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Stage of Change and Coping Skills Acquisition: Ideas for Individualized Treatment Approaches

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Introduction

Coping skills are believed to be a key mechanism of cognitive behavioural therapy (CBT) in treating patients with active addictions. CBT is a psychotherapeutic approach that is used in addiction treatment and focuses on increasing an individual's ability to cope with high-risk situations that frequently lead to relapse [1]. Most readers would have heard of CBT and its use for treating addictions. Increased coping skills are believed to be a mechanism of action in CBT and have been shown to be associated with improved substance reduction outcomes [2,3]. Research has established that the frequency and effectiveness of coping skill use increases throughout therapy [4,5] and that CBT-based interventions may strengthen the relationship between coping skill use and decreased substance use [1]. Given the centrality of coping techniques to CBT-based interventions and their importance to substance use outcomes, it is important to consider how to best teach these skills to our patients. Specifically, we may wish to tailor or individualize treatment, which is also, I am sure, a topic which the reader is surely familiar. There are multiple strategies, including case conceptualization, to help individualize CBT, but less research has focused on whether participants at different stages of change present with different sets of coping skills and which sets of coping skills are effective for different substances of abuse. Interestingly, research suggests that examining individual coping strategies for substance use problems prior to seeking treatment can lead to better treatment outcomes [6,7]. Little research has been done, however, to clarify the type, frequency, and effectiveness of coping skill use in participant populations presenting for treatment.

The Trans-theoretical Model (TTM) of Prochaska and DiClement assesses a participant's readiness to change substance use behaviours [8], and strategies to measure readiness to change or stage of change are well known and widely available. Prochaska suggests six stages that describe the process of change: pre-contemplation, contemplation, preparation, action, maintenance, and relapse. In the pre-contemplation stage, a person indicates no intention to take action within the next six months. In the contemplation stage the individual reports no action to change substance use behaviours but develops an intention to do so. The preparation stage is characterized by behavioural steps toward action and an intention to take full action within 30 days. In the action stage the individual takes overt action and the change has lasted for less than six months. Maintenance is the stage in which change has occurred for at least six months. Finally, a person can be considered in the termination phase when there is no threat of the old behaviour returning.

The TTM has found widespread use in a variety of practice settings [9], and is frequently used as a screening measure to determine participants who are ready for more intensive interventions. Research has shown that forward stage transition is associated with improvement in substance outcomes. It seems to follow that stage based interventions would be superior to interventions that are not stage based, but evidence for the superiority of stage-based interventions compared to non- stage-based interventions has been mixed. A 2003 systematic review of 23 randomized controlled trials concluded that stage based interventions are no more effective than non-stage based interventions or no intervention in changing smoking behaviour [10], and a 2010 Cochrane review concluded that while individual counseling was more effective in bringing about smoking cessation than control conditions of "usual care" or simple observation that the extra value of fitting therapy to a smoker's stage of change is unclear [11].

An area which remains understudied is whether assessing stage of change could yield useful information for therapists who seek to intervene with non-TTM based therapy such as cognitive behavioural therapy (CBT). Studies exploring the relationship between coping skills and stage of change would presumably support that coping skills are used more frequently and effectively among participants who progressed to an 'action' stage, and indeed, the research indicates that the frequency and effectiveness of coping skill use increases as participants progress in therapy [2,5,12]. Participants who have made progress in addressing their own substance abuse problems appear to report a similar process of skill acquisition before presenting for formal treatment. This brings to light a possible interpretation for the success of trials of individualized therapy such as Litt et al. [7]. These researchers used an individualized treatment protocol which analysed situations in which the participant had used in order to determine what strategies had helped the participant and what could be done differently. This approach informs the therapist about the skill base that a participant has acquired on his or her own and may present the opportunity for building upon specific skills in order to incorporate whatever progress the participant has made prior to presentation into therapy. Additionally, increased coping skill use and effectiveness may predict stage of change, suggesting the possibility that an increasing a participant's skill repertoire may push them into increased readiness for change without specific focus on change talk. At least one study suggests that this is the case [13]. The project MATCH research group found forty-one per-cent of CBT and twelve step facilitation clients were abstinent or drank moderately without alcohol-related consequences compared with twenty eight per-cent of motivational enhancement therapy clients and concluded that for quick reduction of heavy alcohol use CBT or TSF should be the treatment of choice. Future studies might ask whether focusing on coping skill training results more advancement through stages of change than focusing on motivation for change. Such findings may have implications for cognitive behavioural therapeutic interventions for participants at different stages of change. Future research could also seek to clarify

whether the relationship between increased coping skills and stage of change is causal, and if so in which direction. In other words, does progressing through stage of change cause increased coping skill use, does increased coping skill use cause progression through stages of change, or is a third factor responsible for a concurrent increase in both? Finally, long term follow-up comparing participants' coping skill use and effectiveness at presentation to various time points throughout treatment and afterward would give a more complete longitudinal picture. Types of skills initially used, stage of change at presentation, and their interactions with types of therapeutic interventions received could be assessed to determine what all of these factors mean for long term abstinence and help further clarify how clinicians can improve therapeutic outcomes using participant starting characteristics.

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