Psychological Treatment of Drug Abuse

Professor Peter W.H. Lee

Hon. Consultant, Hong Kong Sanatorium & Hospital
Hon. Professor in Clinical Health Psychology
Department of Psychiatry, The University of Hong Kong

Adolescents – a crucial stage of development:

- habits are established
- health behaviours become fixed
- preferred coping modes consolidated
- values are strengthened
- peer influences on knowledge, attitudes, values, skills, behavioural patterns
- distorted beliefs about heroism and romanticism
- Initial contacts with the "real world"

Liabilities

- Lack of self value
- Short time perspective
- Impatience – impulsive – lack of perseverance
- Energetic
- Lack of aptitude
- Erratic role modelling
- Low frustration tolerance

Interact with stresses:

- Economic
- Academic
- Occupational - future
- Sexual maturation and challenges
- Peer conflicts and influence
- Parental conflict/mismanagement/neglect
- Drugs
- Psychiatric/psychological problems
- Influx of western values, modernisation, capitalism against traditional Chinese values

Risks pathways increasingly apparent:

- Early sex and other behavioural experimentation (smoking, alcohol, substance use)
- Global influences in values and exposures
- Stresses of competition, interpersonal relationships, self regard, aspirations and hopes for the future: succumbing leads to further implications in: physical (self harm, smoking, alcohol use, illicit drug use, casual sex - abortions, std's, HIV, cervical cancer); mental health (depression, anxiety, low self esteem, adjustment problems); and social issues (school dropouts, disadvantages, delinquency, second generation problems/issues)

End points:

- Underachievement
- School failure, dropouts
- Depression
- Self esteem problems
- Interpersonal problems
- Self destructive behaviours
- Substance abuse
- Delinquency
- Teenage pregnancies, abortions, unprepared motherhood
- Early and unsafe sex
- Family tension and conflicts
- Prostitution, criminality, delinquency
- Exposure to sexually transmitted diseases
- STD, HIV, HPV infections

High risk behaviours:

- Smoking
- Alcohol consumption
- Use of pornography
- Liberal attitudes towards sex

Limited personal/support resources:

- Low self esteem: low perceived ability, appearance and popularity
- Low life satisfaction
- Family conflicts
- Poor self rated mental and physical health
- Poor social relationship

Conclusion:

- no single solution
- Multiple interlinked factors (family, schools, community/culture)
- Timing of intervention is crucial (the earlier the better)

Who, How, and When to intervene:

Find predictors earlier on in the youth's development

High risk behaviours are highly interrelated: a domino effect?

Psychological approaches to substance abuse

- Problem of relapse: 70%-80% relapse within one year (quit alcohol, heroin, nicotine), 2/3 first 3 months after treatment
- no short cut to Rx

Stages of abuse:

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

1. precontemplators: I have no problem, no need for any change
2. Contemplators: I might benefit from changing
3. Preparation: it's time for me to do something different
4. Actions: changed behaviours for at least one day
5. Maintenance: maintain change > 6 months

Characteristics:

- Addicts are ambivalent > in denial
- Diverse individuals – avoid stereotyping
- Multi-psychoactive substance use
- Strong correlation between nicotine dependence and other addictive disorders
- Commonly co-exist with psychiatric disorders (esp. mood disorders, antisocial personality disorders, mania, schizophrenia): 1/3 addicts have coexisting Axis 1 disorders
- Entangled complex social, economic, legal and health problems

Psychological conceptualisation

- Framework for understanding the patient
- Basis for Rx strategy

- Thoughts/beliefs relating to substance use
- What motivates you?
- What goes through your mind when you continue to use substances in spite of their devastating consequences

Developmental risks:

- Beliefs about themselves, their personal world, other individuals, their futures → affects vulnerability

- Early negative experiences: parents who model substance use, lack of validation (in contrast to secure personal relationships, supportive family, validation from important others)

Basic belief structures/schemas:

- Lovability: connectedness, self worth, intimacy
- Adequacy: competence, success, autonomy

- Leads on to conditioned beliefs implicating substances: "if …, then…"
- "If I use drugs, then I'll be popular"
- "If I don't use drugs, then I will be seen as a wimp"

- Perfectionistic: use power drugs
- Fear of pain, or beliefs of situations being unsolvable: use numbing, anxiolytic substances

- Experimenting with and engaging in substance use → reinforce maladaptive schemas → sets off and maintain vicious cycle

- Initial use provides positive experience that becomes chronically sought
- With continued use, drug-related beliefs becomes more pervasive, salient, and accessible
- Activated by ever increasing number of stimuli
- Beliefs become increasingly automatic and available
- Trapped in vicious cycles of drug use and relief reinforcement that escalate their addictions

Activating Stimuli:

- More likely to use under certain stimuli
- High risk situations
- Internal: emotions (anxiety, depression, boredom, anger, frustration, loneliness), physical sensations (pain, hunger, fatigue, withdrawal symptoms)
- External: interpersonal conflicts, availability of substance, peers usage, task accomplishments

Relapse stimuli:

- Negative emotional states (35%)
- Social pressure (20%)
- Interpersonal conflicts (16%)

- Substances provide immediate regulation of mood states:
- Alcohol/benzo: anti-anxiety
- Cocaine, amphetamines, nicotine, caffeine: stimulation
- Almost all drugs: anti-boredom agents
- Celebration with drugs: turn good mood into great moods

- * find alternatives to mood regulation as part of Rx

- Stimuli activates 2 types of drug use related beliefs:
- Anticipatory beliefs: prediction of gratification, increased efficacy, heightened sociability
- Relief-oriented beliefs: relief from unpleasant physical and emotional states

- Strong conviction of impact of drugs: to achieve personally desired states / compared to strong conviction that other things will "not do"

- Lead on to cravings, urges

Related beliefs and thoughts:

- "I can't have fun unless I'm drinking"
- "go ahead" "life is short"
- Images: "being so cool"

- Builds and intensifies urges and cravings

Urges and cravings:

- Very physical "like starving"
- Particularly difficult with ambivalent individuals: escalates during withdrawal, in high risk settings, affected by intrusive thoughts and preoccupation despite efforts to resist

Facilitating beliefs: "permission"

- Themes of entitlement: "I deserve to have it"
- Minimization of consequences: "it won't hurt"
- Justification: "life sucks, what does it matter?", "just one more, eventually I'll quit"

- Undermine ability to tolerate cravings
- The stronger the facilitating beliefs, the more difficult to hold back urges

Action plan: instrumental strategies:

- Analyse the habitual plan

- Total abstinence: develop the conviction that "I can survive without it", "I won't (lose face)…. Without it"

Rx:

Therapeutic relationship:

- Genuine, open, respectful
- Problem with embarrassment, shame and alienation → distrust, distortions and underreporting of problems
- "Non-users simply do not understand"
- Establish that I would not respond to him/her like family members or others
- Increase collaboration by "checking out" understanding, actively getting feedback

- Patient's behaviours/characteristics likely trigger our own negative beliefs:
- "These people are hopeless ….. Cannot be trusted … he thinks I am stupid…this is a waste of time"

More useful thoughts:

- "He is struggling to overcome his problem"
- "his relapse is not a reflection of me"
- When he was dishonest, it's likely that he was feeling ashamed of the truth"
- "A relapse is not the end of the world"
- "can really learn from the relapse"

The case conceptualization:

- Everybody is different
- No simple psychiatric Dx can capture their problems or help in understanding it all
- Get a feel into the patient's life

- Background information: Tell me about your background – whatever you think is most important
- Not just ask at the beginning, use and update every now and then
- Presenting problems: drugs used, pattern of use, effects, chronic problems (job, relationship, mood, self esteem)
- Current or pending crisis

Psychiatric dx:

- how might drugs help you with, or contribute to, your emotional concerns?
- Deal with coexisting psychiatric problems

Developmental and cognitive profile:

- Family used drugs?
- Age of first use?
- When did drugs become a problem?
- How did drug problem develop?
- Other significant events or traumas in your life

Thought processes associated with drug use:

- High risk situations?
- Beliefs about drugs
- How do you give yourself permission to use drugs?
- What beliefs do you hold about yourself, other people or the world that contribute to your drug use?
- Negative (undesired) and positive (desired) consequences of your drug use – cost/return analyses

Integration all information:

- How does drug use serve as a coping strategy?
- How motivated are you to change addictive behaviours?
- How do drug use and self-esteem impact on each other?
- What Rx strategies will be most effective?
- What are the potential barriers to change?

Setting a therapeutic structure:

- Setting and agreeing on the agenda
- No surprises
- Mood check
- Bridge from last session
- Current agenda discussion
- Guided discovery > preaching/lecturing
- Capsule summaries
- Summary and feedback
- (homework: e.g. activity scheduling, time with drug free peers)

Cognitive behavioural techniques:

- Weaken drug related beliefs and bolster control beliefs
- A-D analysis: 2x2 matrix (use – A,D, nonuse – A, D): recognize negative impact, also positive impact *(therefore understand needs and develop alternative methods for attainment)
- 3-Q technique: what is the evidence for this? How else can you interpret the situation? If the other interpretation is true, what are the implications?

Help to formulate rational responses:

- What concrete, factual evidence supports or refutes your automatic thoughts/beliefs?
- Are there other ways you could view the situation? A blessing in disguise?
- What is the worst thing that could happen? What is the best thing? What is most likely to realistically happen?
- What constructive action can you take to deal with the situation?
- What are the pros and cons of changing the way you view the situation?
- What advice would you give your best friend in this situation?

- Communication skills training:
- 36% relapse due to interpersonal determinants: 16% - conflict, 20% social pressure

Integration with 12 step program

- Group support
- Seek help when relapse imminent
- Identify with a higher power
- Serenity prayer: serenity to accept, courage to change, wisdom to know

Activating stimulus → beliefs activated → ATs → urges and cravings →

Permission → focus on actions → continued use or relapse →

- Role of positive prevention:

Developing character LIFELONG:

- Courage
- Interpersonal skills
- Rationality
- Insight
- Optimism
- Honesty
- Perseverance
- Realism
- Capacity for pleasure
- Altruism
- Putting troubles into perspective
- Future-mindedness
- Happiness
- Tolerance of ambiguity and negative emotions
- Finding purpose .....

仁者不憂 ……
愛人

君子不懼不憂
內省不疚，夫何憂何懼

Sense of purpose, service, meaning, and happiness