GRUPO EDITORIAL DE PSICOFUNDACIÓN

Papeles del Psicólogo (2025) 46(2) 76-85

Papeles del Psicólogo
Psychologist Papers

https://www.papelesdelpsicologo.es/ • ISSN 0214–7823 • eISSN 1886–1415

PAPELES DEL PSICÓLOGO
PSYCHOLOGIST PAPERS

Revista del Consejo General de la Psicología de España

Article (Monographic)

Brief Intervention in Addictive Behaviors: Promoting Change

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ARTICLE INFO

Received: February 3, 2025
Accepted: March 3, 2025

Keywords
Motivation
Brief intervention
Addictive behaviors
Promoting change

ABSTRACT

Most individuals with addictive behaviors either persist in their substance use or do not seek treatment. To address this issue, the present article introduces brief interventions (BIs) as a treatment alternative to promote change. BIs originate from natural recovery research, which explores why some people do not seek treatment and how they manage to change on their own. BIs consist of a set of therapeutic strategies designed primarily to motivate and support individuals in considering changes to behaviors that pose health risks. BIs can be categorized into minimal (3 to 10 minutes of counseling), standard (four very brief sessions), and extended (up to 12 sessions) formats. Research has shown BIs to be effective not only in initiating and sustaining behavior change but also in improving treatment adherence. This article presents some of the key techniques used in BIs, focusing on increasing motivation, conducting a functional analysis of substance use, increasing self-efficacy, and training coping skills to prevent relapse. By normalizing change and making treatment more accessible, BIs play a crucial role in improving treatment effectiveness and its outcomes.

Intervención Breve en Conductas Adictivas: la Promoción del Cambio

Palabras clave
Motivación
Intervención breve
Conductas adictivas
Promoción del cambio

RESUMEN

La mayoría de las personas que tienen problemas adictivos siguen consumiendo o no acuden a tratamiento. Ante esta situación, este artículo presenta las Intervenciones Breves (IBs) como alternativa de tratamiento para promocionar el cambio entre la población. Las IBs surgen de las investigaciones de recuperación natural que tratan de explicar porqué las personas no van a tratamiento y qué conductas hacen en ausencia de este para cambiar. Las IBs son un conjunto de estrategias terapéuticas dirigidas a motivar a los individuos para que consideren realizar cambios en conductas que suponen un riesgo para su salud y apoyarlos en ese proceso. Se diferencian distintas modalidades de IBs: mínima (consejo de 3 a 10 minutos), estándar (de 4 sesiones muy breves) y ampliada (hasta 12 sesiones). Se han mostrado eficaces tanto para iniciar el cambio como para mantenerlo, mejorando incluso la adherencia a los tratamientos. Entre las principales técnicas que se aplican, se encuentran: el análisis funcional del consumo y estrategias de entrenamiento en autoeficacia y afrontamiento para prevenir recaídas. Las IBs sirven para normalizar el cambio y acercar el tratamiento a las personas, algo necesario para mejorar la efectividad y resultado de éstos.

Cite this article as: Carballo, J. L., & Coloma-Carmona, A. (2025). Brief intervention in addictive behaviors: promoting change. *Papeles del Psicólogo/Psychologist Papers, 46*(2), 76-85. https://doi.org/10.70478/pap.psicol.2025.46.11
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The Reality of Addiction Treatment

Despite the high prevalence of addiction problems worldwide, the consequences of these problems for all areas of life, and the availability of treatments that have been shown to be effective in reducing these problems (Dellazizzo et al., 2023), demand for treatment remains low. For example, some meta-analyses show that more than 80% of people with problem drinking do not seek treatment (Mekonen et al., 2021). Moreover, over 50% of those who do enter treatment tend to drop out before completing it. According to Biswal et al. (2024) non-adherence to treatment negatively affects treatment effectiveness, resulting in poorer recovery rates. Service efficiency is also reduced due to underutilization, which can further disadvantage others who are waiting for treatment-an impact that is even greater in resource-limited settings.

In the case of Spain, if we take the data and estimates of consumption from the reports of the *Observatorio Español de la Drogas y Adicciones* [Spanish Observatory on Drugs and Addictions] (OEDA, 2023), we can see that the demand for treatment among problematic consumers of alcohol and other drugs is very low. For example, in 2022, there was an estimated total of 1,900,000 people at risk from alcohol use, while admissions to treatment in 2021-including both new cases and relapses-totaled only 25,000 people (representing 36% of all addiction treatment demands). In view of these data, there is a significant gap between problematic consumption and treatment attendance. Some studies focusing on alcohol users have shown that less than 4% of people who consume alcohol and are at high risk of developing an addiction consider seeking help (Coloma-Carmona et al., 2015).

The first question that arises from this situation is: Why don't people with addictive problems seek treatment? Some recent research has attempted to answer this question by analyzing the barriers that may exist to treatment (Farhoudian et al., 2022; Wolfe et al., 2023). There are many factors that can impede help-seeking and participation in treatment for substance use problems, including individual, social, and structural barriers. At the individual level, for example, lack of awareness or acceptance of the seriousness of the substance use problem, the belief that they do not need treatment, and negative emotional states can all decrease motivation to seek treatment. On the other hand, social barriers, such as the stigmatization of people with addiction problems or the normalization of alcohol consumption and other drug use, also contribute to lower rates of treatment seeking. Structural barriers to treatment accessibility include service-level barriers (e.g., long waiting times, costs, or limited treatment options). In this sense, even the health professionals themselves who could refer patients to treatment (e.g., from primary care) encounter barriers to initiating treatment, highlighting the feeling that they will be lied to about their consumption or the lack of time to address these problems (Coloma-Carmona et al., 2017). All these barriers can decrease the intention to seek treatment as well as the commitment once in treatment, even when a positive attitude and strong motivation to change the substance use behavior are present (Wolfe et al., 2023).

From Remission to Recovery

One of the main reasons why people with addictive behaviors do not seek treatment is because they do not consider that treatment is necessary for their case (De Meyer et al., 2024). In a way, this is linked to the fact that people avoid the "label" of "addict" because of the stigma and connotations associated with it. This label is tied to the biomedical model of disease, whose main characteristics can be summarized as follows: recovery is not possible without treatment; complete recovery is also not expected, since the possibility of relapse will always be present throughout life; and any kind of minimal consumption is considered impossible. Furthermore, abstinence is proposed as the only alternative (Férnandez Hermida et al., 2007). As Becoña (2016) and Mackillop (2020) point out, many researchers have disagreed with this definition of addiction as a chronic, relapsing disease, on the basis of the available evidence on recovery in addictions that is incompatible with this conception.

This definition of "incurability" means that many people with addictive behaviors avoid treatment so as not to carry a lifelong label. Considering addiction as a chronic disease, it seems more reasonable to use the term "remission", which is a medical term meaning that the main symptoms of the disease are eliminated or reduced below a predetermined harmful level (NIDA, 2018).

The main diagnostic classification systems, DSM and ICD, are also based on the biomedical model, focusing more on the concept of remission (Carballo, 2023). However, in response to this model, evidence shows the complex, multifactorial nature of addictions, highlighting the need for new approaches to their treatment and prevention (Heather et al., 2018, Secades et al., 2007). Thus, it is necessary to take a step beyond the mere disappearance of symptoms, referred to as remission, and define the concept of recovery in addictions, which encompasses more factors related to change.

Recovery is defined in terms of a dynamic process of change related to improvements in health and social functioning, as well as an increase in well-being, quality of life, and changes in life purpose (Witkiewitz et al., 2020; Witkiewitz & Tucker, 2020). The central focus of recovery is no longer abstinence or the disappearance of symptoms, but the improvement in quality of life and functioning. Operationally, recovery is understood as changes in substance use (abstinence vs. minimal use), increased self-efficacy and coping strategies, improved social support, a healthy lifestyle, and overall improvements in health and quality of life (Carballo, 2023).

This new approach to change and goal-setting breaks with the classic idea of addiction and, therefore, accepts more pathways to recovery than traditional treatment, making it more accessible to those who cannot or do not want to seek formal help. As described in this article, treatment admissions are minimal, either because people continue using or because they choose to change without help, which highlights the need for new strategies to address this issue.

From Natural Recovery to Brief Intervention

Natural recovery, also known as self-change, refers to the improvement that occurs in certain psychopathological disorders

without any type of formal treatment, including self-help groups or similar interventions. In the field of addictive behaviors, as discussed so far, recovery outside of treatment settings does not appear to be exceptional but rather a common pathway to change (Carballo & Fernández-Hermida, 2022; De Meyer et al., 2024). This finding has remained consistent from the classic studies by Robins with war veterans (1974, 2010), through alcohol studies by Sobell et al. (1996), to the most recent research by Kelly et al. (2017). Many studies have tried to seek explanations for this phenomenon to improve the understanding of addictions and their treatment, given that as described above it represents a break with the concept of chronic disease and the myth of formal treatment as the "gatekeeper of recovery" (Humphreys, 2015), i.e., the only possible path to change. Natural recovery opens the way to understanding treatment as just one part of a continuum in which the recovery process can occur, taking place within a complex life context with multiple influencing factors that extend beyond intervention (De Meyer, Zerrouk, et al., 2024, Klingemann et al., 2010).

Research has examined the characteristics of people who recover from their addictive behaviors without treatment (Carballo et al., 2007; De Meyer et al., 2024; Sobell et al., 2000), including the motivations that lead them to initiate the change (e.g., significant life events) and maintain it (e.g., social support), as well as the reasons for not going to treatment (e.g., feeling that they do not need help). These studies have led to the development of strategies for those who do not want to, cannot, or are not ready to attend treatment, but who may still be interested in reducing or stopping their substance use (Carballo & Fernández-Hermida, 2022). Strategies are needed to serve as an entry point, connecting formal treatment and the desire to change, to prevent excessive use from becoming chronic and developing into more severe disorders.

These types of strategies, in which professionals are not involved, are known as "self-change promotion". They have been developed primarily for alcohol addiction in the form of written guides, informational brochures, websites, and smartphone apps. These guides usually consist of self-assessment materials and presentation of coping strategies for quitting or reducing use, with the option of seeking formal treatment as an additional alternative if needed. Several studies have shown that these tools can produce significant changes in drinking habits, for example, the use of personalized feedback e-mails (Sobell et al., 2002) or web pages featuring success stories of cases of natural recovery (Cunningham & Godinho, 2021). It is becoming more and more common for health organizations to use these tools, for example, the "*estilos saludables*" [healthy lifestyles] web platform of the Spanish Ministry of Health. On the other hand, specific manuals and guides have also been developed in which lines of work and action are proposed to promote self-exchange among those who do not want treatment or cannot access it (Klingemann & Sobell, 2007).

The ultimate goal of promoting self-change is to shift from the normalization of substance use to the normalization of change-to ensure that health systems and policies recognize the possibility that people can change their substance use on their own, and, in doing so, increase the likelihood that they will seek help if they need it (Klingemann et al., 2010). From a behavioral economics perspective, this normalization of change fits with the need for macro-social prevention to focus on reducing the cost of accessing alternatives to consumption (González-Roz et al., 2020), such as self-change behaviors.

In this context of promoting change, the question arises as to whether there are effective strategies to help motivate people to start or stay in treatment. In other words, it is possible to move from the traditional model in which people come to ask for help, or even change on their own, towards a model in which healthcare systems actively anticipate and encourage people to initiate change? This creates the need to develop intervention strategies aimed at reducing the number of people who do not access care services by motivating them to begin and stay in treatment. These interventions should be easily accessible and brief, in order to "hook" people into more comprehensive programs.

In a systematic review that evaluated the existing research literature on interventions aimed at initiating and maintaining treatment (pharmacological, psychological, or combined) for addictive behaviors, different groups of strategies employed for these purposes were identified (Biswal et al., 2024): those derived from motivational interviewing (MI), contingency management (CM), prompts and reminders, cue exposure, brief cognitive behavioral therapy sessions, follow-ups, facilitated and peer-directed interventions, attendance contracts, and behavioral couples therapy. Among these, brief motivational interventions stood out, as 90% of the studies considered them effective in all settings, both for facilitating treatment initiation and for promoting adherence. The approach focused on preparing change plans, assessing and intervening in potential risk factors responsible for maintaining the client's addictive behavior, reinforcing existing protective factors that could help them maintain recovery, and addressing resistant attitudes. MI offers individuals the opportunity to acquire information related to treatment, set realistic expectations, and evoke feelings of satisfaction and hope when those expectations are met in the treatment process. CM and the use of reinforcers also proved effective for treatment adherence in studies that tested it. Therefore, in addition to creating a context of choice in which the alternative reward to drug use becomes more immediate and attractive (Secades et al., 2025), CM may also be useful for reinforcing other behaviors such as treatment initiation and adherence. Another noteworthy finding was that the strongest engagement with care was most frequently achieved when additional support measures, such as telephone follow-up and case management, were integrated (Biswal et al., 2024).

As Secades-Villa (2025) points out, the social environment is a complex and multifaceted modulator of the etiology and recovery of addictive disorders, and this will also affect the design of interventions and people's access to treatment. This is why the approach to the treatment of addictive behaviors should be broadened: the classic care model of receiving people with addictive problems in the clinic should give way to a model of anticipation and outreach. This could be achieved by using strategies that motivate people to initiate change, to seek treatment when necessary, and to improve adherence to treatment. Brief interventions stand out as the most effective tool to achieve these objectives.

Definition of Brief Intervention and Classical Models

Brief intervention (BI) is a therapeutic approach that emerged, within the field of public health, as a strategy to reduce and prevent behaviors that put people's health at risk. These interventions are characterized by their short duration, their person-centered style, and their universal approach based on harm reduction. Rather than a standardized treatment, BIs are a set of therapeutic strategies aimed primarily at motivating individuals to consider making changes in behaviors that pose a risk to their health and supporting them in that process (Center for Substance Abuse Treatment, 2012).

Although BIs were initially conceived as a counseling tool for health professionals, with the aim of reducing alcohol consumption in people with risky drinking patterns (McCambridge & Cunningham, 2014), their use has been extended to other contexts, such as community programs or even schools (Adams et al., 2023), social services, and judicial and police environments (Newbury-Birch et al., 2022). However, primary care and emergency departments are still the main areas of application of BIs, where they are applied by different health professionals (mainly medical, nursing, and psychology staff).

Despite the diversity in their formats, application contexts, and objectives, BIs are based on two models, which guide the implementation of the majority of shorter interventions: the FRAMES model (Miller & Sanchez, 1994) and the 5 'A's model (Whitlock et al., 2002). The FRAMES model is an acronym for the following components: 1) providing information about drug use and associated risks (Feedback), 2) encouraging people to take responsibility for their drug use behavior and decisions (Responsibility), 3) offering professional and impartial advice on how to reduce harm to reinforce and facilitate change toward lower-risk use or abstinence (Advice), 4) presenting a range of treatment options and therapeutic strategies (Menu), 5) using empathic communication, avoiding a confrontational style (Empathy), and 6) strengthening people's perceived self-efficacy to cope successfully with situations related to consumption, reinforcing achievements and identifying possible strengths that may facilitate the reduction or cessation of use (Self-efficacy). The 5 'A's' model establishes a structured process that includes 1) assessing substance use (Ask), 2) giving personalized advice on the health consequences that may result from the consumption pattern (Advise), 3) evaluating the interest and willingness to make changes in consumption behavior (Assess), 4) assisting the person in the development of a change plan, setting goals together, and providing them with the tools to achieve them, such as skills training (Assist), and 5) planning follow-up or referral to other services if necessary (Arrange).

Both FRAMES and 5'A' models provide a structured framework to guide the application of the BI, which is generally applied after a substance use screening process. This screening, coupled with the BI, shapes another model widely used in prevention and early intervention programs for problematic substance use: the SBIRT model. Developed in the 1960s as an evidence-based public health strategy, SBIRT integrates three key components: screening, brief intervention, and referral to treatment, with the aim of preventing and reducing problematic substance use in healthcare settings. Its implementation gained momentum from 2003, when it was actively promoted by SAMHSA and progressively expanded internationally (Kaner et al., 2018; O'Donnell et al., 2014). It is currently applied in different countries and health systems, especially in primary care, as part of a universal approach to early detection and intervention in substance use.

Within SBIRT, BI is aimed at people with moderate risk use, although it can also serve as a first step towards more specialized treatment. Its duration varies between one and five sessions, focusing mainly on increasing awareness of consumption, strengthening motivation for change, and planning strategies to reduce use. For this purpose, techniques such as brief advice, the FRAMES model, and motivational interviewing are used (Coloma-Carmona & Carballo, 2022). A practical example of the application of the SBIRT model is the BI linked to ASSIST, a structured tool for detecting the use of alcohol, tobacco, and other substances, developed by the World Health Organization (Humeniuk et al., 2011). The BI linked to ASSIST has also been adapted and validated for use in the Spanish population (Rubio-Valladolid et al., 2014). The use of ASSIST in the SBIRT model screening process allows health professionals to classify individuals according to the level of risk involved in their substance use, with the BI being initiated when the identified risk is moderate or high.

Types of Brief Intervention

Although there is no standardized definition of BIs, the term encompasses a wide variety of therapeutic approaches that, while all characterized by their short duration, vary in the number of sessions, the techniques employed, their goals, and the level of expertise required on the part of the professionals responsible for their implementation (Center for Substance Abuse Treatment, 2012; Evans et al., 2011). As part of a continuum of care, BIs can range from simple advice given by health professionals to more complex strategies aimed at motivating behavioral change or facilitating decision-making in the patient, using motivational interviewing and relapse prevention techniques (Center for Substance Abuse Treatment, 2012). The choice of which type of BI to apply depends on the severity of substance use, the intended objectives (such as universal or selective prevention), and even the resources available in each setting (Coloma-Carmona & Carballo, 2022). Given that multiple terms are used to refer to BIs (e.g., simple advice, minimal interventions, brief counseling), this article will make a proposal focused on their duration and specialization. For this purpose, three main categories are established (see Table 1):

- *Minimal Brief Intervention* (MBI), also known as brief advice, is an opportunistic strategy that can be applied in any context, although it is mostly implemented in the clinical setting. It is characterized by its brevity (a single session of 3 to 10 minutes) and is based on the delivery of information and advice on substance use, tailored to the individual's profile. It can include self-help material and does not require specialization or specific training in therapeutic techniques or addictive behaviors, which facilitates its implementation in various healthcare and non-healthcare settings. In fact, SAMHSA indicates that this type of intervention can also be applied by people outside the field of addictive behaviors and healthcare, such as teachers, student counselors, peer counselors, or even lawyers (Center for Substance Abuse Treatment, 2012).

Table 1
Summary of Types of Brief Interventions

Type of Intervention	Duration	Target Population	Applied by	Main techniques/strategies
Minimal Brief Intervention (MBI)	3-10 minutes in a single session	Opportunistic intervention: general population at risk of problematic use	Professionals in: social work, nursing, medicine, psychiatry, psychology. Non-professionals: peers, educational counselors, police, lawyers, etc.	Brief advice after consumption assessment (e.g., FRAMES model). Delivery of self-help material (e.g., brochures, basic information on options for change).
Standard Brief Intervention (SBI)	Up to 4 sessions of 30 minutes	Risky consumption or abuse	BI-trained professionals	Consumption feedback and brief advice. Psychoeducation. Behavioral support strategies. Alternative behaviors.
Extended and Intensive Brief Intervention (EIBI)	From 4 to 12 sessions of 30-60 minutes, with the possibility of follow-up and post-intervention evaluation after one year	Substance abuse and use disorders	Professionals specializing in addictive behaviors (e.g., psychologists)	Consumption feedback and brief advice. Functional analysis of behavior. Motivational interviewing and relapse prevention.

- On the other hand, the *Standard Brief Intervention* (SBI) differs from the *minimal intervention* in that it is structured in several short sessions (a maximum of 3-4 sessions, each lasting up to 30 minutes) with the objective of generating awareness about substance use and its possible consequences, mainly through psychoeducation. It is usually applied in primary care, hospitals, and community centers, and it can be combined with tools to increase motivation.
- When the duration of this intervention is longer (between 4 and 12 sessions) and it uses techniques typical of formal treatment, then it can be called Extended and Intensive Brief Intervention (EIBI). This is more structured and adopts a motivational approach, aimed at reducing the patient's ambivalence towards substance use and strengthening their capacity to generate sustainable changes over time. Beyond brief advice, the EIBI includes strategies for the development of action plans and follow-up sessions that allow progress to be evaluated and the intervention to be adjusted according to the patient's response. Due to its greater complexity and essentially motivational approach, EIBI is applied by professionals specialized in addiction treatment (e.g., psychologists and psychiatrists).

Effectiveness of Brief Interventions

As mentioned above, BIs have been highlighted in various research studies as an effective and efficient strategy for reducing the use of psychoactive substances, and their implementation in different contexts has shown positive results, although with variations depending on the substance, the type of BI applied, and the context (Barbosa et al., 2015; Sahker et al., 2022; Saitz, 2010). More recently, digital versions of these interventions (e-SBIRT) have been evaluated in several studies, showing mixed results in reducing the use of alcohol, tobacco, and illicit drugs, with no significant differences compared to conventional approaches (Jones et al., 2024).

Alcohol is the area that has been studied the most. According to the WHO's European Union Alcohol Report (Moeller et al., 2012), BIs are an effective, efficient, and low-cost measure, capable of reducing consumption in at-risk drinkers, although with some variability in effect sizes ranging from moderate to large (0.20-0.88). The available economic evidence supports their cost-effectiveness, both as part of SBIRT programs and as a stand-alone strategy, in a variety of settings ranging from schools to primary care and emergency departments, as well as in diverse populations (Le et al., 2023; World Health Organization, 2012).

For adolescents, screening with counseling for high-risk youth has shown a good balance between costs and long-term benefits. Although the meta-analysis by Tanner-Smith and Lipsey (2015) points out that the effect of BIs in young people is modest (g = 0.17-0.27), it highlights that, due to the low cost of implementation, they represent a viable and scalable strategy. Moreover, the review by Carney et al. (2016) highlights that brief motivational therapies in the school setting may be more effective than assessment alone, although there is not yet enough robust evidence to draw definitive conclusions. Similarly, Hogue et al. (2018) assert that BIs for adolescents are likely efficacious, supporting their use in this population. In adults, these interventions can generate a return of up to $39 for every $1 invested (Mundt, 2006). However, effectiveness and savings also depend on the context and modality of implementation, highlighting emergency and primary care settings as key scenarios where their benefits are maximized (Le et al., 2023).

In particular, BIs in the emergency department have been shown to be more cost-effective than when applied in outpatient settings, with an estimated savings of $8.63 per patient, resulting in 13.8% more people reducing their consumption below the risk threshold (Barbosa et al., 2015). In addition, a review of studies developed in these settings (Kaner et al., 2018) found that BIs are more effective than no intervention or minimal interventions, being able to reduce alcohol consumption by an amount equivalent to stopping drinking one day per month (Tanner-Smith et al., 2021). However, in people with more severe drinking, their effectiveness is limited, so combining SBIRT with more intensive treatments or group therapies is recommended for better results (Babor et al., 2017; O'Donnell et al., 2014; Saitz, 2010).

In the area of tobacco use, the effectiveness of brief advice from healthcare providers has also been demonstrated. Brief advice or minimal intervention administered by family physicians in primary care has been shown to be as effective as medication for smoking cessation (Chirila et al., 2024). For people who are not ready to quit smoking, however, motivational interventions seem to have a

superior effect to other BIs or brief advice in inducing quit attempts, especially if cessation is approached gradually (Klemperer et al., 2023). Meta-analyses such as that of Aveyard et al. (2012) conclude that medical advice significantly increases long-term abstinence rates. BIs combined with behavioral support also appear to improve smoking cessation rates, increasing the probability of success by 10% to 20% (Hartmann-Boyce et al., 2019), with these results being maintained even after six months (Hartmann-Boyce et al., 2021).

On the other hand, the application of BIs in cannabis use is less common, partly due to the methodological limitations of the studies and the lack of interventions adapted to these substances (Cortés-Tomás & Giménez-Costa, 2022; Gex et al., 2024). Some systematic reviews indicate that BIs may have positive, albeit modest, results when applied in school or university contexts (Carney et al., 2016; Halladay et al., 2019; Li et al., 2019). However, BIs do not appear to be as effective in reducing the frequency or severity of cannabis use in healthcare settings, for either adults or adolescents (Chazal et al., 2022; Gette et al., 2023; Imtiaz et al., 2020).

In summary, BIs have proven to be a promising strategy for reducing the use of various substances, especially alcohol and tobacco. However, the efficacy of these interventions varies according to the substance, the context, and the population group, so it is important to continue researching and adjusting them to maximize their effectiveness in different scenarios.

Main Components of Extended and Intensive Brief Intervention

In this article, the different types of BIs have been defined. Extended and Intensive BIs also require a more complete analysis, given that they are the most effective due to their complexity and high degree of specialization. Like other effective treatments for addictive behaviors (Cortés-Tomás et al., 2024), the main components of EIBIs combine cognitive-behavioral (CBT), motivational, and relapse prevention approaches.

Functional Behavioral Analysis

Functional analysis is the foundation element of CBT and the first step in the EIBI, allowing for a detailed assessment of the addictive behavior along with its antecedents and consequences. Self-monitoring is a key tool that helps monitor consumption and identify patterns and situations that may be of greater risk. This information is essential for defining treatment goals (which can range from abstinence to minimal consumption), identifying triggers for substance use, and/or providing normative feedback on consumption and its contingencies (Coloma-Carmona & Carballo, 2022).

Motivation Enhancement Strategies

The EIBI incorporates elements of motivational interviewing (Miller & Rollnick, 2023) designed to facilitate decision making and increase motivation in relation to the substance use behavior. Originally, its principles were grouped under the acronym DARES, which included creating discrepancy, avoiding argumentation, managing resistance, expressing empathy, and promoting self-efficacy (Miller & Rollnick, 1991). Later, these principles evolved into four major processes: establishing a bond with the patient, focusing on specific goals, evoking motivation, and planning actions to implement change (Miller, 2023).

To achieve these objectives, various therapeutic strategies are employed within MI that invite reflection and decision-making. One such strategy involves providing feedback on assessment results, often accompanied by normative information about consumption in a reference group. This allows the individual, in a neutral manner and without direct confrontation, to compare their own consumption behavior with that of others and make informed decisions. Another common technique is the decisional balance, which consists of evaluating the costs and benefits of both maintaining and modifying substance use.

Also fundamental within these motivational techniques is the use of what is known as OARS, a set of verbal and nonverbal techniques designed to promote communication and change processes (Center for Substance Abuse Treatment, 2019). OARS is the acronym for four essential skills in MI: the use of *open-ended questions* that facilitate exploration of experiences and beliefs without closed-ended responses, inviting reflection (e.g., instead of asking "Do you use alcohol?" you might say "Tell me about your alcohol use"); *affirmations* that reinforce the person's accomplishments and strengths to increase self-efficacy; *reflective listening*, which demonstrates understanding and encourages recognition of the patient's own thoughts and emotions; and *summaries* and paraphrasing of the person's input, which in addition to demonstrating active listening, helps bring structure and clarity to the conversation.

Relapse Prevention

Relapse prevention, based on the Marlatt and Gordon (1985) model, is a model that incorporates cognitive-behavioral strategies to reduce the risk of relapse after making changes in consumption. Among its main strategies are: (1) *lifestyle* changes (e.g., leisure time) seeking rewarding behavioral alternatives and greater organization of daily activities; (2) *identifying high-risk situations*, such as those associated with exposure to environmental stimuli (e.g., places where the individual used to consume habitually), intense emotional states (both positive and negative), and social pressure (e.g., being offered substances by friends); and (3) *developing action plans* for training in coping skills and individualized problem-solving, with short-term, broken-down goals that facilitate the gradual implementation of change (Marlatt & Donovan, 2005). (4) Additionally, an *increase in self-efficacy* is promoted by encouraging the patient to objectively observe their use and to break down the change goal into small, achievable steps (e.g., to consider cessation of use in specific situations or to reduce consumption gradually if the patient is reluctant to quit), thus facilitating success in coping with these situations), (5) *cognitive restructuring* is also used to modify erroneous beliefs about consumption and the change process, with the goal of helping the individual continue in the process of change, even if they experience a temporary lapse in use (Coloma-Carmona & Carballo, 2022).

Conclusions

The aim of this article has been to present BI in addictive behaviors as an efficacious, efficient, and effective strategy to provide realistic solutions to some of the major problems of addiction treatment. The vast majority of people with addiction problems still do not receive care, and it is necessary for researchers, professionals, and those responsible for healthcare, educational, and social systems to be aware of the variety of interventions that can help bring change options closer to individuals, as well as improve treatment initiation and adherence.

Integrating strategies that promote treatment initiation and adherence into addictive behavior intervention services is crucial for improving treatment effectiveness and outcomes for people with addiction problems. By incorporating these strategies into outpatient, inpatient, educational, social, and aftercare services, the different systems that support people with addictive behaviors can help and engage them better, resulting in improved outcomes.

In conclusion, it is necessary for the professional role in the field of addictions to be more active and closer to the population, working to reduce the barriers to intervention. BIs can be used to normalize change. These interventions are characterized by a greater focus on motivation, a shorter duration, and they are perceived as more open, empathic, and less judgmental interventions. Addiction treatment should move away from being something that is distant from people's realities, reserved only for those with severe problems, and instead become a diversified set of actions that offer useful and context-adapted alternatives to promote change-especially among those who continue to use and are not considering seeking help.

Conflict of Interest

The authors declare that they have no conflicts of interest.

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