Chapter 15
Evidence-Based Practice in Psychotherapy for Substance Use Disorders

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Introduction

The evidence-based practice is based on the premise that the conduct of the health professional must be based on data from scientific research; that is, it refers to the use of empirical data supporting any procedure targeting patient care. However, for a long time the practice in the healthcare area, even in medicine, was based on intuition, knowledge coming from books, and non-systematized professional experiences (Melnik & Atallah, 2011). It was only in the 1990s that the evidence-based practice movement started in medicine (Leonardi, 2017; Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013).

Currently, there is a worldwide demand for evidence-based practices in various healthcare expertise areas (Melnik, Souza, & Carvalho, 2014). In the area of psychology, the presence of practice with this nomenclature began in 2005, when the American Psychological Association (APA) gathered a group of scientists and clinical psychologists and created the Task Force on the Evidence-Based Practice in Psychology (EBPP) (Melnik & Atallah, 2011).

The EBPP can be considered as an approach to clinical decision-making that integrates the best available research evidence, clinical expertise, and patient preferences and characteristics to support the line of care that will be adopted in a given case (Leonardi, 2017; Melnik et al., 2014; Melnik & Atallah, 2011). Thus, the aim of APA is that psychologists, at all stages of clinical management, take into account

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their technical skills, empirical evidence, the characteristics and preferences of the client, and also the context in which the care will be provided, enabling the access to the best possible intervention.

The importance of EBPP is not restricted to the treatment of psychopathologies. Issues related to case evaluation and formulation, therapeutic relationship, psychodiagnosis, mental health prevention, and relapse prevention are also research topics and are areas of interest to EBPP, contributing to effective mental and public health through empirically based principles (Melnik et al., 2014). Such principles apply to various fields of psychology, such as clinical, hospital, health, institutional, among others (Melnik & Atallah, 2011). Ignoring the evidence derived from quality research may result in harm to individuals and the population or lead to unnecessary waste of resources (Atallah & Puga, 2011).

However, EBPP requires the psychology professional to be updated, since he or she needs to be informed constantly about the results of mental health research. Systematic reviews (SR) and meta-analyses stand out in this context as a valuable tool, as they are a research method that condenses into a secondary study a series of primary studies on a given subject. Thus, clinicians can use SR and meta-analysis to keep themselves informed in certain areas of mental health (Atallah & Puga, 2011; Melnik & Atallah, 2011; Riera, 2011).

Systematic reviews and meta-analyses in psychology can be found in the Cochrane Library. This is a worldwide research network who form a non-governmental non-profit organization, with more than 50 groups that produce, maintain, and disseminate research in SR. Thus, therapeutic and preventive decisions for mental health care can be made using the best available source of scientific evidence, according to the topic of interest (Atallah & Puga, 2011).

In addition, Division 12 of the APA has created a committee and a website where the main effective treatments for certain psychiatric and psychological disorders are described. The site provides basic descriptions of the diagnosis and treatment targeting a broad audience, consisting of professionals working in the field, students, researchers, and lay audience (http://www.psychologicaltreatments.org).

There are several levels of quality of evidence that underpin evidence-based practice. SR and meta-analysis are considered the Level I evidence, in terms of reliability and precision to support therapeutic conducts. When a SR is not yet available on a given topic, lower levels of evidence quality should be used (Atallah & Puga, 2011; Melnik et al., 2014; Riera, 2011).

Level II evidence is the large randomized clinical trial, conducted with more than a thousand clients, and with a blinded outcome evaluator. The next level of evidence, Level III, should be the one that underlies the practice when there is not yet a large clinical trial. This is the medium or small randomized clinical trial, with statistically significant clinical results, conducted with less than a thousand patients. Below this level of evidence is the prospective cohort study (level IV), in which there is no randomization. One group receives treatment A and the other treatment B, and the results of the two groups are compared (Melnik et al., 2014).

Level V evidence aims to support professional practice when even Level IV is not yet available. In this case, information is based on case studies and controls. An

even lower level of evidence (VI) is the case series. Finally, the lowest level of evidence to support the practice of health professionals is the case report (VII). When no evidence is available (levels I to VII), expert opinion or consensus among experts should be adopted (Melnik et al., 2014; Melnik & Atallah, 2011).

Here it is necessary to highlight something that has already been highlighted before: EBPP relies on three elements. In addition to the evidence coming from research, the professional must consider his clinical expertise and the characteristics and preferences of the client (and context) to support his practice. The relevance of the second element, clinical expertise, is because the psychology daily practice involves clinical judgments, assessing costs and benefits, and making decisions that will require the incorporation of experience to the practice, since the research data cannot dictate every step taken by the professional in a care session with his client (Lilienfeld et al., 2013).

Furthermore, in addition to the updating research that shows the effectiveness of evaluation protocols, treatment, prevention, and clinical expertise, the psychologist should consider the compliance of the patient to the intervention. Clinical decision-making should be carried out in collaboration with the patient (Lilienfeld et al., 2013; Melnik et al., 2014). The intervention that has proven to be effective and efficient, with internal and external validity, must also work in the real-world conditions of the client.

Some authors, such as Thyer and Pignotti (2011), for example, argue that EBPP should give equal importance to these three elements in clinical decision-making. Other authors, however, believe that scientific data are the primary element of EBPP, as Lilienfeld et al. (2013). These authors argue that not prioritizing empirical data is a problem, as many psychologists continue to place greater weight on their intuition than on evidence-based research when making decisions about the care of their clients.

In a study on the attitudes of clinical psychologists toward EBPP, Lilienfeld et al. (2013) drew attention to the fact that the resistance of these professionals to EBPP is still high, making an investigation about the main reasons for this. Some of the reasons cited were the fact that many professionals graduated in a pre-EBPP era; and the statistical complexity of several studies about the effectiveness of the interventions, making it difficult to understand these studies.

In order to reduce the opposition of psychology professionals to EBPP, Melnik et al. (2014) stressed the need to invest in the knowledge of psychology and mental health students in order to avoid the spread of misconceptions about the nature of EBPP, favoring the interaction and knowledge exchange between research-oriented psychologists and clinical practice-oriented psychologists. The authors also talk about the important role of professional organizations in disseminating knowledge about EBPP and in spreading the latest information about the best practices available, through materials that are simple and didactic, with guidelines for clinical practice.

In the Brazilian context, some ventures have been undertaken in this direction. The first work to contribute to the dissemination of EBPP began in 2011 and needs to be highlighted. It is the book by Tamara Melnik and Álvaro Nagib Atallah,

entitled “Evidence-Based Psychology: Scientific Evidence on the Effectiveness of Psychotherapy,” which covers current evidence on the treatment effectiveness of various psychiatric disorders.

Other initiatives undertaken in the Brazilian context deserve to be mentioned. The first course in Brazil on EBPP took place at the University of São Paulo by Tamara Melnik and Sonia Beatriz Meyer, in 2013. The first Symposium on EBPP articulation between practice and research occurred at the University of São Paulo, organized by Tamara Melnik, Maria Imaculada Sampaio, and Gabriela Silva (Melnik et al., 2014).

Evidence-Based Psychotherapy and the Treatment of Substance-Related Disorder

The search for empirical demonstration of the effect of psychotherapy began after the publication of Eysenck (1952) stating that *no modality of psychotherapeutic intervention was more effective than the mere passage of time* (Leonardi & Meyer, 2015, p. 1141). In this study, the author conducted a survey of reports on the improvement of neurotic patients with and without the use of psychotherapy; and the comparative results, according to him, did not support the hypothesis that psychotherapy was the factor that facilitated recovery (Eysenck, 1952). This questioning of the efficacy of psychotherapy in the context of mental health encouraged clinical research, especially randomized clinical trials, focusing on the evaluation of the results of interventions.

On this topic, several studies have been conducted and published mainly from 1975 onward. The results, unlike the findings of Eysenck (1952), pointed to the beneficial effects of the practice of psychotherapy, regardless of the approach used. In his thesis, the improvement would be due to the so-called common factors, which include the characteristics of the therapist (such as empathic listening) and of the patient (such as motivation for treatment) and the therapeutic relationship, present in all approaches (Cuijpers, Reijnders, & Huibers, 2019; DeRubeis, Brotman, & Gibbons, 2005; Leonardi & Meyer, 2015). On the other hand, some researchers proposed that the evolution of the patient during treatment was due to the theories and techniques characteristic of each approach, and then conducted research to prove their antithesis named “specific factors” (Leonardi & Meyer, 2015). After years of criticism and studies confirming both the common factors thesis and the specific factors antithesis, a synthesis of both arguments began to be discussed in 2000, indicating that certain approaches are more effective than others for specific clinical problems (DeRubeis et al., 2005; Leonardi & Meyer, 2015). Thus, in 2005, APA validated the three elements that make up EBPP aforementioned: clinical expertise, research evidence, and client characteristics, which include both common and specific factors.

Considering substance use disorder (SUD) as a specific clinical problem, several studies on the implementation of evidence-based interventions have been conducted, ranging from brief interventions to psychosocial and behavioral treatments with medium and long-term follow-ups (Ducharme, Chandler, & Harris, 2016; Finney & Hagedorn, 2011; Garner, 2009; Louie, Barrett, Baillie, Haber, & Morley, 2020). As already mentioned, the review studies, mainly the systematic reviews, are considered as quality evidences that support the EBPP, being, therefore, the base for discussing the topic of this chapter. In general, there is consensus that evidence-based psychotherapy interventions for SUD include cognitive-behavioral therapy with relapse prevention, behavior therapy for couples, contingency management, and motivational interview (Manuel, Hagedorn, & Finney, 2011; Pechansky & Baldisserotto, 2014). Counseling and 12-step therapy, although not considered by all authors to be an EBPP, are widely used by SUD experts, as well as brief intervention (Manuel et al., 2011), for which efficacy and effectiveness studies are still recommended.

A systematic review of North American studies on the diffusion of evidence-based psychotherapy for substance abuse treatment identified 65 studies and classified them into three categories: (a) attitudes regarding evidence-based psychotherapy, including studies on beliefs or attitudes about the effectiveness or use of such practices; (b) adoption of evidence-based psychotherapy, including studies that examined the extent to which professionals reported adopting specific practices; and (c) implementation of evidence-based psychotherapy, including studies that evaluated the implementation of such practices. Results for psychotherapy indicated that 93% of respondents indicated that cognitive-behavioral therapy with relapse prevention should be recommended and that clinical therapists were more motivated to adopt 12-step therapy, cognitive-behavioral therapy, motivational interviewing, and relapse prevention than contingency management, behavior therapy for couples, or pharmacotherapy (more details can be found in the Garner review of 2009). In addition, 100% of clinicians stated that treatment manuals provide structure and consistency to therapeutic work, but 42% also indicated that the manuals could hinder the ability to respond to the individual patient needs.

Regarding the brief intervention for alcohol abuse, several studies already pointed out positive results. A review study that evaluated eight different programs conducted in several countries that implemented screening and brief intervention in primary care found both types of intervention to be effective in reducing harmful alcohol use (Williams et al., 2011). In the same direction, in the systematic review of Jonas et al. (2012), after analyzing results from several randomized clinical trials, the authors recommended that general practitioners should conduct adult screening on alcohol consumption and provide behavioral counseling to those who are positive for harmful use. On the other hand, when it comes to the chronic use of other drugs, in which relapse is frequent, there is a consensus that more extensive and multimodal treatments and even hospitalizations should be used approaches. In these cases, group therapies (including self-help) are indicated associated with individual, family, and/or couple therapies, as well as the use of pharmacological

treatment when necessary, all with a focus on constant monitoring (Finney & Hagedorn, 2011).

Regarding factors associated with higher treatment success rates for SUD, a review of 21 studies that applied psychosocial or behavioral interventions identified some strong points that deserve highlighting. The first was the implementation of some type of didactic training for therapists, which, according to the authors, should occur in continuously and not occasionally, as a supervision or discussion space with other specialists. The second was the use of motivational approaches, such as motivational interview and contingency management, revealing that besides the expertise of the therapist, the motivation of the client is a fundamental aspect. The third point is that the intervention is based mainly on several indicators of success, such as promotion of support and motivation, with structure and goals defined and adapted to the patient context than on specific approaches. Such factors increase the chances of the patient engaging in new pleasant and rewarding activities and promote the development of coping skills and a sense of self-efficacy (Manuel et al., 2011). The strengths highlighted are in line with the EBPP tripod previously described in this work.

Analyzing the characteristics of these interventions performed in the United States and those recommended by the EBPP, Finney and Hagedorn (2011) warned that especially regarding SUD, besides the characteristics of the professional and patient, and the evidence of research, the context (hospital, clinic, outpatient, therapeutic community) in which the intervention is implemented should be considered. In addition, they emphasized that the greatest challenge is to adapt the treatment according to the particularities of the patient, given the diversity of patterns and environments of consumption. In the same way, considering the high relapse rates, Ducharme et al. (2016) indicated the evaluation of the sustainability of the intervention, with special attention on whether they meet the demands and restrictions of local settings, such as social vulnerability.

In Brazil, the problematic use of drugs is a public health issue, with a serious impact in terms of social and economic costs. Given the national context, developing public policies based on the evidence of efficiency, effectiveness, and efficacy for the prevention and treatment of psychoactive substance use becomes a major challenge. Concerned with this scenario, Pedroso, Juhásová, and Hamann (2019) conducted a literature review with the objective of analyzing the challenges of adaptation in the dissemination of prevention practices regarding the consumption of alcohol and other drugs evidence-based in Brazil. As results of this review, the authors warned that such practices should be based on scientific evidence and not on ideological, media, or political opinions; should be articulated with all areas of health promotion (prevention and care), as well as with the social reinsertion of the user; and should transpose and adapt the techniques/programs to language, culture, and values, including the vulnerabilities of the "real world." Other recommendations found in this study were the following: (a) evaluating the entire implementation process of programs already developed or under construction, and not just the final result; (b) prioritizing the replication of a previously evaluated program than the implementation of a new one, since the former has already been evaluated and

is more likely effective; and (c) involving professionals voluntarily committed to good practice actions since they tend to be more collaborative. In short, the main recommendation was to remain faithful to the original program (following the manual of what the scientific evidence suggests), but to adapt it according to the context, evaluating each step, and aligning public health policies with those of education and social protection.

Ducharme et al. (2016) pointed out that those international agencies that promote drug research, such as the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), have been investing in discovering ways to improve the treatment for SUD in both primary care and general hospitals. As the study of Pedroso et al. (2019), they focused on adapting the treatment protocol to the local context and individual characteristics of the user as an essential approach to ensure the continuous adjustment of the practice to its local conditions. They also recommended interventions focusing on joint decision-making between professionals, patients, and family members, which is congruent with humanization policies, since the patient preferences are a critical component for the acceptance of the intervention.

Thus, in the area of drug abuse, working under the premises of EBPP is not an easy task. A systematic review identified 32 guidelines on SUD for adolescents, but only nine were considered high quality and evidence-based recommendations, and of these, only four had direct recommendations specific to teenagers (Bekkering et al., 2014). Targeting adult treatment, Damschroder and Hagedorn (2011), in their guide for implementing evidence-based practices for TUS treatment, stated that three objectives should be met: (1) to differentiate essential and adaptive components of the intervention; (2) to develop and apply techniques and strategies that can be adapted and extrapolated for use in different contexts; and 3) to develop strategies for evaluating the intervention considering its sustainability in different contexts. The orientations of the guide are in line with the conclusions and indications of the authors of the described systematic reviews.

Next, a clinical case will be presented illustrating an EBPP approach in which the three elements of a good practice are integrated in the conduct of the case: the empirical evidence, the expertise of the professional, and the characteristics of the client.

Clinical Case

The clinical case reported was attended by a psychotherapist from the Center for Research, Intervention and Evaluation in Alcohol and Other Drugs (CREPEIA), of the Department of Psychology of the Federal University of Juiz de Fora (Brazil), which offers free care to alcohol-dependent patients. The treatment is based on a protocol presented in the Cognitive-Behavioral Coping Skills Therapy Manual of the Project Match (1995), which reproduces the procedures used in the Matching

Alcoholism Treatments to Client Heterogeneity (Project MATCH) of the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

The Project Match was a multi-center clinical trial, conducted only in the United States, based on the concept of "treatment matching," which may be regarded as targeting different treatment approaches according to the particular patient needs and characteristics (Gumier & Sartes, 2015). In order to test the hypothesis that treatment focused on the individual needs of each patient could bring better results compared to the treatment of all the patients with the same diagnosis in the same way (Kadden et al., 1995). The Project Match compared the results of the cognitive-behavioral coping skills therapy with the motivational interview and the 12-step facilitation therapy. For this purpose, the protocol was translated and adapted, and its effectiveness was tested for the Brazilian context and for online care (Gumier, 2019; Gumier & Sartes, 2015).

It is important to mention that, since it is a free service offered in a university context, the population attended at the Center presented moderate to severe alcohol dependency. They were referred from other local health and social services, and had a number of other social vulnerabilities that needed to be considered and adapted in the protocol for a good evidence-based practice. Although the used protocol clearly suggested the interventions to be performed in each session, many times the psychotherapist and supervisor needed to adapt the sessions to the time and need of the patient and according to the perception and experience of the therapist, as suggested by the evidence-based practice.

Patient Marcos (fictitious name), 51 years old, Incomplete Elementary School, sought psychotherapeutic care to treat his problems with the alcohol use. Marcos was divorced twice due to problems related to his alcohol consumption and, during the period of the care, lived alone. The patient had recently undergone surgery and, due to this, it was necessary for him to remain abstinent while hospitalized. During this period, he presented several abstinence symptoms such as irritability, sleep disorders, and hallucinations. Therefore, by resorting to psychotherapy, Marcos was already abstinent for 20 days and his goal was to maintain this consumption pattern.

In adapting the Project Match to the Brazilian population, two evaluation sessions were held, one for applying questionnaires and the other for returning the results. In the evaluation, the patient reported that in the period prior to abstinence he consumed alcohol on a daily basis, during the whole day, which did not allow him to be clear about the number of doses ingested per day. However, he informed the therapist that he consumed, on average, six liters of *cachaça* per week. Besides the consumption in small doses during the day, the patient met with friends regularly only to drink. No psychiatric comorbidity was found and he did not consume other substances.

The adaptation of the protocol for Brazil included motivational elements that needed to be carried out in the devolution session according to the level of motivation of the patient. In most protocols of cognitive-behavioral therapy for substance abuse, such as this one of the Project Match, it is recommended that the patient will benefit more from the treatment if he/she is in an advanced stage of motivation to change his/her drinking behavior, as in "Preparation or Action" (Prochaska &

DiClemente, 1982). However, Marcos, as well as most of the patients of this project, was in the Contemplation Stage according to the University of Rhode Island Change Assessment Scale (URICA). Although the patient had already sought treatment, which might suggest that he was in the Action Stage, he was still ambivalent about being completely abstinent, due to the relationship with friends and the pleasure that the substance brought, and based his motivation on the abstinence symptoms experienced after the surgery and on previous relationship problems. The inclusion of the motivational elements already in the devolution session was a way to include the patients who arrived mostly in the Contemplation Stage. In other words, we tried to make an adaptation according to the necessities of the patients.

The psychotherapy protocol consisted of 12 sessions of which the first seven were of fixed content and the last four of variable content. The standard content sessions were structured in the following sequence: setting goals to be achieved; psychoeducation on alcohol dependence; recognition of risk situations and protective factors; discussion of the pros and cons of quitting drinking; training in alcohol coping skills and problem solving; and self-control tasks of alcohol use and the thoughts and feelings involved in these situations. According to the life history report and self-monitoring of Marcos, the greatest risk factor associated with alcohol consumption were situations that aroused feelings of sadness and anger. Therefore, most of the time, Marcos used alcohol as a strategy to deal with negative feelings, which made it difficult to find solutions to his problems. Other identified risk factors were related to the context of social interaction, the need for disinhibition and relaxation. In contrast, the patient presented important protective factors, such as high motivation for psychotherapy, solid family support network, good cognitive capacity, and high adherence to treatment and proposed activities.

The last four sessions of the protocol were chosen from 14 sessions with varied topics, according to the needs of the patient. This way of performing the protocol meets the evidence-based practice in which the expertise of the therapist and the specificities of the patient are taken into account. In the case of Marcos, the topics "Managing of Anger," "Managing Negative Thinking," "Increasing Pleasant Activities," and "Enhancing Social Support Network" were chosen collaboratively. The first two themes were chosen because of the highest risk factor for this patient were situations that resulted in these feelings. The session "Increasing Pleasant Activities" was selected because, since alcohol consumption was the only activity that generated pleasure before abstinence, after the cessation of its ingestion Marcos saw his life in a boring way, which often resulted in episodes of cracking. Finally, the session "Enhancing the Social Support Network" was picked because the patient and the therapist realized that besides the family, his closest social support network was composed only of people who also consumed alcohol, which frequently put him at risk.

At the end of the therapeutic process, Marcos remained abstinent, without episodes of lapse and/or relapse, and pointed out that the treatment was essential to maintain his abstinence. He reported that he had previously tried to stop consumption, without success, because he did not have the tools that the therapy provided. He pointed out as main interventions the substitution of alcohol consumption by

other pleasurable activities, identification of risk situations and avoidance strategies, distraction techniques, and anger and negative thoughts management. In addition, the therapist identified as crucial for a good psychotherapeutic result the patient involvement in the process. On several occasions, Marcos reported remembering the sessions and techniques during the craving episodes, which resulted in a progressive decrease in both their frequency and intensity. Moreover, the patient performed all the activities and tasks proposed, without demonstrating difficulty or discomfort. Both patient and therapist identified the therapeutic relationship as a very important factor in the process of changing alcohol consumption.

Final Considerations

This chapter systematized studies of EBPP evaluation among people with SUD, concluding that cognitive-behavioral therapy with relapse prevention, behavior therapy for couples, contingency management, and motivational interview are successful practices in the treatment of this problem. This chapter showed that, for the treatment of this type of disorder, besides the type of intervention, aspects such as context, drug of choice, and pattern of consumption needed to be considered when designing an individualized treatment plan. In a complementary manner, this chapter reported a clinical case in which a program already consolidated in the United States was adapted for the treatment of alcohol use disorders, presenting its application in the Brazilian context.

Despite the criticism about the evidence-based practice in psychology, mainly related to the standardization or manualization of certain interventions, such practice has been increasingly widespread among professionals in this area. Considering that in the very definition of EBPP the preferences and profile of the patient must be prioritized in the evaluation for the choice of intervention, any protocol that presents evidence of efficacy and effectiveness must be adapted to the characteristics of the patient and to the social, economic, and cultural context in which he/she is inserted. Thus, it is expected that this chapter will encourage more psychologists who work in the field of drug use/abuse to base their practices on evidence-based psychology.

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