible about a client before the first counseling session. However, when gathering information about a client from other sources, counselors must be sensitive to confidentiality and client consent issues (2).
2. Therapists should identify and discuss the goals of brief therapy with the client early in treatment, preferably in the first session (2).
3. Although abstinence is an optimal clinical goal, it still must be negotiated with the client (at least in outpatient treatment settings). Abstinence as a goal is not necessarily the sole admission requirement for treatment, and the therapist may have to accept an alternative goal, such as decreased substance use, in order to engage the client effectively (2).
4. The provider of brief therapy must accomplish certain critical tasks during the first session (2), including:
 - Producing rapid engagement
 - Identifying, focusing, and prioritizing problems
 - Working with the client to develop a treatment plan and possible solutions for substance abuse problems
 - Negotiating the approach toward change with the client (which may involve a contract between client and therapist)
 - Eliciting client concerns about problems and solutions
 - Understanding client expectations
 - Explaining the structural framework of brief therapy, including the process and its limits (i.e., those items not within the scope of that treatment segment or the agency's work)
 - Making referrals for critical needs that have been identified but cannot be met within the treatment setting

Maintenance strategies, termination of therapy, and follow-up

Maintenance strategies must be built into the treatment design from the beginning. A practitioner of brief therapy must continue to provide support, feedback, and assistance in setting realistic goals. Also, the therapist should help the client identify relapse triggers and situations that could endanger continued sobriety (2).

Strategies to help clients maintain the progress made during brief therapy include the following (2):

- Educating the client about the chronic, relapsing nature of substance abuse
- Considering which circumstances might cause a client to return to treatment and planning how to address them

- Reviewing problems that emerged but were not addressed in treatment and helping the client develop a plan for addressing them in the future
- Developing strategies for identifying and coping with high-risk situations or the reemergence of substance abuse behaviors
- Teaching the client how to capitalize on personal strengths
- Emphasizing client self-sufficiency and teaching self-reinforcement techniques
- Developing a plan for future support, including mutual help groups, family support, and community support

Termination of therapy should always be planned in advance (2). When the client has made the agreed-upon behavior changes and has resolved some problems, the therapist should prepare to end the brief therapy. If a client progresses more quickly than anticipated, it is not necessary to complete the full number of sessions.

Therapist characteristics

Therapists will benefit from a firm grounding in theory and a broad technical knowledge of the many different approaches to brief therapy that are available (2). When appropriate, elements of different brief therapies may be combined to provide successful outcomes. However, it is important to remember that the effectiveness of highly defined interventions (e.g., workbook-driven interventions) used in some behavioral therapies depends on administration of the entire regimen.

- The therapist must use caution in combining and mingling certain techniques and must be sensitive to the cultural context within which therapies are integrated (2).
- Therapists should be sufficiently trained in the therapies they are using and should not rely solely on a manual such as this to learn those therapies (2).
- Training for brief therapies, in contrast to the training necessary to conduct brief interventions, requires months to years and usually results in a specialist degree or certification. The Consensus Panel recommends that anyone seeking to practice the therapies outlined here should receive more thorough training appropriate to the type of therapy being delivered (2).
- Providers of brief therapy should be able to focus effectively on identifying and adhering to specific therapeutic goals in treatment (2).
- Providers who practice brief therapy should be able to distill approaches from longer term therapies and apply them within the parameters of brief therapy (2).

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy represents the integration of principles derived from behavioral theory, cognitive social learning theory, and cognitive therapy, and it provides the basis for a more inclusive and comprehensive approach to treating substance abuse disorders.

Cognitive-behavioral therapy can be used by properly licensed and trained mental health practitioners, even if they have limited experience with this type of therapy--either as a cost-effective primary approach or in conjunction with other therapies or a 12-Step program. Cognitive-behavioral therapy can be also used

early in and throughout the treatment process whenever the therapist feels it is important to examine a client's inaccurate or unproductive thinking that could lead to risky or negative behaviors (2).

Cognitive-behavioral therapy is generally not appropriate for certain clients, namely, those

- Who have psychotic or bipolar disorders and are not stabilized on medication
- Who have no stable living arrangements
- Who are not medically stable (as assessed by a pretreatment physical examination) (2)

Cognitive-behavioral techniques

The cognitive-behavioral model assumes that substance abusers are deficient in coping skills, choose not to use those they have, or are inhibited from doing so. It also assumes that over the course of time, substance abusers develop a particular set of effect expectancies based on their observations of peers and significant others abusing substances to try to cope with difficult situations, as well as through their own experiences of the positive effects of substances.

1. Cognitive-behavioral therapy is generally effective because it helps clients recognize the situations in which they are likely to use substances, find ways of avoiding those situations, and cope more effectively with the variety of situations, feelings, and behaviors related to their substance abuse (2). To achieve these therapeutic goals, cognitive-behavioral therapy incorporates three core elements:
 - **Functional analysis** This analysis attempts to identify the antecedents and consequences of substance abuse behavior, which serve as triggering and maintaining factors.
 - **Coping skills training** A major component in cognitive-behavioral therapy is the development of appropriate coping skills.
 - **Relapse prevention** These approaches rely heavily on functional analyses, identification of high-risk relapse situations, and coping skills training, but also incorporate additional features. These approaches attempt to deal directly with a number of the cognitions involved in the relapse process and focus on helping the individual gain a more positive self-efficacy.
2. Overall, behavioral, cognitive, and cognitive-behavioral interventions are effective, can be used with a wide range of substance abusers, and can be conducted within the timeframe of brief therapies (1).
3. A broad range of cognitions will be evaluated in cognitive-behavioral therapy, including attributions, appraisals, self-efficacy expectancies, and substance-related effect expectancies (2).

Strategic/Interactional Therapies

Strategic/interactional therapies attempt to identify the client's strengths and actively create personal and environmental situations in which success can be achieved. The primary strength of strategic/interactional approaches is that they shift the focus from the client's weaknesses to his strengths.

The strategic/interactional model has been widely used and successfully tested on persons with serious and persistent mental illnesses (1). Although the research to date on these therapies (using nonexperimental designs) has not focused on substance abuse disorders, the use of these therapies in treating substance abuse disorders is growing.

The Consensus Panel believes that these therapeutic approaches are potentially useful for clients with substance abuse disorders and should be introduced to offer new knowledge and techniques for treatment providers to consider (2).

Using strategic/interactional therapies

No matter which type of strategic/interactional therapy is used, this approach can help to

- Define the situation that contributes to substance abuse in terms meaningful to the client (2).
- Identify steps needed to control or end substance abuse (2).
- Heal the family system so it can better support change (2).
- Maintain behaviors that will help control substance abuse (2).
- Respond to situations in which the client has returned to substance use after a period of abstinence (2).
- Strategic/interactional approaches are most useful in learning how the client's relationships deter or contribute to substance abuse (2).
- Shifting power relationships (2).
- Addressing fears (2).

Most forms of strategic/interactional therapies are brief by the definition used in this Treatment Improvement Protocol. Strategic/interactional therapies normally require 6 to 10 sessions, with 6 being most common.

Humanistic and Existential Therapies

Humanistic and existential psychotherapies use a wide range of approaches to the planning and treatment of substance abuse disorders. They are, however, united by an emphasis on understanding human experience and a focus on the client rather than the symptom. Humanistic and existential approaches share a belief that people have the capacity for self-awareness and choice. However, the two schools come to this belief through different theories.

Humanistic and existential therapeutic approaches may be particularly appropriate for short-term substance abuse treatment because they tend to facilitate therapeutic rapport, increase self-awareness, focus on potential inner resources, and establish the client as the person responsible for recovery. Thus, clients may be more likely to see beyond the limitations of short-term treatment and envision recovery as a lifelong process of working to reach their full potential (2).

Using humanistic and existential therapies

Many aspects of humanistic and existential approaches (including empathy, encouragement of affect, reflective listening, and acceptance of the client's

subjective experience) can be useful in any type of brief therapy. They help establish rapport and provide grounds for meaningful engagement with all aspects of the treatment process (2).

Humanistic and existential approaches can be used at all stages of recovery in creating a foundation of respect for clients and mutual acceptance of the significance of their experiences (2). There are, however, some therapeutic moments that lend themselves more readily to one or more specific approaches.

- Client-centered therapy can be used immediately to establish rapport and to clarify issues throughout the session (2).
- Existential therapy may be used most effectively when a client has access to emotional experiences or when obstacles must be overcome to facilitate a client's entry into or continuation of recovery (e.g., to get someone who insists on remaining helpless to accept responsibility for her actions) (2).
- Narrative therapy can be used to help the client conceptualize treatment as an opportunity to assume authorship and begin a "new chapter" in life (2).
- Gestalt approaches can be used throughout therapy to facilitate a genuine encounter with the therapist and the client's own experience (2).
- Transpersonal therapy can enhance spiritual development by focusing on the intangible aspects of human experience and awareness of unrealized spiritual capacity (2).

Using a humanistic or existential therapy framework, the therapist can offer episodic treatment, with a treatment plan that focuses on the client's tasks and experiences between sessions (2).

For many clients, momentary circumstances and other problems surrounding substance abuse may seem more pressing than notions of integration, spirituality, and existential growth, which may be too remote from their immediate situation to be effective. In such instances, humanistic and existential approaches can help clients focus on the fact that they do indeed make decisions about substance abuse and are responsible for their own recovery (2).

Psychodynamic Therapies

Psychodynamic therapy focuses on unconscious processes as they are manifested in the client's present behavior. The goals of psychodynamic therapy are client self-awareness and understanding of the past's influence on present behavior. In its brief form, a psychodynamic approach enables the client to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest themselves in the need and/or desire to abuse substances.

Several of the brief forms of psychodynamic therapy are less appropriate for use with persons with substance abuse disorders, partly because their altered perceptions make it difficult to achieve insight and problem resolution. However, many psychodynamic therapists use forms of brief psychodynamic therapy with substance-abusing clients in conjunction with traditional substance abuse treatment programs or as the sole therapy for clients with coexisting disorders (2).

Although there is some disagreement in the details, psychodynamic brief therapy is generally thought more suitable for (2):

- Those who have coexisting psychopathology with their substance abuse disorder
- Those who do not need or who have completed inpatient hospitalization or detoxification
- Those whose recovery is stable
- Those who do not have organic brain damage or other limitations to their mental capacity

Integrating psychodynamic concepts into substance abuse treatment

Most therapists agree that people with substance abuse disorders comprise a special population, one that often requires more than one approach if treatment is to be successful. Therapists whose orientations are not necessarily psychodynamic may still find these techniques and approaches useful, and therapists whose approaches are psychodynamic may be more effective if they conduct psychotherapy in a way that complements the full range of services for clients with substance abuse disorders (2).

Family Therapy

For many individuals with substance abuse disorders, interactions with their family of origin, as well as their current family, set the patterns and dynamics for their problems with substances. Furthermore, family member interactions with the substance abuser can either perpetuate and aggravate the problem or substantially assist in resolving it. Family therapy is particularly appropriate when the client exhibits signs that his substance abuse is strongly influenced by family members' behaviors or communications with them (2).

Family involvement is often critical to success in treating many substance abuse disorders--most obviously in cases where the family is part of the problem (2).

Family therapy can be used to

- Focus on the expectation of change within the family (which may involve multiple adjustments)
- Test new patterns of behavior
- Teach how a family system works--how the family supports symptoms and maintains needed roles
- Elicit the strengths of every family member
- Explore the meaning of the substance abuse disorder within the family

Appropriateness of brief family therapy

Long-term family therapy is not usually necessary for the treatment of substance abuse disorders. While family therapy may be very helpful in the initial stages of treatment, it is often easier to continue to help an individual work within the family system through subsequent individual therapy (2).

Short-term family therapy is an option that could be used in the following circumstances (2):

- When resolving a specific problem in the family and working toward a solution
- When the therapeutic goals do not require in-depth, multigenerational family history, but rather a focus on present interactions
- When the family as a whole can benefit from teaching and communication to better understand some aspect of the substance abuse disorder

Definitions of "family"

Family therapy can involve a network that extends beyond the immediate family, involves only a few members of the family system, or even deals with several families at once (2). The definition of "family" varies in different cultures and situations and should be defined by the client.

Therapists can "create" a family by drawing on the client's network of significant contacts (2). A more important question than whether the client is living with a family is, "Can the client's problem be seen as having a relational (involving two or more people) component?"

Using brief family therapies

In order to promote change successfully within a family system, the therapist will need the family's permission to enter the family space and share their closely held confidences. The therapy, however, will work best if it varies according to the cultural background of the family (1).

Most family therapy is conducted on a short-term basis. Sessions are typically 90 minutes to 2 hours in length. The preferred timeline for family therapy is not more than 2 sessions per week (except in residential settings), to allow time to practice new behaviors and experience change. Therapy may consist of as few as 6 or as many as 10 sessions, depending on the purpose and goals of the intervention.

Group Therapy

Group psychotherapy is one of the most common modalities for treatment of substance abuse disorders. Group therapy is defined as a meeting of two or more people for a common therapeutic purpose or to achieve a common goal. It differs from family therapy in that the therapist creates open- and closed-ended groups of people previously unknown to each other.

Appropriateness of group therapy

Group psychotherapy can be extremely beneficial to individuals with substance abuse problems (2). It gives them the opportunity to see the progression of abuse and dependency in themselves and others; it also provides an opportunity to experience personal success and the success of other group members in an atmosphere of support and hope.

Use of psychodrama techniques in a group setting

Psychodrama has long been effectively used with substance-abusing clients in a group setting. Psychodrama can be used with different models of group therapy. It offers persons with substance abuse disorders an opportunity to better understand past and present experiences--and how past experiences influence their present lives (2).

Using time-limited group therapy

The focus of time-limited therapeutic groups varies a great deal according to the model chosen by the therapist. Yet some generalizations can be made about several dimensions of the manner in which brief group therapy is implemented.

Client preparation is particularly important in any time-limited group experience. Clients should be thoroughly assessed before their entry into a group for therapy (2). Group participants should be given a thorough explanation of group expectations.

The preferred timeline for time-limited group therapy is not more than 2 sessions per week (except in the residential settings), with as few as 6 sessions in all, or as many as 12, depending on the purpose and goals of the group.

Sessions are typically 1 1/2 to 2 hours in length. Residential programs usually have more frequent sessions.

Group process therapy is most effective if participants have had time to find their roles in a group, to "act" these roles, and to learn from them. The group needs time to define its identity, develop cohesion, and become a safe environment in which there is enough trust for participants to reveal themselves (2).

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations are based on a combination of clinical experience and research-based evidence.

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Lower delivery costs
- Increased timeliness and access to substance abuse treatment
- Decreased substance use

- Improved treatment engagement and compliance
- Reduced risk of harm that may result from continued use of substances
- Brevity of treatment
- Temporary treatment for clients on waiting lists for treatment programs

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The types of therapy presented in this guideline have been selected for a variety of reasons, but by no means do they represent a comprehensive list of therapeutic approaches currently in practice. Some of these approaches (e.g., cognitive-behavioral therapy) are supported by extensive research; others (e.g., existential therapy) have not been, and perhaps cannot be, tested in as rigorous a manner.
- Throughout this Treatment Improvement Protocol, the term "substance abuse" has been used in a general sense to cover both substance abuse disorders and substance dependence disorders (as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition [DSM-IV]). Because the term "substance abuse" is commonly used by substance abuse treatment professionals to describe any excessive use of addictive substances, it will be used to denote both substance dependence and substance abuse. The term includes the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine the meaning; in most cases, the term will refer to all varieties of substance abuse disorders as described by DSM-IV.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Treatment Improvement Protocols are distributed to facilities and individuals across the country.

The original Treatment Improvement Protocol document includes resources to help providers implement the recommendations in the Treatment Improvement Protocol.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Treatment Improvement Protocol Series 34 Consensus Panel. Brief interventions and brief therapies for substance abuse. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1999. (Treatment improvement protocol (TIP) series; no. 34). [583 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999

GUIDELINE DEVELOPER(S)

Substance Abuse and Mental Health Services Administration (U.S.) - Federal Government Agency [U.S.]

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

Treatment Improvement Protocol (TIP) Series 34 Consensus Panel

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [National Library of Medicine Health Services/Technology Assessment Text \(HSTAT\) Web site](#).

Print copies: Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Publications may be ordered from [NCADI's Web site](#) or by calling (800) 729-6686 (United States only).

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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