Psychotherapy with Opioid-Dependent Patients

November 01, 1998
By George E. Woody, MD [1], A. Thomas Mclellan, PhD [2], Lester Luborsky, PhD [3], and Charles P. O'Brien, MD, PhD [4]

Psychotherapy as a sole treatment for noncoerced opioid addicts in outpatient settings has been shown to have little patient interest and low chances for success. However, when integrated into a treatment plan that includes methadone maintenance and drug counseling, it can be associated with additional benefits for patients who have moderate to severe levels of psychiatric symptoms.

Psychotherapy as a sole treatment for noncoerced opioid addicts in outpatient settings has been shown to have little patient interest and low chances for success. However, when integrated into a treatment plan that includes methadone maintenance and drug counseling, it can be associated with additional benefits for patients who have moderate to severe levels of psychiatric symptoms.

The psychotherapy outcome often depends on who administers the therapy, thus making it difficult to separate therapy from therapist effects. The chances for improvement of psychiatric symptoms in opioid addicts during methadone maintenance are often better, however, if psychiatrically trained therapists are used to supplement paraprofessional drug counseling.

Efforts to control medical costs by restricting accessibility to methadone maintenance and reducing the availability of psychotherapy, drug counseling and medical services are inconsistent with the available data on treatment quality. **Background**

Prior to the advent of methadone maintenance in the mid-1960s, effective treatment for heroin addiction was limited to a small number of programs such as the public health hospitals in Lexington and Fort Worth, where patients were confined-often under coercion from the criminal justice system. Voluntary outpatient treatment was ineffective, as demonstrated by Marie Nyswander, M.D., who attempted psychotherapy with heroin addicts and saw little interest and high dropout rates (1958).

Methadone maintenance changed this situation. When administered according to principles outlined by Vincent Dole, M.D., and Nyswander (1965), methadone engaged heroin addicts in outpatient treatment; reduced drug craving, drug use and crime; and improved overall social adjustment. These results were obtained under strict experimental protocols with highly trained staff; patients were selected on the basis of chronic heroin addiction with few serious medical and psychiatric problems. Methadone's success led to a rapid expansion in the number of programs available and, as it moved into the clinical realm, patients with serious medical and psychiatric disorders entered treatment. These new methadone programs were staffed by less experienced individuals, often one or more part-time physicians, a few nurses and social workers and drug counselors. Most of the psychosocial therapy was done by drug counselors who had little formal psychiatric or medical training. Treatment results were not always as good as reported in the early studies by Dole and Nyswander, and this observation resulted in efforts to improve outcome.

One idea that emerged from a series of meetings sponsored by the National Institute on Drug Abuse (NIDA) in the late 1970s was based on the observation that many methadone patients had psychiatric disorders and that these disorders seemed to intensify the course of the addiction. Though treatment for these disorders was usually effective in other populations, the staffing patterns of most methadone programs did not include people with psychiatric training; thus these additional psychiatric problems often were not treated. A criticism of these typical staffing patterns was that treatment of some of the most disturbed people in the public health system had been delegated to persons with the least psychiatric training.

Since combining psychotherapy with pharmacotherapy was usually helpful among nonaddicts, the question emerged: Would psychotherapy improve outcome if it were added to methadone maintenance and drug counseling? NIDA funded two studies in the late 1970s to address this question; these were followed by two related studies in the early 1990s. **The First Two Studies**

**Design:** One study was done at Yale University and the other at the University of Pennsylvania/Veteran's Administration Medical Center (Penn/VA). Each involved random assignment of methadone-maintained heroin addicts to paraprofessional drug counseling alone (DC), or counseling plus psychotherapy.
Interpersonal psychotherapy (IPT) was used at Yale, and Supportive-Expressive (SE) or Cognitive-Behavioral (CB) therapy was used at Penn/VA. Counselors held a bachelor's degree or less. Psychotherapists were psychiatrists or clinical psychologists. Psychotherapy was made available to subjects for six months with follow-ups at 7 and 12 months. Outcome was evaluated by the Addiction Severity Index (ASI), measures of psychiatric symptoms and urine test results. Efforts were made to oversample patients who had psychiatric disorders, such as depression, since they might benefit the most from psychotherapy. Methadone maintenance was continued throughout the study and afterwards; the average dose was 40 mg to 50 mg in each program.

Results: Each study found that most patients had a current or past psychiatric disorder in addition to the heroin addiction, and that all groups improved; however, the psychotherapy results differed. The Yale study found no difference in outcome between counseling and psychotherapy (Rounsaville et al., 1983), while the Penn/VA study found that psychotherapy patients did better (Woody et al., 1983).

The differences in outcome at Penn/VA were mainly among patients with high levels of psychiatric symptoms; psychotherapy was not associated with additional benefits in patients with low levels of psychiatric symptoms (Woody et al., 1984). In the Penn/VA study, patients with antisocial personality disorder (ASPD) and a current or past depressive illness who received psychotherapy improved in several areas as measured by the ASI, including drug use (Woody et al., 1985). Patients with ASPD and no additional psychiatric disorder also improved, but only in drug use. The better outcome associated with psychotherapy was sustained at the 12-month follow-up, six months after psychotherapy ended (Woody et al., 1987).

There were also significant differences in outcome between psychotherapists. One SE therapist was particularly effective; another produced less change than the drug counselors (Luborsky et al., 1985). These differences in outcome were most strongly associated with the patient's evaluation of the "helping relationship," but were also related to the degree to which the psychotherapist was able to comply with the techniques of the manual-guided psychotherapies. Overall, there were no clear advantages for SE as compared to CB.

In trying to understand the differences in results from Penn/VA and Yale, two factors emerged. First, psychotherapy was better accepted by patients at the Penn/VA program because more patients were interested and fewer dropped out. Penn therapists were more integrated into the daily operations of the methadone clinic than at Yale. Their offices were located in the methadone program and they had regular interactions with clinic staff; at Yale, the therapists' offices were in a nearby neighborhood but not in the program. These differences seem small, but they can have a significant impact on compliance and outcome (Umbricht-Schneiter et al., 1994).

The second factor is that the Yale program was run under a powerful contingency-patients were required to attend group therapy and produce "clean" urines within three months of beginning treatment; those who failed were discharged, according to H.D. Kleber (1998). This administrative procedure resulted in little room for finding differences between psychotherapy and counseling due to the combined effect of the contingency in changing behavior and discharge for nonresponsive patients. Two Follow-Up Studies

First Study: For the purpose of comparison, the Penn/VA researchers performed a follow-up study in three community-based methadone programs. Patients with moderate to high levels of psychiatric symptoms were identified as possible candidates since the first study showed that those with low symptom levels had no additional benefit from psychotherapy. In this study, a balanced design, in which patients were assigned to two drug counselors or to a counselor and a psychotherapist, was used. Only SE therapy was used because it had been found equally effective to CB; outcome measures and follow-up points were the same as before.

As in the first Penn/VA study, patients generally improved but here there were no differences between the groups at the 7-month evaluation point, implying that adding the second counselor helped. However, by 12 months the gains seen in the DC group at 7 months diminished and those in the SE group strengthened, so that there were now significant differences, including drug use, all favoring the SE condition (Woody et al., 1995). Here again, there were differences in outcome according to which individual therapists gave the treatment.

Second Study: A study by McLellan et al. (1993) conducted about the same time as the community-based project, built on the findings of the first psychotherapy study, but had different aims. It was developed when questions were being raised about delivering methadone maintenance with few or no psychosocial services (i.e., "minimal methadone"), and its focus was to determine the efficacy of different intensities of psychosocial therapy.
Psychotherapy with Opioid-Dependent Patients
Published on Physicians Practice (http://www.physicianspractice.com)

In this study, addicts who had been stabilized on 60 mg/day of methadone were randomly assigned
to minimal services (MMS, one 10-minute counseling session/month); standard services (SMS, one
30- to 45-minute counseling session/week); or enhanced services (EMS, weekly counseling plus
on-site medical, psychiatric, family-social and employment services). Results showed that there was
a stepwise improvement as services intensified, with 69% of patients in the MMS condition needing
to be "protectively transferred" to SMS due to unremitting opiate or cocaine use, or repeated medical
or psychiatric emergencies. Though not focused on psychotherapy per se, the EMS group contained
elements of psychotherapy and the results clearly showed differences between the MMS condition
and the other two groups.

Psychotherapy 'Effects'

Though differences favoring psychotherapy were found in the two Penn/VA studies, one cannot be
certain that they were due to psychotherapy per se, because there were differences in outcome
according to therapist (Luborsky et al., 1985). This result has been found in psychotherapy studies
with other populations as well; thus, it was not unexpected. However, the fact that therapist
differences exist makes it difficult to separate therapy from therapist effects.

On the other hand, from a practical point of view, the fact that therapist differences occurred
suggests that "active" healing ingredients were associated with psychotherapy, at least in some
cases. Whether these healing ingredients were related to the therapist/patient relationship, to
technique or to some combination made little difference to the patients. However, a better
understanding of the source of these benefits probably would make a difference to those who pay for
substance abuse treatment, a point that is discussed below.

Program Recommendations

Data from the Yale study suggest that additional psychotherapy is not very useful if few patients are
interested and a powerful behavioral contingency program is in operation. However, the Yale and
Penn/VA studies both indicate that participation in psychosocial treatment improves outcome and
that patients with ASPD can benefit in very meaningful ways from methadone maintenance
treatment (Woody et al., 1985; Gerstley et al., 1989).

The Penn/VA studies suggest that psychotherapy can be particularly useful for psychiatrically
symptomatic patients when it is integrated into the ongoing services of methadone programs. This is
not to say that drug counselors with little psychiatric training are unable to help the more
psychiatrically impaired and difficult patients, only that the odds can be improved when these
patients are assigned to therapists with more psychiatric training.

Few or none of the positive results that were seen in all of these studies would have been possible
without methadone. As in the study by Nyswander et al. (1958), very few heroin addicts enroll
voluntarily in outpatient psychotherapy when it is offered as a "stand alone" treatment without
methadone. Thus, these studies combined an effective pharmacotherapy (methadone) with

About Managed Care?

Current efforts to control psychiatric costs through capitation, HMOs and managed health care
appear to use treatment models that are not consistent with research data for heroin addicts. The
focus on brief and inexpensive interventions run counter to the data that addiction treatment,
especially methadone maintenance, is long-term, and that results are best when it is integrated with
appropriate levels of counseling, psychiatric and medical services.

Medical reimbursement plans that include methadone (many do not) seem to compete for contracts
on the basis of costs, which are reduced by cutting back on services. Even without psychotherapy in
the treatment package, many heroin addicts find that it is difficult to become enrolled in a program;
if they succeed, they are lucky to get a good counselor who sees them regularly!

One cannot but wonder if these models truly save money or if they mainly shift the costs of addiction
treatment, and of the psychiatric and medical services that improve outcome, to other parts of the
health care and social service system.

References:

1. Dole VP, Nyswander ME (1965), A medical treatment for diacetylmorphine (heroin) addiction.
   JAMA 193:646-650.
2. Gerstley L, McLellan AT, Alterman AI et al. (1989), Ability to form an alliance with the therapist: a
   possible marker of prognosis for patients with antisocial personality disorder. Am J Psychiatry
   146(4):508-512.
   Gen Psychiatry 42(6):602-611.
4. McLellan AT, Arndt IO, Metzger DS et al. (1993), The effects of psychosocial services in substance

Source URL: http://www.physicianspractice.com/articles/psychotherapy-opioid-dependent-patients

Links: