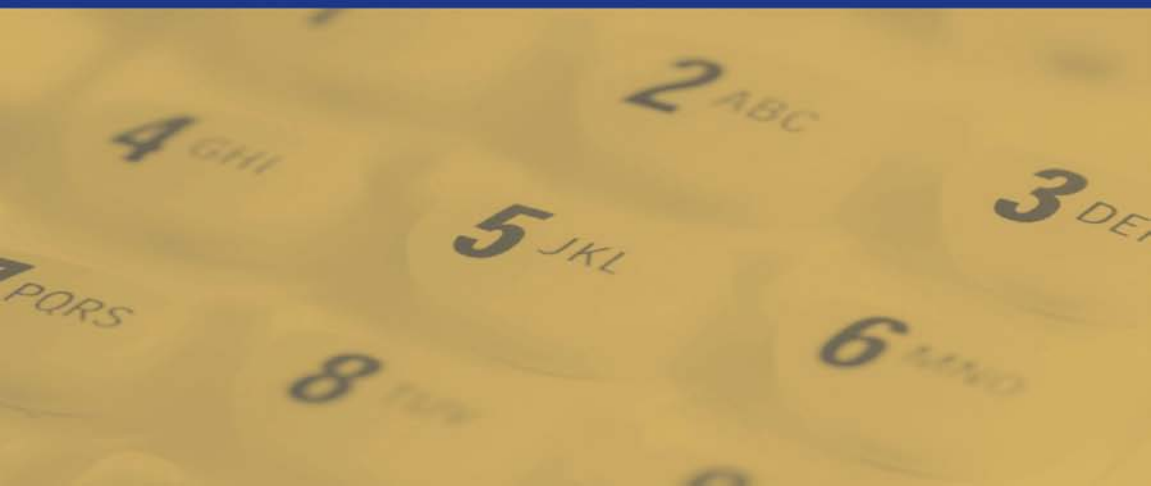




Brief Telephone Continuing Care Therapy for Adolescents

Yifrah Kaminer, M.D., M.B.A. | Chris Napolitano, M.S., L.M.F.T.



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The names, details, and circumstances may have been changed to protect the privacy of those mentioned in this publication.

This publication is not intended as a substitute for the advice of health care professionals.

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Acknowledgments

THE DEVELOPMENT OF THIS MANUAL followed the evolution of theory-driven protocols for the treatment of adult and adolescent alcohol and substance abuse. The adult-based literature includes cognitive behavioral therapy CBT (Monti et al. 1989) and brief motivational interviewing (MI), known also as Motivational Enhancement Therapy (MET) (Kadden et al. 1992), which was developed while considering the influential transtheoretical paradigm of change (Prochaska, DiClemente, and Norcross 1992) and Miller and Rollnick's (2002) seminal work on MI. The adolescent literature included two MET/CBT manuals developed at our Alcohol Research Center at the University of Connecticut Health Center for the multi-center Cannabis Youth Treatment (CYT) study (Sampl and Kadden 2001; Webb et al. 2002).

The authors also wish to graciously acknowledge the following contributors to the development of the first draft of the Brief Individual Aftercare Therapy Algorithm: Dr. James McKay of the University of Pennsylvania and Dr. Susan Sampl of the University of Connecticut Health Center.

Introduction

THIS THERAPY PROGRAM ADDRESSES THE NEED for reliable, brief, and cost-effective aftercare for adolescents with alcohol and other substance use disorders (AOSUD). Its aim is to establish a viable alternative method for delivering high-quality intervention via the brief telephone intervention when significant impediments in distance, weather, transportation, staffing, space, funding, and other resources may limit the delivery of traditional face-to-face therapeutic contact. Nevertheless, the program may also be used in a traditional face-to-face psychotherapy session because the active ingredients are similar. The only difference is that the clinician will have fewer nonverbal cues to help facilitate dialogue.

The telephone as a readily accessible interpersonal medium has a variety of therapeutic uses (Rutter 1987). Its use in crisis intervention (Spirito et al. 2002), advice provision, and after-hours triage is common among adolescents and their caregivers (Baker et al. 1999; Kaminer 1994). According to studies of alcoholic clients who have completed treatment, communication between client and clinician via telephone has played an increasing role in the therapeutic process since the 1960s (Catanzaro and Green 1970; Intagliata 1976; Koumans, Muller, and Miller 1967).

This clinician's manual includes the essential components of the program and specific instructions on how to implement it. These include the models of change and psychotherapy that are integrated into the approach, the goals and objectives, the potential settings that the program might be used in, the types of clients appropriate

for receiving the intervention, the rationale for its use, and the clinical and evaluation/supervision issues.

The manual also includes a clinician's guide that provides step-by-step instructions for each session. Examples of dialogue that a clinician might employ during the course of a session are provided.

Part 1

Essential Ingredients

Chapter 1

The Program at a Glance

THE BRIEF TELEPHONE THERAPY PROGRAM is designed to deliver a treatment regimen of continuing care for adolescents and young adults who have a mild to moderate substance use disorder and have recently completed a more intensive course of treatment. The program is brief both in the number of sessions (five) and the time required to deliver the sessions. It is designed to be implemented over a twelve-week period. The first session is a fifty-minute office session, while the remaining four sessions should take approximately fifteen minutes each. Ideally, session 1 should occur within two weeks of the completion of the more intensive AOSUD treatment phase. Sessions 2 and 3 are delivered two weeks following session 1 (and are also two weeks apart). Sessions 4 and 5 are delivered three weeks after session 3 (and are also three weeks apart).

What Treatment Models Does the Program Use?

The program combines components of MI/MET and CBT into an algorithm (see the diagram on page 16) that is based on the client's present level of substance use and the degree of motivation to achieve desired goals (Kaminer and Napolitano 2004). This formula was derived in part on the notion that if a particular individual is sufficiently motivated to achieve his own identified goals, then the focus of the session can be *how* to help the client achieve those goals using CBT coping skills, by targeting high-risk situations. Within the

CBT framework, the process includes an emphasis on coping skills that may be useful and/or necessary for the individual to incorporate, or continue using, in his life to help achieve desired goals. According to the algorithm, an identified level of intrinsic motivation must be present for the session to proceed to a CBT dialogue about the use of coping strategies in high-risk situations. If the client's motivation for change is not sufficient, the session then targets this aspect with the use of MI/MET. The client's goals are defined with the help of the clinician in the first aftercare session.

The treatment algorithm that guides the flow of dialogue between clinician and client is based in part on the stages of change theory proposed by Prochaska, DiClemente, and Norcross (1992). The stages of change theory proposes that an individual progresses through a predictable process of internal reflection as she considers the idea of change. Motivational interviewing/enhancement strategies in this substance abuse aftercare intervention aim to facilitate this naturally occurring process. By meeting clients at the stage of change they are in relative to the behavior of substance abuse, clinicians can simultaneously enhance clients' motivation to continue moving forward in the stages of change framework. The clinician uses dialogue focused on reducing resistance, emphasizing the client's stated reasons for change, focusing on a future-oriented mindset, and other strategic language that is designed to increase the client's motivation for change.

When clients are deemed to have a "sufficient" degree of motivation to change (to be discussed in detail later), CBT coping skills strategies become the primary emphasis of the session. Coping skills are designed to address internal and external factors that present "high-risk" circumstances—that is, predictors that increase the likelihood that substance use will occur. Those particular aspects, while highly specific to each individual, will generally fall into the category of "internal triggers" or "external triggers." Internal triggers are factors that occur inside an individual (intrapersonally), such as thoughts, emotions, moods, cravings, and urges. External triggers are factors that occur in the individual's context (interpersonally), such as relationships with friends and family, exposure to drugs and alcohol, and peer pressure (Marlatt 1996). Often, there is a dynamic relationship between internal and external triggers. For example, an individual may have a conflict with a family member (external trigger) that results in feeling angry and depressed (internal triggers). The combination of these factors can increase the degree to which an

individual experiences craving or has an urge (internal triggers) to use a particular substance. Cognitive-behavioral coping skills aim to help the individual use a productive/adaptive means of coping with these internal and external factors so that the individual has a variety of other more productive options readily available to cope with high-risk situations, thereby decreasing the likelihood that alcohol or drug use will occur (Kadden et al. 1992).

As clients experience success by employing these more adaptive/productive skills, their self-efficacy—that is, confidence in their ability to refrain from substance use in high-risk situations—increases. Increase in self-efficacy is correlated with increased abstinence rates (Burlinson and Kaminer 2005). Emphasis on reducing the negative consequences of substance use, and increasing the positive benefits of change, is part of the interplay between MET and CBT. The clinician acts as an empathic mentor, teacher, and guide in the learning process and implementation of productive coping skills for high-risk situations.

Is the Program Evidence Based?

The Adolescent Alcohol Treatment and Outcome Maintenance (AATOM) study was conducted at the University of Connecticut Health Center, Department of Psychiatry, from 2001 to 2006 by Dr. Yifrah Kaminer. The study investigated the effects of an aftercare intervention for adolescents ages thirteen to eighteen, treated initially for AOSUD with nine weekly group sessions of CBT. This treatment phase was followed by a twelve-week aftercare regimen similar to the aftercare process described in this manual. Following the nine sessions of CBT group therapy, subjects were randomly assigned to one of the following conditions:

- ▶ five fifty-minute sessions of in-person aftercare
- ▶ one session of individual therapy followed by four fifteen-minute aftercare sessions via the telephone
- ▶ no active aftercare

Results from this study indicated that, first, the phone intervention is feasible and acceptable for both adolescents and clinicians (Burlinson and Kaminer 2007). Second, the twelve-week aftercare treatment phase following an initial course of nine weekly CBT group

therapy sessions was significantly better than the “no aftercare” treatment condition. Further, there was no statistically significant difference between subjects assigned to the five individual in-person aftercare sessions and the subjects assigned to the telephone aftercare sessions (Kaminer, Burleson, and Burke 2008). These results were maintained during a nine-month follow-up, although the magnitude of difference gradually decreased (Burleson, Kaminer, and Burke 2009). In conclusion, aftercare interventions for substance use disorders in adolescents can help maintain progress made by individuals in an initial treatment phase. The results also indicate that the telephone is at least as effective a modality as in-person sessions for delivery of aftercare.

It is also noteworthy that aftercare interventions reduced suicidal ideations compared to the “no active intervention” condition (Kaminer et al. 2006).

What Are the Program’s Goals and Objectives?

In terms of substance use, the goals of the program are client driven. Let’s say, for example, that an individual had been using a particular substance (such as alcohol or marijuana) heavily in terms of frequency and/or quantity, but was able to reduce her use significantly during the more intensive phase of treatment. The client would now like to maintain a level of use that is less harmful, but is not motivated for abstinence. In session 1, the clinician would help the individual define a goal with specific parameters for her substance use based on this agenda. During this dialogue, the clinician can use MET language to help emphasize to the client her own reasons for change. A discussion of abstinence and how the individual feels about the idea can be useful, but caution should be used to avoid pressuring an agenda the clinician may have for the client in this direction. The goal for the clinician is to avoid eliciting resistance while staying just ahead of where the client is in her own thought process, and/or stage of change, in relation to substance use.

Other goals that are set during the first session should also be client driven. With the guidance of the clinician, specific goals can be identified that are (1) related in some way to the client’s substance use and (2) deemed to be productive for the client. For example, the individual may have a goal of using alcohol only once per month, but struggles to think of what other activities could be incorporated

that would be fun and exciting. The clinician might suggest that a goal be to establish new activities for fun and excitement. A dialogue could then ensue on how to go about doing this. Other goals can be set in a similar fashion.

Why Use Brief Individual Aftercare Therapy with Drug-Abusing Youth?

Kaminer, Bureson, and Burke (2008) describe three potential short-term treatment outcomes for adolescents diagnosed with AOSUD:

1. reaching the most desired objective, abstinence
2. achieving partial improvement, such as reduction in symptom count and severity of use (for example, frequency, dosage, type of drug(s) used, and consequences)
3. no response to treatment

Although improvement is obtained in treatment by a significant number of youth, the pathway to adulthood rarely includes abstinence. Treatment is usually followed by relapse rates of more than 60 percent three to twelve months after treatment completion (Brown, Vik, and Creamer 1989; Kaminer, Bureson, and Goldberger 2002). These findings do not come as a surprise given the growing consensus that AOSUD is a chronic, relapsing, and remitting disorder characterized by periods of abstinence followed by relapse (McLellan et al. 2000; O'Brien and McLellan 1996) and reentry into the treatment system (McKay et al. 2004). Hence, there is a need to increase the overall effectiveness of treatment as well as maintain treatment gains by developing and testing the efficacy of behavioral aftercare interventions and services for youths.

There has not been a clear consensus regarding what terms should be used to describe post-treatment interventions. Partially overlapping terms—such as “continued care,” “aftercare,” “step-down,” or “transition of care”—have been used interchangeably.

The American Society of Addiction Medicine (2001) has defined continued care as “the provision of a treatment plan and organizational structure that will ensure that a patient receives whatever kind of care necessary at the time. Thus the program is flexible and tailored to the shifting needs of the patient’s level of readiness to change.”

Lack of continuity of care or aftercare programs for adults (McKay 1999) and adolescents with AOSUD is the rule rather than the exception (Kaminer 2001). The only aftercare intervention with youth successfully tested so far has been the Assertive Community Reinforcement Approach (Godley et al. 2007).

In addition to providing flexibility by using the telephone for treatment delivery, this program can benefit youth through several means. Since the client directs the variables for producing positive change, there is likely to be less resistance experienced by both the clinician and the client. Essentially, the clinician asks the client in the first session, “Where are you right now in relation to drug and alcohol use, and what do you want to accomplish from here?” Given that the expectation for the clinician is to refrain from projecting his ideas for change onto the client, clients are then freer to say what they believe to be most useful to achieve their treatment goal. This process helps support the self-efficacy of the client, which is an important aspect related to positive outcome in substance use disorders (Annis et al. 1989).

Additionally, this process helps increase the therapeutic alliance between the client and clinician, which is also a significant predictor of positive treatment outcome (Duncan, Miller, and Sparks 2004). The clinician provides a framework and focuses attention on the client’s ideas about how to continue improving (what coping skills to work on, what goals to set, and so on). Even if/when resistance is elicited or experienced in a session, clinicians rely on MET strategies that are aimed at eliciting and maintaining motivation to change substance abuse. This approach is consistent with the developmental stage of adolescence in that this age group is more likely to respond to a “what’s in it for me, what do I want” process, which can fuel motivation. Motivation then fuels effort, and effort fuels self-efficacy and outcome, which then reinforce this positive cycle to continue.

Why Use the Telephone to Conduct This Therapy?

Recent reports have supported the effectiveness of telephone-based continued care in the clinical management of clients with AOSUD (Breslin et al. 1996; McKay et al. 2004). Zhu et al. (1996) demonstrated the effectiveness of using the telephone as a means of providing therapeutic support for smoking cessation.

Gumpert and Fish (1990) reported that in many cases the telephone was the client’s preferred means of communication with the

clinician due to its ability to bridge distance and transportation problems, appointment conflicts, and contact boundaries (for example, phone contact may encourage disclosure by minimizing the perception of risk and vulnerability). The phone contact is essentially a two-way and relatively private communication. Thus, interpersonal relationships may be successfully developed and/or maintained over the telephone and improve compliance with follow-up procedures (Intagliata 1976; Williams 1984).

Which Clients Can Benefit from Brief Telephone Therapy?

This program is most likely to help produce positive change in youths ages thirteen to eighteen who have completed a prior course of AOSUD treatment. Clients need not be completely abstinent from drugs and alcohol to participate in this program. They may be youths who are deemed at risk for continued substance abuse, or those who made only small changes in their previous treatment episode. Individuals who are still using alcohol or drugs more frequently may be considered for this program on a case-by-case basis; however, a clinical determination will need to be made to decide whether this intervention will be sufficient or if a more intensive course of treatment is indicated.

Who Can Implement the Program?

This method of providing brief AOSUD management in aftercare is designed for a trained behavioral health specialist who may use it to deliver, monitor, or enhance treatment and aftercare of a given case. Behavioral health specialists may include specifically trained psychiatrists, counselors, marital and family therapists, psychologists, and social workers. With proper training and supervision, professionals working in the criminal justice system (such as probation officers) and school psychologists might also be able to implement the program.

How Can You Evaluate the Effectiveness of This Aftercare Intervention?

Ideally, clinicians who are trained in conducting this intervention are routinely supervised to ensure that aspects of the program are

being implemented according to manual guidelines. Whether after-care sessions 2 through 5 are conducted by telephone or completed in person, they can be audiotaped with the client's consent, and these tapes can be rated using the Brief Telephone Therapy Supervision Rating Form (on the CD-ROM). Since there are very few differences in conducting the intervention in person or via telephone, the supervision rating form can be used to rate the clinician for both interventions. Informed consent for audiotaping is included in the Client Contract for Aftercare (on the CD-ROM).

If regular supervision of clinicians is not possible, self-review and ratings of audiotaped sessions will be helpful in ensuring that essential components of the intervention are being employed consistently.

Chapter 2

Session Structure

THIS AFTERCARE INTERVENTION IS UNIQUE because the therapy can be delivered via the telephone, but it can also be used in traditional face-to-face psychotherapy. There are five sessions in this program. The first session is fifty minutes in length and should be conducted in person. The remaining four sessions take approximately fifteen minutes each to conduct.

NOTE

A note about session length: In the AATOM study, fifteen-minute telephone aftercare sessions were adhered to for research protocol purposes. Clinicians employing the aftercare intervention using this manual may not be required to adhere to the research protocol time period; however, it should be noted that results from the study are based on performing the telephone intervention using a fifteen-minute time block.

Ideally, session 1 should occur within two weeks of the completion of the more intensive AOSUD treatment. Sessions 2 and 3 are delivered two weeks following the previous session and are two weeks apart, with sessions 4 and 5 being delivered three weeks from the previous session, also being three weeks apart.

About the Authors

Yifrah Kaminer, M.D., M.B.A., is a Professor of Psychiatry and Pediatrics at the University of Connecticut Alcohol Research Center. Dr. Kaminer was trained as a Child and Adolescent Psychiatrist and has been conducting research on the assessment and treatment of youth substance use disorders since 1988. He is the primary author of the Teen Addiction Severity Index (T-ASI) and has authored 130 publications. His most recent books include *Adolescent Substance Abuse: Psychiatric Comorbidity and High-Risk Behaviors* (Routledge, 2008) and *A Clinical Manual of Adolescent Substance Abuse Treatment* (American Psychiatric Publishing, 2010).

Chris Napolitano, M.S., L.M.F.T., has been a full-time clinician and research associate for the University of Connecticut Health Center for the past thirteen years. He has authored several unpublished psychotherapy treatment manuals for research studies in adult and adolescent substance abuse. In addition to his clinical expertise in the delivery of psychotherapy for children, adolescents, and adults, Mr. Napolitano has conducted extensive trainings and supervision for clinicians delivering manualized research psychotherapy protocols. He has also maintained a private part-time clinical practice out of offices in the towns of Portland and Bristol, Connecticut, for the past ten years, where he utilizes both individual and systemic models of psychotherapy.



Based on an integrated treatment model of motivational interviewing and cognitive-behavioral therapy, ***Brief Telephone Continuing Care Therapy for Adolescents*** is an evidence-based program for adolescent clients who have recently completed a substance abuse treatment program. Research shows that those who follow a continuing care plan after finishing treatment report higher rates of abstinence compared to those who do not follow such a plan. Telephone-based therapy makes continuing care accessible for adolescents who cannot attend face-to-face appointments due to school or family obligations or transportation issues.

Created by Yifrah Kaminer, renowned expert in adolescent psychiatry, this program is ideal for adolescents who have a mild to moderate substance use disorder and have recently completed treatment, including treatment in a criminal justice setting. ***Brief Telephone Continuing Care Therapy for Adolescents*** includes a clinician's manual and a CD-ROM of essential resources that allows clinicians to print and copy materials at their convenience.

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