X. Chapter: The psychotherapy of addictions

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Aim

The aim of this chapter is to become acquainted with non-medication methods necessary for the assessment and treatment of alcohol and drug addiction. Subsequent to mastering the knowledge contained in this chapter, the student will become acquainted with the methods of short intervention and motivational interviews, and gather information about the cognitive behavioural therapy of addictions.

Introduction

Introduction

In this chapter you will become acquainted with simple non-medication treatment methods, through which substance abuse may be approached in general medical practice.

Target group: general practitioners, psychologists, psychology undergraduates and medical students

Task

Suggested study methods:

Read the texts.
Following this, answer the comprehension questions.
If you were not able to answer all the questions, survey the problematic parts in the texts again.

Total **amount of study-time necessary:** 6 hours

Key words: Addiction, substance abuse, short intervention, motivational interview

Content of chapter

	X./2.4.: Education for low-risk drinkers X./2.5.: Simple counselling for those belonging to the second risk group X./2.6.: Short consultation for those belonging to the third risk group X./2.7.: Fourth risk group: further direction **X./3. The motivational interview** X./3.1.: Motivational models X./3.2.: The method of the motivational interview **X./4. Techniques used in the psychotherapy of addictions** X./4.1. Behavioural therapy X./4.2. Cognitive therapy X./4.3. Dynamically oriented psychotherapy X./4.4. Summary

	## *X./1: General questions of addiction*
Aim	In the course of the reading of this chapter the student becomes acquainted with the general questions and models of addictions.
	## X./1.1: The epidemiology of substance abuse
Important	In Hungary drinking problems are the most frequent substance abuse. If we estimate the number of alcoholics on the basis of the number of those who died of liver cirrhosis, then it comes close to one million, but at the same time the number of high-risk drinkers (the group of those at risk) is even bigger. According to the survey of Péter and his colleagues, the number of alcoholics combined with the number of those at risk may be put at two million (Péter 1997). From among the illegal substances the most widespread ones are marihuana, amphetamine derivatives, and heroin. A permanent problem for both the authorities and public health is the appearance of new drugs on the market.
	## X./1.2: Psychiatric diagnoses connected with substance abuse
Question: What psychiatric diagnoses do you know which are connected to substance abuse?	[P_1a_figure_X_1_chapter.doc, P_1b_figure_X_1_chapter.doc, P_1c_figure_X_1_chapter.doc] Legend: *Figure 1.: Psychiatric diagnoses connected with substance abuse according to DSM IV. on page 6*
	## X./1.3: General principles of the treatment
Important	In the psychotherapeutic approach to addictive diseases we may find non-professional and professional methods, as well as the combination of the above. It is a widely held view in lay public circles and often exists in professional circles, that the efforts made for curing alcoholics and drug addicts are of no use the chance of an effective cure issmall. On the other hand, many non-professional (e.g. Anonym alcoholics) and professional methods (e.g. short intervention, cognitive behavioural therapy) produce promising results. One of the characteristics of addict patients is a truly **unstable or deficient disease consciousness** and an **ambivalent motivation** shown towards recovery. For this reason **the essential question in the first phase of the treatment is the**

strengthening and preservation of motivation, the clarification of the intentions of the patient, and the recognition and discussion of contingent hesitations. At the establishment of the therapeutic alliance the patient must be aware of the advantages, drawbacks and dangers of giving-up, of what sufferings and risks he must reckon with, and of what the treatment means and oft his responsibilities.. Moreover, this is the phase when we have to discover those surrounding the patient who will support him in the giving-up and establish what kind of help he may expect from whom. With patients using illegal substances the consolidation of the therapeutic relationship is further encumbered by the distrust of the patient. In many cases this process requires great flexibility from the therapist.

X./1.4: Models of the treatment of addiction

Important

From the point of view of the evolvement of addictions and their therapeutic approach various kinds of working models exist. The integrated models born from a combination of certain elements of the five basic models introduced below have proven most useful in the clinical practise. The five basic models are the following (Gerevich 2008):

Question:

What are the advantages and drawbacks of the five basic models?

1. **Moral model**
   - The cause of addiction: moral weakness, weak will
   - The aim of the treatment: the development of willpower
   - Its drawback: the therapist acquires the role of the examiner and judge
   - Advantage: it directs attention to the moral questions as well
   - The method based on the model: certain religious communities; a few steps of the 12-step integrative model of the Anonym Alcoholics is based on the moral model (e.g. step 4: introspection: *"We draw up a thorough and daring moral inventory of ourselves"*).

2. **Learning model**
   - The cause of addiction: defective learning. Drug consumption entails repeated positive (getting a pleasant and joyful experience as an effect of the drug) and negative (relief of an unpleasant condition as an effect of the drug) reinforcements, and this defective conditioning preserves the consuming behaviour.
   - The aim of the treatments: the assessment of the consumption strengthening factors and the termination of their incentive (promoting drug consumption) effects
   - Its drawback: it hardly emphasizes the responsibility of the patient and the original promoting factors of drug consumption
   - Its advantage: the patient's responsibility is raised in learning, though not in consumption; it is practical
   - Method based on the model: behavioural therapy

3. **Disease model**
   - The cause of addiction: unknown. Addictions are independent, idiopathic diseases that are to be treated as primary disease units
   - The aim of the treatments: long-term symptomatic treatment (preserving abstinence with e.g. with medication)
   - Its drawback: it hardly emphasizes comorbid diseases and the responsibility of the patient
   - Its advantage: it has no punitive character; it encourages asking for

help
- Method based on the model: methadone preserving treatment

4. Self-medicalization model
- The cause of addiction: psychiatric or psychological deviation or disease; the patient uses the substance for the "curing" of this
- The aim of the treatments: treatment of the basic disease
- Its drawback: its is hard to decide whether the psychopathological conditions comorbid with the addiction are causes or consequences; the cure of the addiction does not entail, in itself, the treatment of the psychiatric disease (e.g. depression)
- Its advantage: it does not punish; it pays attention to the comorbid conditions
- Method based on the model: psychopharmacologic treatments, dynamically oriented psychotherapies

5. Social model
- The cause of addiction: social, environmental influences, poverty, peer group, family pathology etc.
- The aim of the treatments: lifting out of the surroundings or establishing better coping strategies
- Its drawback: It overemphasizes the responsibility of the environment
- Its advantage: it can be well integrated with the other models; it treats the patient as a part of his environment
- Method based on the model: long-term, living-in, rehabilitational work-therapy institution

Question:

What example can be given for an integrative model?

In reality we mostly use **integrative models**, which blend individual elements of the above approaches, since each model emphasizes factors that cannot be ignored. In selecting the model to be employed it is important which model the patient thinks in. **An example of the integrative model is the model of double diagnosis**, which deems both addiction and the extant psychiatric disease or pathological personality factor as a primary problem, thus although it pays attention to both, these are not in a cause and effect relationship with each other.

Summary

X./1.5: Summary

In Hungary the substance which most often leads to addiction is **alcohol**, which together with the risk drinkers, affects some two million people. DSM IV. knows of several disorders connected to substance abuse: besides intoxication, abuse, dependence and deprivation syndrome, a mood disorder, a sleep disorder, anxiety, psychosis, dementia and amnestic syndrome induced by the substance may also be characteristic of the individual substances.
A frequent difficulty of the treatment of addict patients is an unstable disease consciousness and an **ambivalent motivation**, thus a cardinal point of therapy is the strengthening of the motivation. Different therapies employ different ***working models***. The five basic models are the moral, the learning, the disease, the self-medicalization, and the social model, but in clinical practice the most useful is the employment of integrative models.

Literature

Literature

	American Psychiatric Association, DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, fourth ed. American Psychiatric Association, Washington, DC. 1994.

Figure 1.: Psychiatric diagnoses connected with substance abuse according to DSM IV.

Abuse	The maladaptive use of substances resulting in clinically significant damage or disorder during a 12 month period when at least one or more is true from the list below: 1. Re-occurring substance use which results in faults in the person's performance at work, in school or at home 2. Re-occurring substance use in cases when it is physically dangerous 3. Legal problems related to substance use 4. Continuous substance use in spite of durable/persistent or re-occurring interpersonal or social problems caused or aggravated by the effect of the substance.
Dependence	The maladaptive use of substances resulting in clinically significant damage or disorder during a 12 month period when at least three of the statements below are true at any time within the same twelve-month-period: 1. **Tolerance** (the need for substantially increased amount of the substance; the effect decreases if the intake of the same dose remains) 2. **Withdrawal** (Typical withdrawal syndrome connected to a particular substance; the withdrawal is alleviated by the intake of the same substance) 3. Often the substance is taken in higher doses or for a longer period than it has originally been intended 4. Constant craving or unsuccessful attempts for controlling or quitting the substance intake 5. Substantial time and activity is directed towards acquiring and use of the substance or towards freeing oneself from the effects of the substance 6. Reducing or giving up important professional, social and recreational activities due to the substance use 7. Continuing the substance use in spite of physical or psychological problems by being aware of the fact that these problems are likely to be caused by the substance abuse
Intoxication	**Reversible substance specific syndrome** caused by the actual exposure to, intake or actual intake of a substance. Clinically significant maladaptive behavioural or psychological changes due to the effects of the substance on to the central nervous system manifesting during or shortly after the substance intake
Withdrawal Syndrome	Substance specific syndrome with clinically significant damage or disorder induced by the reduction of the prolonged use or break in the heavily used substance
Disorders induced by psychoactive substances	The following disorders are included: Delirium induced by a psychoactive substance Dementia induced by a psychoactive substance Amnestic disorder induced by a psychoactive substance Psychotic disorder induced by a psychoactive substance Mood disorder induced by a psychoactive substance

	Anxiety disorder induced by a psychoactive substance Sexual disorder induced by a psychoactive substance Sleeping disorder induced by a psychoactive substance Perceptual disorder induced by a hallucinogen substance

	## *X./2.: The short intervention*
Aim	In the course studyingthis chapter the student will become acquainted with the field of application and the methods of short intervention
Introduction	## X./2.1. Theoretical bases of short intervention
Important	In Hungary in most cases alcoholics and other addicts are treated only after severe internal organic complications (e.g. cirrhosis, pancreatitis) or neuropsychiatric diseases (e.g. alcoholic dementia, delirium tremens) have already developed, or the patient gets confronted with the legal consequences of illegal drug consumption. And even in such a case it is a frequent occurrence that the treatment only focuses on the existent internal organic, traumatological or other problem, and no intervention regarding substance abuse happens. ***Short Intervention technique has been developed by the WHO for the assessment and treatment of problematic alcohol consumption.*** Problematic drinkers constitute a greater proportion of the population than alcoholics do. ***The characteristics of the problematic/risk drinkers are the following:*** 1. Consuming a large amount of alcohol on a daily basis or drinking occasionally but recurrently until intoxicated 2. Alcohol consumption causes physical and/or mental problems 3. Alcohol consumption causes workplace, domestic and relationship problems. 4. With a certain proportion of problem drinkers an alcohol addiction evolves later on. ***The aim*** of Short Intervention ***is the screening of risk and problem drinkers, and arousing motivation to change.*** Through the employment of the method, the alcohol consumption of risk and problem drinkers can be reduced; moreover, the method is suitable for motivating alcoholics to sign up for addictological treatment. Since its 1980 introduction, the efficiency of the method has been proved in many countries by several large sample analyses (Moyer 2002).
Question: What are the questions we use for assessing drinking habits?	## *X./2.2. Screening* According to the recommendation of WHO, the first step of the method is the taking of ***a test that assesses drinking habits*** (Alcohol Use Disorders Identification Test, AUDIT). The test is comprised of 10 questions by the help of which it can be promptly ascertained which risk-group our patient belongs to. The test can be taken in an interview as well as a self-completion questionnaire. (Babor 2001). Read the test questions. [P_1a, 1b, 1c_figure_X_2_chapter.doc]

Question:

List the four risk zones.

Important

Question:

What should low-risk drinkers be educated about?

Question:

What belongs to the scope of counselling in risk zone II?

Legend: *Figure 1.: Test gauging drinking habits*

Questionnaire for Surveying Habits of Alcohol Consumption (AUDIT)

1. How often do you consume alcoholic beverages?

Never (0)
Every month or more seldom (1)
2-4 times a month (2)
2-3 a week (3)
4 times a week or more often (4)

2. Generally how many drinks do you have on one occasion?

One or two (0)
Three or four (1)
Five or six (2)
Seven to nine (3)
Ten or more (4)

3. How often do you consume more than six drinks?

Never (0)
Less than once a month (1)
Once a month (2)
Once a week (3)
Every day or almost every day (4)

4. In the past year how often did you experience that if you had started drinking you were unable to stop?

Never (0)
Less than once a month (1)
Once a month (2)
Once a week (3)
Every day or almost every day (4)

5. In the past year how often did it occur that you were unable to fulfil some of your task due to drinking?

Never (0)
Less than once a month (1)
Once a month (2)
Once a week (3)
Every day or almost every day (4)

5. In the past year how often did it occur that after you had been drinking heavily in the evening you needed a drink in order to start your day in the morning?

Never (0)
Less than once a month (1)
Once a month (2)
Once a week (3)
Every day or almost every day (4)

7. In the past year how often did it occur that you felt regret or remorse after you had been drinking (heavily)?

Never (0)
Less than once a month (1)
Once a month (2)
Once a week (3)
Every day or almost every day (4)

8. In the past year how many times did it occur that due to drinking you were not able to remember what had happened the night before?

Never (0)
Less than once a month (1)
Once a month (2)
Once a week (3)
Every day or almost every day (4)

9. Was someone else ever injured because of your drinking?

No (0)
Yes but not last year (2)
Yes during last year (4)

10. Did someone (a relative friend your doctor or some other professional) worry about your drinking or suggested that you consume less alcohol?

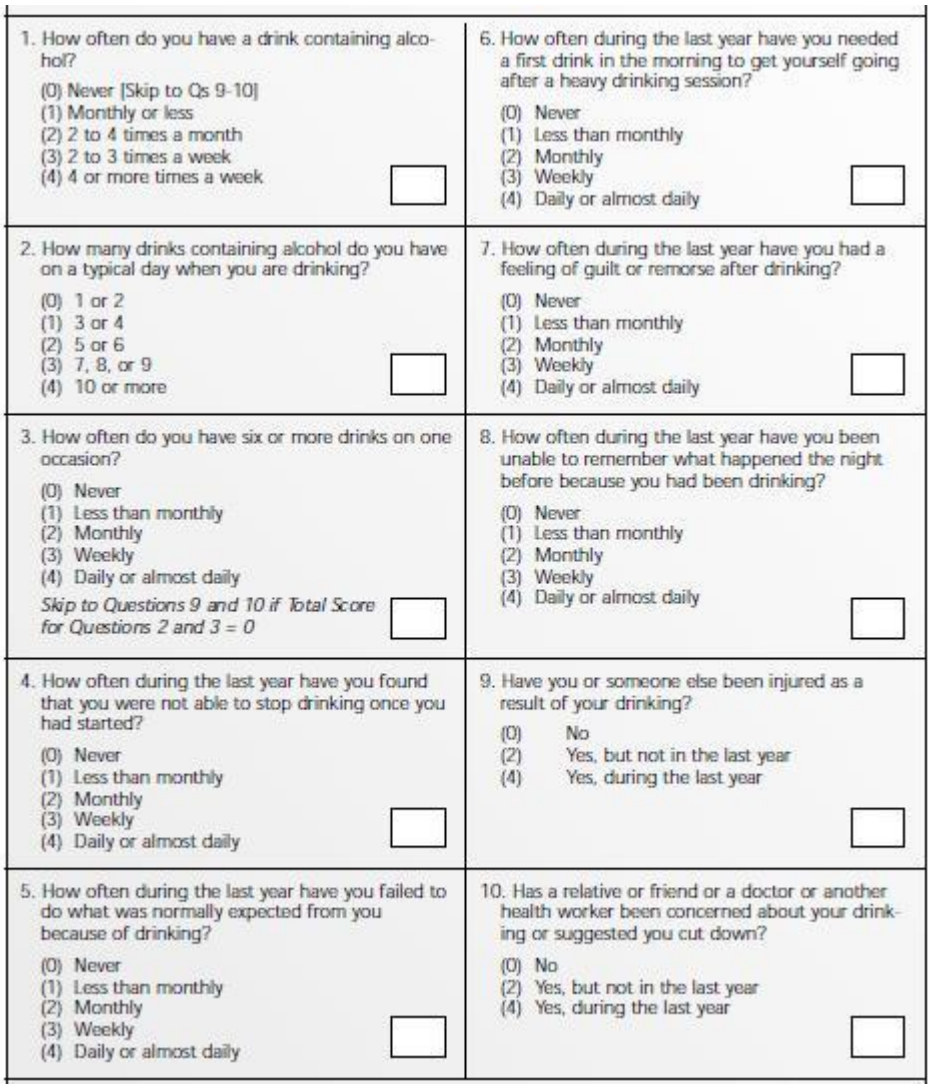
No (0)
Yes but not last year (2)

Yes during last year (4)

rce: Babor TF, Higgins-Biddle JC, Saunders JC, Monteiro MG. The Alcohol Use Disorders Identification Test. Guidelines for use in primary care
://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

Question:

What is the difference between short consultation and simple counselling?



1. How often do you have a drink containing alcohol?
(0) Never [Skip to Qs 9-10]
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily
Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Question:

Who do we direct to addictology care?

According to the recommendation of WHO, based on the test we may separate the different drinkers needing different therapeutic interventions according to the following. It is important to know that point limits are not normative, they may change from country to country and from individual to individual, thus when classifying the actual clinical picture has to be considered as well.

[P_2_figure_X_2_chapter.doc]
Legend: *Table 2.: Recommended interventions in the case of problem drinking*

Risk group	**Recommended Intervention**	**AUDIT points**
1.	Education	0-7
2.	Counselling	8-15
3.	Short consultation and regular follow-up	16-19
4.	Directing patient to a medical doctor specialized in addictology	20-50

X./2.3. The measure of risk drinking

Summary	According to the recommendation of WHO, the upper limit of safe alcohol consumption is a maximum two drinks a day with two alcohol free days a week. Naturally, these data may be slightly modified by the type of the alcoholic beverage, the eating habits, the sex and body weight of the patient, but the limit may not rise significantly. By a "drink" we mean the following: - one glass (330 ml) 5 % alc/vol beer, OR - one pony (40 ml) 40 % alc/vol hard liquor OR - one glass (150 ml) 12 % alc/vol wine For women during the period of pregnancy as well for hepatopaths and patients taking certain medications they recommend complete abstinence.
	X./2.4. Education for low-risk drinkers For those patients, who belong to the group of low-risk drinkers (scored less than 8 points in the AUDIT test), education about alcohol consumption is useful for preventive reasons.
Literature	[P_3_figure_X_2_chapter.ppt] Legend: *Figure 3.: Things to do in the case of low-risk drinkers*
	X./2.5. Simple counselling for those belonging to risk zone II Those patients, who belong to risk zone II (they scored 8-15 points in the test), do not yet experience the harmful effects of alcohol. At the same time there is a great risk for them in developing alcohol-related chronic diseases, and to have accidents, injuries and social problems occurring in their lives. For these patients ***we provide a few minutes counselling***. It is important that during the conversation we behave empathetically, we should not judge, but at the same time be resolute, explicit and clear about what we have to say. We should avoid using threats and pejorative words (e.g. "alcoholic") and should try to motivate the patient instead by providing information and an attentive attitude. A brochure helping the counselling can be found in the material of WHO (in English): http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf [P_4_figure_X_2_chapter.ppt] Legend: *Figure 4.: Counselling in risk zone II*
	X./2.6. Short consultation for those belonging to risk zone III To risk zone III (test-result: 16-19 points) belong patients who already experience the harmful effects of alcohol in the form of somatic and mental diseases, accidents, legal problems, low workplace performance or difficulties in social relationships. ***Short consultation*** is partly comprised of the same elements as those of simple counselling, but discusses the topics in more details, requires more time, and deals with motivation and the developing of skills aiming at the reduction of alcohol consumption as well. ***The elements of short consultation are the following:*** 1. Simple counselling, the elements of which are the same as those in risk zone II 2. Assessing the need for change: • Which are the factors that preserve alcohol consumption?

- Which motivational phase is the patient in? Motivational interview, if needed.
- We should ask the patient, how important it is for him to quit drinking? Evaluate it on a 10-point scale (Miller 1999).

3. Skill development for the sake of reducing alcohol consumption
4. Long-term follow-up

[P_5_figure_X_2_chapter.ppt]
Legend: *Figure 5.: Skill development in risk zone III*

[P_6_figure_X_2_chapter.doc]
Legend: *Figure 6.: A list about the advantages of reduced alcohol consumption*

For skill development a self-help brochure can be found in the material of WHO (in English). http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf

X/2.7. Risk zone IV: further direction

Those patients who scored more than 20 points in the test need ***further examination and specialist treatment***. Short intervention does not substitute for this. It is important to further direct these patients to the adequate places. For this purpose we should always have a list at hand of the helping places of our locality, such as:

- Addictological, psychiatric care-centres
- Addictological, psychiatric and toxicological wards
- Rehabilitational wards, homes
- Anonymous Alcoholics (http://www.anonimalkoholistak.hu)
- Other civil society organizations specialized for alcohol addicts

The result of the test is reported back to the patient as earlier. We should inform the patient that his alcohol consumption far exceeds the secure limit; the drawbacks of this can already be experienced, and the possibility of an alcohol addiction cannot be excluded. We emphasize that this is a serious health problem, which requires further examination and treatment. We should explain to the patient that there is a **causal relation** between his current problems (e.g. somatic symptoms, sleep disorder, workplace worries, etc.) and his alcohol consumption. We should give a detailed explanation to the patient of what awaits him at the place we are sending him for further treatment, which treatment possibilities exist, all of which entails what they are, how much time they take, and what they require from the patient. We should encourage him and stimulate him, and tell him that alcohol addiction is in many cases treatable, and it is still not too late to utilize treatment.

X/2.8. Summary

The method of Short Intervention has been developed by the WHO for the assessment and treatment of problematic alcohol consumption, though similar methods have since been employed in other fields (drug addiction, movement-deficient lifestyle) as well. The ***education*** of low-risk alcohol consumers is useful for preventive reasons. Those consumers who have not yet experienced the harmful effects of alcohol, but their alcohol consumption has already exceeded the secure measure, are provided with ***simple counselling***, where, subsequent to making test-results known, patients are familiarized with the long-term effects of alcohol. Patients already experiencing the harmful effects of alcohol require – besides the above – ***short consultation***, in the course of which skills are taught to them for the sake of changing their drinking habits. Alcohol addicts are ***further***

	directed to a specialized outpatient department or a hospital ward. **Literature** **Babor** TF, Higgins-Biddle JC. Brief intervention for hazardous and harmful drinking. A manual for use in primary care. http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf **Babor** TF, Higgins-Biddle JC, Saunders JC, Monteiro MG. The Alcohol Use Disorders Identification Test. Guidelines for use in primary care. http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf **Miller** WR. Enhancing motivation for change in substance abuse treatment. U.S. Department of Health and Human Services, SAMHSA/CSAT, Rockville, 1999. **Moyer** A, Finney JW, Swearingen CE, Vergun P. Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. *Addiction* 2002 Mar;97(3):279-92.

	## *X./3.: The motivational interview*
Aim	In this chapter the student will become acquainted with the models of motivation as well as with the practical questions of motivation
	## X./3.1. Motivational models
Introduction	The motivation for change of patients struggling with similar problems may be very different. Motivation plays a major role in changing behaviour, but according to the research, between the motivation extant at the beginning of each therapy and the success of the therapy there is no explicit connection. The **inconstancy of motivation** may be responsible for this: scarcely motivated patients may become committed to change even after only one therapeutic session, while the failure experienced during therapy may lead to the decrease of motivation (Lambert). The motivation of alcohol and drug addicts is generally ambivalent and vulnerable. Many deny even the existence of the problem, others acknowledge it, but they have not committed themselves to change, others again have already committed themselves to change, and perhaps have even started executing it. In the individual phases of change different therapist attitudes are necessary.

Question

What is the aim of the motivational interview?

[P_1_figure_X_3_chapter.doc]
Legend: *Figure 1.: Phases of readiness for change (Prochaska 2003).*

Stages	Characteristics	The therapist's Tasks
Pre-contemplation	The patient does not recognize the problem; therefore, he/she does not want to change. The patient is hostile and has arguments with the treating staff. The patient denies the problem or feels that the problem is with other people not with him/her.	Defining the patient's objectives Facilitating the problem recognition Providing information
Contemplation	The patient recognizes/admits the problem, but he/she is still contemplating about the change and has not committed himself/herself to change; he/she is ambivalent.	Revealing contradictions between the patient's behaviour in the present and his/her future objectives
Determination	The patient is dedicated to change.	Reinforcement
Action	The patient starts to change.	Recognising barriers, managing the difficulties
Maintenance	The behaviour change is stable.	Bolstering stability
Relapse	The problem behaviour reoccurs.	Admitting relapse Finding new grounds for motivation Creating new behaviour strategies
Termination	The change is stable.	Facilitating stability

Important

According to another model of motivation, the **self-determination theory**, the intensity of motivation depends on its place (Pelletier 1997). The patients with **external or extrinsic** motivation are those who have been sent to therapy by another person, so there is someone else insisting on change: e.g. family member, spouse, boss. We speak of **internal or intrinsic** motivation when the patient wishes to change his life in his own interest.

X.3.2. The method of the motivational interview

The aim of the motivational interview is to strengthen the intrinsic motivation of the patient so that he recognises the extant problem, be confronted by the contradiction between his own aims and his problematic behaviour, and commences change.

The five basic elements of the motivational interview *(Millner és Rollnick 1991):*

1. We should behave empathically, and try to understand the points of view of the patient
2. We should help the patient to ***recognise the discrepancy*** between his future aims and current behaviour
3. We should avoid argument, because goading and arguing intensifies the resistance of the patient
4. In case of resistance we should change strategy and find solutions
5. We should maintain the feeling of self-efficacy in the patient: as soon as he recognises the problem and offer solution options, we should express our optimism and our faith in change

Advice for the motivational interview *(Millner és Rollnick 2002, Lambert:)*

- Assess the patient's **own motivation**, e.g. ask him how much he strives for change (on a 10 point scale)
- Instead of asking ourselves, *"Why does this patient lack motivation?"* we should rather ask, *"What is this patient motivated byr?"*

Summary

Literature

- We should communicate with the patient by the method of open-ended questions and reflective listening
- We should talk about the patient's ***aims***, principles, commitments
- Ask the patient to imagine and write down ***what he would like*** his life ***to look like***
- Discuss how the ***current behaviour*** of the patient relates to these aims
- Discuss how the patient's current behaviour may affect his surroundings
- Emphasize the ***contradictions*** between the patient's own aims and his current behaviour
- Discuss the ***advantages and drawbacks*** of problem behaviour
- Discuss the advantages and drawbacks of a contingent change: ask the patient to write down why it would be and why it would not be good to change
- We should express our trust that our patient will be able to change
- We should avoid offering ready solutions! In this phase the aim is to thoroughly examine the patient's ambivalence
- At the end of the interview we asses by using open-ended questions, how ready the patient is to commit himself

X.3.3. Summary

The patient's motivation to change may be interpreted in several model frames. Prochaska's model defines the stages of the readiness for change as follows: pre-contemplation, contemplation, and determination, which may be followed by the stages of action, maintenance, termination and in certain cases relapse. Other models emphasize the external or internal nature of motivation.
The aim of the motivational interview is for the patient to recognise the contradiction between his current behaviour and his future aims, for his motivation to be internalised and for him to become committed to change. Instead of arguing and goading, the motivational interview attains its aim by empathic reflections and open-ended questions.

Literature

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Aim	## *X./4.: Techniques used in the psychotherapy of addictions* In the course of reading this chapter the student will become acquainted with psychotherapeutic techniques used in the treatment of addiction and the prevention of relapses.
Important	## X./4.1. Behavioural therapeutic methods ***Stimuli, connected to substance abuse, play a significant role*** in preserving addiction and in relapses. Reinforcing stimuli or triggers may be of two kinds (Gerevich 2008): ***1. Primary triggers:*** They create pleasant effects by themselves. These must be permanently avoided right from the beginning of the treatment. E.g.: pubs, drug dens, dealers, junky pals, festivals. ***2. Secondary triggers:*** Inner stimuli that often lead to consumption. It is an aim that the patient should learn to deal with these stimuli in such a new way that differs from drug consumption. E.g.: craving, stress, depression, boredom, relationship conflicts. **Techniques used in behavioural therapy** (Bodrogi 2010, Gerevich 2008):
Question What does systematic extinction mean? What does stimulus control mean?	1) **Developing abstinence:** the first step of therapy. In the course of this it is important to avoid primary triggers, in which the 24 hour control of family members or living-in treatments may be of help. 2) **Systematic extinction:** If the patient encounters drug-connected stimuli, but these are not reinforced by drug effect, conditioned stimuli gradually lose their drug-seeking behaviour inducing effect – their effect gets extinguished. The first imagined then real presence of primary and secondary triggers is not followed by drug effect. 3) **Learning alternative responses:** We substitute the function of drugs with some different activity that induces similar effects. With extreme sports, for example, in the case excitement inducing drugs, with meditation, in the case of relaxing drugs, and a drug-free circle of friends in the case of party drugs. It is necessary to establish constructive, substantial activities that are adjusted to the needs of the patient. The patient keeps a diary about these under the supervision of the therapist. 4) **Stimulus control:** A part of the situations connected to drug abuse can be avoided, another part cannot (e.g. sadness, boredom, failure). The patient and therapist together work out alternative solutions for these situations

(e.g. sad – phones one of his family members, goes for a bike ride , phones the therapist, writes into his diary, listens to music, goes to the movies)

5) **Life skills:** Drug abusers often have poorer social and coping strategies. The aim of skill development is the teaching of these skills, for example: decision making, expressing emotions, the ability to say no, the ability to use one's time well, social skills etc. Skill development is also possible in the course of role-plays or group work.

6) **Refusal:** We especially highlight the ability to refuse, since many patients may be pressured into substance use by their surroundings. For example: workplace and family events, celebrations, where alcohol consumption is the expected norm. In such cases it is important to be able to say no, which is practised in the course of role-plays, then in real-life situations. (Bodrogi 2002).

X./4.2. Cognitive therapy methods

The aim of cognitive psychotherapy is the **identification of those dysfunctional attitudes and negative automatic thoughts** that are in the background of unwanted behaviour or an emotional state. In the case of addictive disorders, specific events activate the patient's beliefs, which lead to negative automatic thoughts and addictive behaviour (Bodrogi 2010).

Question:

Can you give an example of addictive beliefs?

Addictive beliefs can be of various kinds. Anticipatory beliefs are the so-called "self-fulfilling prophecies", that is the expectations anticipating the effect of the substance. For example: *"I'll soon mellow out from the grass", "I cannot cool down, unless I smoke a cig", "I always get cheerful from a shot of good brandy".* Another large group of beliefs is comprised of the **concessive type of beliefs**, with which the patient may resolve the contradictions and conflicts connected to substance abuse. E.g.: *"I can put it down anytime", "After such a stressful day I really deserve some chilling out", "I had a quarrel with my girlfriend, so I can safely have a drink."*

The aim of cognitive therapy is the **identification and modification** of beliefs characteristic of the patient. Dysfunctional beliefs are mostly generalizing, and while the patient feels them to be completely and unquestionably true, generally this does not conform to the facts. In the course of keeping a **thought diary** the patient becomes able to recognise his own negative automatic thoughts, and learns to substitute them with more realistic and more adaptive thoughts.

Question:

What is a thought diary?

X./4.3. Dynamically oriented psychotherapy

The psychoanalytic (dynamic) approach to addiction is essentially different from that of behavioural and cognitive therapy. While cognitive therapy builds on the learning model, psychoanalytic therapy is based on the self-medicalization model. The properties of the individual substances are also considered essential by the psychoanalytically oriented therapies: uppers vs. downers, aggressive vs. regressive drugs. As for the efficiency of psychoanalytic therapy there are as yet no available convincing data (as opposed to those of cognitive and behavioural therapies), on account of its clinical significance, however, it deserves mentioning.

	While earlier theories assumed repressed sexuality, homosexuality or aggression as causes, the current psychoanalytic conception of addiction emphasize the collective role of a peculiar personality organization (e.g. borderline or narcissistic) and external exciting factors (Gerevich 2008). Psychoanalytic therapy aims to be thoroughly acquainted with the personality structure, to reveal the primitive self-defence mechanisms (splitting, projection, projective identification) and to evolve more developed self-defence mechanisms. An advantage of the analytically orientated therapy is that it also pays attention to the person of the therapist, and the feelings and impulses generated in him, since patients suffering from addiction often provoke negative impulses with their aggressive, inconsistent and extreme behaviours, which the therapist may treat in the scope of supervision (Gerevich 2008). It is important that the first step is to reach abstinence, because active substance use is counter-indicated by psychoanalytic psychotherapy. **X./4.4. Summary** The primary aim of the psychotherapy of patients suffering from addiction is the **prevention of relapses**. Cognitive behavioural therapy, the efficiency of which has been proved by literature data, is based on the learning model. The aim of the **behavioural therapy** is the systematic extinction of the conditioned stimuli connected to the substance, the development of alternative response behaviours, and skill development. The method of **cognitive therapy** is the revelation and modification of addictive dysfunctional beliefs, the recognition of negative, automatic thoughts and the substitution of them with more realistic thoughts. One of the methods of cognitive therapy is the thought diary. Cognitive and behavioural therapeutic methods are often employed together. **Psychoanalytically** (dynamically) orientated therapy plays a minor role in the treatment of addicts, but with some patients it can be useful through the revelation of personality pathology. It is based on the self-medicalization model, and an advantage of it is that it deals also with the impulses that are generated in the therapist. The introductory step of psychotherapies is always the attainment of abstinence.
Summary	
Literature	