Indira Gandhi
National Open University
National Centre for Disability Studies

MCFTE-003
Substance Abuse Counselling and Family Therapy

Block

2

THERAPEUTIC INTERVENTIONS

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BLOCK 2 THERAPEUTIC INTERVENTIONS

Introduction

The previous Block of this course clarified the problem of substance abuse *vis-a-vis* different population groups. Units under the previous Block dealt with an overview of alcohol, tobacco and drugs abuse, impact of substance abuse on family issues, HIV/AIDS, and special population groups. In this Block, "Therapeutic Interventions'' you will be introduced to various therapautic interventions with substance abusers. You will study the important principles and techniques used for treatment. This Block consists of five Units.

Unit 4 is on *"Principles of Treatment of Substance Use"*. The Unit discusses the goals of treatment and further explains the method of assessment of substance abuse. Treatment modalities are explained and approaches to treatment are delineated. One needs to remember that addiction is a complex but treatable disease that affects brain function and behaviour. Counselling both individual and group and other behaviour therapies are the most commonlly used forms of drug abuse treatment.

Unit 5 is *"Motivation Enhancement and Relapse Prevention Therapy"*. This Unit deals with the critical significance of motivation enhancement and relapse prevention therapy in the context of individuals suffering from substance use disorders. The Unit explains the therapies in detail regarding their principles, components and strategies used to implement the same. In the end, the Unit explains the efficacy of relapse prevention therapy.

Unit 6 is entitled *"Tobacco Cessation"*. As the name suggests, this Unit starts with tobacco dependence and further explains strategies for tobacco cessation. Use of tobacco is quite prevalent in our society and effective treatment to control this problem is of utmost concern. The unit also explains how to handle the situations and promote tobacco cessation in special situations.

Unit 7 is *"Family Intervention for Substance Use"*. In the first year of study, we learnt in detail about family therapy — its definitions, theories, etc. In this Unit, we would study about the various approaches of family therapy used for interventions for substance use.

Unit 8 is on *"Psychosocial Rehabilitation and Lifestyle Management"*. This Unit starts with discussion on consequences of substance use and need for psychosocial rehabilitation and lifestyle management. It describes in length how psychosocial rehabilitation of substance abusers should be done. It emphasises on proper assessment, family relationships, social support, family relationships, social support, employment and income related aspects, legal issues, stigma and discrimination; and social and recreational opportunities for the persons who are trying to get rid of their addiction.

UNIT 4 PRINCIPLES OF TREATMENT OF SUBSTANCE USE

Structure

4.1 INTRODUCTION

As discussed in the earlier Units, the path to drug dependence begins with the act of taking drugs. Over time a person's ability to choose not to do so becomes compromised, and seeking and consuming the drug becomes compulsive. This behaviour results largely from the effects of prolonged drug exposure on brain functioning. Some individuals are more vulnerable than others to becoming addicted, depending on genetic makeup, age of exposure to drugs, other environmental influences, and the interplay of all these factors.

Drug Dependence is often more than just compulsive drug taking — it can also produce far-reaching consequences. For example, dependence increases a person's risk for a variety of other mental and physical illnesses related to a drug-using lifestyle or the toxic effects of the drugs themselves. Additionally, a wide range of dysfunctional behaviours can result from drug use and interfere with normal functioning in the family, the workplace, and the broader community.

Treatment for drug dependence must help the individual stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in the family, at work, and in society. It is important to understand that drug dependence is a "disease". Hence, people cannot simply stop using drugs for a few days and be "cured". In fact drug dependence should not be seen as an acute condition (like viral fever or malarial fever) which requires a short term treatment. Drug dependence is best seen as chronic, non-communicable disease (like diabetes or hypertension) in which most patients require long-term or repeated episodes of treatment and care to achieve the ultimate goal.

The general principles of treatment for all drugs including alcohol are similar. However, treatments for specific substances may differ as the problems associated with drug abuse and medicines needed are different. Further, pre-treatment variables and severity of addiction vary significantly from person to person and from one substance to another.

Individuals with substance use disorders are heterogeneous with regard to a number of clinically important features, including the following:

- The number and type of substances used;
- The individual's genetic vulnerability;
- The severity of the disorder and the degree of associated functional impairment(s);
- The individual's awareness of the substance use disorder as a problem;
- The individual's readiness for change and motivation to enter into treatment;
- The associated general medical and psychiatric conditions; and
- The social, environmental, and cultural context in which the individual lives and will be treated.

There are several approaches to treat drug addiction. These include medications, psychosocial therapy (behaviour therapy, counselling, cognitive therapy, psychotherapy) or their combination. Behaviour therapies offer people strategies to cope with craving, prevent relapse, and help them deal with relapse, if it occurs. The most effective treatment combines therapies and other services for comprehensive management.

Treatment involves several categories of professionals. They are most commonly general physicians and psychiatrists, psychologists, counsellors, family therapists and social workers. Community leaders, spiritual leaders and even lay volunteers and patients (recovering drug users) have an important role to play in the treatment process.

This Unit discusses various treatment issues, treatment as a process and generalities from a medical perspective. According to the medical model, drug dependence

is understood as a bio-behavioural condition and manifests as a chronic non-communicable disease, with specific symptoms and signs. Thus, affected individuals are considered to be medically ill. Hence, as with many diseases of the above nature (viz. diabetes mellitus, arthritis and asthma), treatment can only modify and alter the course. Use of the term "cure" following treatment, as understood in traditional medical parlance and as applicable to infective diseases, is inappropriate. Many professionals, notably health specialists, accept the above concept. As with treatment models for chronic diseases, treatment for individuals with substance use disorders occurs in temporal phases that include initial assessment, acute intervention, and long-term intervention and/or maintenance, with frequent reassessment during episodic flares in substance use.

Objectives

After studying this Unit, you will be able to:

- Understand the goals of treatment of substance use disorders;
- Outline the vital parameters in making a comprehensive assessment of an individual suffering from a substance use disorder; and
- Understand the the various modalities of treatment available for substance using population.

4.2 GOALS OF TREATMENT

Treatment goals differ from patient to patient and over time and may need to be reframed as the treatment progresses. Traditionally, the primary goal of treatment was to achieve permanent abstinence. The evidence to date also suggests that substance-dependent individuals who achieve sustained abstinence from the abused substance have the best long-term outcomes. However, this goal may remain elusive and alternate goals have to be pursued for some. In this sub-group, intervention is directed towards decreasing the harmful consequences of continued drug use. Such an effort is practical and attainable, and is called "harm reduction". Strategies for harm minimisation are discussed later. The other goal pursues improvement of physical, psychosocial and occupational functioning.

Goals of treatment

- Abstinence
- Harm reduction
- Improvement of health, social, occupational functions
- Improved quality of life

For these patients who wish to reduce their substance use to a "controlled level", treatment may be initially facilitated by the clinician's accepting the patient's goal for moderation while sharing with the patient any reservations the clinician may have about the likelihood of success. If the clinician believes that any level of substance use for the individual carries a risk of acute or chronic negative consequences, he or she should share with the patient this concern and the belief that long-term abstinence would be the best course of action.

The goals for treating a substance use disorder begin with engaging the patient in treatment and may ultimately progress to the patient's achieving and maintaining

complete abstinence from all problematic substances. Along this treatment spectrum or timeline, an individual and his or her physician need to develop *immediate*, *short-term* and *long-term* goals.

- *Immediate* goals may be treatment of withdrawal symptoms (detoxification), intervention of psychosocial and medical crisis.
- *Short-term* goals may include management of medical and psychiatric comorbidity and reintegration with family.
- *Long-term goals* consist of prevention of relapse, reintegration into the society, occupational rehabilitation and improvement in overall quality of life.

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. All the following are immediate goals in the management of substance use treatment except:
   a. Assessment
   b. Detoxification
   c. Management of medical comorbidity
   d. Occupational rehabilitation
2. The following statements about harm minimisation are true except:
   a. Educating about harms of substance use
   b. Improving physical health
   c. Complete abstinence
   d. Minimize hazardous drug taking

4.3 ASSESSMENT

Treatment planning and appropriate interventions follow assessment. Assessment helps in developing a therapeutic relationship with the patient. This relationship is based on trust, empathy and a non-judgmental attitude. Successful treatment of substance use disorders depends on a careful, accurate assessment and diagnosis.

The goals of assessment of patients with substance use disorders are as follows:

- Identifying signs and symptoms of harmful or hazardous substance use
- Making an accurate diagnosis
- Formulating and implementing a management plan
- Developing a therapeutic relationship

The following parameters are vital in making a comprehensive assessment.

4.3.1 Eliciting the Substance Abuse History

A systematic and organized way of collecting information about the patient's history of substance use is to address the following areas:

1) Age at first substance use
2) Frequency of substance use
3) Amount of the substance taken during an episode of use
4) Route of administration for the substance
5) Consequences associated with substance use
6) Treatment history
7) Periods of abstinence
8) Relapses

General questions about the consequences of substance use focus on changes in academic performance, occupational functioning, and interpersonal relationships, as well as medical and legal problems associated with substance abuse.

4.3.2 Psychiatric and Medical History

Patients diagnosed with substance use disorders are more likely to have a co-occurring psychiatric disorder and this can worsen the prognosis. Detailed assessment of co-existing or substance induced psychiatric disorder should be made. A complete medical history—including current and past medical problems, surgical procedures, and medication allergies should also be elicited.

4.3.3 Family History

The family history of substance use disorders may reveal a genetic vulnerability to the patient's own development of these disorders.

4.3.4 Psychosocial Factors

Patient's social and developmental histories provide information about factors that may have influenced the development and maintenance of substance use disorders. Factors like relationships with family, friends and peers, education, occupation, marital status provide information on support, barriers to treatment and expectations from treatment.

4.3.5 Physical and Mental Status Examination

Physical and mental status examinations of patients presenting for an assessment of a substance use disorder are a critical part of the evaluation because (as discussed earlier) both medical and psychiatric disorders are commonly found in this population. A complete general physical examination to identify any medical complications and mental status examination to assess comorbid psychiatric illness is vital as both the factors influence level and nature of treatment required.

4.3.6 Laboratory Tests

These help in confirmation of drug use, screening for illnesses predisposed by the drug used, and investigation of abnormalities uncovered in assessment. You will read more about this aspect in Sub-section 4.11.

4.3.7 Motivation

Individual preferences, motivations, and barriers for treatment need to be explored. Individuals vary in their treatment preferences regarding pharmacotherapy, group therapy, individual therapy, and self-help treatments. Working with the individual's preferences is likely to lead to better treatment adherence and outcomes.

Issues in Assessment

- Drug use and treatment
- Medical & psychiatric problems
- Psychosocial factors responsible for continued drug use
- Physical assessment
- Laboratory tests
- Opportunities for pursuing various treatment goals

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. The following factors need to be assessed in a patient reporting for treatment of alcohol dependence:
   a. Duration of alcohol use
   b. Amount of alcohol used daily
   c. Physical examination
   d. Family history
   e. All the above
2. All the following are goals of assessment except:
   a. Diagnosis
   b. To identify complications of substance use
   c. To formulate a management plan
   d. To enhance motivation

4.4 TREATMENT SETTINGS

Currently, most countries including India have established specialised treatment facilities to treat drug dependence disorder run by either government (GOs) or nongovernment organisations (NGOs). Most government treatment centres are part of a medical college/general hospital. However, many patients report to other settings including general medical OPD / general practitioners / counsellors with ailments directly attributable to excess drug and alcohol consumption. Often they go undetected. It is important to identify these patients in the non-specialised settings and offer prompt treatment. The above arrangement is convenient to patients and cost effective too.

Most patients and their families including many professionals think that for treatment of drug dependence, one needs inpatient care. In fact, majority do not require admission. They do well on OPD treatment and through domiciliary care.

Inpatient care provides obvious advantages of restrictive care, more intensive patient contact, closer monitoring and usually enforces abstinence. Care can also be rendered through community clinics, psychiatric hospitals and prisons. Each of these has specific purpose to serve. Treatment from community clinic and exclusive OPD treatment needs a fair clinical trial before inpatient treatment is considered. Inpatient treatment is usually not the first line of treatment.

Treatment Settings

- Community clinics, Primary Health Centres
- District hospitals (Non-specialised settings viz. Medical OPD, Dispensary)
- Psychiatric hospitals
- Specialised de-addiction centre
- Residential care – Therapeutic community
- Prisons
- OPD vs Ward

Some of the factors that determine the treatment setting are:

1) Capacity and willingness to cooperate with treatment
2) Ability for self-care
3) Social environment (which may be supportive or high risk)
4) Need for structure, support, and supervision to remain safe and abstinent
5) Need for specific treatments for co-occurring general medical or psychiatric conditions
6) Need for particular treatments or an intensity of treatment that may be available only in certain settings
7) Preference for a particular treatment setting

4.5 PERSONNEL REQUIRED AT VARIOUS LEVELS

The treatment team consists of various categories of staff and is multidisciplinary in nature. The team comprises of doctors, nurses, psychologists, counsellors, social workers, pre-clinical scientists, laboratory staff and others for support services.

The role of each team members is distinct and complementary. However, there are grey areas. Certain duties can be performed by more than one category of staff, especially after training. To illustrate, a nurse can carry out the following activities besides providing nursing care and dispensing medicines:

1) Obtaining drug use history from patients

2) Assessment of patients

3) Counselling the patient

4) Counselling the relatives of the patient

These should be reinforced and opportunities should be provided for in-service training so as to encourage broader participation of various activities. These are even more evident in a community clinic where strict division of role should be discouraged.

Personnel

- Multidisciplinary
- Traditional hospital setting - Clarity of role, division of work
- Community Settings - Multiplicity of role

4.6 PHASES/STAGES OF TREATMENT

Comprehensive treatment of drug abuse comprises initial, middle and late phases. In the pre-treatment period acceptance of the problem by the patient occurs and the patient prepares himself for treatment. The peer group and family members play a significant role.

The initial phase is of detoxification (i.e. treatment of withdrawal symptoms), which usually lasts for 2-4 weeks. Here efforts are made to free the person of all intoxicants and attend to the immediate medical consequences of drug abuse.

The middle phase is aimed at maintaining a drug free status and initiates the process of reintegration into the society. It may last for 3-6 months.

During the late phase, a healthy life style and alternate coping strategies are taught. Usually treatment is multi-modal, which includes medications and non-pharmacological therapy (i.e. counselling and psychosocial interventions).

Treatment Phases

Initial	2 to 4 weeks
Middle Phase	3 to 6 months
Late Phase	> 6 months

4.7 TREATMENT MODALITIES

Certain basic principles of management are common, irrespective of the nature of substance being abused. In this Unit, the focus is on commonalties and general principles of management rather than issues that are specific to a particular substance.

Broadly speaking, there are two modalities: pharmacotherapy and psychosocial therapy.

4.7.1 Pharmacotherapy (Medications)

Medications have a very important role in the treatment of drug dependence. Pharmacotherapy has various goals: reversal of acute effects (intoxication and overdose), amelioration of withdrawal symptoms, decline of craving, prevention of relapse and restoration of normal physiological functions. Currently, various pharmacological agents are available for the above purposes.

General physicians or specialists from other disciplines are more often engaged in providing treatment for toxicity and organ damage. Specialists from addiction medicine provide long-term care. Both can carry out detoxification.

Detoxification is the initial step in drug abuse intervention. Various long-term medications are used subsequently. These compounds promote abstinence and minimise relapse.

4.7.2 Psycho-Social Interventions

A simple pharmacological answer to treat substance use disorder is still elusive. Thus medications have to be supplemented with various forms of psychological and social interventions. These include single session counselling and brief therapies. In tertiary care settings, more complex therapies are carried out to promote sobriety and drug free healthy life style. These are adjuncts to pharmacotherapy and important for aftercare and rehabilitation.

Achieving permanent abstinence is a slow process. Patients go through short periods of abstinence and a reduction in drug consumption before becoming totally drug free. Considerable patience is required on part of the patient, family members and the treating team in the process of treatment.

Following improvement, treatment is terminated in a phased fashion. It is important to decide about the length of treatment. Obviously, treatment cannot go on indefinitely. Treatment should be terminated in a planned manner.

4.8 RELAPSE PREVENTION

Recovery from a substance use disorder is the process of initiating abstinence from alcohol or other drug use, as well as making intrapersonal and interpersonal changes to maintain this change over time. The term *lapse* refers to the initial episode of alcohol or other drug use following a period of abstinence, whereas the term *relapse* refers to failure to maintain behaviour change over time. Relapse prevention involves strategies, which help the patient to maintain the necessary changes in their drug taking behaviour over time. These strategies are used in the middle and late stages of treatment. Family support is encouraged.

The basic aim in Relapse Prevention is to:

- Help clients identify their high-risk relapse factors and develop strategies to deal with them
- Help clients understand and deal with alcohol or drug cues as well as cravings
- Help clients understand relapse as a process and as an event
- Help clients understand and deal with social pressures to use substances
- Help clients develop and enhance a supportive social network

- Help clients develop methods of coping with negative emotional states
- Assess clients for psychiatric disorders and facilitate treatment if needed
- Facilitate the transition to follow up outpatient or aftercare treatment
- Help clients learn methods to cope with cognitive distortions
- Help clients work toward a balanced lifestyle

4.9 TREATMENT RESISTANCE

Resistance to treatment is a barrier one has to overcome fairly often. This may happen in the initial phase of substance abuse when patients deny or minimise their substance use and its consequences. Among patients receiving treatment, patient with additional psychiatric illnesses such as personality disorders and those with minimal socio-occupational dysfunction offer the maximum resistance to treatment.

Though many alcohol and drug dependent individuals ultimately reach formal treatment settings, many remain untreated. Such patients can be helped by "concerned others" such as a family member, friend, co-worker, religious or community leaders to initiate contact with a treatment agency for help. When such a patient does contact the treatment provider, motivational interviewing is the single most important step in breaking the resistance to treatment.

4.10 OTHER APPROACHES TO TREATMENT

4.10.1 Self Help Approach

In this approach, people with similar problems unite to form a group for mutual help. These groups are called 'self-help' groups. These groups are voluntary and self-sufficient and provide mutual assistance to all its members. Self-help groups like "Alcoholic Anonymous" (AA) and "Narcotic Anonymous" (NA) have congregations in most cities. Additionally, 'self-help' groups for family members, friends and children of drug and alcohol abusers have been developed, e.g. Al Anon, Al Teen etc.

4.10.2 Social Correctional Approach

According to this approach, drug and alcohol abuse is seen as a social deviance and residential programmes are offered as a correctional method. Therapeutic Community (TC) is the most well known of the facilities offered under this concept. The term therapeutic community is generic, describing a variety of short-term and long-term residential programmes, as well as day treatment and ambulatory programmes that serve a wide spectrum of drug-abusing and alcohol-abusing patients. Although the TC model has been widely adapted for different populations and settings, it is the traditional long-term residential prototype for adult substance abusers that have documented effectiveness in rehabilitating substance-abusing individuals.

4.10.3 Workplace Based Intervention

Substance abuse problems in the workplace and their cost to the industry are difficult to estimate and are usually underestimated. Also, the ultimate goal in the treatment of substance abuse is employment. Of late, Governments have acknowledged these issues and are adopting corrective measures. Though the main focus is on alcohol and nicotine dependence, use of other drugs is also addressed. Employee's Assistance Programme (EAP) identifies and resolves productivity problems associated with employees impaired by personal problems, including alcohol and drug abuse. It offers assessment, referral and follow-up services for mental health, alcohol and other drug related problems.

4.10.4 Network Therapy

Network therapy is a multi-modal approach to office-based rehabilitation in which specific family members and friends are enlisted to provide ongoing support and promote attitude change. It is complementary to other therapies. It has 3 critical tasks:

a) *Maintaining abstinence:* The network offers a safe place with trusted family and friends who help the patient stay in therapy and avoid cues that can lead to relapse;

b) *Caring for the network:* A unique therapeutic instrument, the network stays involved in enhancing the patient's coping skills, offering common sense and a positive team attitude;

c) *Securing future behaviour:* It structures the clinical situation to limit the possibility of relapse.

4.11 LABORATORY SERVICES

Laboratory tests have an important role to play in assessment and treatment. Confirmation of use of particular drugs, detection of sporadic use and relapse, assessment for co-morbid infectious diseases, assessment of physical complications and monitoring of blood parameters as prerequisite for medical therapy are the common situations where laboratory services are required. Detection of substances being abused is important even from the legal aspect.

In most instances, self-report and collateral report by family members about extent and nature of current drug use pattern would suffice. However, when in doubt, monitoring is called for. Commonly qualitative methods like Thin Layer Chromatography (TLC) or Enzyme Multiplied Immunoassay Test (EMIT) are used, and can be confirmed by Gas Liquid Chromatography (GLC). These methods can detect common drugs like opiates, cannabis, benzodiazepines and antihistaminics in biological samples like urine and blood. Alcohol can be estimated quantitatively in blood and breath. Breath-analysers are now commercially available.

Other laboratory tests are required in the assessment of the effects of drugs on various organ systems, e.g. altered liver function in chronic alcohol use; in acute management, e.g. Delirium tremens or in monitoring of treatment programmes, e.g. Liver function before and during therapy with certain medications. Additional tests include haemogram, blood counts, urine examination, Chest X-Ray, tests for Hepatitis B virus and HIV, and sputum for Acid Fast Bacillus (AFB) to assess the health status of the patient.

4.12 OUTCOME MEASURES

Traditionally treatment success was measured by abstinence. Today most clinicians feel that drug use/ abstinence should not be the sole criteria to assess outcome. Hence there is more emphasis on the patient's well being, beliefs about drug use, readiness to change, social functioning and social support. Improvement should be seen in total functioning of the person. Thus, any after-care programme should attend to these areas as well. Current approaches to treatment of alcohol and drug-related problems reflect a continuum of treatment.

Important issues about outcome of treatment

- Drug dependence is a chronic relapsing disorder: up to 80% patients may relapse within three months
- Even if drug use continues, efforts may be made so that least amount of harms due to drug use are experienced, i.e. "Harm reduction"
- Overall outcome should not be defined just by whether drug use has continued or stopped but by whether patient has been able to lead a productive life and fully re-integrated into the society

4.13 LET US SUM UP

- Addiction is a complex but treatable disease that affects brain function and behaviour
- No single treatment is appropriate for everyone
- Treatment needs to be readily available
- Effective treatment attends to multiple needs of the individual, not just his or her drug abuse
- Remaining in treatment for an adequate period of time is critical
- Medications are an important element of treatment for many patients, especially when combined with counselling and other behavioural therapies
- Counselling — individual and/or group — and other behavioural therapies are the most commonly used forms of drug abuse treatment
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs
- Many drug-addicted individuals also have other mental disorders
- Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse
- Drug use during treatment must be monitored continuously, as lapses during treatment do occur
- Treatment programmes should assess patients for the presence of HIV/ AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counselling to help patients modify or

change behaviours that place them at risk of contracting or spreading infectious diseases

4.14 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. d
2. c

Check Your Progress Exercise 2

1. e
2. d

4.15 UNIT END QUESTIONS

1. Enumerate the immediate, short-term, and long-term goals in treating a substance use disorder.
2. What are the common parameters used in making a comprehensive assessment of a patient with a substance use disorder?
3. Write short notes on the following:
   i) Relapse prevention
   ii) Treatment resistance

4.16 FURTHER READINGS AND REFERENCES

American Psychiatric Association. Practice Guidelines for the Treatment of Patients with Substance Abuse Disorders: Alcohol, Cocaine, Opioids. American Journal of Psychiatry, 1995, 152 (Suppl.): 1-59

Galanter M and Kleber HD, eds. The American Psychiatric Publishing Textbook of Substance Abuse Treatment. 4th ed. American Psychiatric Publishing Inc. Washington, DC, 2008.

Lowinson JH, Ruiz P, Millman RB and Langrod JG - eds. Substance Abuse- A Comprehensive Textbook. 3rd edition. Williams & Wilkins, Baltimore, 1997.

Saxena, S., Pal, H., & Ambekar, A. (2003). Alcohol and drug abuse.New Delhi:New Age International.

Shuckit MA. Drug and Alcohol Abuse: Clinical Guide to Diagnosis and Treatment. Plenum Press. New York, 1994.

UNIT 5 MOTIVATION ENHANCEMENT AND RELAPSE PREVENTION THERAPY

Structure

5.1 INTRODUCTION

In this Unit, we will learn about motivation enhancement and relapse prevention therapy, which are of critical significance in the context of individuals suffering from substance use disorders.

Objectives

After studying this Unit, you will be able to:

- Understand the key elements of motivation enhancement therapy and the significance of the same;
- Conceptualize the transtheoretical model of change;
- Appreciate the principles of motivation enhancement therapy and their application;
- Identify why relapse prevention intervention is needed;
- Analyse the components inherent in relapse prevention; and
- Carry out functional analysis.

5.2 MOTIVATION ENHANCEMENT THERAPY (MET)

Motivational enhancement is a style of person-centered counselling approach developed to facilitate change in health-related behaviours. This therapeutic intervention is based on principles of motivational psychology and is designed to produce rapid internally motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client's own change resources.

The core principle of the approach is negotiation rather than conflict. It aims to help people explore and resolve their ambivalence about behaviour change.

It combines warmth and empathy with focused reflective listening and the development of discrepancy between where the person is and where they would like to be. A core principle is that the person's motivation to change is enhanced if there is a gentle process of negotiation in which the client, and not the counsellor, explores the benefits and costs involved in change.

Another strong principle of this approach is that conflict is unhelpful and that a collaborative relationship is essential between counsellor and client, in order to tackle the problem together (Miller & Rollnick, 1991).

Drawing on strategies from various approaches in psychology — client-centered approach, cognitive therapy, systems theory, and the social psychology of persuasion (Miller & Rollnick, 2002), some features of motivational enhancement therapy (MET) are:

- Motivation to change is elicited from the counsellee
- It is brief in duration
- Direct persuasion is avoided
- The counsellor's style is generally quiet and eliciting
- Readiness to change is seen as fluctuating in relation to interpersonal interaction
- The counselling relationship is more like a partnership or companionship than

expert/recipient roles

5.3 TRANSTHEORETICAL MODEL OF CHANGE

Primarily, MET is a development of the Transtheoretical Model of Change (TMC) (Prochaska et al., 1992). This model is conceptually different from most theories of psychotherapy because its focus is on how people change rather than on defining the problem. This model allows counsellors with different theoretical orientations and styles to share a common focus.

Based on their research and the findings of others, Prochaska et al.(1992) proposed that people who change behaviours, whether on their own or with the help of a counsellor, tend to go through five stages of change and frequently use different processes or methods at various stages. These five stages (as cited in Ingersoll & Wagner, 1997) which you have studied in the earlier Units as well, are as follows:

1. *Precontemplation* : The counsellee does not consider his or her behaviour to be a problem and/or is not currently considering changing his or her behaviour.

2. *Contemplation* : The counsellee is considering that his or her behaviour may be a problem and is seriously thinking of, or contemplating, changing his or her behaviour.

3. *Preparation* : The counsellee has made a commitment to change a behaviour he or she considers problematic, and is intending to make the change soon. The individual may have a specific plan in mind or may simply have a target date set for change.

4. *Action* : The counsellee is currently in the process of modifying his or her behaviour or environment to reduce or eliminate the problem. The individual is considered to be in the action stage for up to 6 months following the initial behaviour change (assuming that he or she maintains the change during the period).

5. *Maintenance* : The counsellee works to prevent a return to the problem behaviour and to stabilize the new behaviours and/or environment that supports his or her new way of living.

It has been conceptualized that change is difficult, and most people do not successfully maintain behaviour change on their first attempt. Thus, TMC offers a spiral pattern of the stages of change (linear progression toward change is possible, but rare) in which people can progress from contemplation to preparation to action, but most people will lapse to an earlier stage (Prochaska, 1995). Furthermore, TMC is based on the belief that people learn from the lapse and can try something different the next time to avoid the same mistakes (Prochaska et al., 1992).

TMC can guide the counsellor to more successful outcomes by matching counselling processes to the counsellee's individual level of readiness to change (Ingersoll & Wagner, 1997). Most counsellees beginning a counselling relationship are in precontemplation or contemplation stage of change (Isenhart, 1994). In these stages, the counsellor works to reduce resistance by using nondirective counselling techniques such as asking open-ended questions, listening reflectively, affirming,

and summarizing. As the individual moves to the higher stages of change (preparation, action, and maintenance), the counsellor becomes more directive and behavioural by assisting the counsellee in developing and implementing a plan for behavioural change (Miller & Rollnick, 2002).

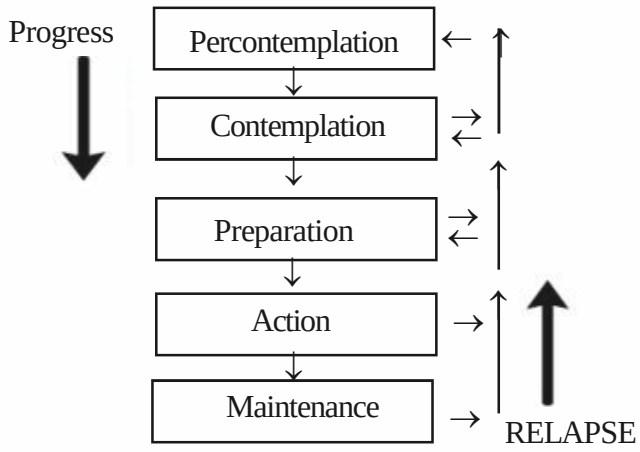

Fig. 5.1: Transtheoretical Model of Change

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. What are the stages listed in the transtheoretical model of change?

   .....

   .....

   .....

2. Are these stages linear or spiral in nature?

   .....

   .....

   .....

5.4 APPROACH OF MOTIVATION ENHANCEMENT THERAPY

Motivation Enhancement Therapy (MET) has been thoroughly researched in the field of substance abuse with some research specific to adolescent clients with substance use disorders. Clients with substance abuse issues and adolescents often share the stereotypical characteristics of being resistant, challenging, and narcissistic (Lambie, 2004). Therefore, it is postulated that an effective substance abuse counselling approach would also be successful with adolescents.

MET was designed as a standardized four-session counsellor approach in Project MATCH (Matching Alcohol Treatments to Client Heterogeneity), a clinical trial of patient-treatment matching sponsored by the National Institute of Alcohol Abuse

and Alcoholism (NIAAA). MET is designed to help people work through their ambivalence about change, primarily through the use of active listening and gentle feedback techniques. The MET approach is founded on the assumptions that counsellees have the capacity and responsibility for change and that it is the counsellor's task to create conditions that enhance clients' motivation for and commitment to change (Miller et al., 1995). In brief, the goal is to prepare people for change, not necessarily to push them into changing right away (Ingersoll & Wagner, 1997). MET seeks to support intrinsic motivation for change, which leads the counsellee to initiate, persist in, and comply with behaviour change efforts.

Miller and Rollnick (2002) listed six basic motivational principles underlying the MET approach as listed in the box below:

Motivational Principles of Motivation Enhancement Therapy

1. *Expression of empathy:* The counsellor communicates respect for the counsellee and listens rather than tells what to do.
2. *Assisting the counsellee in perceiving discrepancy* : The counsellor uses motivational psychology principles to help the counsellee perceive a discrepancy between where he or she is and where he or she wants to be.
3. *Avoiding argumentation:* Argumentation is avoided because it is seen to evoke resistance, which is a counsellee's reaction to a threatening interpersonal interaction and resistance is a counsellor's issue.
4. *Rolling with resistance:* The counsellor does not meet resistance head on, but rather rolls with the momentum, with a goal of shifting counsellee perceptions in the process.
5. *Ambivalence:* It is viewed as normal and openly discussed — the counsellor elicits solutions from the counsellee.
5. *Support of self-efficacy:* The counsellor works to enhance the counsellee's sense of self-efficacy, or ability to achieve goals.

People only move toward change when they perceive that there is a chance of success. Other central constructs of MET are its unique strategies to increase the likelihood of behaviour change, which include handling resistance, the use of a decision balance sheet, and change talk. Each of these strategies is discussed in the following section.

5.5 STRATEGIES FOR SUPPORTING CHANGE

Miller and Rollnick (2002) described four types of resistance:

1. **Arguing**—the counsellee challenges, discounts, or is hostile to the counsellor
2. **Interrupting**—the counsellee cuts the counsellor off or talks over him or her
3. **Denying**—the counsellee blames others, minimizes, disagrees, makes excuses, and is reluctant
4. **Ignoring**—the counsellee is inattentive and does not respond or give input.

A goal of MET is to reduce resistance because a lower level of counsellee resistance is associated with long-term change. MET offers counsellors specific

approaches to addressing resistance. Resistance is viewed not as a counsellee trait but as a normal response to a perceived threat in an interpersonal context. Resistance communicates to the counsellor that he or she is moving too fast and needs to appropriately match the counsellee.

Defusing resistance requires counsellors to change their approach and increase the client's sense of control by using the following strategies:

1. ***Simple reflection***:- Acknowledgment of the counsellee's disagreement, emotion, or perception can permit further exploration rather than evoking defensiveness. The counsellor responds to the client's resistance with understanding and allowing the energy to dissipate.

2. ***Amplified reflection***:- Here the counsellor reflects back what the counsellee has said in an exaggerated form, which often results in the counsellee recanting what he or she has said and can elicit the other side of the individual's ambivalence to change. Amplified reflection encourages the counsellee to reexamine what he or she is saying. It must be executed artfully without a sarcastic tone or hostility may be elicited.

3. ***Shifting focus***:- Here the counsellor re-focuses the counsellee's attention away from what seems to be a barrier blocking progress. This approach moves the client away from a topic where he or she is entrenched to an area where he or she may feel more comfortable and less defensive.

4. ***Agreement with a twist***:- Using this technique, the counsellor initially offers agreement with the counsellee, but with a slight change in direction. This supports the relationship while allowing the counsellor to continue to influence the direction and momentum of change.

5. ***Emphasis on choice and control***:- The counsellor continuously emphasizes and acknowledges the counsellee's personal choice and control because resistance often arises from psychological reactance, from people thinking that their freedom of choice is being threatened and reacting by asserting their power (resistance).

5. ***Reframing***:- This strategy is helpful when a counsellee is offering arguments that serve to refute a personal problem. By acknowledging the validity of the client's observations and perceptions, the counsellor offers a new meaning or interpretation to them. It is important to use the counsellee's own words, perceptions, and understanding about the behaviour when reframing (Miller & Rollnick, 2002).

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in the space provided below.
b) Check your answer with that provided at the end of this Unit.

1. What are the different types of resistance that the counsellor can be expected to face? Give examples for each.

.....

.....

.....

5.5.1 Decisional Balance Sheet

Decision making is a vital process in behavioural change (Lambie, 2004). MET views people who are not changing their dysfunctional behaviours as being ambivalent to change. MET is designed to elicit, clarify, and resolve ambivalence in a person-centered and respectful approach (Miller & Rollnick, 1995). Therefore, a goal of MET is to help counsellees work through their ambivalence and not to directly persuade. It is the counsellee's task to resolve his or her ambivalence, not that of the counsellor.

The decision balance strategy is designed to help counsellees consider the positives (advantages) and negatives (disadvantages) of changing their current behaviours. When people consider making a change, it is helpful to think not only about the benefits (pros) of changing and the cost (cons) of staying the same, but also to reflect upon the possible consequences of changing and the potential benefits of staying the same. This approach fosters the construction of a more realistic plan for change and helps put into action a plan of change the individual has decided upon from multiple perspectives (Ingersoll & Wagner, 1997).

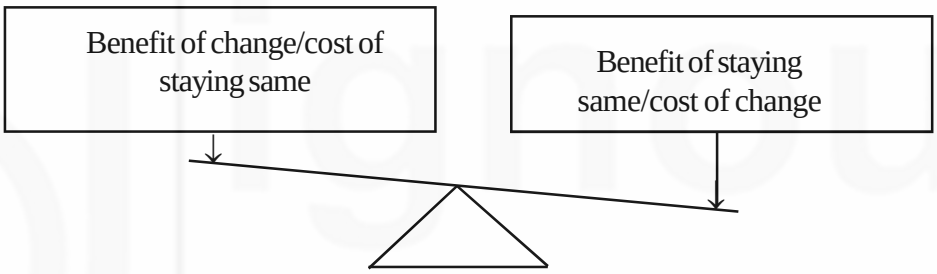

Fig. 5.2: Decisional Balance

A decision balance worksheet is a counselling activity in which the client is asked to fill in four specified boxes. In the first box, the counsellee is asked to write the benefits he or she receives from not changing, while in the box below he or she writes the potential positives; reasons for changing. In the top-right box, the counsellee then identifies negative consequences of not changing, while below writing the possible cost of making the change. This strategy offers the counsellee and counsellor a more complete picture of the client's ambivalence toward change.

Decisional Balance Sheet

Benefits of remaining the same	Costs of not changing
Benefits of changing behaviour	Costs of changing behaviour

5.5.2 Change Talk

Change is linked to an individual's self-efficacy, which is a person's confidence in his or her ability to maintain the behavioural change. Change talk is an MET approach employed to increase clients' self-efficacy. Miller and Rollnick (2002) presented three categories of change talk: **Cognitive** (problem recognition), **Affective** (statements of concern and optimism), and **Behavioural** (intention to change).

Examples of the four types of statement used to support change talk are as follows:

1. *Cognitive (problem recognition)***:** What things may make you think that not completing . . . might be a problem for you? Can you think of any ways in which not completing . . . has made your life more difficult? How has not completing . . . stopped you from being able to do what you want?

2. *Affective (concern)***:** What is there about not completing . . . that makes you feel concerned? Is there anything that worries you about not completing ...? What bothers you about knowing you have not completed . . . ?

3. *Affective (optimism)***:** What gives you hope that things can get better? What do you think would work for you if you decided to make a change?

4. *Behavioural (intention to change)***:** The fact you are talking about not completing . . . shows that at least part of you thinks it's time to do something. What are the possible reasons you see for making some changes? It seems that you may be stuck right now in a pattern of not doing your homework. What changes might help you to get unstuck and change? (Miller & Rollnick, 2002; Miller et al., 1995). These statements allow the client to identify his or her concerned behaviour and support his or her intention to change with optimistic encouragement.

Check Your Progress Exercise 3

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Categorize the following statements as cognitive, affective or behavioural.

   i. What are the potential problems that you may face when you try to quit cigarettes?

   .....

   ii. What are the steps that you need to take if you want to leave alcohol?

   .....

   iii. How do you feel about smoking again after being abstinent for 4 days?

   .....

5.6 RELAPSE PREVENTION THERAPY

"Quitting smoking is easy, I have done it a hundred times" (Mark Twain)

Substance use disorders are understood as chronic, relapsing conditions. An individual who has been abstinent from alcohol/substances for some time may have occasional slips, which are known as "lapses". For example, the individual may not be drinking at all since the last 3 months, but in one of the parties, he takes a small drink. However, when the individual returns to previously problematic

pattern of use after a period of abstinence, it is termed as "relapse". A relapse is never an isolated event, but rather a process or a series of events unfolding over a period of time (Annis 1986; Litman et al. 1979; Marlatt and Gordon 1985).

Relapse Prevention Therapy (RPT) is thus a cognitive-behavioural approach that specifically addresses the nature of the process of relapse and helps the client in developing coping strategies which would be useful in maintaining change (Marlatt & Gordon, 1985; Parks, Marlatt, & Anderson, 2001). The most influential model of relapse prevention has been provided by Marlett & Gordon (1985) and is followed world-wide.

5.7 PRINCIPLES OF RPT

The relapse prevention model is based on the following principles:

- Addictive behaviours are acquired, over-learned habits which typically provide immediate rewards that either increase pleasure or decrease pain.
- The rewards serve to maintain the habit of substance use despite the delayed negative consequences, which may be quite severe and long-lasting.
- Behaviours that are learnt can be eliminated by extinguishing the connection between alcohol/drug use and increasing pleasure/decreasing pain.
- The client can be helped to build a repertoire of new behaviours which are more adaptive.

5.8 MAJOR COMPONENTS OF RPT

- *"Relapse Prevention"*: Focuses on self-efficacy and effective coping to deal with high-risk situations in order to prevent a lapse or slip.
- *"Relapse Management"*: In case of a lapse, it is treated as a *crisis* and client is taught effective strategies to stop or reduce further use to prevent the lapse from developing into a full-blown relapse.
- *Assessment:* It involves assessment of
    - o "High risk situations", which are client's potential interpersonal, interpersonal or environmental factors that may trigger a lapse and those factors that may eventually lead to a relapse.
    - o Ability of the client to cope with high-risk situations and the coping skill deficits.
- *Management*: It involves:
    - o Specific strategies:- The strategies used to prevent lapses and manage them in case they occur.
    - o Global Strategies: To address lifestyle balance, craving and cognitive distortions that may set-up exposure to high risk situations.

The therapeutic components of relapse prevention therapy can be understood as:

- It teaches coping strategies, that is, constructive ways of thinking and behaving, to deal with stressors and problems that may lead to a lapse.

- By discussing the potential high risk situations, it provides the clients with *maps* delineating the various situations which may be tempting and dangerous along with information on *detours* to avoid such situations.
- It teaches the client to recognize *early warning signs* that can trick their mind and lead them, unknowingly, to decisions that may trigger a lapse. It further teaches them how to cope with these cognitive distortions.
- It helps the client in making important changes in their day-to-day lifestyle so that maladaptive behaviours are substituted by adaptive behaviours.
- It helps the client to be prepared in advance for *possible breakdowns*, to be prepared for failures and it further teaches them how to learn from experience and move on.

5.9 COGNITIVE BEHAVIOURAL MODEL OF RELAPSE

The cognitive-behavioural model of relapse process was developed over the past 30 years by Marlett and colleagues (Marlett et al., 1985; Parks, Anderson & Marlett, 2001). They have tried to pay particular attention to situational, interpersonal, and psychological factors that precede a relapse and also to the individual's expectations and attributions in reaction to a lapse. In this model, l*apse* has been viewed as a crisis involving both the dangers of a full-blown relapse and the opportunity for new learning to occur from the slip to avoid future relapse. The model is depicted in Figure 5.3.

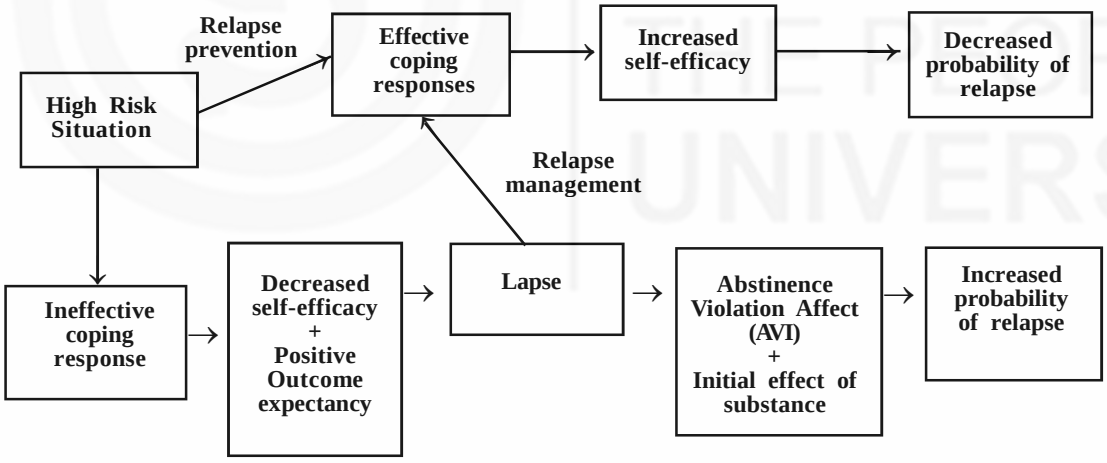

Fig. 5.3: Cognitive Behavioural Model of Relapse Process

The model begins with the immediate precipitant of relapse that occurs when the client is exposed to a high-risk situation. If the client has not yet learnt effective coping response to avoid a lapse, or is not able to implement it due to lack of motivation or high anxiety, then the probability of having a lapse increases. This is further mediated by positive expectancies for the initial use of the substance coupled with a decrease in self-efficacy.

Even when the lapse occurs, incorporating relapse management strategies may prepare the client to reduce further harmful consequences and conversion into a full-blown relapse. After a lapse, the client may experience *Abstinence Violation*

Affect, that is, loss of perceived control experienced after failure of client to adhere to code of conduct regarding the use of alcohol or other substances (Curry et al., 1987). It may lead to development of negative emotional states, such as guilt, shame and anger and may further precipitate a relapse. It also affects the individual at a cognitive level when the client may feel that *"I am a failure."* or *"I can never improve"*. Along with these, the client also is experiencing the intoxicating effect of the substance (e.g. enhancing pleasure and/or reduction in pain) which further contributes to increased chances of having a full-blown relapse.

Check Your Progress Exercise 4

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Mark the following statements as True or False:

   i. Lapse and relapse are synonymous.

   ii. A lapse always means that a relapse would occur.

   iii. The client entering treatment does not have any coping skills to deal with high risk situations.

   iv. Shame and guilt regarding a lapse can lead the way to a full blown relapse.

   v. If a person is motivated to quit, he will never encounter high risk situations.

   vi. A lapse is always a possibility and should be treated as a warning signal rather than a failure.

5.10 POTENTIAL HIGH RISK SITUATIONS

5.10.1 Overt Antecedents of Relapse

Certain events, situations or factors have the potential for acting as "triggers" or "high-risk" for a lapse and eventually a relapse. The triggers can be "Internal", that is, within the individual or "External" , that is, intrapersonal or environmental as shown in the table below.

Overt Antecedents of Relapse

Internal Triggers	*External Triggers*
• Coping with negative emotional states	• Coping with interpersonal conflicts
• Coping with negative physiological states	• Dealing with social pressures
• Enhancement of positive emotional state	• Places
• Testing personal control	• Time-periods

Let us now take a look at each of these triggers individually:

- **Coping with negative emotional states**:- Inability to deal with emotional states that are unpleasant or aversive, like frustration, anger, guilt, sadness, hopelessness, anxiety, loneliness, apprehension etc. can lead to a lapse.

V is home alone and begins to feel bored. He also receives a phone call from his colleague that he did not get the contract that he was eagerly waiting for. He is tensed and worried and feels like having a drink.

- **Coping with negative physiological states**:- Inability to cope with physical states that are specifically associated with alcohol or substance. For example, pain relief is usually associated with use of opioids, sleep is associated with intake of alcohol. Sometimes, even when a negative physiological state is not associated with prior drug use, it may still act as a trigger for a lapse.

V is having stomach cramps and diarrhoea. He is unable to eat anything properly. Earlier, he only had this problem when he did not get smack. So he associates it with withdrawal from opioids and has an intense craving to use again.

- **Enhancement of positive emotional state**:- Use of substance to increase feelings of pleasure, joy, freedom, celebration etc.

V was working overtime for the project and finally his hard-work paid off and he got a promotion as well as salary hike. To celebrate his success, he feels like taking all his friends to a bar and drink.

- **Testing personal control**:- Use of substance to "test" one's own ability to engage in controlled or moderate use; or to "just try it once" to see what happens.

V was abstinent from alcohol for last 3 months. One day, he had the sudden thought that now that he has not been drinking, he has developed enough control and one drink would not do him harm. He goes out, buys a bottle of IMFL and decides to take only one peg. However, once he starts, he is unable to stop and finishes half a bottle in no time.

- **Coping with interpersonal conflicts**: Coping or inability to cope with current or relatively recent conflict associated with any interpersonal relationship– marriage, family, friendship, job etc. The situation may be one involving anger or frustration or it may involve fear, anxiety, worry, concern etc.

V came home late from work and his eyes were appearing red. His mother immediately started shouting that he has again used marijuana and started blaming and cursing him that he would never improve. He tried to explain that he got late because his scooter had a puncture and there was a traffic jam, but his mother would not hear. In anger, he went out of the house and got himself a joint.

- **Dealing with social pressure**:- It involves coping with influences of another individual or a group who exert either direct or indirect pressure to use substance.

V was sober for 5 months when he had to attend a close friend's party. There he again met his group of friends with whom he used to drink. Though, he told them that he had left alcohol. They pressurized him to take one drink for "old time's sake". He could not say "No".

- **Places**:- Involves those places where individual used to use substances. For example, bars, lanes, empty houses etc.

V was coming back from work when he decided to take the older route for no specific reason. On the way, he crossed the chemist shop from where he used to buy injections. He just thought of stopping by and saying hello. But when he went inside, he ordered an injection, needle and a bottle of the substance he was trying to give up.

- **Time periods:** Involves dealing with specific time-periods that were associated with use of alcohol or substance. For example, travelling, vacations, festivals.

V was abstinent from cannabis since last 6 months. However, on Holi he had significant craving as every Holi, he used to take "Bhaang" with his friends.

Check Your Progress Exercise 5

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

Classify the following situations into "Internal" and "External" triggers:

1. Feeling restless and irritated
2. Being thrown out of the job
3. Breaking up with girl-friend
4. Diwali
5. Having a splitting headache
5. *"I have lots of will-power, I can control after one drink"*
7. Meeting up with old friends with whom alcohol/drug was taken
8. Being alone at 8 PM when normally he/she used to drink
9. Going to a party where drinks are served
10. Feeling happy after a salary hike

5.10.2 Covert Antecedents of Relapse

Research indicates that sometimes a client, unknowingly, and even paradoxically, may set up himself/herself for relapse. Presence of cognitive distortions, such as denial and rationalizations make it easier to set up one's own relapse episode without having to take personal responsibility. The process of relapse is often

determined by a number of covert antecedents that eventually lead to a high-risk situation (Fig. 5.4); observed by researchers and experts globally.

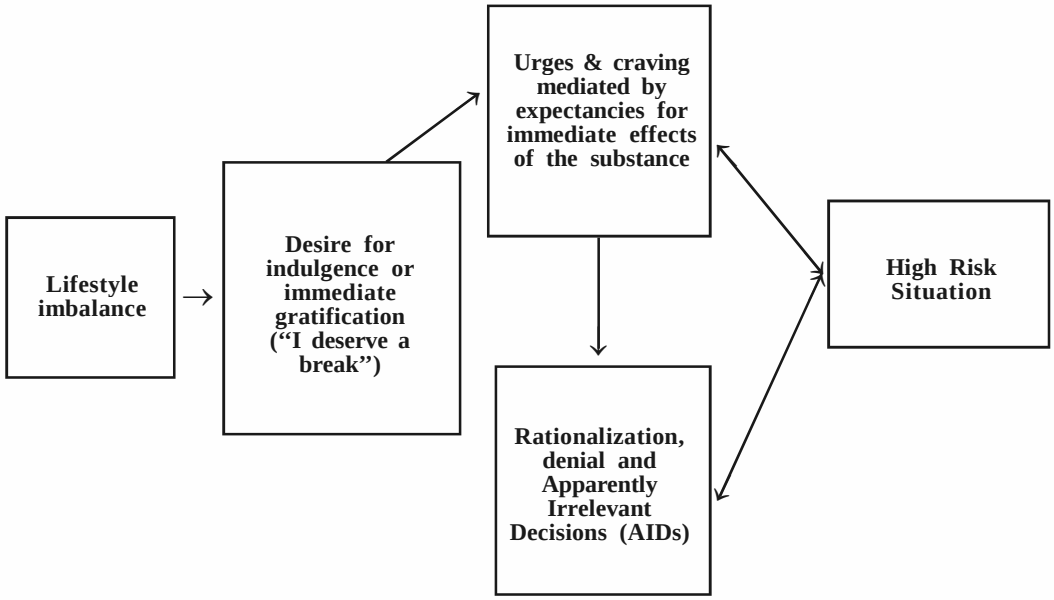

Fig. 5.4 : Covert Antecedents of Relapse Situation

Check Your Progress Exercise 6

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

Ramesh, who had been abstinent for several weeks, drove home from work on a night when his wife was going to be away. On the way, he turned left instead of right at an intersection, so that he could enjoy the "scenic route". On this route, he drove past a bar he had frequented in the past. Because the weather was hot, he decided to stop for a glass of coke. However, once inside, he decided that since his problem was with the whiskey, he would have beer. After two beers, he lost control.

1. When do you think Ramesh first got into trouble?

.....

.....

.....

.....

2. What rationalization did he use to take the other route?

.....

.....

.....

.....

5.11 ASSESSMENT AND TREATMENT

5.11.1 Assessment

As with any therapy, the first step is a thorough assessment. Assessment is never a one-time activity, rather it is a process that needs to be continued throughout therapy. Specifically, for carrying out relapse prevention therapy, the assessment includes the following components: Assessment of motivation and commitment and Assessment of high risk situations.

- **Assessment of Motivation and Commitment:** It has been found that, at times, the client may not use coping skills because of poor motivation or commitment for change. Thus, it becomes vital to assess the same. The stages of change has been elaborated by Prochaska and DiClamente (1982) and they have described relapse within a trans-theoretical model as described earlier in the Unit. Relapse prevention as well as management strategies are necessary at the time of action, maintenance and relapse stages in order for habit change to be successful over time. Assessment of motivation can be done with the help of an interview or questionnaires as mentioned earlier.

- **Assessment of "High Risk Situation" or "Triggers"**:- It involves carrying out a functional analysis to understand what happened before the individual had a lapse.

5 W's of Functional Analysis

- When?
- Where?
- Why?
- With whom?
- What happened?

The 5 W's form the basis on which functional analysis can be carried out. If the client has not had any lapse, a useful way can be trying to understand the past relapses or lapses when they tried to abstain from alcohol and substances. Asking the client to describe these past experiences can provide important clues to future high-risk situations. The therapist and client can then classify these experiences as per the categories given above. Cognitive reframing of the past relapses is a necessary part as it would help in reducing client's fear about the prospect of another relapse. The therapist should then encourage the client to view the past relapses as due to lack of skill or effort rather than unchangeable and uncontrollable factors.

A useful way in noting down previous relapse or a current lapse is in the form of A-B-C charting: **Antecedent → Behaviour → Consequences.**

A-B-C CHARTING

Date & Time	Antecedent	Behaviour	Consequences
	Exact situation in as much detail. Who was there? What were you doing? What were you thinking? What were you feeling? Where were you?	To note down what exactly you did	Note down immediate or short-term consequences
29/09/10 *10:30 PM*	*I came back from office and there was no one at home as everyone had gone to a party. I was lonely and frustrated as my work was not liked by my boss. I was feeling angry and felt that I had to bear everything alone and no-one really cared. I wanted to forget all this and just relax*	*I went out and got myself a bottle of whiskey and despite knowing that it would harm me, I started drinking*	*I had not had a drink in days. So the first sip tasted a bit bitter, but gradually I started having a floating, light sensation. My tensions reduced and I started feeling more and more relaxed.*

5.11.2 Therapy

As the assessment progresses, the counsellor and the client can prioritize the areas that need to be worked upon and start working on them. As mentioned previously, the therapeutic techniques can be specific, like coping with high risk situations and general, like, lifestyle modifications.

Therapeutic Thechniques

I. Specific
   1. Coping with high risk situations
      i. The Situational Competency Test
      ii. Stimulus Control
      iii. Coping Skill Training
      iv. Stress Management
   2. Increasing self-efficacy

II. General
   1. Lifestyle Balance
   2. Increasing lifestyle balance
   3. Management of craving

Let us now take a look at some of the commonly used therapeutic techniques individually, begining with an overview of the specific techniques and moving on to getting acquainted with the more general therapeutic techniques.

Specific RPT intervention techniques

- **Coping with high risk situations: The Situational Competency Test**:- It is a role-play technique that requires the client to give a verbal response to a series of high-risk situations presented by the counsellor or pre-recorded audio-tape. Each presented situation is followed by the question: *"What would you do or say?"* It is important that the client imagines the situation in as much detail as possible and respond accordingly.

- **Coping with high risk situations: Stimulus Control**:- These behavioural techniques are very important in the early stages of habit-change. It is a known fact that the situational and psychological cues previously associated with use of alcohol or other substances are likely to induce craving and temptation to resume the old patterns on behaviours. Thus, the first option is avoidance of all the high-risk situations identified in the assessment phase. However, where avoidance is not possible or appears unexpectedly, escape is the second best option. Finally, if neither avoidance or escape is possible, delay of action may be used to interrupt the lapse process.

- **Coping with high risk situations: Coping Skill Training**:- Once the high risk situation has been identified, the client can be taught to respond to these cues appropriately. Taken together, the assessment of high risk situations and coping skill deficits can be used to target areas that require special training or attention. Coping skill training methods incorporate components of *direct instructions, modeling, behavioural rehearsal, and feedback from the counsellor*. *Modeling* of self-instructional statements or adaptive self-talk is found to be particularly useful in teaching clients cognitive self-statements. Some of the common skills that need to be usually taught to the clients are: Problem-solving, handling boredom, handling social pressure, management of negative feelings.

Problem - Solving

In this approach, counsellor helps the client in identifying the problems and teaching how to solve the problem logically. The steps involved in problem-solving are:

- Noting down the problem in as much details as possible
- Brain-storming all possible solutions
- Evaluating each solution for its pros, cons and feasibility
- Implementing the best solution
- Evaluating whether the solution worked or not

Handling Boredom

Boredom and loneliness can pose as a major trigger and needs to be handled. Thus, it is a useful strategy to help the client develop a schedule and structure his days accordingly. Following strategies may be helpful:

- Scheduling each hour of the day so that unplanned sections of time can be used to explore interesting activities
- Starting new hobbies or picking up interests that were previously enjoyable but abandoned during alcohol/substance use
- Scheduling specific time-periods, like holidays or weekends
- Discussing the feeling of boredom with a friend, spouse, parents etc.

Handling Social Pressure

Pressure to use by other people especially peers can be difficult to handle and the client must be taught "refusal skills". First and foremost, the client needs to be told that he has a right to say NO and he can say No without feeling guilty or overwhelmed. He should also be told the advantages and disadvantages of being assertive.

It is useful to carry out behavioural rehearsal of assertiveness in the session and then ask the client to practice on less threatening situations. Once, the client is able to be assertive in non-threatening situations, they are discussed in the session regarding the obstacles faced, the thoughts/feelings of client before and after being assertive.

Once the client feels confident, he is asked to practice this skill in high risk situations.

Handling Negative Emotional States

Negative emotional states, such as anger or sadness usually occur during the recovery phase and its important to teach the client how to handle these states. It can be useful to tell the client the relationship between emotions, thoughts and actions.

The first and foremost aspect is recognizing and accepting feelings and the motivation to take action. Some of the useful strategies can be:

- Distraction
- Talking to a friend/spouse
- Indulging in a positive alternative activity, for example, watching TV
- Practicing relaxation
- In case of anger, it is useful to talk to the person in clear terms about what was hurting and resolving the issue in a positive way.

- **Coping with high risk situations: Stress Management**:- Apart from the cognitive techniques that can be used to help the client in avoiding high-risk situations, teaching relaxation exercises also is important. Relaxation training can provide the client with a global, increased perception of control, thereby reducing the "stress load". Procedures such as progressive muscular relaxation training, meditation, exercises can be extremely useful in aiding the client to cope more effectively with the hassles and demands of daily life.

- **Increasing self-efficacy**:- As mentioned previously, a particular coping response would fail to be executed if the client has low self-efficacy concerning his/her ability to engage in the behaviour. However, a paradox occurs that self-efficacy usually enhances when the individual is able to successfully cope with a high-risk situation. Repeated experiences of successful coping strengthens self-efficacy and reduces the risk that occasional failures or slips will precipitate a relapse.

A way of developing self-efficacy is *Guided Imagery Technique* in which the counsellor guides the client with subtle prompts in generating successful coping strategies. These prompts can later be internalized by the client.

What To Do When A Lapse Occurs

The list below can be used as a reminder card that the client can use in the event of a lapse:

- *Stop, look and listen*
- *Carry out the lapse management plan* (For example, call your spouse)
- *Keep calm*
- *Renew commitment*
- *Review the situation leading up to the lapse*

II. General RPT Intervention Strategies

Providing clients with behavioural skills training and cognitive strategies to effectively cope with high risk situations is vital, but not enough. Research indicates that developing a more comprehensive and effective programme of habit change can help the client in: (1) developing a more balanced lifestyle in order to increase their overall capacity to cope with stress and gradually increase self-efficacy and (2) identifying and anticipating early warning signals and thus implementing coping strategies.

- **Lifestyle Balance**:- Lifestyle balance can be defined as the degree of equilibrium that exists in one's daily life between the variety of activities a person engages in and the effects of those activities on one's level of health and well-being (Marlett et al., 2002). In a broader sense, it refers to the amount of stress in a person's daily life compared with stress-reducing activities such as social support, meditation, exercise etc. It is also related to diet, social relationships and spiritual endeavors.

  The RPT model elucidates that when there is an imbalance in the lifestyle, a desire for indulgence and immediate gratification will occur and this would set up a chain of covert antecedents that would eventually lead to a relapse.

- **Increasing Lifestyle Balance**: Lifestyle modification procedures are designed to identify and circumvent the covert antecedents of relapse and to promote life-long habit change to create greater mental, emotional, physical and spiritual well-being. Some of the possibilities can be jogging, meditation/yoga, enhanced social activities, making new friends etc.

  Since lifestyle imbalance creates desire for indulgence, another useful strategy can be substituting indulgences that are not harmful or addictive. Glasser (1974) described excessive drinking or substance abuse as "negative addictions" that initially feel good but produce long term negative consequences. Conversely, behaviours like exercise or meditation are termed as "positive addictions" which produce short-term discomfort, but long-term advantages.

- **Management of Craving**: In addition to desire for indulgence, relapse is also promoted by affective and cognitive processes that move the individual closer to a high risk situation. These processes can induce craving or urges in the individual, which are defined as a relatively sudden impulse to engage in a pleasurable act. Various techniques for coping with urges and craving are: stimulus control (as described above) and cue exposure (either real or imagery along with practicing implementation of coping skills).

Craving Management

Some of the simple and effective strategies can be:

- Distraction
- Talking about the urge with someone who is supportive
- Visualizing the urge as a wave, watching it rise and fall and not being "wiped out" by it
- Recalling the negative consequences of using alcohol or drugs
- Positive self-statements – "I can do it."

5.12 EFFICACY OF RELAPSE PREVENTION THERAPY

Several studies have evaluated the effectiveness and efficacy of the relapse prevention approach for substance use disorders (Carroll, 1996; Irvin, et al., 1999). In a narrative review of 24 randomized controlled trials, which also included relapse prevention therapy, Carroll (1996) found that relapse prevention was more effective than no treatment and equally effective as other active treatments in improving outcome for substance use disorders.

Studies have also shown a long-term, continued improvement with relapse prevention therapy compared to other treatments which are effective over a shorter duration (Rawson et al., 2002).

On the basis of a meta-analysis of 26 studies involving relapse-prevention techniques, Irvin et al. (1999) demonstrated that relapse prevention was a successful intervention for not only reducing substance use but also in improving psychosocial adjustment. They also suggested that, there is a need to modify relapse prevention strategies dependent upon the type of substance used.

5.13 LET US SUM UP

MET is a brief counselling approach supported in research that offers a specific tangible model of behavioural change while providing counselling strategies on how best to match adolescents' level of readiness to change. Furthermore, MET provides clear strategies for how to work with clients who appear resistant and unmotivated. This model presents counsellors with a different perspective towards clients while providing useful and effective strategies to support change. MET's approach to client resistance and change can be integrated into other theoretical models, and is effectively used in the case of individuals with substance use disorders.

Relapse remains a formidable challenge in the treatment of substance use disorders. The individual who is engaging in behaviour change is constantly faced with urges, cues and cognitive distortions that may slow down recovery. Research demonstrates that teaching individual how to prevent slips or coping skills in the face of slips can go a long way in the recovery process by decreasing the probability of relapse as well as improving quality of life.

5.14 GLOSSARY

Abstinence Violation Affect	Loss of perceived control experienced after failure of client to adhere to code of conduct regarding the use of alcohol or other substances
Empathy	The action of understanding, being aware of, being sensitive to the thoughts, feelings and experiences of another person
Lifestyle	The way in which a person or a group lives. It may be healthy or unhealthy
Reflective listening	A communication strategy involving two key steps: seeking to understand a speaker's idea, then offering the idea back to the speaker, to confirm the idea has been understood correctly
Relapse	Moving back to the same level of consumption of alcohol/drugs after a period of abstinence
Self-efficacy	A person's belief about his or her ability and capacity to accomplish a task or to deal with the challenges of life
Triggers	Those events/situations that lead a person towards a lapse/relapse. They can be overt/ covert or internal/external

5.15 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Pre-contemplation, contemplation, preparation, action and maintenance
2. Spiral in nature. Can lead to lapse/relapse anytime

Check Your Progress Exercise 2

1. Arguing — "I have only smoked 3 cigarettes since morning. So what is your problem with that?"

   Interrupting —"…No what I am trying to say is…"

   Denying — "Its not my fault. I did not drink for 3 days. My wife drives me crazy. I needed a drink to keep me sane."

   Ignoring — Looking outside while the counsellor talks

Check Your Progress Exercise 3

1. i. Cognitive; ii. Behavioural; iii. Affective

Check Your Progress Exercise 4

1. i False; ii. False; iii. False;
   iv. True; v. False; vi. True

Check Your Progress Exercise 5

1. Internal; 2. External; 3. External; 4. External; 5. Internal; 5. Internal; 7. External; 8. External; 9. External; 10. Internal

Check Your Progress Exercise 6

1. When he turned in the other direction than his usual one
2. He rationalized that he wanted to experience the scenic beauty

5.16 UNIT END QUESTIONS

1. List down the features of MET in your own words.
2. What are the strategies used to deal with resistance?
3. What are the principles behind Motivation Enhancement Therapy?
4. Imagine that you have been eating chocolates everyday. Your dentist asks you to stop, however, you are not too convinced that you should. Prepare a decisional balance sheet for the situation.
5. List down the internal and external triggers for lapse with two examples each.
5. Put the following situation in a A-B-C format.

   "Shiv has not been getting along well with his wife. They keep on having constant arguments about financial matters. On 3rd May, when Shiv handed the salary to his wife, she found that it was lesser than last month. Instead of asking where the money was, she started shouting at him for spending money on his Ganja. Shiv got very angry as he felt that his wife did not understand him or respect him. He also felt that all she cared about was money. In anger, he left the house and went to his friend's place with whom he used to smoke ganja. There, he took ganja and immediately felt a sense of relief and reduction in tension."

5.17 FURTHER READINGS AND REFERENCES

Abuse Treatment Outcomes Evaluation (SATOE) model: Theoretical background and clinical guidelines. Richmond: Office of Mental Health and Substance Abuse Services, Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services.

Aubrey, L. L. (1998). Motivational interviewing with adolescents presenting for outpatient substance abuse treatment (Doctoral dissertation, University of New Mexico, Albuquerque, 1998). *Dissertation Abstracts International, 59*, 1357. *behaviour* (2nd ed.). New York: Guilford Press. Miller, W. R., Zweben, A., DiClemente, C. C. & *Behaviours, 19*(5), 463–475.

Cowen, E. W., & Presbury, J. H. (2000). Meeting client resistance and reactance with reverence. *Journal of Counselling & Development, 78*(4), 411–419.

Ingersoll, K., & Wagner, C. (1997). *Motivational enhancement groups for the Virginia Substance*

Jayaraman, R & Ranganathan, S (2010). *Tips and Tools for a Comfortable Recovery*. T T Ranganathan Clinical Reasearch Foundation

Lambie, G. W. (2004). Motivational Enhancement Therapy: A tool for professional school counsellors

Larimer, ME; Palmer, RS & Marlatt, GA (1999). Relapse Prevention: An Overview of Marlatt's Cognitive-Behavioural Model. *Alcohol Research and Health*, 23 (2): 151-160

Marlatt, GA & Gordon, JR (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Disorders*. New York: Guilford Press.

Marlatt, GA; Parks, GA; Witkiewitz, K (2002). "Clinical Guidelines for Implementing Relapse Prevention Therapy: A guideline developed for the Behavioural Health Recovery Management Project. Available at http://www.bhrm.org/guidelines/RPT%20guideline.pdf

McCoy, K. (1995, April). *Communication barriers.* Retrieved June 3, 2002, from the Parent Resource

Miller, W. R., & Rollnick, S. (1995). What is Motivational Interviewing? Behavioural and *Cognitive Psychotherapy, 23*(4), 325–334.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change addictive*

Prochaska, J. O. (1995). An eclectic and integrative approach: Transtheoretical therapy. In A. S. Gurman & S. B. Messer (Eds.), *Essential psychotherapies: Theory and practice* (pp. 403–440). New York: Guilford Press.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviour. *American Psychologist, 47*(9), 1102–1114.

Rychtarik, R. G. (1995). *Motivational Enhancement Therapy manual: A clinical research guide for* Series). Rockville, MD: National Institute of Alcohol Abuse and Alcoholism.

Witkiewitz, K & Marlatt, GA (2004). Relapse Prevention for Alcohol and Drug Problems: That was Zen, This is Tao. *American Psychologist*. 59 (4): 224-235.

UNIT 6 TOBACCO CESSATION

Structure

6.1 INTRODUCTION

Tobacco use is a leading cause of preventable deaths all over the world. Tobacco is also one of the major causes of deaths and diseases in India, accounting for almost a million deaths every year.

The data from India from the Global Adult Tobacco Survey (GATS, 2010) revealed that more than one out of three adults in India (35%) used tobacco in some form or the other. Among them, 21 % of adults used only smokeless tobacco, 9% only smoked and 5 % smoked as well as used smokeless tobacco. Overall tobacco use is much higher among Indian males at 48 per cent but is also a serious concern among females among whom prevalence is 20 per cent.

In India, *khaini* or tobacco-lime mixture (12%) is the most commonly used smokeless tobacco product, followed by *gutkha (*a mixture of tobacco, lime and areca nut) (8%), betel quid with tobacco (6%) and tobacco dentifrice (5%). *Bidi* (9%) is most commonly used smoking product, followed by cigarette (6%) and *hukkah* (1%).

As per the Global Health Professions Student Survey (GHPSS, 2009), in India, 6.5% third year dental students smoked cigarettes and 8.6% used other tobacco products. Among medical students, 13.4% third year medical students smoked cigarettes and 11.6% used other tobacco products. Global Youth Tobacco Survey (GYTS, 2009) revealed that 14.6% of 13-15 years school going children in India used tobacco products, out of which 4.4% smoked cigarettes and 12.5% used other forms of tobacco. These figures are alarming because these professional students will themselves lead the war against tobacco, and also in light of the fact that earlier initiation increases chances of long term dependence on tobacco.

Tobacco is a highly addictive substance since it contains nicotine, which has a very high dependence potential. Nicotine reaches brain within 10 seconds of smoking.

Article 14 of WHO FCTC (Framework Convention on Tobacco Control) prescribes demand reduction measures concerning tobacco dependence and cessation. It states that "each party (country) shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence".

To help countries fulfill the obligations under FCTC, WHO has established **MPOWER** strategy, the policies of which are proven to reduce tobacco use :

M – Monitor tobacco use and prevention policies.

P – Protect people from tobacco smoke.

O – Offer help to quit tobacco use.

W – Warn about the dangers of tobacco.

E – Enforce bans on tobacco advertising, promotion and sponsorship.

R – Raise taxes on tobacco.

India is a signatory to the FCTC along with 171 other countries. The Government of India enacted the "Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act" in 2003. To fulfill its obligations under the law and WHO FCTC, National Tobacco Control Programme was initiated on a pilot basis. The programme is now under implementation in 42 districts of 21 states in the country. Under the District Tobacco Control Programme, cessation facilities are being made available at the district hospital level by making trained counsellors available for the same. The programme will be expanded to cover more states and districts in the 12th Five Year Plan.

Against this back drop, that brings home the gravity and magnitude of the problem, in this Unit you will learn about the menace of tobacco dependence as well as effective treatment strategies that help in promoting tobacco cessation.

Objectives

After studying this Unit, you will be able to:

- Analyze how the use of tobacco produces dependence;
- Analyze why it is important to provide tobacco dependence treatment; and
- Provide behaviour counselling treatment for tobacco dependence.

6.2 TOBACCO DEPENDENCE

Tobacco dependence is defined as, "Cluster of behavioural, cognitive and physiological phenomena that develop after repeated tobacco use and that typically include a strong desire to use tobacco, difficulties in controlling its use, persistence in tobacco use despite harmful consequences, a higher priority given to tobacco use than other activities and obligations, increased tolerance and sometimes a physical withdrawal state". (ICD – 10)

Both smoked and smokeless forms of tobacco contain nicotine, a highly addictive chemical, making it difficult for habituated tobacco users to quit.

In fact, it is as addictive, or even more, than heroin or cocaine. Over time, users become dependent on nicotine and suddenly stopping produces both physical and psychological withdrawal symptoms.

Nicotine is readily absorbed from the respiratory tract, buccal mucosa and skin. There is minimal absorption through the gastrointestinal tract when administered orally. Cigarettes are highly effective mechanism for delivering nicotine. Inhaled nicotine takes about 10 seconds to reach the brain and its stimulation releases chemicals which provide feeling of goodness, alertness and energy.

As the person stops tobacco use, these chemicals decrease in the body and withdrawal symptoms occur. These can be very distressing for the unprepared potential quitter. Thus, the tobacco user is compelled to continue using tobacco, and remains trapped in the vicious cycle of tobacco use.

Studies have shown that tobacco users must effectively deal with both the physical and psychological symptoms of withdrawal to quit and stay quit.

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Which chemical in tobacco produces dependence/ addiction?

.....

.....

.....

.....

2. How does tobacco produce dependence?

.....

.....

.....

.....

6.3 TREATMENT OF TOBACCO DEPENDENCE

Tobacco dependence is a chronic condition that often requires repeated interventions. Because effective tobacco dependence treatments are available, **every patient who uses tobacco should be offered at least one of these treatments.** Tobacco dependence treatments are both clinically effective and cost effective in comparison to other medical and disease prevention interventions.

It is very important to record use of tobacco and follow up in respect of all tobacco users, both smokers and chewing tobacco users.

Following are the treatment interventions used for tobacco dependence :

6.3.1 Behavioural Interventions

A variety of behaviour therapies, ranging in complexity from simple advice offered by a physician or other health care providers to much more extensive therapy offered by counsellors, have been shown to be efficacious for tobacco cessation.

Brief Advice – This consists of advice to stop using tobacco, usually taking only a few minutes, given to all tobacco users, usually during the course of a routine consultation or interaction.

Behavioural support – This involves support other than medications, aimed at helping people stop their tobacco use. It can include all cessation assistance that imparts knowledge about tobacco use and quitting, provides support and teaches skills and strategies for changing behaviour.

Basic knowledge, certain competencies and skills are required to provide effective counselling for tobacco cessation.

6.3.2 Strategies For Tobacco Cessation: The 5 "A"s and 5 "R"s Approach

The Five **A**'s (**A**sk, **A**dvise, **A**ssess, **A**ssist and **A**rrange) and Five **R**'s (**R**elevance, **R**isk, **R**ewards, **R**epetitions, **R**oadblocks) is a five to fifteen minute research based counselling approach that has proven global success in tobacco cessation.

The five "A"s Approach

- **Step 1: Ask**

  Systematically identify all tobacco users at every visit. It should be an essential part of evaluation that for every tobacco user at every consultation, tobacco-use status be queried and documented.

- **Step 2: Advise**

  "Strongly urge all tobacco users to quit."

  Advice should have:

  - *Clear Message:* "I think it is important for you to quit tobacco now and I can help you." "Cutting down while you are ill is not enough".

  - *Strong message:* "As your health carer, I need to advise you that quitting tobacco smoking/chewing/sniffing is the most important thing you can do for your health and your family's health." . "I can surely help you in this matter."

  - *Personalized message:* Relate the tobacco use to current health/ illness, and/ or its social and economic cost, motivation level/ readiness to quit, and /or the impact of tobacco use on children and others in the house hold.

    All tobacco users should be firmly advised to quit in a way that is supportive and non-confrontational. Tell them about benefits of quitting.

Benefits of quitting

It is important to tell and explain the tobacco user about the benefits of quitting. Some hints are presented below. Individual users may have other motives to quit, which should be explored and documented for future use.

Begin thus - From the moment you quit smoking, it only takes 20 minutes for your body to start undergoing beneficial changes.

20 Minutes:

Blood pressure drops to normal; Pulse rate drops to normal; Temperature of hands and feet increases to normal

Within 8 Hours:

Carbon-monoxide level in blood drops to normal; Oxygen level in blood becomes normal.

Within 24 Hours to 48 hours:

Chance of heart attack decreases

Nerve endings start regenerating; Ability to smell and taste begins to improve

Within 72 hours:

Bronchial tubes relax, making breathing easier.

Within 2 Weeks to 3 Months:

Circulation improves. Lung function increases up to 30%

Within 6 Months:

Coughing, sinus congestion, fatigue and shortness of breath decrease. The lungs function better, as congestion reduces, so does the chance of infection.

Within 1 Year:

Risk of coronary heart disease decreases to half as compared to that of a smoker.

Within 10 Years:

Risk of dying from lung cancer is reduced to half.

Within 15 Years:

Risk of dying from a heart attack is equal to a person who never smoked.

Motivational Interviewing Techniques – Stages of Readiness to Change Model

Not ready (Pre-contemplation)

These tobacco users are not seriously considering quitting in the near future. They only see the positive aspects of tobacco and do not like to acknowledge the disadvantages.

- *Encourage such a person to think about his/her tobacco use and make an offer of help. Offer them written information on the harms of tobacco use and benefits of quitting.*

Unsure (Contemplation)

These tobacco users are seriously considering quitting in the near future. This group is particularly amenable to brief motivational interviewing. Talk to them about the relevant health effects of tobacco use and barriers to cessation.

- *Provide them the written information and inform them that quitting is possible with will power and support from the family, friends, peer group and health professionals.*

Ready (Preparation)

These tobacco users are planning and ready to quit and have usually made a 24-hour quit attempt in the past year. This group is motivated to quit soon and is the group most likely to attempt to quit in the near future.

- *This is the best opportunity, which may be available for only a short time, and is the group most likely to ask for help with quitting.*

Action

These are former tobacco users who have quit in the last 6 months. This is when the risk of relapse is highest with about 75% of relapses occurring in this stage, within the first week. This is a period where support and strategies to prevent relapse are important.

- *If relapse occurs, it is important that this should not be seen as failure, but considered a learning experience and as part of quitting process.*

Maintenance

These are tobacco users who quit for more than 6 months. The non-tobacco use behaviour is established and the threat of tobacco use gradually diminishes. The chances of relapse diminish over time.

Only about 4% of those who quit for more than two years ever go back to tobacco use.

- **Step 3: Assess**

Assessment of Nicotine Dependence : If the tobacco user is in the ready stage:

Assess willingness to quit, and determine the level of nicotine addiction. This can be measured by *Fagerstrom Scoring.* The tool has six simple questions. Scoring is done as follows:

A high level of addiction will rank between 7 and 10 points.

A medium level of addiction will rank between 4 and 6 points.

A low level of addiction will rank between 0 and 3 points.

- **Step 4: Assist**

Strategies commonly suggested to assist tobacco users in motivational stage are enumerated in Table 6.1.

Table 6.1: Strategies for Assisting Tobacco Users in Motivational Stage

Action	*Strategies for implementation*
Help in making a **QUIT plan**.	**Preparations for quitting:** ***Set*** a quit date; ideally, the quit date should be within 2 weeks. ***Tell*** family, friends, and co-workers about quitting, plan and seek their support. ***Anticipate*** challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. ***Remove*** tobacco products from surroundings. ***Avoid –*** *Avoid smoking or using tobacco in places where a lot of time is spent e.g. work place.* Avoid all forms of tobacco, do not substitute one tobacco product for another.
Provide practical counselling (Problem solving / skills training)	***Past quit experience –*** Identify what helped and what failed in previous quit attempts. ***Anticipate triggers*** or challenges in upcoming attempt – Discuss challenges and how user will successfully overcome them. ***Alcohol –*** The tobacco user should consider limiting/abstaining from alcohol while quitting. ***Other tobacco users in the household / workplace*** – Quitting is more difficult when there is another smoker/ tobacco user in the household/ workplace. Other housemates/ coworkers/ peers should also be encouraged to quit.

Provide intra-treatment social support.	Provide a supportive environment by encouraging tobacco users in their quit attempts.
Help in obtaining extra-treatment social support.	Provide help in developing social support for quit attempt in the environment outside of treatment. "Ask your spouse / partner, friends and coworkers to support you in your quit attempt."
Recommend Pharmacotherapy	Explain how the medications improve success rates and reduce withdrawal symptoms.

There is a strong dose response relation between the intensity of tobacco cessation counselling and its effectiveness.

Withdrawal symptoms

Commonly experienced withdrawal symptoms on stopping tobacco use include:

Depressed mood

Insomnia

Irritability, frustration , anger

Anxiety

Craving and difficulty in concentration

Restlessness

Decreased heart rate

Increased appetite or weight gain

Withdrawal symptoms of tobacco products should be discussed in advance with the tobacco user who is planning to quit. In addition, behavioural coping methods (kinly refer to Table 6.2) should be taught at the outset and it should be explained clearly that the worst of the physical symptoms are over within 2-3 days and most have passed after 10-14 days but in some, can last up to 4 weeks.

Table 6.2: Some Common Withdrawal Symptoms and Coping Strategies

Symptom	*Coping Strategy*
Irritability	Take walk, take bath, relax and talk to friends, listen to favourite music, do breathing exercises/ Yoga.
Fatigue	Relax, take naps, increase intake of fluids
Insomnia	Avoid tea, coffee, aerated drinks after 6 pm; develop habit of reading books

Cough	Drink plenty of fluids, use lozenges, steam inhalation
Nasal Drip	Drink plenty of fluids
Dizziness	Change positions slowly, relax
Lack of Concentration	Plan workload, avoid stress, time management
Constipation	Add fiber to your diet through fresh fruits, vegetables etc; drink plenty of fluids
Headaches	Drink plenty of fluids, and practice relaxation, eat small snacks
Hunger	Increase intake of fruits/ vegetables/ fluids; avoid heavy meals, take smaller meals at shorter intervals
Craving for tobacco	Distract yourself – Drink water, read, exercise, talk to family members/friends. Remind yourself that the urne will die down in a few minutes

- **Step 5: Arrange**

Arrange – Schedule a follow-up contact

Time **-** Follow up contact should occur soon after the quit date, preferably during the first week. A second follow up contact is recommended within the first month. Schedule further follow up contact as indicated. Follow up visits after advice to quit have been shown to increase the likelihood of successful long term abstinence.

During the follow up, quitters have some common problems and a solution should be suggested accordingly. Some of these are described in Table 6.3.

Table 6.3: Some Common Problems and Appropriate Responses

Problems	*Responses*
Lack of support for cessation	• Schedule follow-ups or telephone calls with the tobacco user. • Help in identifying sources of support.
Negative mood or depression	• Provide counselling, prescribe appropriate medications, or refer to a specialist.
Strong or prolonged withdrawal symptoms	• Use an approved pharmacology or add/combine pharmacologic medications to reduce strong withdrawal symptoms.
Weight gain	• Recommend starting or increasing physical activity.

Flagging motivation/feeling deprived	• Emphasize the importance of a healthy diet. • Reassure the tobacco user that weight gain is normal and will not increase beyond a point, and that there is just a need to watch it. • Reassure the tobacco user that these feelings are common. • Recommend rewarding activities. • Emphasize that even a puff or chew will increase urges.

For those tobacco users who may need a specialized treatment, referral to a specialist must be arranged for further evaluation and treatment.

The 5 "R"s Approach

For tobacco users who are not ready to make a quit attempt, provide a brief intervention designed to promote the motivation to quit and information about harmful effects of tobacco. The tobacco user may have fears and concerns about quitting, or may be demoralized because of previous unsuccessful attempts and relapse. This group may respond to a commonly employed motivational intervention designed to educate, reassure and motivate and built around the 5 "R"s; i.e. Relevance, Risk, Rewards, Roadblocks and Repetition.

Relevance Encourage the tobacco user to consider the personal relevance of cessation. Take into account the disease status (if any), family or social situation, health concerns, age and gender.

Risks Discuss short term, long term and environmental risks of continued tobacco use, including effects of exposure to second hand smoke on the family members especially children. Relate with the symptoms.

Rewards Encourage tobacco user to identify benefits of cessation. These may include withdrawal symptoms, fear and concern associated with quitting, depression, lack of social support, weight gain etc. Discuss strategies to address potential barriers.

Roadblocks Barriers that the tobacco user may face in his/her quit attempt should be identified. Withdrawal symptoms, fear and concern associated with quitting, depression, lack of social support, enjoyment of tobacco are some of the barriers that the tobacco user may face in an attempt.

Repetition This information should be reviewed regularly with tobacco users who are not yet ready to quit. It is also important for tobacco users who have not yet successfully quit to understand that most people attempting cessation quit several times before finally succeeding in quitting.

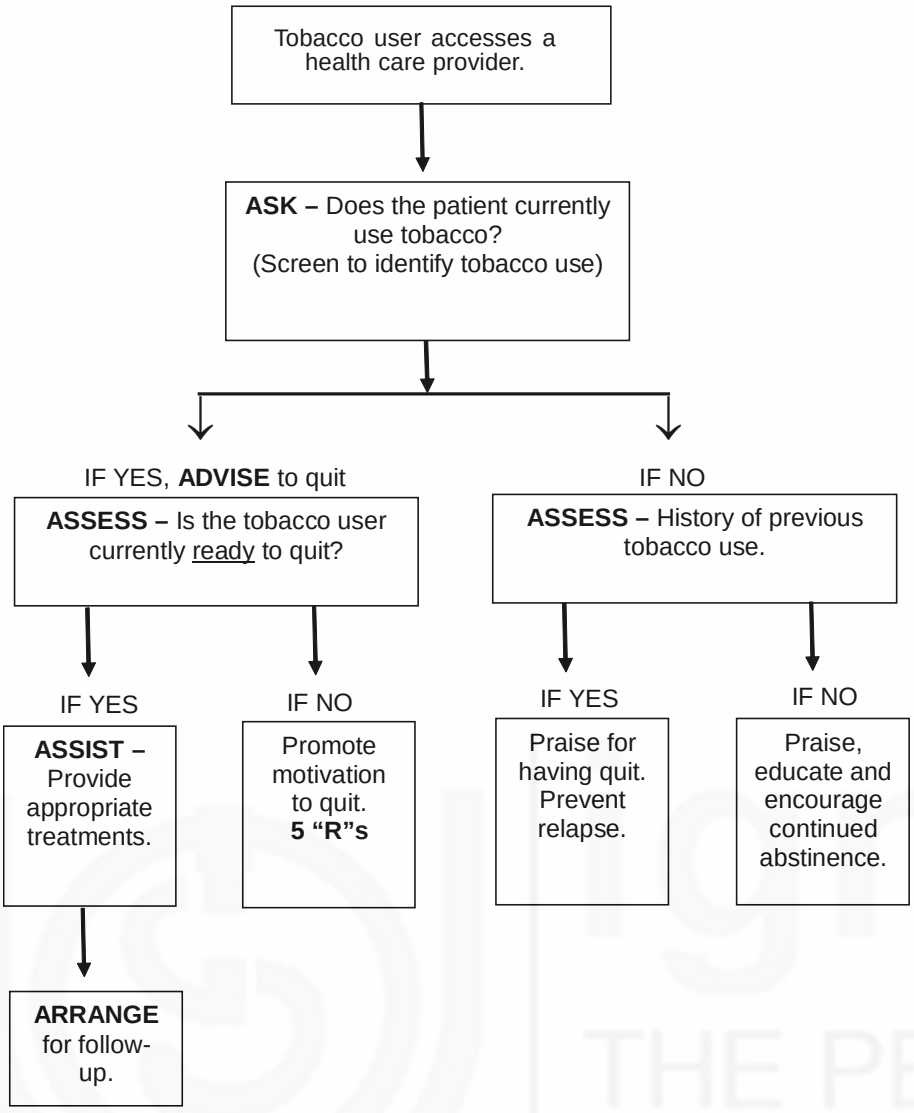

Fig. 6.1: Globally Recommended Intervention Method Algorithm for Quitting Tobacco Use

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1 How can the tobacco users who are trying to give up their dependence on tobacco be assisted?

.....

.....

.....

2. Mention any three withdrawal symptoms of tobacco products, and the coping strategies for the same.

.....

.....

.....

6.4 TOBACCO CESSATION IN SPECIAL SITUATIONS

Pregnant and lactating females

Women who use tobacco during pregnancy and breast-feeding should strongly be advised against it. They should be asked to quit using the behavioural strategies that were mentioned earlier, to deal with withdrawal. However if they are unable to quit just by behaviour counselling, then use of Nicotine Replacement Treatment (NRT) may be considered. Pregnant and breast-feeding women who opt for NRT should be advised to use shorter acting products to minimize overnight foetal exposure to nicotin (e.g. nicotine gum).

Cardiovascular disease

In stable cardiovascular disease conditions, use of NRT is safe. Caution should be taken while considering NRT in patients of unstable angina, myocardial infarction, or stroke as nicotine is a vasoconstrictor. In these cases, rapidly reversible NRT like nicotine gum is preferable.

Patients with tobacco use related diseases

This is a group where tobacco cessation is an urgent clinical need, as continued tobacco use greatly increases the risk of further illness. There is evidence that pharmacotherapy can increase cessation rates in chronic tobacco users with co-morbidity and those with mild to moderate Chronic Obstructive Pulmonary Disease. People with tobacco use related diseases may benefit from a multidisciplinary care plan.

Patients with mental illness

Patients with mental health problems have higher rates of smoking/tobacco use and are prone to serious health problems both on account of their mental illness and on account of tobacco use. The treatment of mental illness needs to be monitored carefully during tobacco cessation.

Persons with substance-use disorders

Smoking and tobacco use is common in persons with substance use disorders. Tobacco cessation must be offered to such persons in inpatient and outpatient settings.

Tobacco users with apprehension of weight gain

Some tobacco users are apprehensive of quitting tobacco use as it may lead to weight gain. Such persons should first be reassured that weight gain can be minimized by proper diet and exercise and the need to quit must be emphasized. Use of pharmaco therapy or nicotine gum has been shown to delay weight gain. Continuing reassurance and support are vital for successful quitting.

6.5 LET US SUM UP

Tobacco use leads to chronic dependence. The users who are willing to quit may

be offered treatment for assisting in quitting. This includes behavioural counselling techniques. The same can be used by health care professionals and health care providers or health workers who are approached by tobacco users or as part of their routine treatment.

The behavioural counselling for tobacco cessation has been used globally and is a successful cost effective strategy for tobacco cessation.

In view of high prevalence of tobacco use among men and women in India, the health professionals are required to be adequately trained in tobacco cessation techniques.

6.6 GLOSSARY

5 As	Ask, Advise, Assess, Assist and Arrange
5 Rs	Relevance, Risk, Rewards, Repetitions, Roadblocks
FCTC	Framework Convention on Tobacco Control
GATS	Global Adult Tobacco Survey
GHPSS	Global Health Professional Students Survey
GYTS	Global Youth Tobacco Survey
ICD 10	International Coding of Diseases – 10th version
MPOWER	Policies for tobacco control
	M – Monitor tobacco use and prevention policies.
	P – Protect people from tobacco smoke.
	O – Offer help to quit tobacco use.
	W – Warn about the dangers of tobacco.
	E – Enforce bans on tobacco advertising, promotion and sponsorship.
	R – Raise taxes on tobacco.
NRT	Nicotine Replacement Treatment
WHO	World Health Organization

6.7 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Nicotine

2. Both smoked as well as smokeless forms of tobacoo contain nicotine, a highly addictive chemical, making it difficult for habituated tobacco users to quit. In fact, it is as addictive, or even more, than heroin or cocaine. Over

time, users become dependent on nicotine and suddenly stopping produces both physical and psychological withdrawal symptoms.

Check Your Progress Exercise 2

1 Through help in making a QUIT plan.

- By providing practical counselling
- By helping in obtaining intra-treatment and extra-treatment social support
- By recommending pharmacotherapy.

2.
- Irratibility - Take walk/bath, relax and talk to friends, listen of favourite music, do breathing exercises/yoga.
- Insomnia - Develop habit of reading books, avoid tea, coffee and aerated drinks after 6 p.m.
- Fatigue - Take rest/nap relax, increase intake of fluids.

6.8 UNIT END QUESTIONS

1. How would you define tobacco dependence?
2. Why do tobacco users need treatment for quitting tobacco use?
3. What is 5 As approach in behavioural counselling for tobacco cessation?
4 What strategy would you adopt for a tobacco user who is unwilling to quit tobacco use ?
5 What would you explain to tobacco users who are willing to quit but are apprehensive of weight gain ?

6.9 FURTHER READINGS AND REFERENCES

Asian Pacific Journal of Cancer Prevention, vol 11:939-942

Barker D (1994) Reasons for tobacco use and symptoms of nicotine withdrawal among adolescent and young adult tobacco users-United States, 1993. MMWR Morb Mortal Wkly Rep 43:745–750.

Belperio P, Chen T. (2009) Pharmacology for tobacco use cessation (TUC): 2008 Clinical Practice Guideline Update. Conference: 2/25/2009

Britton J. Nicotine replacement can be obtained on prescription. BMJ 2000; 321 : 379.

Byran J, Bailey, Jonas, T Johnson, Shawn D Newlands; Tobacco Cessation: How to guidance and resources for practitioners; in Head and Neck Surgery – otolaryngology.

Davis, Ronald M. et al. (eds.) The Health Consequences of Smoking: Nicotine Addiction: A Report of the Surgeon General, US, 1988 (http:// profiles.nlm.nih.gov/NN/B/B/Z/D/ Accessed 14January, 2011).

Director, Ministry of Health and Family Welfare, Government of India.

F. Ram et al. Global Adult Tobacco Survey 2009-10 Document. New Delhi, India, National Tobacco Control Programme, Ministry of Health and Family Welfare, Govt. of India, 2010

Ferris RM, Cooper BR. Mechanism of antidepressant activity of bupropion. J Clin Psychiatry Monogr 1993;11:2-14

Global Youth Tobacco Survey (GYTS), 2009 (http://www.who.int/tobacco/surveillance/gyts/en/ Accessed 13 January, 2011).

Global Health Professions Student Survey (GHPSS), India, 2009, (http://www.searo.who.int/LinkFiles/GHPS_India_2009_Dental.pdf and http://www.searo.who.int/LinkFiles/GHPS_India_2009_medical.pdf Accessed 13 January, 2011).

Guidelines for Article 14 of WHO, FCTC.

GH Thompson and DA Hunter, Nicotine replacement therapy, The Annals of Pharmacotherapy: Vol. 32, No. 10, pp. 1067-1075.

Hatsukami DK, Hughes JR, Pickens RW, Svikis D (1984) Tobacco withdrawal symptoms: An experimental analysis. Psychopharmacology 84:231–236.

Hatsukami DK, Gust SW, Keenan RM (1987) Physiologic and subjective changes from smokeless tobacco withdrawal. Clin Pharmacol Ther 41:103–106.

Hwa-Jeong Lee, Han-Young Guo, Sun-Kyung Lee et al. Effects of nicotine on proliferation, cell cycle, and differentiation in immortalized and malignant oral keratinocytes, Journal of Oral Pathology & Medicine,Volume 34, Issue 7, pages 436–443, August 2005.

Hughes JR, Hatsukami D (1986) Signs and symptoms of tobacco withdrawal. Arch Gen Psychiatry 43:289–294.

Holm KJ, Spencer CM (2000). Bupropion: A review of its use in the management of smoking cessation. Drugs, 59(4): 1007–1024.

J. Taylor Hays MD. Jon O. Ebbert MD and Amit Sood MD. Efficacy and Safety of Varenicline for Smoking Cessation. The American Journal of Medicine Volume 121, Issue 4, Supplement 1, April 2008, Pages S32-S42

Jha P, Jacob B, Gajalakshmi V, Gupta PC, Dhingra N, Kumar R, et al. A nationally representative case-control study of smoking and death in India. N Engl J Med 2008, 358:1137-46.

Miller and Rollnick. Motivational Interviewing: Preparing People for Change, 2nd ed. 2002.

Moxham J. Nicotine addiction. BMJ 2000; 320 : 391-2.

Murthy P, Saddichcha S. (2010) Tobacco cessation services in India: Recent developments and the need for expansion. IInd J Cancer, 47; 5:69-74.

Policy recommendations for smoking cessation and treatment of tobacco dependence, WHO, 2003.

Prochaska, J.O. & DiClementi, C.C. (1984). The transtheoretical approach: Crossing the traditional boundaries of therapy. Malabar, FL: Krieger.

Prochazka AV, Kick S, Steinbrunn C, Miyoshi T, Fryer GE. A randomized trial of nortriptyline combined with transdermal nicotine for smoking cessation. Arch Intern Med 2004; 164 : 2229-33.

Rollnick, Miller & Butler. Motivational Interviewing in Health care: Helping Patients Change Behaviour. 2008.

Saddichcha S, Rekha DP, Patil B, Murthy P, Benegal V, Isaac MK. 2010. Knowledge, attitude and practices of Indian dental surgeons towards tobacco control: Advances towards prevention.

Shiffman S (1991) Refining models of dependence: Variations across persons and situations. Br J Addiction 86:611–615.

Sweeney C.T., Fant R.V., Fagerstrom K.O.,McGovern J.F., Henningfield J.E; Combination Nicotine Replacement Therapy for Smoking Cessation: Rationale, Efficacy and Tolerability. CNS Drugs, Volume 15, Number 6, 2001 , pp. 453-467(15)

Tobacco Cessation Centre, NIMHANS. 2009. Starting tobacco cessation services. Available at:http://www.nimhans.kar.nic.in/deaddiction/1221/pub/Starting_TCC_Services-Nimhans_2009.pdf

VA/DoD Clinical Practice Guideline for the management of Tobacco Use: Update 2004. U.S. Army Medical Command, & The Veterans Health Administration.

WHO report on the global tobacco epidemic. Geneva, World Health Organization, 2008.

World Health Organization, Regional Office for South-East Asia. Helping people quit tobacco. A manual for doctors and dentists. ISBN 978-92-9022-380-1

World Health Organization, Regional Office for South-East Asia. Tobacco cessation: A maual for nurses, health workers and other health professionals. ISBN978-92-9022-384-9.

Zevin, S., & Benowitz, N.L. (1999). Drug interactions with tobacco smoking: An update. Clin Pharmacokinet. 36(6). 426-436.

UNIT 7 FAMILY INTERVENTIONS FOR SUBSTANCE USE

Structure

7.1 INTRODUCTION

Substance use disorders impact both the individual and the family which he or she is a part of and may be perpetuated by a host of factors operating within the familial context. Hence, one of the effective intervention strategies to address the problematic substance use of a person is one which involves family members in the therapy process and changes the maladaptive patterns operating within the family context that may have perpetuated and maintained the substance use problem. This unit addresses the family interventions used to address the problem of substance use.

Objectives

After studying this Unit, you will be able to:

- describe what is a family intervention or family therapy;
- understand the goals of family therapy for substance abuse; and
- discuss the different approaches to family therapy in the context of substance abuse.

7.2 FAMILY THERAPY

7.2.1 Definition

Family therapy or family intervention consists of therapeutic approaches based on family-level assessment and intervention. Family therapy in substance abuse treatment has two main purposes. First is to utilize the family's strengths and resources to help find or develop alternative ways to cope with various problems rather than resort to excessive use of substances. Second, it reduces the impact of chemical dependency on both the person who uses substances and the family. The unit of treatment in family therapy comprises the family, and/or the individual within the context of the family system. The person abusing substances is regarded as a subsystem within the family unit — the person whose symptoms have severe repercussions throughout the family system. The focus of family interventions is the relationships among family members. The therapist facilitates discussions and problem solving sessions with the entire family group or a family member, who may or may not be the person with the substance use disorder.

7.2.2 Family Therapy versus Family Involved Therapy

Family therapy differs from family involved therapy. Family involved therapy attempts to educate families about the relationship patterns which may contribute to the formation and continuation of substance abuse; whereas family therapy attempts to address the maladaptive relationship patterns among family members, which may contribute to substance abuse problems. In family involved therapy, the family is not the primary therapeutic grouping, nor is the intervention in the system of family relationships; whereas family therapy focuses on intervening within the system of family relationships. Family involved therapy is a psycho-educational approach to provide information to the family about substance abuse, related behaviours, as well as the behavioural, medical and psychological consequences of use. Family therapy however utilizes psycho-education as the initial step in addressing maladaptive family functioning patterns.

7.2.3 Characteristics and Principles

The key characteristics and principles of family therapy are delineated below:

- **Comprehensive Treatment Approach –** Family therapy consists of clinical treatment, clinical support, and community support services addressing substance use, mental health, physical health, and developmental, as well as social, economic, and environmental needs of persons with substance use as well as their family members.

- **Centered on Family –** Family is inclusive of the supportive network of relatives and others who the person with substance abuse identifies as part of his/her family. Family therapy focuses on healthy attachment and relationships among parents and children and on the relationships of the person with substance abuse with others. Hence, this mode of therapy helps the family function as a unit.

- **Need Based –** The goals, interventions, type, length, frequency, location, and method of delivering intervention is based on the strengths and needs of the family members.

- **Dynamic –** Since families are dynamic, the intervention is also dynamic and is aimed at addressing the evolving and changing family engagement. All family members may not participate at the same time, stay the same length of time, or have the same motivations. Hence, the treatment modality needs to be flexible and dynamic.

- **Conflict Resolution –** Multiple crises are inevitable while dealing with families. Families must juggle conflicting needs and priorities and balance the needs of members.

- **Co-ordination and Collaboration –** Meeting complex family needs requires coordination across systems. Coordination and collaboration prevents conflicting objectives and helps to provide optimal support for family members.

- **Substance use disorders are chronic, but treatable –** The treatment process involves a gradual process that moves individuals and families toward the goal of lasting recovery. Family therapy includes a wide variety of programmes and strategies designed to address dependence, remove adverse consequences associated with substance use, return biopsychosocial functioning and reduce/eliminate substance use. Behavioural therapies, motivational enhancements, pharmacological interventions, and case management are common elements of treatment.

- **Services must be gender responsive and specific and culturally competent –** Services provided should utilize the knowledge and skills that fit the background of individuals and families. Gender-responsive services recognize the unique characteristics of initiation of use by a person, effects of use, histories of trauma, co-occurring mental health and physical disorders, and other treatment issues including the primacy, importance, and continuity of relationships in women's lives. Culturally competent services are embedded in the language, values, and experiences of the person's culture.

- **Family-centered treatment requires an array of staff professionals as well as an environment of mutual respect and shared training –** The therapeutic approach should encourage learning, constitute a team approach, and provide consultation among diverse staff members to work together.

- **Safety –** Family therapy should provide a safe environment for all family members. Programmes must have policies for addressing inappropriate behaviour in children, youth, and adults and protecting confidentiality. Maintaining trauma-informed and trauma-sensitive services is extremely important.

- **Treatment must support creation of healthy family systems –** Healthy family systems include structure, appropriate roles, and good communication that allow the family to function as a unit while supporting the needs of each individual member side by side.

7.2.4 Important Concepts in Family Therapy

There are certain important concepts to bear in mind while conducting family therapy. These include:

- **Triangles** – These constitute the triadic interactional configurations, which build the emotional system. When two persons system becomes unstable because of anxiety, a third person is involved to stabilize them. For example, if a couple is having a lot of interpersonal conflict, a therapist may stabilize their relationship by helping them work through their problems.
- **Coalitions** – It is a version of triangles, in which there are negative relationships between two or more family members.
- **Family Belief Systems** – These constitute the construction or perception of the problems experienced by family members.

7.2.5 Goals of Family Therapy

The goals of family therapy include:

- To help the family become aware of its own needs and facilitate better functioning among family members.
- To inculcate better communication strategies among family members and encourage them to work towards common goals.
- To help the family make interpersonal, intrapersonal, and environmental changes affecting the person using alcohol or drugs.
- Preventing abuse patterns to continue across generations.

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Define family therapy.

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2. What are the goals of family therapy?

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7.3 APPROACHES TO FAMILY THERAPY

There are various approaches to conduct family based interventions. These can be understood in terms of their theoretical orientation, goals of therapy and strategies or techniques employed. The approaches are discussed under the following heads.

7.3.1 Behavioural Contracting

This approach was proposed by Steinglass et al. (1987) and views substance use as a source of stress for the whole family. It suggests that substance abuse constitutes the central organizing principle for a substance-abusing family. It views families with members who abuse substances as a highly heterogeneous group.

The goals of therapy include:

- Identifying and addressing the family's problems (including substance abuse by one or more family members) as family problems.
- Developing a substance-free environment.
- Helping families cope with the emotional distress caused by substance abuse problems.

The strategies and techniques which are used in this approach include:

- Developing a written contract to ensure a drug-free environment.
- Using enactments and rehearsals to make the family members aware of the triggers of substance use, to anticipate problems, and avoid them.
- Use of family re-stabilization or reorganization to change functioning and organization.

7.3.2 Bepko and Krestan's Theory

This theory was developed by Bepko and Krestan (1985) and focuses on the person who abuses substances and the substance of abuse as a system as well as looking at intrapersonal, interpersonal, and gender systems.

The goals of therapy include:

- Helping everyone in the family achieve appropriate responsibility for self and decrease inappropriate responsibility for others.
- Pre-sobriety goals aim to unbalance the system that was balanced around substance abuse to promote sobriety.
- Early sobriety goals include balancing the system around a self-help group; maintaining people in a corrective context (a zone of right relationship, avoiding overinflated pride and abject self-loathing) recognizing that no one stays there all the time.
- Maintenance goals include rebalancing the system in a deep way by going back and working on developmental tasks that were previously missed.
- Clarifying the adaptive consequences of substance abuse.

The strategies and techniques employed by this approach are based on the phase of treatment, namely, pre-sobriety, early sobriety and maintenance.

- Pre-sobriety – Interrupting and blocking emotional and functional over-responsibility using the pride-system of the spouse and the individual with a substance use disorder and referring to a self-help group.
- Early sobriety – Group therapy involving reparative and restorative work with children (in order to have children express feelings in a safe environment).
- Maintenance – Anger management techniques; dealing with toxic issues such as sexual abuse. Looking at gender stereotypes with respect to sex, power, anger, and control.

7.3.3 Behavioural Marital Therapy

This theory was proposed by Epstein and McCrady (2002) to treat alcohol problems within a couples counselling framework. This approach adopts a social-learning framework to conceptualize drinking (or other substance use) problems and family functioning as well as examines the current factors maintaining substance use, rather than historical factors. Further, it explores the cognitions and affective states that may mediate the relationship between external antecedents and substance use, and expectancies about the reinforcing value which may provide information regarding the substance use pattern of a person. Substance abuse is maintained by physiological, psychological, and interpersonal consequences. It is part of a continuum that ranges from abstinence to non problem use to different types of problem use. This perspective differs significantly from the psychiatric diagnostic approach of the DSM-IV-TR (APA, 2000) in that it does not assume that certain symptoms cluster, or suggest that an underlying syndrome or disease state is present.

The goals of therapy include:

- Achieving abstinence
- To develop coping skills for both partners to address problematic substance abuse.
- To develop positive reinforcers for abstinence or changed use.
- To enhance the functioning of the relationship.
- To develop general coping skills.
- To develop effective communication and problem solving skills.
- To develop relapse prevention skills.
- Other couple-specific goals may also be identified.

The strategies and techniques employed are as follows:

- Intervening at multiple levels, with the individual who is abusing substances, the spouse/partner, the relationship as a unit as well as the family and other social systems.
- Conducting a detailed assessment to determine the primary factors that may contribute to the maintenance of substance use, identify the skills and deficits

of the individual and the couple, as well as elicit the sources of motivation to change.

- Helping the client to assess individual psychological problems associated with use, potential and actual reinforcers for continued use and for decreased use or abstinence, negative consequences of use and abstinence, and beliefs and expectations about substance use and its consequences.
- Teaching individual coping skills (e.g., self-management planning, stimulus control, substance refusal, and self-monitoring of use and impulses to use).
- Teaching behavioural and cognitive coping skills individually tailored to the types of situations that are the most common antecedents to use.
- Providing clients with a model for conceptualizing substance abuse and how it can be changed.
- Teaching spouses a variety of coping skills based on an individualized assessment of behaviours that may either cue or maintain substance use (for instance, learning new ways to discuss use and learning new responses to partner's use).
- Using substance-related topics (such as how to manage a situation where substances are being used or what to tell family and friends about the treatment) to teach problem solving and communication skills.
- Helping the clients identify high risk situations, that is interpersonal situations including people associated with substance use who may motivate the client to use substances.
- Teaching harm reduction concepts (e.g., reduced or decreased use as opposed to abstinence).

7.3.4 Brief Strategic Family Therapy

This approach was proposed by Santisteban et al. (1996) and further developed by Szapocznik and Williams (2000). This approach is a family therapy approach aimed at adolescents and their families with a specific focus on the family environment. However this approach is not suggested with adults with addictions and is applied mostly with adolescents. It is based on the premise that adolescents' lack of success dealing with developmental challenges leads them to substance abuse. Rigid family structures may increase substance abuse as parents may need to be able to re-negotiate as the adolescent grows. Intra family and acculturation conflict impact relationships negatively and increase substance abuse.

The goals of therapy include:

- Changing parenting practices (such as leadership, behaviour control, nurturance, and guidance).
- Improving the quality of relationship and bonding between parents and the adolescent(s).
- Improving conflict resolution skills.

The strategies and techniques used in family therapy include:

- Interview the client and gauge whether he/she will be resistant to treatment and engagement.

- Identify the normal processes of acculturation and then help families learn to overcome these differences.
- Block or reframe negativity and promote supportive interactions.
- Modify the therapeutic programme based on data and research.
- Provide culturally competent treatment.
- Actively work on engaging the family.
- Intervene in the family system through the parents rather than directly intervening (and therefore put traditional hierarchies back into place).

7.3.5 Multidimensional Family Therapy (MDFT)

This approach was proposed by Liddle (1999) and developed further by Liddle and Hogue (2001). It was developed to treat adolescent drug problems and related behavioural problems such as conduct disorder from a multiple systems perspective. It conceptualizes adolescent substance abuse as a multi-determined and multidimensional disorder. This approach employs an integrative developmental, environmental, and contextual framework to conceptualize the beginning, progression, and cessation of drug use and abuse. It incorporates the knowledge about the risk and protective factors to arrive at a case conceptualization that includes and integrates the individual, familial, and environmental factors. The framework further suggests that both normative (failure to meet developmental challenges and transitions) and non-normative (abuse, trauma, mental health, and substance abuse in the family) crises play a role in starting and maintaining adolescent drug problems.

The goals of therapy include:

- To facilitate a process of adaptation to the youth's and family's developmental challenges as drug use and other problem behaviour would reduce or stop when sufficient adaptive developmentally appropriate functioning is restored or created.
- To enhance and bolster the psychosocial functioning of the youth and family in their key developmental domains.
- To improve adolescent functioning in several realms, including individual developmental adaptation, coping skills training relative to drug and problem solving situations, peer relations, and family relationships.
- To improve parents' functioning in several realms including their own personal functioning (e.g., substance abuse or mental health issues) and functioning in their parental role (e.g., parenting practices).
- To improve family functioning as evidenced by changes in day-to-day family environment and family transactional patterns.
- To improve adolescent and parent functioning in the extra-familial domain, including more adaptive and positive transactions with key systems such as school and juvenile justice.

Some key aspects of the strategies and techniques employed include:

- The overall therapeutic strategy calls for multilevel, multidomain, multicomponent interventions.
- Treatment is flexible and it is a therapy system rather than a general model.
- As such, therapy length, number, and frequency of the sessions are determined by the treatment setting, provider, and family.
- Treatment format includes individual and family sessions, and sessions with various and extra familial sessions.
- Treatment begins with an in-depth, multi-systems assessment that uses a developmental/ecological and risk and protective factor framework to establish a case conceptualization based on this approach.
- The case conceptualization individualizes the treatment system and pinpoints areas of strength and deficit in the multiple and inter-locking realms of a teen's psychosocial ecologies.

7.3.6 Multifamily Groups

This therapeutic approach was suggested by Kaufman and Kaufmann (1992). This is based on the traditional medical model and disease concept. It conceptualizes substance abuse as a disease that affects the whole family.

The goals of therapy include:

- To work to achieve abstinence for family member(s) with substance use disorders.
- To consolidate abstinence by focusing on resolving dysfunctional rules, roles, and alliances.
- After sobriety is achieved, deepen intimacy through appropriate expression of suppressed feelings (such as mourning of losses or hostility).
- Maintain a sober family core that acts as a central homeostatic organizer for the client who abuses substances, especially during times of stress.

The strategies and techniques employed involve:

- Beginning the therapy with an assessment of substance abuse, individual psychopathology, and family systems.
- Addressing developmental issues and individual Axis I and II disorders, and including these issues as part of a family contract.
- Preparing a family relapse prevention plan.
- Making use of 12-Step and other self-help modalities.

7.3.7 Multi-systemic Therapy

This theory was proposed was Henggeler et al. (1998) and developed by Cunningham and Henggeler (1999). This mode of therapy seeks to understand the fit between substance abuse and the broader systemic context as well as understand specific problems in a real-world context. Serious clinical problems, such as substance abuse, are multi-determined and influenced by variables from multiple systems.

The goals of therapy include:

- The initial goal is to engage family members and, if necessary, to identify barriers to engagement and develop strategies for overcoming those barriers.
- To examine the strengths and needs of each system and their relationship to the identified problem.
- To address risk and protective factors as they impact the family from a range of sources.
- Family members and caregivers have a major role in defining treatment goals.

The key aspects of strategies and techniques used in this therapeutic approach include:

- Interventions are designed to promote responsible behaviour.
- Interventions are present-focused and action oriented, targeting specific and well defined problems.
- Developmentally appropriate interventions, are provided.
- Daily or weekly effort by family members is required.
- Responsibility is placed on the therapist for overcoming barriers.

7.3.8 Network Therapy

This theory was developed by Galanter (1993). Like some of the earlier family therapy approaches described above, this therapeutic approach is based on the traditional medical model and disease concept, which views substance abuse as a disease which affects the entire family.

The goals of therapy include the following:

- Balance the family system in terms of gender, age, relationship, and so on.
- Family and significant others work to help the individual who abuses substances maintain his abstinence and a stable support system that promotes his recovery.
- Focus is on the individual's efforts to maintain abstinence.

The strategies and techniques employed can be enumerated as below:

- Create secure, stable, substance-free residence.
- Avoid people, places, and things that promote substance use. Encourage self-help group attendance.
- Establish a healthy support system.
- Avoid areas of conflict and negative exchanges.

- Family and significant others work as a team and are coached to help the person abusing substances to achieve and maintain abstinence.

7.3.9 Solution-Focused Therapy

This theory was developed by Berg and Miller (1992); Berg and Reuss (1997); and de Shazer (1988). This mode of therapy puts emphasis on the solutions that are available to the family, not on how the problem developed or what function it might serve.

The goals of therapy include:

- A therapeutic relationship needs to be built on trust and respect.
- Help client to realize that she can maintain sobriety and has done so on occasions in the past.
- Goals of therapy are defined by the client.
- Focus on exceptions (such as times when substance abuse does not occur).
- Focus on problems that can be solved and on finding unique solutions to those problems that can enhance optimism.
- The focus is on solution, not problems.

The strategies and techniques used in therapy include:

- Use solution-focused techniques to help the family system realize its ability to help the member abusing substances to maintain abstinence.
- Make rapid transitions to identifying and developing solutions intrinsic to the family.

7.3.10 Stanton's Therapeutic Techniques

This approach was developed by Stanton et al. (1982). Substance abuse is part of a cyclical process that takes place between connected people who form an intimate, interdependent, and interpersonal system. Substance use often begins in adolescence as an attempt at individuation. Within the family there is a "complex homeostatic system" of feedback that serves to maintain stability and in the process maintains substance abuse behaviour.

Specific goals are negotiated with the family at the beginning of treatment. There are, though, three primary stated goals:

- The IP should be substance free.
- The IP should be either gainfully employed or involved in some sort of school or training programme.
- The IP should establish a stable and autonomous living situation.

The strategies and techniques used in this approach include:

- Emphasize present situation.
- Alter repetitive behavioural sequences.
- Emphasize process over content.

7.3.11 Wegscheider-Cruse's Theory

According to this theory, substance abuse is a progressive family disease affecting every member and every facet of life. In the substance-abusing family system, the members, in the interests of their own survival, assume behavioural patterns that maintain a balance. When one member becomes dependent on a substance, it affects the others, causing psychological and/or biological symptoms. As the member who abuses substances progressively experiences a sense of worthlessness, so do all other family members. There are six basic roles family members assume:

Substance abuser, Enabler, Hero, Scapegoat, Lost child and Mascot

The goal of this therapeutic approach constitutes:

- Making the family system more open, flexible, and whole — as when the family system begins to change, other problems such as substance use will subside as well.

The strategies and techniques employed in this therapeutic approach include the following:

- Educate every family member about the disease.
- Break through the family's denial.
- Confront any crisis.
- Treat the immediate problems of substance abuse.
- Offer concrete recommendations for help, including self-help group attendance.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Fill in the blanks:

i. …….therapy puts emphasis on the solutions that are available to the family, not on how the problem developed or what function it might serve.

ii. ……. approach focuses on the person who abuses substances and the substance of abuse as a system as well as looking at intrapersonal, interpersonal, and gender systems.

iii. …….. approach treats alcohol problems within a couples counselling framework.

7.4 ADVANTAGES AND LIMITATIONS OF FAMILY THERAPY

Family therapy as a theoretical conceptualization and intervention has certain advantages and limitations.

The advantages of family therapy/intervention include:

- It focuses on the family dynamics and familial variables which may precipitate or maintain substance use patterns.
- This approach helps to correct the maladaptive familial interaction patterns, which may have a long-standing impact on managing problematic substance use patterns.
- It involves the family members, thus utilizing the social support systems available to an individual facing problematic substance use.
- This approach helps to enhance the communication and facilitates emotional catharsis among family members, thus fostering healthier relationships among family members.

The limitations of the family therapy approach are:

- The concepts and constructs in some theories are not operationally defined.
- This form of therapy doesn't address power influences within the familial structure well.
- It may be expensive and time consuming as co-operation among family members to address a common goal may be an arduous task.
- It is based on the assumption that familial patterns are the basis of pathology or substance use problems, which may not be true in all cases.
- It neglects individual psychological factors.
- The traditional approaches ignore the role of gender, socio-cultural and political contexts of family life.
- At times, traditional roles are forced upon, for example emphasizing parental authority structure to bring about changes, which may not be an effective mode of intervention for someone who has issues with authority.

7.5 LET US SUM UP

To summarize, the key points of the Unit are as follows:

- Family therapy or family intervention comprises therapeutic approaches based on family-level assessment and intervention.
- Family therapy in substance abuse treatment has two main purposes. First is to utilize the family's strengths and resources to help find or develop alternative ways to cope with various problems rather than resort to excessive use of substances. Second, it reduces the impact of chemical dependency on both the person who uses substances and the family.
- The family therapy approaches have the following characteristics: they are comprehensive, centered on family, need based, dynamic, focused on conflict resolution, emphasize co-ordination and collaboration, based on the premise that substance abuse disorders are chronic but treatable, provision of gender and culturally competent services which create safety and support creation of healthy family systems.

- The basic concepts in family therapy include triangles, coalitions and family belief systems.
- The goals of family therapy include: to help the family become aware of its own needs and facilitate better functioning among family members, inculcate better communication strategies among family members and encourage them to work towards common goals, help the family make interpersonal, intrapersonal, and environmental changes affecting the person using alcohol or drugs and prevent abuse patterns to continue across generations.
- The approaches to family therapy include behavioural contracting, Bepko and Krestan's theory, behavioural marital therapy, brief strategic family therapy, multidimensional family therapy, multifamily groups, multi-systemic therapy, network therapy, solution-focused therapy, Stanton's therapeutic techniques and Wegscheider-Cruse's theory.
- Family therapy has certain advantages such as focusing on familial patterns in substance use and fostering better communication and relationships among family members. However, there are certain disadvantages such as it is time consuming, expensive, and may not focus on individual psychological factors.

7.6 GLOSSARY

Behavioural Contracting Approach — It views substance use as a source of stress for the whole family and employs use of contracts and enactments to reduce substance use.

Behavioural Marital Therapy — This approach adopts a social-learning framework to conceptualize substance use problems and family functioning as well as examines the current factors maintaining substance use, rather than historical factors. It explores the cognitions and affective states that may mediate the relationship between external antecedents and substance use, and expectancies about the reinforcing value which may provide information regarding the substance use pattern of a person.

Bepko and Krestan's Theory — This approach focuses on the person who abuses substances and the substance of abuse as a system as well as looking at intrapersonal, interpersonal, and gender systems.

Brief Strategic Family Therapy — This approach is a family therapy approach aimed at adolescents and their families with a specific focus on the family environment. It is based on the premise that adolescents' lack of success in dealing with developmental challenges leads them to substance abuse.

Coalitions	It is a version of triangles, in which there are negative relationships between two or more family members.
Family Belief Systems	These constitute the construction or perception of the problems experienced by family members.
Family involved therapy	This therapy attempts to educate families about the relationship patterns which may contribute to the formation and continuation of substance abuse.
Family therapy	It comprises therapeutic approaches based on family-level assessment and intervention.
Multidimensional Family Therapy	It conceptualizes adolescent substance abuse as a multi-determined and multidimensional disorder. This approach employs an integrative developmental, environmental, and contextual framework to conceptualize the beginning, progression, and cessation of drug use and abuse.
Multifamily Groups	This is based on the traditional medical model and disease concept. It conceptualizes substance abuse as a disease that affects the whole family. This approach focuses on consolidating abstinence by focusing on resolving dysfunctional rules, roles, and alliances; and after sobriety is achieved, it attempts to deepen intimacy through appropriate expression of suppressed feelings (such as mourning of losses or hostility).
Multi-systemic Therapy	This mode of therapy seeks to understand the fit between substance abuse and the broader systemic context as well as understand specific problems in a real-world context. Serious clinical problems, such as substance abuse, are multi-determined and influenced by variables from multiple systems.
Network Therapy	This theory views substance abuse as a disease which affects the entire family and aims to help family and significant others work to help the individual who abuses substances maintain his abstinence and foster a stable support system that promotes his recovery.

Solution-Focused Therapy

This mode of therapy puts emphasis on the solutions that are available to the family, not on how the problem developed or what function it might serve.

Stanton's Therapeutic Techniques

This approach views substance abuse as part of a cyclical process that takes place between connected people who form an intimate, interdependent, and interpersonal system. Within the family there is a "complex homeostatic system" of feedback that serves to maintain stability and in the process maintains substance abuse behaviour.

Triangles

When two persons system becomes unstable because of anxiety, a third person is involved to stabilize them.

Wegscheider-Cruse's Theory

It views substance abuse as a progressive family disease affecting every member and every facet of life. In the substance-abusing family system, the members, in the interest of their own survival, assume behavioural patterns that maintain a balance. When one member becomes dependent on a substance, it affects the others, causing psychological and/or biological symptoms. As the member who abuses substances progressively experiences a sense of worthlessness, so do all other family members.

7.7 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Family therapy or family intervention consists of therapeutic approaches based on family-level assessment and intervention. Family therapy in substance abuse treatment has two main purposes. First is to utilize the family's strengths and resources to help find or develop alternative ways to cope with various problems rather than resort to excessive use of substances. Second, it reduces the impact of chemical dependency on both the person who uses substances and the family.

2. The goals of family therapy include: to help the family become aware of its own needs and facilitate better functioning among family members; inculcate better communication strategies among family members and encourage them to work towards common goals; help the family make interpersonal, intrapersonal, and environmental changes affecting the person using alcohol or drugs; and to prevent abuse patterns to continue across generations.

Check Your Progress Exercise 2

1. i. Solution Focused

   ii. Bepko and Krestan's Theory

   iii. Behavioural Marital Therapy

7.8 UNIT END QUESTIONS

1. What is the difference between family therapy and family involved therapy?
2. Write a note on multidimensional family therapy.
3. Highlight the advantages and disadvantages of family therapy in the context of substance abuse.

7.9 FURTHER READINGS AND REFERENCES

Berg, I.K., and Miller, S.D. (1992). *Working with the Problem Drinker: A Solution-Focused Approach.* New York: W.W. Norton.

Berg, I.K., and Reuss, N. ((1997). *Solutions Step-By-Step: A Substance Abuse Treatment Manual.* New York: W.W. Norton.

Bepko, C., and Krestan, J.A. (1985). *The Responsibility Trap: A Blueprint for Treating the Alcoholic Family.* New York: Free Press.

Cunningham, P.B., and Henggeler, S.W. (1999). Engaging multiproblem families in treatment: Lessons learned throughout the development of multisystemic therapy. *Family Process 38*, 265-281.

de Shazer, S. (1988). *Clues: Investigating Solutions in Brief Therapy.* New York: W.W. Norton.

Epstein, E.E., and McCrady, B.S. (2002). Couple therapy in the treatment of alcohol problems. In A.S. Gurman and N.A. Jacobson (Eds.), *Clinical Handbook of Couple Therapy (*3rded.) New York: Guilford Press.

Galanter, M. (1993). *Network Therapy for Alcohol and Drug Abuse: A New Approach in Practice.* New York: Basic Books.

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., and Cunningham, P.B. (1998). *Multisystemic Treatment of Antisocial Behaviour in Children and Adolescents.* New York: Guilford Press.

JBS International, Inc., and The Center for Children and Family Futures, Inc. (2007). *Family-Centered Treatment for Women With Substance Use Disorders -History, Key Elements, and Challenges.* Rockville, MD: Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment.

Kaufmann, P., and Kaufman, E. (1992). From multiple family therapy to couples therapy. In E. Kaufman and P. Kaufmann. (Eds.), *Family Therapy of Drug and Alcohol Abuse* (2nd ed) (pp.85-93). Boston: Allyn and Bacon.

Kaufman, E., and Yoshioka, M.R.M. (2005). *Substance abuse treatment and family therapy: A treatment improvement protocol (TIP) 39*. Rockville: U.S.

Department of Health and Human Sciences, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

Liddle, H.A. (1999). Theory development in a family-based therapy for adolescent drug abuse. *Journal of Clinical Child Psychology, 28*, 521-532.

Liddle, H.A., and Hogue, A. (2001). Multidimensional family therapy for adolescent substance abuse. In E.F. Wagner and H.B. Waldron (Eds.), *Innovations in Adolescent Substance Abuse Interventions* (pp.229-261). New York: Pergamon.

Santisteban, D.A., Szapocznik, J., Perez-Vidal, A., Murray, E.J., Kurtines, W.M., and LaPerriere, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology, 10,* 35-44.

Stanton, M.D., Todd, T.C., and Associates. (1982). *The Family Therapy of Drug Abuse and Addiction.* New York: Guilford Press.

Steinglass, P., Bennett, L.A., Wolin, S.J., and Reiss, D. (1987). *The Alcoholic Family.* New York: Basic Books.

Szapocznik, J., and Williams, R.A. (2000). Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behaviour problems and drug abuse. *Clinical Child and Family Psychology Review, 3,* 117-134.

Wegscheider, S. (1981). *Another Chance: Hope and Health for the Alcoholic Family.* Palo Alto, CA: Science and Behaviour Books.

UNIT 8 PSYCHOSOCIAL REHABILITATION AND LIFESTYLE MANAGEMENT

Structure

8.1 INTRODUCTION

Substance use affects practically every area of user's life. It makes the person physically weak and runs him down. It interferes with education and jeopardizes job prospects. It results in emotional scarring — the user is often torn by shame, guilt and fear of the future. Family relationships become weaker and lack emotional closeness and warmth. Socialization gets limited to alcohol or substance-abusing peers and the substance user comes close to losing the regard and respect of others. The treatment of substance use requires intensive efforts on the part of the individual to modify and rectify the damages done by his prolonged substance use to the various aspects of his life. The pressing need to use substance changes the individual's relationship with himself, his family and society at large. Healthy life

styles take a back seat and unhealthy life style takes precedence over them. Remediating various areas of their lives is the key for successful treatment.

Though, the consequences of substance use disorders and the principles of treatment have been dealt with in earlier units, a quick recap of the same is provided in this Unit. Thereafter the Unit focusses on the need, scope and modalities of psychosocial rehabilitation and lifestyle management in the context of substance use treatment.

Objectives

After studying this Unit, you will be able to:

- Understand what is the role, need and scope of psycosocial rehabilitation as part of substace use treatment;
- Analyse the issues that need to be addressed while carrying out psychosocial intervention;
- Understand the need for lifestyle management and identify the unhealthy practices that require change; and
- Develop skills in carrying out psychosocial rehabilitation intervention.

8.2 CONSEQUENCES OF SUBSTANCE USE

Substance use is not simply a problem for the user. It affects families, communities and society in general. Major adverse consequences of substance use are as follows:

Health consequences: The impact of addiction can be far reaching. Cardiovascular disease, stroke, cancer, HIV/AIDS, hepatitis, and lung disease can all be affected by substance abuse. Some of these effects occur when substances are used at high doses or after prolonged use; however, some may occur after just one use.

Family and social consequences: Substance use is not simply a problem for the user. It affects families, communities and society in general. Every substance user is somebody's son or daughter, brother or sister, father or mother. Studies have shown that:

- Substance problems are strongly associated with chaotic home environments, chronic unresolved family conflict in the home, and particularly homes in which parents are stressed and isolated, abuse substances, and/or suffer from mental illnesses.
- Children are less likely to develop substances problems where there are strong and positive family bonds, parental monitoring of children's activities and peers, clear rules of conduct that are consistently enforced within the family and involvement of parents in the lives of their children (Moggi,et al 2002).
- Effects of substance use on other family members include depression, adjustment and behavioural disorder, deterioration in family relationships, increased likelihood of domestic violence, criminal behaviour, isolation, withdrawal, stigma and concealment (Bancroft, at al 2002). It also impacts on "family functioning as well as on the social lives and on the physical and

mental health of those family members who struggle to come to terms with and adapt to the effects of the substance problem on all their lives (Barnard, 2005).

- Many people living in communities with high levels of substance use feel stigmatized and resent outside representations of their communities that focus on substances problems.
- The presence of high levels of visible substance use and substance dealing on streets negatively influences the quality of life of city dwellers.

Legal consequences: Substance use is also associated with:

- Increased levels of crime and imprisonment.
- Increased level of road traffic accidents.
- Domestic violence, judicial separtion etc.

Occupational and financial consequences: Unemployment and substance abuse disorders are intertwined. The 2006 National Household Survey on Substance Abuse and Health in US revealed among adults aged 18 years or older, the rate of the substance use was higher by more than two times for unemployed persons (18.5%) than those employed fulltime (8.8%) or part time (8.4%). On the other hand substance use may lead to under employment or unemployment. The unemployment rates of people with substance abuse disorders are much greater than those of the general population; even though the mean educational levels of the two groups are comparable (Platt, 1995).

The treatment to be effective thus needs to address all the aspects related to the individual's life. Treatment if tailored to individual's physical, psychological, social, occupational and legal needs would always result in better treatment outcome.

8.3 DEFINING TREATMENT

Treatments and attitudes toward substance use disorder vary widely among different countries. The goal of substance use treatment also varies and may range from total abstinence from all substances to reduction in use to the point that substance use no longer interferes with normal activities such as work and family commitments, shifting the user away from more dangerous routes of substance administration such as injecting to safer routes such as oral administration, reduction in crime committed by users, and treatment of other co morbid conditions such as AIDS, hepatitis and mental health disorders. These kinds of outcomes can be achieved without eliminating substance use completely. Treatment programmes based on functional outcomes produces favourable outcomes and is more popular than abstinence based programmes (Moggi et al 2007). Whatever may be the objective of the treatment, but the goal is always optimization of psychosocial functioning and enabling the individual to achieve optimum level of functioning.

World Health Organization (WHO) Expert Committee on Substance Dependence defines the term *treatment* as "the process that begins when psychoactive substance users come into contact with a health provider or any other community service, and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached" (WHO, 1998).

It is important to understand that treatment of substance use disorder is not restricted to just medical management of the problem. It is much beyond that and includes a range of treatment services and opportunities which maximize their physical, mental and social abilities, by which these persons can be assisted to attain the ultimate goal of freedom from substance dependence and to achieve full social reintegration.

It is important to note that:

- Treatment process proceeds differently for each individual and the same individual may find it easier to change in certain areas than others.

- Treatment requires giving up or reducing the use of alcohol/substances as well as initiating qualitative changes in lifestyle.

- Both these aspects of treatment need to progress hand in hand as they support, complement and sustain each other. Progress in one aspect without the other does not lead to complete treatment. For example, if the client is substance-free, but is demanding, irritable and does nothing worthwhile throughout the day, it means that he/she has not really recovered.

- Recovery does not occur automatically after treatment. It requires a conscious effort and continuing support for change. It is erroneous to believe that once abstinence is established after treatment, recovery in other areas will follow automatically. Simply recognizing problems will not lead to qualitative changes without the active, sustained effort of the individual.

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. How would you define the term treatment in the context of substance use treatment?

   .....

   .....

   .....

   .....

2. List the broad objectives of substance use disorder treatment.

   .....

   .....

   .....

   .....

8.4 PSYCHOSOCIAL REHABILITATION AND NEED FOR LIFESTYLE CHANGE

8.4.1 Defining Psychosocial Rehabilitation

Psychosocial rehabilitation in simple terms can be termed as the provision of services that facilitate social reintegration. A formal definition of the term as provided in WHO *Lexicon of Alcohol and Substance Terms,* is "the process by which an individual with a substance-related problem achieves an optimal state of health, psychological functioning and social well-being". Psychosocial Rehabilitation typically follows an initial phase of treatment in which detoxification or other medical and psychiatric treatment occurs. It encompasses a variety of approaches including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half-way home, provision of vocational mainstreaming and addressing stigma and discrimination. There is an expectation of social reintegration into the wider community.

A schematic representation of elements of psychosocial rehabilitation, identified by various researchers and experts, is given in Fig 8.1.

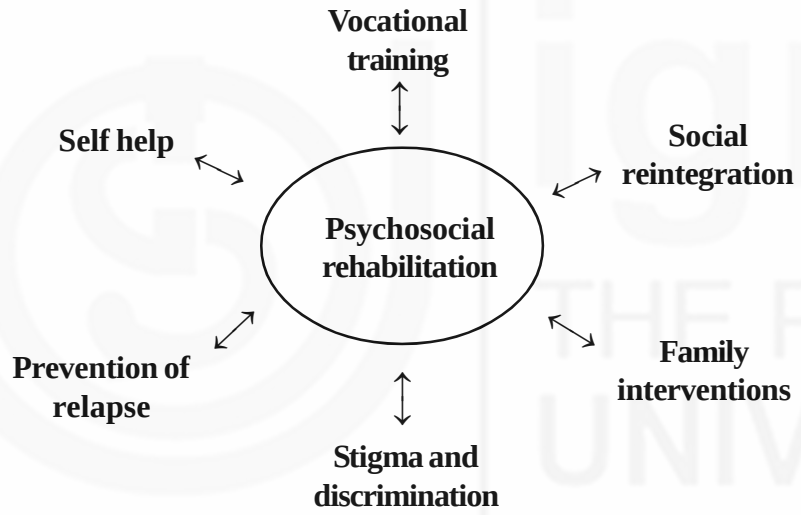

Fig. 8.1 : Elements of psychosocial rehabilitation

8.4.2 Scope of Psychosocial Rehabilitation

The scope of rehabilitation also varies from the treatment philosophy being followed. Management of substance use disorder mainly can be viewed from two perspectives:

- ***Social model***: The thrust of this model is on changing the environment in which the individual lives, rather than the person. It is achieved and sustained by peer interaction and mutual self-help. In the social model approach, the process is known as recovery and the process of rehabilitation is termed as "recovery process". The recovering individual becomes engaged in a "recovery" environment, whether residential (including detoxification programmes) or non-residential, where the culture constantly reinforces an alternative set of values and beliefs. The core beliefs or values generally include mutual respect and help, teamwork, and belonging to a group that supports recovery. Social model emphasizes the process of learning through "doing," "experiencing," and providing positive role models. Intervention approaches such as *therapeutic community* and *peer led intervention* can be seen as off shoots of this model

- ***Disease model*** : In contrast to the social model, the disease model considers substance use as biopsychosocial disorder and is based on the philosophy where the primary method for recovery is the relationship between the professional therapist and the client. Recovery here is a 'do-it-yourself plan'. According to this model, individuals suffering from substance use disorder require professional treatment in order to recover. Treatment methods may include psychotherapy, group and individual counselling in residential and non-residential settings, and use of medications such as substitution or replacement treatment, and/or antagonist medication (Lecklitner, and Crane 2006).

Whatever may be the treatment philosophy but the treatment or recovery process does not end when an individual completes pharmacological treatment. Continuing support upon completion of substance and alcohol treatment is the key to a healthy recovery from substance use disorders. Substance use is chronic relapsing disorder and lot of emphasis of the treatment is geared towards preventing relapse and normalisation of social functioning. Treatment is just the beginning of a lifelong process of growth and recovery in all areas of life that have been affected by substance use. The eventual goal of substance use disorder treatment is to reintegrate the individual into the mainstream of society.

Scope of rehabilitation is wide and includes:

- Enabling the individual to complete pharmacological treatment.
- Prevention of relapse.
- Improving quality of life .
- Reintegration of individual into mainstream of the society.

After the active treatment phase is over, the individual no longer requires services at the intensity required at the beginning of the treatment. This should not be seen as an end to the treatment. There is a need to have an after-care mechanism in place. Aftercare can occur in a variety of settings, such as periodic outpatient aftercare, relapse/recovery groups, 12-Step and self-help groups, and halfway houses. Whether individuals completed primary treatment in a residential or outpatient programme, they have at least some of the skills to maintain sobriety and begin work on remediating various areas of their lives.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. How would you define the term psycosocial rehabilitation in the context of substance use treatment ?

   .....

   .....

2. Describe the scope of psychosocial rehabilitation in reference to substance use disorder.

   .....

   .....

8.5 CARRYING OUT PSYCHOSOCIAL REHABILITATION

As discussed above, the scope of rehabilitation is wide and requires a comprehensive approach. It is important therefore that besides addressing health concerns, the other needs of the individual like lack of trust by the family and society, stigma attached to the illness, financial complications, loss of employment and legal complications need to be addressed.

Rehabilitation intervention must precede a careful assessment of the major areas. Focus in the early rehabilitation phase is to assist or refer individuals who need help with legal, educational, employment, and financial problems. Serious problems that threaten an individual's continued treatment, such as ongoing criminal activity and serious financial problems should be addressed as soon as possible after treatment is initiated.

Later on, efforts are required to focus towards productive participation in constructive activities such as full- or part-time employment, education, vocational training, childbearing or rearing, homemaking, or volunteer work.

8.5.1 Psychosocial Assessment for Rehabilitation

Psychosocial assessment is a vital prelude to treatment planning and an effective process that provides the opportunity to understand specific needs of the individual seeking help for substance use, develop therapeutic relationship and enhancement of motivation, so that the treatment is matched to the needs of the individual. A basic assessment consists of gathering key information and engaging in a process with the individual that enables the therapist to understand the client's problem areas (social, emotional and interpersonal, familial, occupational, financial and legal), his readiness to change, disabilities, and strengths.

Psychosocial Assessment consists of gathering information about following issues:

- Socio-familial,
- Emotional,
- Interpersonal,
- Occupational,
- Financial,
- Legal,
- Readiness to change,
- Disabilities and Strengths.

Psychosocial assessment ideally includes careful exploration and examination of the individual's:

- Socio-demographic profile: (name, age, sex, education, employment, income, etc.)
- Complications (socio-familial, occupational, financial and legal)
- Past abstinence attempts (number of attempts, duration and circumstances, reasons for relapse)

- Associated high risk behaviour (presence of unsafe sexual practices, injection use with sharing of needles and paraphernalia)
- Assessment of social support
- Reason for seeking treatment
- Assessment of expectation from treatment and understanding of the problem.

After the completion of assessment the patient is expected to make the problem list that will be worked on during treatment and includes the following areas of life functioning:

Employment and support status	Family relation-ships	Social and recreational functioning	Psychological status	Legal status	Medical status	Employment status

8.5.2 Practical Needs Assessment

Another very important yet often ignored aspect of psychosocial intervention is assessment of needs of the individual. It constitutes the ability and resource of the individual to access the services. The focus here is on such areas as distance from the treatment centre, ability to follow up if the individual is working, the working hours and transportation needs. Any significant problems that might impede treatment compliance or success should be targeted for intervention as soon as possible. For example, talking to the employer for permission to follow-up, or if the individual does not have transportation or a ride to the treatment facility, transportation issues should be discussed with the family members. Hopefully, therapists can initiate some problem solving and action as soon as these types of issues are identified. Assisting individual seeking treatment for substance use very early with problems like these can help tremendously with treatment compliance in general. This type of aid also enhances the credibility of the therapist, making therapists appear as people who understand individuals' basic needs and can help make things happen to change their lives.

8.5.3 Managing Intrapersonal Issues

Ideally the treatment programme needs to enable the individual to reestablish himself as a productive and contributing member of society.

Enable the individual to identify relapse triggers that remain even after abstinence. Examples of triggers are boredom, passing by specific locations, spending time

with specific individuals, having unresolved family problems, or experiencing psychiatric symptoms. Emphasis should be given to helping individuals develop and maintain coping skills to deal with these triggers.

8.5.4 Managing Craving

After a person quits taking drugs, craving (the strong urge or desire to take drugs) is likely to reoccur. Therefore it is important for the individual to learn how to manage it. Out of many effective ways of handling craving the important one is *not succumbing to the temptations*. In other words the individual must be helped to see the craving as a 'monster', which keeps on growing if it is fed (i.e. if craving is responded by taking drugs). On the other hand if we just ignore this craving monster, it is likely to die of starvation!

8.5.5 Restoring Healthy Family Relationships and Social Supports

No family can escape the stress and conflict that are brought on by another family member's substance use. Broken trust, disappointment, anger, and conflict are the realities that individuals in treatment must come to face during the rehabilitation phase. Many of these individuals have been isolated by families and have been surviving in the absence of a family support system. Mistrust by family members is one of the most commonly reported problems by recovering individuals.

Attitudes of family members and significant others influence the treatment outcome. Thus normalization of social relationships is a prerequisite for effective substance-use disorder treatment.

The focus of intervention here is to enable the individual to understand that:

- Substance-dependence invariably harms family and social relationships.
- Substance-dependence can create distance between the individual and his non-substance using friends and family members, and may draw the individual even closer to other substance-users.
- When individuals' relationships with active substance users outnumber his relationships with non-substance-users, his recovery and his health are in great peril.
- Relationships with non-substance users lead to non-substance related values, attitudes, and behaviours that are more likely to help in re-establishing in the society.

The way to handle this problem is to heal old relationships that have been damaged by substance use. This can be a challenge, especially for people struggling with substance use disorders. Many people, who have been substance users, find it hard to ask for help from old friends and family members, because they may have disappointed people in their lives who have provided a source of support in the past. When they try to re-establish these relationships, they are likely to face rejection, anger, and loss of trust. Healing these damaged relationships is possible, though is slightly difficult; it requires skill, practice, and patience.

Healing broken relationships: Point to remember

- Don't expect to get immediate support from family and friends. State your commitment to healing the relationship but let the other person set the pace. Be individual, but realize that the outcome may not be the one you desire.
- Don't expect others to trust you. Trust must be earned. It is your responsibility to work on being trustworthy. Remember it will take longer for the person to believe that you are trustworthy than for you to become trustworthy. Often, we expect others to trust us before we even trust ourselves. Being able to tolerate the other person's doubts about you is extremely important in your recovery.
- Don't expect trust to develop overnight; trust neither goes at once nor rebuilds suddenly. It would have taken months or years by your family members and friends to stop trusting you and normalization of trust will require at least the same amount of time if not more.

Healing broken relationships: What Helps

- *Stating the desire to heal the relationship.*
- *Demonstrating that one is committed to healing the relationship.*
- *Remaining open to suggestions as to how to facilitate the healing process.*
- *Allow the other person sufficient time to join the recovery and reconciliation process; be individual.*

8.5.6 Addressing Employment and Other Income-Related Issues

Gainful employment is one of the major determinants of treatment outcome. It has also been established that gaining gainful employment is one of the most difficult obstacles faced by individuals attempting to stabilize their lifestyle due to many factors related to the individuals, society and lack of resources (Gerstein, et al 1994). It is important to note that during the rehabilitation phase, individuals should be employed, actively seeking employment, or involved in a productive activity such as school, childrearing, or regular volunteer work. It is most important that individuals have a stable source of legal income, whether from employment or other sources, to ensure that they will not resort to substance dealing or other criminal activities.

Occupational mainstreaming therefore is one of the very crucial aspects of psychosocial rehabilitation. Research has appreciated the role of gainful employment in improving individual's self-esteem, which in turn may reduce the use of illicit substances. Employment can also serve as a means of social integration. A literature review found that employment is linked to positive clinical outcomes. Furthermore, providing vocational services improves treatment outcomes.

Although there is a dearth of services and programmes to address the employment need of the individual seeking treatment for substance use, however livelihood

options can be explored once the individual manages to stop substance use. Various options may be: family extending support to the individual, invoking secondary social support, enabling the individual to access services available for the underprivileged or marginalized sections of the society, like employment guarantee schemes, micro finance programme and self help groups etc.

While carrying out occupational rehabilitation intervention it is important to link it with the special needs and characteristics of the individual. In case of people recovering from substance use disorders, certain situations may trigger relapse: having adverse working conditions, physically tiring job, availability of substance at the workplace, association with substance using peers etc. It is important to consider the following while carrying out occupational rehabilitation intervention as these may trigger relapse:

- Active drinking or substance-use by other employees.
- Plans for the pay day; as excess money might trigger craving.
- Working on rotating, night shifts.
- Lack of supervision.
- Excessive labour-intensive job.
- Substance availability near the place of work.
- Access to marketable goods or petty cash.
- Receiving cash tips.
- Too much free time on the job.
- Too much pressure on the job.
- Job dissatisfaction or boredom.
- Required business meetings, dinners, and parties where use of substance is expected.

8.5.7 Addressing Stigma and Discrimination

> A great saint among his visitors had one very dishonest businessman who progressed by exploiting poor people and grabbing their land and property. But to the amusement of the other disciples, whenever he used to visit the saint he was welcomed warmly by the saint and was always introduced as a very honest, nice and considerate businessman. Slowly, the businessman started acting as per the labels given to him. And he turned out to be the biggest philanthropist of the city.

Majority of individuals with substance use problems have to cope with the label and the characteristics attributed to them every day, and some of them may even have come to believe that they really are what this label represents. In our society, individuals suffering from substance-use disorder are frequently stigmatized. They are termed as addicts (with the hindi equivalent being *nashedi, nashebaz, bhangedi, charasi, bewda, darubaz* and a host of other stigmatizing terms in many Indian languages). The word “addict” brings to mind many negative images, and is generally associated with defects in character, criminality, and immorality. Many individuals restart substance use because of the stigma.

Stigmatization can cause:

- Low self-esteem, depression, anxiety
- Stress and stress-related illnesses
- Restarting of substance abuse.

For rehabilitation of the individual into the mainstream of society, it is important therefore to prepare an individual to face the stigma and handle it without resorting to substance use. This can be done by:

- Spreading awareness that substance use is an illness and anybody can be affected by it.
- Enabling the individual reclaim his potentials even if they are yet to emerge.
- Taking up pro-social behaviour.
- Assuring the individual that with the change in behaviour he can regain his status in the family and society.

8.5.8 Managing Legal Issues

Substance use is often associated with criminal charges, court cases, and ongoing illegal activities. Any of these problems can easily precipitate a relapse to illicit substance use, and all must be addressed as thoroughly as possible as a part of rehabilitation intervention.

Counsellors may have to probe into personal legal issues such as custody status and obligations. Many individuals ignore these issues during periods of substance use; however; these issues may pose a serious threat to ongoing recovery. Individuals should be encouraged to take responsibility for their own legal problems. The counsellor may need to help the individual overcome guilt, fear, or uncertainty in relation to these problems. In addition, the treatment programme must ensure that individuals have access to adequate counsel to handle their legal problems. It may be difficult for some individuals to extricate themselves from continued illegal activities, for either economic or social reasons. Nevertheless, efforts must be made to identify obstacles to eliminating these activities and finding ways to replace them with constructive, legal activities. All major legal problems should be resolved — or be in the process of resolution — and all illegal activities should cease before individuals can move beyond the rehabilitation phase.

8.5.9 Social and Recreational Functioning

During the period when an individual is involved in using substances, his life usually revolves around either the pleasure and fun associated with drug use or illegal activities.

After stopping substance use individuals report a void, lack of enjoyment and lot of free time which can on many occasions lead to relapse. It is therefore important for the individual to replace their dependence on substances with “dependence” on healthy leisure activities – a phenomenon also called ‘positive addictions’. It may seem highly improbable to them, during recovery, that any leisure activity could ever replace substance-use or the powerful, all-consuming, role it has

played in the individual's life. However, it is important to put it across to the individual that if they don't begin to pursue healthy activities, then in no time at all unhealthy activities will begin to fill the void in their life left by their substance use lifestyle, and may lead them back to substance-use or risk their health in other ways.

The problem with not engaging in fun activities is that life can become dull, which can precipitate relapse. Discuss that prolonged substance abuse often robs the individual of learning substance-free ways to have fun. If the individual is serious about being abstinent from drugs and would like to improve his future outlook, he will benefit from engagement in substance-free social, spiritual and religious alternate activities.

Helping individual to adopt healthy activities:

- Listing non-substance-related pleasurable hobbies or activities.
- Identifying pleasurable hobbies and activities individual engaged in prior to using illicit substances.
- Suggesting some of the following activities like cooking, gardening, exercise, fixing home appliances, going to the movies, listening to music, reading, shopping, sports, indoor games etc.

Many drugs can develop a very powerful control over a person's life. To stop using substances, people must have something equally powerful to look forward to that will fill their time. It is believed that certain section of individual's engagement in spiritual and religious activities can compete against the powerful effects of drug use and the activities associated with its use. It is crucial to facilitate individual's involvement in these programmes as they have been proved to be effective in preventing relapse and improving quality of life among those who have interest in these activities.

8.5.10 Self Help Groups

Facilitating individual in joining self help group like AA/ NA (Alcohol Anonymous / Narcotic Anonymous) may also be useful. Joining such groups and following their principles can also facilitate reintegration into the mainstream of society.

Check Your Progress Exercise 3

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List the important areas for psychosocial assessment.

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2. Mark as True or False:

   a. Once the individual is abstinent , he is unlikely to experience craving. ( )

   b. For some one who is prolonged substance user, it is impossible to regain trust of family members. ( )

3. How would you define stigma associated with substance use?

   .....

   .....

   .....

8.6 LET US SUM UP

Substance use is multidimensional illness and its management requires multi pronged approach. The chronic relapsing nature of substance use makes intervention more challenging. The process of recovery requires thrust on different aspects of the illness and individual's life. Contrary to popular belief that abstinence is the goal of treatment, re-integration of individual as a productive member into the mainstream of society is the eventual goal of substance use treatment. Many programmes provide long term medicines (maintenance/ substitution programme) to the individual and intervention during the period in which the individual is taking medicines is on re-organizing his life style. Treatment need of the individual may vary during different stages of recovery. As the individual progress as in treatment process, prevention of relapse, family support, gainful employment, and alternative pleasurable activities gain precedence over his physical problems and compulsion to use psychoactive substance. Substance use disorder is a multidimensional problem and requires a multipronged approach for its effective management. Addressing all the dysfunctional areas of individual life completes the treatment and renders it more effective. For effective reintegration and rehabilitation, it is important to assess an individual's needs and then address various areas such as employment, stigma and discrimination, relationships, craving, legal issues, social and recreational issues etc.

8.7 GLOSSARY

Domestic violence : Pattern of abusive behaviour in any relationship that is used by one partner to gain or maintain power and control over another intimate partner.

Peer group/group of equals : A social group consisting of people who are equal in such respects as age, education, or social class etc.

Psychosocial : The process by which an individual with a substance-

rehabilitation related problem achieves an optimal state of health, psychological functioning and social well-being.

Social integration : Social integration refers to supportive relationships within the community.

Social stigma : Severe social disapproval of personal characteristics or beliefs that are perceived to be against cultural norms. It can be defined as the process by which the reaction of others spoils normal identity.

Social support : The perceived availability of people whom the individual trusts and who make one feel cared for and valued as a person. Whereas the concept of social support mainly refers to the individual and group level, the concept of social integration can refer to the community level.

Socialization : The process whereby an individual learns to get along with and to behave similarly to other people in the group, largely through imitation as well as group pressure.

8.8 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Treatment may be defined as "the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service, and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached".

2. Complete abstinence or harm reduction and social integration.

Check Your Progress Exercise 2

1. Psychosocial rehabilitation is the process by which an individual with a substance-related problem achieves an optimal state of health, psychological functioning and social well-being".

2. Scope of psychosocial rehabilitation is :

   a. Enabling the individual to complete pharmacological treatment.

   b. Prevention of relapse.

   c. Improving quality of life.

   d. Reintegration of individual into mainstream of the society.

Check Your Progress Exercise 3

1. Important areas of psychosocial assessment are:

   a) Socio-demographic profile (name, age, sex, education, employment, income, etc.)

   b) Complications (socio-familial, occupational, financial and legal)

   c) Past abstinence attempts (number of attempts, duration and circumstances, reason for relapse)

   d) Associated high risk behaviour (presence of unsafe sexual practices, injection use with sharing of needles and paraphernalia)

   e) Assessment of social support

   f) Reason for seeking treatment

   g) Assessment of expectation from treatment and understanding of the problem

2. a) False

   b) False

3. Severe social disapproval of personal characteristics, actions or beliefs that are perceived to be against cultural norms.

8.9 UNIT END QUESTIONS

1. Describe the significance of lifestyle change for the treatment of substance use disorder.

2. Explain the impediments in social integration for the individual suffering from substance use disorder.

3. What is the role of counsellor in facilitating psychosocial rehabilitation?

8.10 FURTHER READINGS AND REFERENCES

Bancroft, A. (2002) Support for the Families of Substance Users: A review of the literature. Effective Interventions Unit: Scottish Executive, Substance Misuse Research Programme & Centre for Research on Families & Relationships, University of Edinburgh.

Barnard, M (2005) Substances in the Family - The Impact on Parents and Siblings. University of Glasgow.

Brewington, K.J., Arella,S., & Deren,S. (1987): Obstacles to the utilization of vocational services: Analysis of the literature. International Journal of the Addictions 22: 1091-1118.

Center for Substance Abuse Treatment.(2000). Integrating Substance Abuse Treatment and Vocational Services. Treatment Improvement Protocol (TIP) Series, number 38. DHHS, Washington, DC: U.S. Government Printing Office.

Gerstein, D.R., Johnson, R.A., Harwood, H.J., Fountain, D., Suter, N., & Malloy, K. (1994). Evaluating Recovery Services: The California Substance and Alcohol Treatment Assessment (CALDATA). Sacramento, CA: California Department of Alcohol and Substance programs.

Moggi F, Giovanoli A, Strik W, Moos BS, Moos RH (2007). "Substance use disorder treatment programs in Switzerland and the USA: Program characteristics and 1-year outcomes". Substance Alcohol Depend 86 (1): 75–83. National Institute on Substance Abuse, NIDA Notes Volume 16, Number 6, February 2002

Platt, J.J. (1995). Vocational rehabilitation of substance abusers. Psychological Bulletin. 117(3):416-433:

S. Kelly Avants and Arthur Margolin. (1999) Ed. Holistic Health Recovery Program for Substance addicted individuals of negative or unknown HIV serostatus. Project sponsored by Yale University School of Medicine from the National Institute on Substance Abuse, and National Institutes of health.

OPTIONAL PAPER 3: SUBSTANCE ABUSE COUNSELLING AND FAMILY THERAPY (MCFTE-003)