# Group therapy for drug addiction

The Department of Addiction Medicine at Haukeland University Hospital is developing an outpatient group-therapy service for those who want help to gradually reduce and finally cease using addictive drugs. The purpose is to replace these medications with more appropriate strategies to be able to deal with various forms of discomfort.

Several articles in this journal have indicated the need for appropriate and sufficient treatment services for people who are addicted to medications (1–3). The establishment and development of such services are consistent with the intentions of the National Action Plan for Alcohol and Drugs, introduced in 2008 (4). Several Norwegian institutions provide group therapy to people who are addicted to medications (2). As a rule, people who are addicted to pharmaceutical drugs tend to be assigned to treatment in groups that also include other substance abusers. However, a separate therapy option for people who are addicted to medications is being called for (2).

The outpatient service for addictive medications was established as a section of the Department of Addiction Medicine at Haukeland University Hospital in the spring of 2010. The perspective of our treatment model is that those who are addicted to pharmaceuticals constitute a separate category with particular therapeutic needs, and have an identity that differs from that of other groups of substance abusers (2).

## Target group and objective

The service targets those who have developed an addiction to addictive pharmaceuticals. Many patients are unaware of the fact that long-term use will serve to exacerbate their affliction, and the patients have rarely been informed of such effects. Second, it can be hard to acknowledge and accept that a drug that was helpful at first has gradually started to make their condition worse.

The patient is initially summoned to an interview to assess suitability and motivation for group therapy. It is essential to acknowledge the patient's afflictions and background for his or her use of addictive drugs, while communicating the hope that ceasing to use such drugs and replacing them with more appropriate coping strategies is possible.

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**Table 1:** Psycho-educative topics

| Session | Topics |
|---|---|
| 1 | Presentation of the treatment programme. What is mindfulness? |
| 2 | Addiction to addictive drugs. Effects and side effects |
| 3 | The origin of vicious circles, part I – the bio-psycho-social model |
| 4 | The origin of vicious circles, part II – the cognitive model |
| 5 | The origin of muscular tensions |
| 6 | Accepting reality for what it is |
| 7 | Good advice for better sleep |
| 8 | Emotions |
| 9 | Self-esteem |
| 10 | Communicating and interacting with others |
| 11 | Preventing setbacks |
| 12 | The road ahead |

## Individual de-escalation plan

The doctor at the outpatient service has the main responsibility for elaborating a written de-escalation plan in cooperation with the patient and the psychologist who is responsible for the treatment. The de-escalation plan, which runs over a period of 12 weeks, will come into effect when the group therapy starts. First and foremost, the de-escalation plan foresees that the intake of the medication will be restricted to specific hours, and not taken as needed. It is recommended to reduce the dosage by approximately ten per cent per week. At first, the de-escalation may go faster. When total cessation of the medication approaches, many patients will need to slow down the de-escalation. As a rule of thumb, the patient should seek to avoid a re-escalation, and extend the intervals instead.

The patient's GP receives a copy of the plan and any later revisions, and is responsible for prescribing the drugs. The GP should follow the patient up after the end of the treatment. The patient signs a treatment contract, with the objective of making him/her responsible for activities and cooperation during the treatment process.

## Treatment model

The group sessions are based on cognitive behavioural therapy. Identifying and questioning negative patterns of thought associated with symptoms and discomforts are key elements. Mindfulness exercises, or being actively attentive to the present moment, are a regular item in the group sessions. Integration of mindfulness in the treatment of various conditions is in accordance with recent developments in the field of cognitive behavioural therapy (5). This approach has also proven to be effective with regard to addiction (6). Being mindful involves observing all events and experiences with an accepting and open attitude, without following impulses to change or escape from what is unfolding, even though it may be uncomfortable or unwanted (7). The exercises are intended to help the patient break away from habitual reactions to the craving for drugs once the de-escalation starts. At the same time, the purpose is to allow the participants to experience how systematic training in mindfulness can enhance the awareness of momentary personal choices and actions.

## Therapy manual – framework and content

Treatment is provided in closed groups of up to eight participants, over a period of 12 weeks. Each group has two therapists, whereof the responsible therapist is a specialist in clinical psychology. The group sessions take place during daytime on the same day every week, and last for 2.5 hours including a break.

The sessions are organised with a repeating schedule of items, which gives the participants a degree of predictability. Three follow-up sessions are held four, eight and 36 weeks after the end of the treatment programme respectively.

The sessions start and finish with a mindfulness exercise. The exercises take place with the participants seated, and last for 15 to 20 minutes.

### *Status report for de-escalation*

Each participant reports to the group how far he/she has advanced in the de-escalation

plan. The therapists have a copy of each plan, and record the status of each patient. Adjustments and amendments to the plan during the course of the treatment are undertaken in cooperation with the doctor at the outpatient clinic. In our experience, such individual follow-up in front of the group helps make the participants responsible for following the plan.

*Psycho-educative topics*

The teaching is undertaken with the aid of PowerPoint presentations, and the participants receive a hard copy of the presentation for each topic (Table 1). The material is assembled in each participant's folder, which serves as a kind of «reference manual» that the participants can consult as needed. The psycho-educative topics are based on a bio-psycho-social theoretical model (8), in which raising awareness of the complicated interplay between various reinforcing and sustaining factors associated with uncomfortable symptoms is a key element.

*Home assignments*

Home assignments are provided orally and in writing for each session, the intention of which is that the participants should use them to reflect on their own situation and propose alternative strategies for addressing symptoms and discomfort. They are encouraged to gradually expose themselves to uncomfortable experiences. The purpose of this is to gain new experience and tolerance of uncomfortable symptoms. The home assignments are introduced and reviewed in plenary sessions, and the participants share their thoughts and experiences with the others in the group (Box 1).

## Outcome of the treatment

To date, four treatment programmes have been implemented. The groups of participants have been diverse in terms of age, background and general ability to function. Most of them have used addictive drugs over a number of years, some of them for as long as 30 years. There appears to be a preponderance of persons who struggle with pains and various symptoms of anxiety. A total of 30 patients have been included in four groups. Of these, 17 have completed the treatment programme. Of these 17, altogether ten have ceased to use their drug/drugs in the course of 12–20 weeks.

Of those who have been unable to cease their use of medication we are unaware of any who have increased their dosage or have reverted to the initial level. The participants claim that the treatment has provided them with some tools that help them handle distress, and that the mindfulness exercises help them endure discomfort.

## Further development of the treatment programme

In spite of the individual assessment and preparatory interviews we still see that many participants withdraw or fail to meet for the sessions. Treatment attrition may be caused by poor motivation or insufficient preparation for the implications of de-escalation of drug use.

Increased attention to stabilisation of the intake of medications prior to the start of the treatment programme could possibly forestall some of the attrition observed. Stabilisation as a preparation for de-escalation and group therapy may be an attainable goal that the patient and his/her GP could seek to achieve. The patient will need information on why such stabilisation is an advantage for de-escalation, and the assessment interview could possibly include formulation of some written material that the patient can bring with him/her.

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### Box 1

**Home assignment for the second session – setting goals for treatment/change**

- Think through your goals and values and how you wish to live your life without drugs. In what way is the affliction that is distressing you a hindrance to these goals? Is it conceivable that you can reach these goals in spite of the discomfort, or could you change these goals to adapt them to your situation?
- Think through what it is that you wish to achieve by your participation in the group therapy. Define a **main goal** for the aspects of your situation that you wish to focus on. Define two smaller goals (objectives) that will lead to the main goal. The objectives must be as concrete and specific as possible, and have a time frame.

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