

Drug Rehabilitation

Authored by
mohammad looti

November 19, 2022

RECOMMENDED CITATION

mohammad looti (2022). *Drug Rehabilitation*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=39249>

Drug rehabilitation (often drug rehab or just rehab) is a term for the processes of medical and/or psychotherapeutic treatment, for dependency on psychoactive substances such as alcohol, prescription drugs, and so-called street drugs such as cocaine, heroin or amphetamines. The general intent is to enable the patient to cease substance abuse, in order to avoid the psychological, legal, financial, social, and physical consequences that can be caused, especially by extreme abuse.

Psychological dependency

Psychological dependency is addressed in many drug rehabilitation programs by attempting to teach the patient new methods of interacting in a drug-free environment. In particular, patients are generally encouraged, or possibly even required, to not associate with friends who still use the addictive substance. Twelve-step programs encourage addicts not only to stop using alcohol or other drugs, but to examine and change habits related to their addictions. Many programs emphasize that recovery is a permanent process without culmination. For legal drugs such as alcohol, complete abstinence--rather than attempts at moderation, which may lead to relapse--is also emphasized ("One is too many, and a thousand is never enough.") Whether moderation is achievable by those with a history of abuse remains a controversial point, but is generally considered unsustainable.

Types of treatment

Various types of programs offer help in drug rehabilitation, including: residential treatment (in-patient), out-patient, local support groups, extended care centers, and recovery or sober houses. Some rehab centers offer age- and gender-specific programs.

In a survey of treatment providers from three separate institutions (the National Association of Alcoholism and Drug Abuse Counselors, Rational Recovery Systems and the Society of Psychologists in Addictive Behaviors) measuring the treatment provider's responses on the Spiritual Belief Scale (a scale measuring belief in the four spiritual characteristics AA identified by Ernest Kurtz); the scores were found to explain 41% of the variance in the treatment provider's responses on the Addiction Belief Scale (a scale measuring adherence to the disease model or the free-will model addiction).

Scientific research since 1970 shows that effective treatment attends multiple needs of the addict person and not just his or her drug abuse. In addition, medically assisted detoxification is only the first stage of treatment and it does not help much to change long-term drug abuse. Professionals from the National Institute on Drug Abuse (NIDA) recommend medication and behavioral therapy combined, as important elements of a therapeutic process that begins with detoxification, follows with treatment and doesn't set aside relapse prevention, since this is essential to maintain the

positive effects of therapy. Therefore, every kind of treatment should address all aspects of a patient's life: medical and mental health services; as well as follow-up options, such as community of family based recovery support systems. Drug and alcohol treatment centers provide medication, guidance and the right environment needed, with doctors and staff qualified to provide help and support to patients and assist them with their habits rather well. Despite of this, patients are expected to also desire to break free from these addictions, since after rehabilitation they will reincorporate into society. The alcohol and drug treatment administered to a patient will depend on the level and intensity of addiction. Therefore, if the patient is strongly addicted to the substance, many centers provide facilities as the ones listed at the beginning: residential treatment, recovery houses and sober houses. Other centers may aim to a more general addiction and work better with counseling and other similar strategies.

For individuals addicted to prescription drugs, treatments tend to be similar to those who are addicted to drugs affecting the same brain systems. Hence, medication like buprenorphine and behavioral therapies for stimulant and Central Nervous System depressant addiction are often used. Among behavioral therapies there are: Cognitive-behavioral therapy: a method that helps patients to recognize, avoid and cope with situations in which they are most likely to relapse. Multidimensional family therapy: designed to improve family functioning as well as the member who has drug abuse problems. Motivational interviewing: emphasizes on the willingness of patients to change their behavior and enter treatment. Motivational incentives: This method takes advantage of positive reinforcement to encourage abstinence from the addictive substance. The Substance Abuse and Mental Health Services Administration has provided a list of programs and institutions that offer diverse treatments according to the age group, type of addiction and other aspects. Among these programs can be found: Partners for Recovery (PFR), Medication Assisted Treatment (MAT), Recovery Community Services Program (RCSP), and the National Center on Substance Abuse and Child Welfare (NCSACW).

Pharmacotherapies

Certain opioid medications such as methadone and more recently buprenorphine (In America, "Subutex" and "Suboxone") are widely used to treat addiction and dependence on other opioids such as heroin, morphine or oxycodone. Methadone and buprenorphine are maintenance therapies used with an intent of stabilizing a patient and reducing illegal drug use, and the risks associated with it, such as disease, arrest, incarceration, and death, in line with the philosophy of harm reduction. Both drugs may be used as maintenance medications (taken for an indefinite period of time), or used as detoxification aids. All available studies collected in the 2005 Australian National Evaluation of Pharmacotherapies for Opioid Dependence suggest that maintenance treatment is preferable, with very high rates (79-100%) of relapse within three months of detoxification from LAAM, buprenorphine, and methadone.

Ibogaine is a hallucinogenic drug promoted by certain fringe groups to interrupt both physical dependence and psychological craving to a broad range of drugs including narcotics, stimulants, alcohol and nicotine. To date, there have never been any controlled studies showing it to be effective, and it is accepted as a treatment by no association of physicians, pharmacists, or addictionologists. There have been several deaths related to ibogaine use, which causes tachycardia and long QT syndrome. The drug is an illegal Schedule I controlled substance in the United States, and the foreign facilities in which it is administered tend to have little oversight, and range from most often motel rooms to one moderately-sized rehabilitation center. Some antidepressants also show use in moderating drug use, particularly to nicotine, and it has become common for researchers to re-examine already approved drugs for new uses in drug rehabilitation.

According to the National Institute on Drug Abuse (NIDA), patients stabilized on adequate, sustained doses of methadone or buprenorphine can keep their jobs, avoid crime and violence, and reduce their exposure to HIV and Hepatitis C by stopping or reducing injection drug use and drug-related high risk sexual behavior. Naltrexone is a long-acting opioid antagonist with few side effects, and it's usually prescribed in outpatient medical conditions; even though initiation of the treatment begins after medical detoxification in a residential setting. Naltrexone blocks the euphoric and all other effects of self-administered (and physician-administered) pills or injections (leaving the patient at a loss if he requires unplanned surgery or another painful procedure or condition requiring pain control or even general anaesthesia, as the chemicals, fentanyl and sufentanyl, most commonly used to induce anaesthesia are also opioids which are blocked), reducing with this the craving or addiction to the drug. It also works as treatment against alcohol addiction. Specialists claim that Naltrexone cuts relapse risk during the first 3 months by about 36%. However, it is far less effective in helping patients maintain abstinence or retaining them in the drug-treatment system (retention rates average 12% at 90 days for naltrexone, average 57% at 90 days for buprenorphine, average 61% at 90 days for methadone).

Acamprosate, disulfiram and topiramate (a novel anticonvulsant sulphonated sugar) are also medications that help patients treat alcohol addiction. Acamprosate has shown to work in patients with severe dependence, since they can keep abstinence for several weeks to months. Disulfiram (also called Antabuse) produces a very unpleasant reaction when drinking alcohol that includes flushing, nausea and palpitations. It works better on patients with high motivation and some addicts use it just for high risk situations.

Criminal justice

Drug rehabilitation is sometimes part of the criminal justice system. People convicted of minor drug offenses may be sentenced to rehabilitation instead of prison, and those convicted of driving while intoxicated are sometimes required to attend Alcoholics Anonymous meetings. There are a number of ways to address an alternative sentence in a drug possession or DUI case; increasingly,

American courts are willing to explore outside-the-box methods for delivering this service. There have been lawsuits filed, and won, regarding the requirement of attending Alcoholics Anonymous and other twelve-step meetings as being inconsistent with the Establishment Clause of the First Amendment of the U. S. Constitution, mandating separation of church and state.

Counseling

Traditional addiction treatment is based primarily on counseling. However, recent discoveries have shown those suffering from addiction often have chemical imbalances that make the recovery process more difficult.

Counselors help individuals identifying behaviors and problems related to their addiction. It can be done on an individual basis, but it's more common to find it in a group setting and can include crisis counseling, weekly or daily counseling, and drop-in counseling supports. They are trained to develop recovery programs that help to reestablish healthy behaviors and provide coping strategies whenever a situation of risk happens. It's very common to see them work also with family members who are affected by the addictions of the individual, or in a community in order to prevent addiction and educate the public. Counselors should be able to recognize how addiction affects the whole person and those around him or her. Counseling is also related to "Intervention"; a process in which the addict's family requests help from a professional in order to get this person into drug treatment. This process begins with one of this professionals' first goals: breaking down denial of the person with the addiction. Denial implies lack of willingness from the patients or fear to confront the true nature of the addiction and to take any action to improve their lives, besides of continuing the destructive behavior. Once this has been achieved, professional coordinates with the addict's family to support them on getting this family member to alcohol drug rehabilitation immediately, with concern and care for this person. Otherwise, this person will be asked to leave and expect no support of any kind until going into drug rehabilitation or alcoholism treatment. An intervention can also be conducted in the workplace environment with colleagues instead of family.

Historical approaches to substance abuse treatment

Disease model and twelve-step programs

The disease model of addiction has long contended the maladaptive patterns of alcohol and substance use displayed by addicted individuals are the result of a lifelong disease that is biological in origin and exacerbated by environmental contingencies. This conceptualization renders the individual essentially powerless over his or her problematic behaviors and unable to remain sober by himself or herself, much as individuals with a terminal illness are unable to fight the disease by themselves without medication. Behavioral treatment, therefore, necessarily requires individuals to admit their addiction, renounce their former lifestyle, and seek a supportive

social network who can help them remain sober. Such approaches are the quintessential features of Twelve-step programs, originally published in the book *Alcoholics Anonymous* in 1939. These approaches have met considerable amounts of criticism, coming from opponents who disapprove of the spiritual-religious orientation on both psychological and legal grounds. Nonetheless, despite this criticism, outcome studies have revealed that affiliation with twelve-step programs predicts abstinence success at 1-year follow-up for alcoholism. Different results have been reached for other drugs, with the twelve steps being less beneficial for addicts to illicit substances, and least beneficial to those addicted to the physiologically and psychologically addicting opioids, for which maintenance therapies are the gold standard of care.

Client-centered approaches

In his influential book, *Client-Centered Therapy*, in which he presented the client-centered approach to therapeutic change, psychologist Carl Rogers proposed there are three necessary and sufficient conditions for personal change: unconditional positive regard, accurate empathy, and genuineness. Rogers believed the presence of these three items in the therapeutic relationship could help an individual overcome any troublesome issue, including alcohol abuse. To this end, a 1957 study compared the relative effectiveness of three different psychotherapies in treating alcoholics who had been committed to a state hospital for sixty days: a therapy based on two-factor learning theory, client-centered therapy, and psychoanalytic therapy. Though the authors expected the two-factor theory to be the most effective, it actually proved to be deleterious in outcome. Surprisingly, client-centered therapy proved most effective. It has been argued, however, these findings may be attributable to the profound difference in therapist outlook between the two-factor and client-centered approaches, rather than to client-centered techniques per se. The authors note two-factor theory involves stark disapproval of the clients' "irrational behavior" (p. 350); this notably negative outlook could explain the results.

There are newer, more-client-specific methods of delivering addiction and alcoholism treatment. One effective, although very expensive, method of delivering treatment is the Sober Coach. In this approach, the client is serviced by provider(s) in his or her home and workplace - for any efficacy, around-the-clock - who functions much like a nanny to guide or control the patient's behaviour.

Psychoanalytic approaches

Psychoanalysis, a psychotherapeutic approach to behavior change developed by Sigmund Freud and modified by his followers, has also offered an explanation of substance abuse. This orientation suggests the main cause of the addiction syndrome is the unconscious need to entertain and to enact various kinds of homosexual and perverse fantasies, and at the same time to avoid taking responsibility for this. It is hypothesised specific drugs facilitate specific fantasies and using drugs

is considered to be a displacement from, and a concomitant of, the compulsion to masturbate while entertaining homosexual and perverse fantasies. The addiction syndrome is also hypothesised to be associated with life trajectories that have occurred within the context of traumatogenic processes, the phases of which include social, cultural and political factors, encapsulation, traumatophilia, and masturbation as a form of self-soothing. Such an approach lies in stark contrast to the approaches of social cognitive theory to addiction--and indeed, to behavior in general--which holds human beings regulate and control their own environmental and cognitive environments, and are not merely driven by internal, driving impulses. Additionally, homosexual content is not implicated as a necessary feature in addiction.

Cognitive models of addiction recovery

Relapse prevention

An influential cognitive-behavioral approach to addiction recovery and therapy has been Alan Marlatt's (1985) Relapse Prevention approach. Marlatt describes four psychosocial processes relevant to the addiction and relapse processes: self-efficacy, outcome expectancies, attributions of causality, and decision-making processes. Self-efficacy refers to one's ability to deal competently and effectively with high-risk, relapse-provoking situations. Outcome expectancies refer to an individual's expectations about the psychoactive effects of an addictive substance. Attributions of causality refer to an individual's pattern of beliefs that relapse to drug use is a result of internal, or rather external, transient causes (e.g., allowing oneself to make exceptions when faced with what are judged to be unusual circumstances). Finally, decision-making processes are implicated in the relapse process as well. Substance use is the result of multiple decisions whose collective effects result in consumption of the intoxicant. Furthermore, Marlatt stresses some decisions--referred to as apparently irrelevant decisions--may seem inconsequential to relapse, but may actually have downstream implications that place the user in a high-risk situation.

Consider Figure 1 as an example. As a result of heavy traffic, a recovering alcoholic may decide one afternoon to exit the highway and travel on side roads. This will result in the creation of a high-risk situation when he realizes he is inadvertently driving by his old favorite bar. If this individual is able to employ successful coping strategies, such as distracting himself from his cravings by turning on his favorite music, then he will avoid the relapse risk (PATH 1) and heighten his efficacy for future abstinence. If, however, he lacks coping mechanisms--for instance, he may begin ruminating on his cravings (PATH 2)--then his efficacy for abstinence will decrease, his expectations of positive outcomes will increase, and he may experience a lapse--an isolated return to substance intoxication. So doing results in what Marlatt refers to as the Abstinence Violation Effect, characterized by guilt for having gotten intoxicated and low efficacy for future abstinence in similar tempting situations. This is a dangerous pathway, Marlatt proposes, to full-blown relapse. Figure 1 presents a schematic diagram, adapted from Marlatt & Gordon (p. 38), which has been

modified to present examples of the cognitive and behavioral processes that may occur at each juncture of the model.

Cognitive therapy of substance abuse

An additional cognitively-based model of substance abuse recovery has been offered by Aaron Beck, the father of cognitive therapy and championed in his 1993 book, *Cognitive Therapy of Substance Abuse*. This therapy rests upon the assumption addicted individuals possess core beliefs, often not accessible to immediate consciousness (unless the patient is also depressed). These core beliefs, such as "I am undesirable," activate a system of addictive beliefs that result in imagined anticipatory benefits of substance use and, consequentially, craving. Once craving has been activated, permissive beliefs ("I can handle getting high just this one more time") are facilitated. Once a permissive set of beliefs have been activated, then the individual will activate drug-seeking and drug-ingesting behaviors. The cognitive therapist's job is to uncover this underlying system of beliefs, analyze it with the patient, and thereby demonstrate its dysfunctionality. As with any cognitive-behavioral therapy, homework assignments and behavioral exercises serve to solidify what is learned and discussed during treatment.

Emotion regulation, mindfulness, and substance abuse

A growing literature is demonstrating the importance of emotion regulation in the treatment of substance abuse. For the sake of conceptual uniformity, this section uses the tobacco cessation as the chief example; however, since nicotine and other psychoactive substances such as cocaine activate similar psychopharmacological pathways, an emotion regulation approach may be similarly applicable to a wider array of substances of abuse. Proposed models of affect-driven tobacco use have focused on negative reinforcement as the primary driving force for addiction; according to such theories, tobacco is used because it helps one escape from the undesirable effects of nicotine withdrawal or other negative moods. Currently, research is being conducted to determine the efficacy of mindfulness based approaches to smoking cessation, in which patients are encouraged to identify and recognize their negative emotional states and prevent the maladaptive, impulsive/compulsive responses they have developed to deal with them (such as cigarette smoking or other substance use).

Behavioral models

Behavioral models make use of principles of functional analysis of drinking behavior. Behavior models exists for both working with the substance abuser (Community reinforcement approach) and their family (community reinforcement and family training). Both these models have had considerable research success for both efficacy and effectiveness. This model lays much emphasis

on the use of problem solving techniques as a means of helping the addict to overcome his addiction.

ARABPSYCHOLOGY.COM