

Old Psychotherapies for Cocaine Dependence Revisited

THE PUBLICATION of the results of the National Institute on Drug Abuse Collaborative Cocaine Treatment Study (CCTS),¹ like the publication of and comments on some of the first pharmacologic trials in this journal more than 7 years ago,²⁻⁴ denotes a landmark in the development and evaluation of treatments for cocaine dependence. Since 1992, myriad pharmacotherapies have failed to demonstrate efficacy against the Goliath of cocaine dependence. Instead, “weak” approaches such as psychotherapy have emerged as the David of this field; note that the review by Meyer in 1992 of the state of pharmacotherapies for cocaine dependence ended with “. . . lest we forget the importance and efficacy of nonpharmacological treatments.”² Behavioral therapies, in particular contingency management approaches,⁵⁻⁹ have been demonstrated to be effective and sufficient treatments for most cocaine-dependent patients who receive them. While important efforts continue to identify effective pharmacotherapies, the results of this excellent study highlight several points deserving further comment, including (1) poor retention but generally good improvement across treatments; (2) failure to replicate an earlier study on the effects of professional psychotherapy vs disease-model approaches for methadone-maintained opiate addicts; and (3) the need to distinguish the therapies evaluated in the CCTS from other behavioral treatments demonstrated to be effective for cocaine dependence. First, however, this outstanding group of investigators is to be applauded on an extraordinarily well-conducted study, and in particular their use of the most rigorous methods to define and imple-

ment the treatments studied, which make these findings so compelling.

LESS IS OFTEN MORE

Ever since cocaine abusers began seeking treatment, researchers and clinicians have noted how difficult it is to retain them in treatment; so much so that retention has become more or less a proxy for treatment “success.” The CCTS, which offered intensive psychotherapy (36 individual and 24 group sessions for 24 weeks—a total of 60 sessions), had poor retention, with patients on average completing less than half of sessions offered and only 28% completing treatment.

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However, it is difficult to compare retention in this study with other outpatient studies of cocaine abusers because of the practice used here of selecting for individuals who completed a 2-week orientation phase prior to randomization, which resulted in loss of almost half of the eligible study population (383 of 870), and apparently individuals with more severe cocaine use and other problems.¹⁰ The orientation procedure might be seen as an effective intervention in itself, as the figures suggest the bulk of the reduction in cocaine use occurred during this early period, with comparatively lesser reductions for the remainder of treatment. Thus, it is possible to interpret the study as evaluating the effects of intensive psychotherapy on a lower-severity sample who were motivated to seek additional psychotherapy after having already made substantial reductions in their cocaine use. Thus, the poor retention does not suggest the treatments offered were ineffective; instead, it is likely that too much treatment was

offered to this select sample and briefer versions of these treatments may have been sufficient.

Another issue with impractical expectations regarding any protocol’s ability to retain participants is subsequent methodological problems. For example, it was not possible to use biological measures such as urine toxicology screens as an outcome measure, as only 43% of the weekly urine samples were collected, leading to reliance on self-report data. Compliance bias is another potential problem, as rates of follow-up at 3 and 6 months after treatment seemed somewhat higher for the better-retained groups (cognitive therapy [CT] and supportive-expressive [SE] therapy) than the drug counseling groups.

TREATMENTS AND MODELS OF TREATMENT EVALUATION MAY NOT BE INTERCHANGEABLE ACROSS DRUG TYPES

The CCTS adapted all of its treatments and much of its basic design from those used in another landmark study of psychotherapy for opioid dependence, where SE and CT were contrasted with drug counseling among methadone-maintained opioid addicts.^{11,12} Thus, SE and CT had strong prior empirical support as treatment for stabilized opioid addicts; however, no data existed on the efficacy of these approaches with cocaine-dependent populations when this study began.

In the studies by Woody et al,^{11,12} the 2 professional psychotherapies were essentially evaluated as “add-ons” to methadone maintenance and contrasted with drug counseling alone. Both SE and CT were found to enhance outcome, particularly for patients with higher psychiatric severity and those

with antisocial personality disorder. Essentially the same study, with similar hypotheses regarding main and matching effects, was conducted here, with group drug counseling essentially substituting for methadone maintenance as in the studies by Woody et al (although with a more restricted range of psychiatric severity in the CCTS). The results of the 2 studies are quite different, pointing to limitations of assuming interchangeability of models of treatment and study design for opioid- vs cocaine-dependent subjects.

TREATMENTS FOR DRUG ABUSE SHOULD TARGET DRUG ABUSE FIRST

A major finding from the CCTS is the comparatively good outcomes seen with the individual drug counseling condition, a manualized approach that draws heavily from 12-step philosophy. This finding, while striking, is not exactly surprising after several major recent studies have indicated that manualized, disease-model treatments are as effective and durable as other treatments with stronger levels of prior empirical support, including Project MATCH¹³ and a study of alcoholic cocaine abusers by our group.¹⁴ This should not be interpreted as meaning that merely sending patients to self-help meetings constitutes sufficient treatment, however, as that is unlikely to be the case. Instead, manualized individual approaches drawn from widely used disease-model approaches and delivered by carefully selected and trained therapists can be as effective as professional psychotherapies for many cocaine abusers. The possible mechanisms for this—focus on abstinence and facilitating enduring relationships with supportive networks of other abstinent individuals—should be the subject of future investigations.

Another possible interpretation of these findings is that it may not be wise to change theoretical horses in midstream: the stabilization period that preceded randomization involved at least 3 sessions that encouraged attendance at self-help meetings and resulted in many patients having been exposed to 12-step principles prior to receiving SE

or CT.¹⁵ Possible “diluting” of SE and CT in this manner, combined with their primary emphases on substance-related problems that may have been less applicable to a more select sample (eg, primary focus on interpersonal themes or cognitions related to drug abuse) may have reduced their effectiveness here.

Both SE and CT are also different in this manner from 2 approaches that have been demonstrated to be effective with many populations of cocaine abusers, contingency management⁵⁻⁹ and cognitive-behavioral therapy,^{14,16-19} both of which emphasize abstinence and strategies to achieve it. It is notable that in a recent study of alcoholic cocaine abusers by our group, cognitive-behavioral therapy was found to be as effective as a manualized 12-step facilitation approach, and significantly more effective than a supportive control condition.¹⁴

More generally, the CCTS illustrates a common problem for behavioral research in the addictions, namely selection of appropriate “control” conditions against which to evaluate the effectiveness of new behavioral approaches. Until recently, many of us assumed, incorrectly, the inferiority of “treatment as usual” approaches that relied heavily on disease-model concepts. Our efforts to specify these approaches have resulted in our proving (to ourselves at least) just how effective they can be; when carefully conducted, as in the CCTS, they are not by any means a “placebo” treatment. It is the onus of treatment researchers to develop approaches that are more, or at least, as effective as these. “Old” psychotherapies that relied on pharmacologic platforms like methadone to foster abstinence and address drug craving appear less applicable to cocaine dependence; “new” therapies must attend to old problems, particularly helping patients initiate and maintain abstinence.

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