PSYCHO-EDUCATIONAL GROUP THERAPY FOR ALCOHOL AND DRUG DEPENDENCE RECOVERY

KISHORE CHANDIRAMANI, B.M.TRIPATHI

SUMMARY

A brief psychosocial intervention model for alcohol and drug dependence recovery has been evolved in the form of psycho-educational group therapy. The package comprises of eight sessions conducted thrice a week over a period of about three weeks following detoxification. It aims to equip the patients with information and knowledge relevant to the needs of recovery. The program covers topics such as craving and relapse, medical complications, treatment process and recovery, family, social and job problems and structuring free time. Apart from achieving abstinence, the objectives of the program include enhancing functioning in personal, social and professional spheres by developing healthy and intimate relationships and promoting alternate activities.

INTRODUCTION

Group therapy is the most commonly used psychotherapeutic approach for the treatment of alcoholism (Nace, 1987) and substance use disorders. It can be employed both in early treatment as well as in the later stages of recovery. The commonly used therapy models are psycho-educative, cognitive-behavioral or psychodynamic. These may be conducted in a variety of areas such as inpatient, outpatient, after-care and community settings (Yalom, 1985; Vingradov & Yalom, 1989). This paper describes a psycho-educational model for substance use disorders.

Apart from achieving abstinence, the goal of this program is to enhance patients' quality of life by means of improved functioning in personal, social and professional spheres. The package consists of eight sessions, each focusing on a specific issue or topic considered important in the process of recovery. While being complete on its own, each session also complements the other sessions in the package. All those admitted as inpatients undergo all the eight sessions. Patients who relapse and are readmitted, and those who have previously attended this package are referred for a more intensive "relapse management program" of group therapy.

THE GROUP PROCESS

THE GROUP

The group comprises of eight to twelve alcohol and/or drug dependent individuals who have undergone detoxification. The group sessions are conducted thrice a week over a period of about three weeks. Each session is held for about 45 to 60 minutes. Patients with serious discipline problems are excluded from the group as they are unlikely to benefit, and could even be disruptive. Although no suggestion is made in the group for socialization among members outside sessions, it has been observed that the group therapy package promotes socialization among members and the opportunity has potential for constructive use.

THERAPIST ACTIVITY AND GROUP PROCESS:

The group leader establishes a climate within the group that fosters a sense of acceptance and permissiveness with everyone. He gives equal attention to every statement expressed in the group and avoids preaching and moralizing. He avoids didactic lectures and allows the group members to pick up issues related to the topic and respond to them with minimal help from him. Since this approach is education oriented, no attempt is made to interpret or resolve deeper conflicts. Although transference is not a common occurrence in such situations, the therapist should always remain on guard for any evidence of negative counter-transference which is most likely in a drug dependence setting.

The group leader tries to identify, define and state real issues. He seeks relevant information, clarifications and solutions from the group and in turn suggests constructive alternatives. He encourages the members to participate by supporting them and harmonizing the interaction. In order to elicit relevant information he sometimes confronts individual members, but in the end seeks consensus and summarizes the discussion.

THE SESSIONS

As described earlier the package comprises of eight sessions. These can be facilitated by psychiatrist, psychologist or social worker. Session wise details of the coverage and key points are as follows:

SESSION I: INTRODUCTION

The session starts with the group leader explaining the reasons for assembling, the objectives of the program and a brief introduction of each member to the group. The patients are encouraged to narrate their experiences related to starting the drug habit and seeking treatment. The relevance of increasing the awareness and knowledge of the nature of dependence and recovery process is discussed, giving the example of a diabetic patient who needs to be educated about the illness, diet control, blood sugar levels, side effects and overdosing of drugs etc. for successful treatment (Zuckon et al, 1985).

SESSION II: MEDICAL COMPLICATIONS

The general awareness of most patients about the adverse health consequence of various addictive substances is restricted to a few physical hazards only. The therapist, therefore, tries to discuss all possible health hazards including psychological consequences. The factors respon-
sible for medical complications such as impurities in street drugs, unsafe modes of administration, neglect of normal dietary and hygienic habits are discussed.

Key Points:
1. After a certain stage bodily changes become irreversible e.g. cirrhosis of liver and memory loss. If detected early, normalcy can be restored following abstinence.
2. Symptoms may not appear until significant damage has already occurred, so having no symptoms does not mean one is free from health hazards.
3. The chronic effects of addictive drugs can be just the opposite of the acute effects for which the patient takes these. For example, acute effects like euphoria, increased energy and sexual enjoyment for which a person takes the drug are generally followed by chronic effects like depression, poor motivation and sexual inadequacy.

SESSION III: FAMILY ASPECTS
The majority of drug dependents have family problems which could be the cause or the consequence of drug habit, or both. Small tiffs usually act, as triggers for drug use. The self defeating nature of patients behavior in response to family members in terms of both positive and negative aspects.

Key Points:
1. The family members may get angry and hostile towards the patient because they love him and cannot remain indifferent to him. Their distrust of the patient is generally the result of patient's past behavior and this should be faced. Trust will be gradually regained following continued abstinence.
2. The patient should develop the conviction that he can give up drugs irrespective of receiving help from others. However, if any help comes his way, he should accept it gracefully without exploiting or rejecting it.
3. It is well known that to some extent discord leads to drug use. On the other hand, intimacy in family relationships can be a great help in recovery.

SESSION IV: SOCIAL AND PROFESSIONAL ASPECTS
The drug habit usually starts as a social activity and gradually over a period of time the "peer group" influence assumes a major role in the continuation of drug habit. The need to form a 'new peer group' by choosing non drug users as friends and rearranging social life to avoid dangerous (drug offer) situations is emphasized in the group.

Key Points:
1. The patient may request his close friends for help by asking them not to tease, mock at his attempts or tempt him with drugs.
2. Active drug users might force the recovering patient to take drugs because his abstinence evokes guilt and envy in them. The patient is advised to be firm and accept any leg pulling with good humor.
3. The patient needs to learn new ways of interacting with active drug users. To say 'no' and mean it can be a source of pride and strength. Simply telling "I don't use any drug or alcohol because I am a former addict" usually elicits support and respect.

SESSION V: TREATMENT PROCESS AND RECOVERY
The controversial issue of 'disease' vs 'lifestyle' concept of drug addiction is discussed in the group. An integrated view point encourages the patient to seek treatment and also to take responsibility for his addiction and behavior change. The various phases of treatment i.e. detoxification, follow up, after care and rehabilitation are discussed. Patients are advised to maintain contact with treating physician for at least a year. The discussion includes patients' expectations from drugs prescribed, the nature and mechanism of action of prescription drugs, dependence on prescription drugs and coping with withdrawal symptoms. Patients who hold extreme views about using minor tranquilizers, i.e. either demanding too much of it or being reluctant to use it, are encouraged to adopt a balanced view. The possibility of a psychological problem co-existing with drug addiction e.g. an anxiety or depressive disorder is discussed.

SESSION VI: CRAVING AND RELAPSE
Craving is a universal phenomenon among drug addicts; it usually leads to relapse. The common trigger situations for relapse and the ways to handle them are discussed in the group. The triggers could be stress, overjoy, anger over mistrust, teaching somebody a lesson, feeling unhappy and peer pressure. The symbolic value and the impact of triggers is determined both by external and internal factors. Although external factors such as unemployment, family and social problems, chronic illness, financial gain or loss do contribute to drug taking, internal factors are generally more important. The common internal factors are inability to cope with everyday stresses, depression, boredom, loneliness, feeling of emptiness, masochism, insomnia, sexual inadequacy, anger outbursts and poor utilization of leisure time. The patients are encouraged to discover their own reasons for drug taking. Invariably, the real reasons for taking drugs are not what the patient believes or pretends to be.

Key Points:
1. Craving could be a conditioned response in certain situations that are strongly associated with drug use.
2. Craving is related to expectancy. It is much less in a controlled environment.
3. Complete abstinence is easier than taking drugs off and on.
4. Though general craving may persist for days together and perhaps even longer, the actual craving for a dose lasts only for a couple of minutes at the longest. If the patient can control himself for even a few minutes, the urge will fade and his self control will increase.
5. Willpower isn't everything. Relapse means bad planning rather than poor willpower. A lapse should not be confused with relapse. One might slip; if that happens, one should get back to recovery
immediately. These slips probably indicate a need to work on a better plan.

SESSION VII: STRUCTURING FREE TIME

Perhaps the biggest and toughest void to fill in an addict's life during recovery, is that of pleasure and recreation. For many ex-addicts good times meant drugs and nothing else and they start missing those enjoyable moments. It is therefore essential that the 'conditioned enjoyment' is delinked from the drug ritual and attached to a new set of habits and experiences. This session deals with the task of adapting to drug free pleasures. The group members are asked to think about the activities they always thought of doing but could never pursue and are asked to see how others enjoy life and to incorporate those missing elements in their life. The various leisure time activities which can be offered to the group are trying new magazines, music, movies, gardening, painting, cooking favorite dishes, brisk walk, exercise, yoga, meditation, writing letters, swimming, joining evening classes, meeting new people etc. Stopping drugs is a positive action, a beginning of something new and not simply saying no to ill health and premature death.

SESSION VIII: CONCLUSION

The discussion during this last session deals with the following issues.

Key Points:

1. The new identity of the patient should be a balanced mix of the "new image of non-user" and that of "an ex-addict".
2. A confirmed non-user is one who does not report craving and has succeeded in preventing relapses which might take a few months to a few years. Therefore, they should not preach, lecture or handout pamphlets to reform other addicts till their own recovery is complete.
3. Voluntary community service can offer an ex-addict many benefits such as increased self esteem, new opportunities for meeting positive people, constructive use of spare time, a chance to make restitution for past wrongs and to learn new skills with little risk of rejection.
4. Recovery is a special opportunity to set new goals and new life directions and this is a chance to formulate short term and long term plans. The goals should be consistent with the needs of recovery. To begin with, the initial goals should be relatively simple to achieve and fun to work on.
5. Existential issues:
One must take full responsibility for his addiction and recovery. The external circumstances are nothing but a reflection of one's own existence.

No matter how hard one tries one cannot remove all the misery from his life. Therefore it is important to keep trying without resorting to drugs and to accept the remaining problems.

The feelings of loneliness and 'being unloved' are, to some extent, universal. One should not lose hope because of these feelings.

COMMON PROBLEMS:

The group process may be affected by disruptive members. Keeping the focus of the group on the assigned topics is a difficult task. Some patients tend to monopolize and therefore disrupt the group process. Jones (1980) has identified some common disruptive behaviors in the group and the ways to handle them.

DISRUPTIVE BEHAVIOR

Intervening people while they are talking
Speech making, dominating
Side tracking, Polarising
Emotionalizing and personalizing issues
Complaining about the system, other patients, meetings etc.

Challenging the leader with regard to data, source and legalities.

The leader should be able to anticipate these problems, prevent their occurrence and be able to respond to such disruptions when they occur in a meeting.

Responding To Disruptive Behavior

Agreeing with the individual's need to be heard and supported and developing the dominant individual's perspective and helping him contribute in a productive manner.

Turning questions into statements. This forces the person to take responsibility for expressing a point of view rather than blocking the process through questions.

Reflecting the dominator's feelings and responding to his motives rather than the contents of his presentation.

DISCUSSION

Early studies recommended that more intensive treatment would provide a better outcome. However, most recent studies have concluded the treatment of some kind is superior to no treatment but differences in treatment methods do not significantly affect the long-term outcomes of substance use disorders (Edwards et al, 1977; Emmick, 1975; Chapman & Huygens, 1988). In a study on comparison of simple advice and extended treatment for alcoholism Chick et al (1988) found that patients on extended treatment were functioning better, even though abstinence was not more common. The effectiveness of brief intervention programs have been demonstrated in alcohol dependence (Orford & Edwards, 1977; Babor et al, 1986) and cigarette smoking (Russell et al, 1979, 1983; Richmond et al, 1986). However, no reports are available on the application of brief interventions to the areas of illegal drug use (Heather, 1989).

This proposed treatment paradigm falls between the 'minimal advice' and 'intensive treatment programs' models. It is more like a 'brief intervention' delivered in a group setting. The program is aimed at imparting knowledge about the treatment of alcohol and drug dependence and the recovery process to a large number of clients. It requires less degree of specialist time and can be conducted by a trained social worker or psychologist in an inpatient or out-patient setting. The psycho-educational...
group therapy can be used as an adjunct to other treatment modalities like family and marital therapy, cognitive behavior therapy, social case work up etc.

Being psycho-educational in nature, the various interpersonal aspects of the group are not analyzed in detail. The educational approach has its own limitations and it may be argued that only imparting education might not bring about the desired change in attitude and behavior. However, a psycho-educational approach could form a vital part of a multi-modal treatment program for alcohol and drug dependent individuals.

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Kishore Chandiramani MD*, Assistant Professor; B.M. Tripathi MD, Associate Professor, Deaddiction Centre & Department of Psychiatry, All India Institute of Medical Sciences, New Delhi 110 029.

*Correspondence.