Foundations of Evidence-Based Practice

How did the field of Adolescent Substance Abuse Treatment begin?

According to the Monitoring the Future Study, adolescent drug use started increasing in the early 1990s, while perceived harm and risk from drug use declined.[1] Adolescents also were using drugs at earlier ages than in years past, causing a myriad of public health problems such as injuries, behavioral and mental disorders, and sexually transmitted diseases.[1,2] Because adolescents are fundamentally different from adults, they often do not benefit from adult treatment approaches.[2] For example, adolescents differ from adults in the developmental issues they are dealing with, the values and beliefs that they hold, and environmental considerations such as school climate and peer influences.[2] The field of adolescent substance abuse treatment began to grow when clinicians and researchers sought to reconcile the gap in services. Highlighted below are Behavior Therapy (BT), Cognitive Behavior Therapy (CBT), and Motivational Interviewing (MI); these are modalities which serve as foundations for many evidence-based practices.

Behavior Therapy - Also known as Behavior Management / Modification

Behavior Therapy's (BT) major tenant is that behavior is learned and, thus, can be unlearned.[3] Therapy reduces or extinguishes maladaptive behaviors by reinforcing desired behaviors with contingency rewards.[4] Reinforcement schedules are set up to increase positive behaviors (i.e., abstinence) and decrease negative behaviors (i.e., substance use).[4] Change occurs by only reinforcing desirable behaviors and ignoring or punishing negative behaviors. This is done with practices such as homework, self-recordings of behaviors between sessions, increasing positive activities, setting up reinforcement schedules for outside of sessions, and extensive praise for progress.[5] In this model, thoughts do not really matter; instead, behavioral contingencies ultimately drive behaviors.

BT has not been approved for adolescent substance abuse treatment as a stand-alone practice. However, Contingency Management (CM), providing rewards for meeting treatment milestones, appears to offer some promising results.[3,4] See Appendix C at the end of this primer for current research articles.

In addition, read The Center for Youth, Family, & Community Partnerships' (CYFCP) fact sheet and April 2008 newsletter devoted to this practice. You can access both at www.uncg.edu/csr/asatp.

Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy (CBT) is a psychotherapeutic approach that emphasizes the connections between how we think, feel, and behave.[6] The "cognitive" part of CBT involves examining the automatic, irrational, and maladaptive thoughts related to a particular person or problem.[6] In the case of substance use, CBT would examine thought patterns during, before, and after the use of any substance.[7] A person may have recurring automatic thoughts that cause them to seek out substances. The clinician using cognitive-behavioral therapy would help the person identify these thoughts and realize the connection they have to the resulting behaviors.[7] The person is then taught other coping behaviors to use instead of substance use.[8] The person also is taught that the automatic thoughts and beliefs are not necessarily true and are akin to hypotheses that need to be tested.[8] The "behavior" part of CBT involves examining what behaviors occur before, during, and after the use of any substance that result from the underlying irrational beliefs.[7] This examination is sometimes called a functional analysis and can help a person identify and cope with triggers.[7]

CBT strategies include skills training using role plays, behavioral modeling, practice exercises, realistic goal setting, and reward contingencies (i.e., reinforcement).[6,7,9] Another technique involves documenting automatic thoughts to become more aware of patterns of thinking.[8] In this sense, CBT views substance use as a learned behavior that can be unlearned through the development and use of new skills, more adaptive thinking processes, and a change in reinforcement patterns.[6,7,9]

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Motivational Interviewing

Motivational Interviewing (MI) is a client-centered, directed method that providers can integrate into any therapeutic process.[10] Some use MI as a stand-alone approach while others incorporate it into other approaches. The goal is to enhance a person's internal motivation for change.

The basic MI principles include:[10]

1) Expressing empathy—demonstrating an understanding of the client's perspective;
2) Developing discrepancy—exploring the difference between where clients currently are and where they want to be;
3) Rolling with resistance—accepting a reluctance to change as a normal occurrence; and
4) Supporting self-efficacy—embracing client autonomy and helping them develop confidence in their ability to change.

Another important consideration in MI is The Stages of Change Model developed by Prochaska & DiClemente in 1982.[11,12] The stages are as follows:

Pre-contemplation: Adolescents in this stage typically do not recognize that they have a problem and do not see any reason to change. Adolescents seemingly are unaware of the consequences of their behavior and do not typically respond well when other people try to talk to them about the problem. Because there is no intention for change, change is not likely at this stage. Individuals at this stage are typically referred by others to treatment (rather than self-referred).

Contemplation: Ambivalence is the hallmark of this stage, with adolescents typically thinking about making changes, but not sure they are currently able to do so. These adolescents are able to see the pros and cons of their behavior, but may not be ready to move towards change as the pros tend to weigh more heavily in their decisions.

Preparation: Adolescents in this stage typically accept the need to change and plan to take action. They see the benefits of changing as outweighing the costs and begin to take small steps toward reaching their ultimate goals. Depending upon the outcomes of these small steps, the risk of relapse back into the contemplation stage is great. Thus, adolescents in this stage should be provided with additional support and encouragement.

Action: Adolescents in this stage typically use a set of identified strategies to directly change their behavior. For the greatest likelihood of relapse prevention and maintenance of positive behavioral changes, clients should be in the action phase for at least six months.

Maintenance: Adolescents in this stage continually work toward strengthening the positive outcomes of the action stage and minimizing the risk for relapse. Adolescents spend different amounts of time in this stage (depending on the presenting issue) with some remaining in this stage for life.

Adolescents can begin anywhere within these stages, and thus, clinicians are encouraged to work with them where they are.[11,12] Clients in the pre-contemplation and contemplation stages may benefit from more consciousness-raising and environmental reevaluation techniques.[11,12] Self-evaluation may be beneficial for clients in the preparation stage.[11,12] Some techniques for clients in the action and maintenance phases include self-liberation and contingency management.[11,12]

See Appendix C at the end of this primer for more current research articles on the use of MI as a brief intervention for adolescent substance abuse and the stages of change model.

REFERENCES

1. Johnston, L.D., O'Malley, P.M., & Bachman, J.G. (2001). *The Monitoring the Future national survey results on adolescent drug use: Overview of key findings, 2000* (NIH Publication No. 01-4923). Rockville, MD: National Institute on Drug Abuse.

2. Winters, K.C. (1999). *Treatment of adolescents with substance use disorders: Treatment Improvement Protocol (TIP) series 32* (DHHS. Publication No. (SMA) 99-3283). Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).

3. Higgins, S., & Petry, N. (1999). Contingency management: incentives for sobriety. *Alcohol Research & Health, 23*(2), 122-127.

4. Petry, N. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. *Drug and Alcohol Dependence, 58*, 9-25.

5. Onken, L.S., Blaine, J.D., & Boren, J.J. (1993). *Behavioral treatments for drug abuse and dependence.* Rockville, MD: National Institute on Drug Abuse. http://www.nida.nih.gov/pdf/monographs/137.pdf

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6. Waldron, H.B., & Kaminer, Y. (2004). On the learning curve: The emerging evidence supportive cognitive-behavioral therapies for adolescent substance abuse. *Addiction, 99*, 93-105.

7. Carroll, K.M. (1998). *Therapy manuals for drug addiction. A cognitive-behavioral approach: Treating cocaine addiction*. (NIH Publication Number 98-4308). Rockville, MD: National Institute on Drug Abuse (NIDA). http://www.drugabuse.gov/pdf/CBT.pdf

8. Warman, D.M., & Beck. (2003). *About treatments & supports: Cognitive-behavioral therapy*. Retrieved July 21, 2008 from http://www.nami.org/Template.cfm?Section=About_Treatments_and_Supports&template=/ContentManagement/ContentDisplay.cfm&ContentID=7952

9. Kadden, R., Carroll, K., Donovan, D., Cooney, N., Monti, P., Abrams, D., et al. (1995). *Cognitive behavioral coping skills therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence.* (NIH Publication No. 94-3724). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism (NIAA). http://pubs.niaaa.nih.gov/publications/MATCHSeries3/Project%20MATCH%20Vol_3.pdf

10. Rollnick, S., & Miller, W.R. (n.d.). *What is MI?* Retrieved July 20, 2008 from http://www.motivationalinterview.org/clinical/whatismi.html.

11. Prochaska, J.O. & DiClemente, C.C. (1982). Transtheorical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, & Practice, 19*, 276-288.

12. Prochaska, J.O., & Prochaska, J.M. (1999). Why don't continents move? Why don't people change? *Journal of Psychotherapy Integration, 9*, 83-102.

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