ALCOHOL DRUG FINDINGS *Hot topic*

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GO Is it futile to match alcohol treatments to the patient?

It was the great hope for alcohol treatment: even if overall one type of therapy was no better than another, surely this was just because certain therapies worked best with certain patients; at the subgroup level, important differences might emerge. If we could get this 'matching' right, then patients would benefit and overall effectiveness would improve because patients could be offered the treatment best suited to them.

Mega-tests fail to find matching

The huge US Project MATCH trial was designed to be the definitive test. It was followed by the British UKATT trial, for which testing matching was a secondary but important objective. After pitting deliberately distinct psychosocial therapies against each other, both studies concluded that the outcomes differed little overall, and that there were few indications that certain types of patients benefited more from one therapy than another.

Though its intended contribution to treatment was never realised, efforts to account for this unexpected failure helped make Project MATCH arguably the most fertile alcohol treatment study ever. The trial ended up prioritising not technical differences between therapies, but what they had in common – most of all, what the *patient* brings to treatment. This perspective accounts for why patients who did not return for therapy did almost as well as those who attended all 12 sessions of the longer therapies, and why the degrees to which patients wanted to change and were ready to do so were strongly and lastingly linked with how well they did. Perhaps by the time a drinker has decided they have a problem they have to do something about, most of the therapeutic work is done, and treatment's role is primarily (as MATCH researchers concluded) to offer a "culturally appropriate solution to a socially defined problem" – not a 'technical fix', but a door through which patients can pass to actualise their impetus to get better.

It's how you do it

That may be a large part of the story, but it is not all of it. From the disappointment of Project MATCH also emerged more fine-grained analyses which (along with other studies) revealed that while matching to specific therapies may not be directly relevant, some therapies are more conducive to certain *interpersonal styles* than others, and these styles *do* matter; certain styles suit some patients more than others. So matching lives on, but more in the form of *how* someone is treated in the conventional meaning of the term, rather than what they are treated 'with' in the form of the brand of therapy.

In this respect addiction is catching up with and contributing to the trend in psychotherapy in general to focus on the match between the relationship styles of patients and therapists. A high-level task force of the American Psychological Association explored the candidate dimensions and found that adapting psychotherapy to four (patient preferences, tendency to reactance/resistance, culture, and religion/spirituality) demonstrably improved effectiveness. Of these, the match between the patient's tendency to react against being led (or 'directed') and the directiveness of the therapist has the most solid grounding in addiction-related research (as Findings discovered in this review) and makes a big contribution to how well patients do in psychotherapy in general. It takes the form of submissive patients doing better when given direction, while patients who like to feel 'in control' do better when allowed at least to share the lead. A Dutch study added the intriguing finding that patients who differ from their therapists on this dimension are drawn during treatment to become more like their therapist.

Pharmacotherapies may be 'matchable'

While matching to different types of psychosocial therapy has little support, matching drugs to types of patients has a long and not entirely unsuccessful history, including reanalyses of results from the US COMBINE trial. This had randomly allocated alcohol-dependent patients to one of nine combinations of pharmacological and psychosocial treatments. Overall, adding psychological therapy to the mix or adding the medication naltrexone improved drinking outcomes to roughly the same degree, but more fine-grained analysis showed they did so in different ways. Psychological therapy particularly helped prevent patients who started treatment well escalating to near daily drinkers, while naltrexone helped patients sustain near abstinence. The two together particularly helped increase the number of patients who cut the frequency of their drinking over the 16-week treatment period.

These indications of which treatment to offer based on initial response to treatment have been supplemented by indications based on drinking in the three months *before* the patients entered the COMBINE study. Most notably this analysis suggested that acamprosate – overall ineffective – *did* have an impact, but a negative one, making some of most heavily dependent near daily drinkers *more* likely to drink heavily at the end of treatment than if they had been prescribed a dummy tablet. Negative impacts of acamprosate on some patients were counterbalanced by positive impacts on other types of patients, especially intermediate severity patients who had drunk frequently before treatment, but not nearly every day. These same intermediate patients also particularly benefited from naltrexone. In contrast, there was no sign that the COMBINE's psychological therapies were differentially effective for different types of pre-treatment drinkers.

Other obvious matching criteria apply to the drug disulfiram, which causes very unpleasant reactions to drinking. Even more so than other medications, this powerful drug is reliant (1,2,3) on the patient's

drinking. Even more so than other medications, this powerful drug is reliant (1 2 3) on the patient's motivation and social support, especially the availability and cooperation of relatives and partners who (with the patient's agreement) will ensure the pills are taken.

More tentatively, compared to acamprosate, naltrexone may be the better option for people who are not aiming for or find it hard to stop drinking altogether, and for those with a strong desire to drink in order to achieve what they experience as a pleasurable state of intoxication. Other non-mainstream medications also seem to work more or less effectively for different types of patients.

Treatment setting and format matter too

Beyond the content of the treatment, there are some obvious matches in respect of format and setting. Treating couples together, for example, has impressive research support, but is usually only applied when there is a settled couple whose relationship has survived one partner's dependence, one of the partners is not a substance user, it is safe (aggravating domestic abuse can be a concern), feasible, agreeable to both parties, and a suitable therapist is available – conditions which limit it to a minority of patients.

Similarly, residential therapy is particularly suitable for homeless patients or those whose current accommodation substantially impedes therapy, and those whose vulnerability or needs demand 24-hour care or care of the kind only available in an inpatient setting. Another matching dimension involves providing ancillary or 'wrap-around' services such as employment, housing or psychiatric support to match the multiple needs of many patients.

In all these senses, matching is far from a dead issue, and remains a fascinating and fertile research area which has thrown up meaningful messages for therapists and services seeking to maximise impacts. See what you make of it by running this hot topic search.

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