International Handbook of Occupational Therapy Interventions

Chapter 27
Behavioral Approach to Rehabilitation of Patients with Substance-Use Disorders

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At last, I learned how to clean a potato. Before I was 40,
I never held anything heavier than a syringe in my hand.

—A former drug abuser

Abstract This chapter describes the practice of treatment and rehabilitation of persons suffering from substance-use disorders (i.e., abuse of drugs or alcohol). It uses the experience gathered in one of the departments of the Narcologic Clinic of St. Petersburg, Russia, and works as a therapeutic society (TS). Therapeutic societies are organizations, sometimes voluntary, aimed at helping drug and alcohol abusers to rid themselves of substance-use disorders.The treatment is based on the philosophical concept of the 12-step programs and the method of the cognitive behavioral therapy approach. Patients participate in three stages of treatment. During this treatment the patient is placed in an artificial environment similar to a normal society.

Keywords Cognitive behavioral therapy • Dependency syndrome • Detoxification • Group treatment • Psychoactive substances • Withdrawal.

Background

Dependency Syndrome

This syndrome is a combination of physiologic, behavioral, and cognitive phenomena in which the use of psychoactive substances (PASs) has the highest priority in the patient's system of values, while all other interests and needs are neglected. The patients spend more and more time and effort to get drugs and to recover from the usage of drugs. The main features of the dependency syndrome are (1) a very strong, often insatiable, need of getting drugs; (2) inability to control the dosage; (3) withdrawal; and (4) growing tolerance to drugs, that is, the need to increase the dosage with time to achieve the same effect that earlier could be achieved with lower dosages (Tschurkin and Martushov, 1999).

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Implications of Intervention

The main difficulty in dealing with such patients is their lack of *motivation*. In order to continue with drugs, they create protective mechanisms that justify their drug abuse. More often it is their relatives, rather than the patients themselves, who are interested in getting help and who ask for it. For the patient to be sincerely motivated to completely refrain from drugs, some objective conditions should be fulfilled that force the patient to make this choice. It happens when drugs or alcohol becomes a problem not only for their family but also for themselves. A typical scenario is that the family refuses to accept the person's behavior and he or she faces the choice of "the family or the drugs," and risks of being thrown out of the home. A similar situation arises if the drug user develops serious health problems or legal troubles. In order to return to normal life, the patient has to address his physical dependency, learn how to deal with his psychological dependency, and consciously refrain from drugs or alcohol even under external or internal stress factors.

Intervention

The framework of intervention among patients with dependency syndrome is in Russia based on the Order of the Ministry of Health of Russian Federation (2003). This chapter refers to the experience of one of the departments of the Narcologic Clinic of St. Petersburg.

The clinical work with patients suffering from chemical dependences is based on the concept of the 12-step programs (Wallen et al., 1987), in which (1) patients admit that they have a disease, want to recover, and agree that it is possible; (2) patients accept assistance from the team, and analyze their own behavior, including all the failures and damages inflicted on other people: and (3) patients perform self-control and correct the misbehavior. This program is conducted in an artificial environment—*a therapeutic society*—which is a model of a normally functioning society. To facilitate abstention from drugs/alcohol, the patients' environment should be free from provoking factors (substance-abusers, easily accessible drugs or alcohol);, therefore, their environment should be completely changed.

Within this concept, the *cognitive behavioral approach* is used for the intervention (Karvasarsky, 2007). This approach, as it is interpreted in the clinic, is based on the beliefs that (1) abuse of drugs or alcohol is a behavioral disorder; (2) behavioral disorder is a consequence of deficiency of education; and (3) if the patient learns the correct behavior, such as by learning a pattern (model), the symptoms of the disease will decrease or disappear. The clinic uses the system of learning called "token economy" in the following way:

- The patient is rewarded for "desired" behavior by a special token.
- The patient gets more tokens the better the behavior that he/she demonstrates.

- The tokens can be exchanged for something the patient wants, such as a trip to the theater.

The intervention program includes three stages that are carried out simultaneously: (1) disconnection and complete abstention from drugs and treatment of withdrawal and postwithdrawal syndrome with medication, (2) rehabilitation by a combination of a cognitive behavioral approach and medication, and (3) supportive and antirelapse treatment by a combination of cognitive behavioral therapy and medication.

Purpose

The main aim of the intervention for patients with dependency syndrome is learning how to return to normal life. During this process the patient first has to overcome the physical dependence on drugs or alcohol, and second to learn how to deal with the psychological dependence. Patients have to learn how to control the desire to use drugs or alcohol and to acquire new habits of normal behavior and social communication.

Method

Candidates for the Intervention

Rehabilitation from substance-use disorders is suitable for any patient and is not limited by age, type of drugs, or duration of the abuse. Contraindications are (1) developed psychopathology, and (2) behavior that is dangerous for other patients or the team members.

Admission to the Clinic

Patients are admitted to the rehabilitation program in the following ways: (1) about 40% of the patients are admitted after detoxification treatment; (2) 25% of the patients seek rehabilitation help by themselves; (3) 20% of the patients are admitted for antirelapse treatment (not necessarily after having been treated in this clinic); and (4) 15% of the patients seek help after having been informed by previous successful patients, by other medical centers, by parents visiting the meetings of Azaria, an organization for "mothers against drugs."

Each patient is accepted after a collective decision by the psychologists, social workers, and narcologists, sometimes after a trial period of 1 week.

Epidemiology

> *There are more than 300,000 registered drug abuses in Russia, but experts believe the real figure to be between five and eight times greater than this.*
>
> (Dalziel, 2002)

In St. Petersburg there were 9,604 registered drug abusers and 35,280 alcoholics in 2006, and 10,094 drug abusers and 33,024 alcoholics in 2007. The clinic accepted about 10,000 patients in 2007, including the patients admitted several times during the same year.

Settings

The settings concern one of the departments of the clinic with a capacity of 85 patients. Thirty-five patients, mainly heroin abusers, are going through the rehabilitation stage. The other patients are treated for detoxification, withdrawal, and post-withdrawal syndrome.

The Role of the Therapists

The job title of occupational therapist does not exist in Russia. The corresponding functions with focuses on the patients' occupational performances are conducted by psychologists, social workers, and consultants on chemical dependency (i.e., people who once abused drugs or alcohol but are drug-free for several years).

The team of the present department consists of 28 members who conduct the intervention program. They represent various specialists, such as narcologists, psychologists, social workers, and consultants on substance-use disorders. They work as a *semiprofessional therapeutic society*. Medical team members conduct seminars aimed at discussing dependency, codependency, problems that occur during the first days of sobriety, and reasons for recidivism. A lot of work is also done with the patient's relatives in order to deal with possible codependency. The team members' roles are to (1) help the patient to overcome the drug dependency, and (2) to increase the patients' motivation.

The *psychologist/narcologist* prescribes medication for treatment of the withdrawal and the postwithdrawal syndrome, treats possible psychological complications such as depression, and makes decisions regarding involvement of other medical specialists. The whole process of intervention and rehabilitation is under control of this staff member.

The *social workers* are employed by the clinic, and their role is to help the patients find jobs in cooperation with employment agencies. When a job is found, they follow the client for 1 year.

The *consultants on substance-use* have a special and important role in the clinic, which is to demonstrate that the treatment can be successful. This role is extremely important for the motivation of patients in the process of overcoming the addiction and to help them gain a realistic view of the disease. The consultant's personal positive experience makes this possible because he becomes a kind of mirror for the patient. One of the functions of consultants on substance-use is psychological support for the groups.

Results

Clinical Application

Organization

Stages of Rehabilitation

The treatment is arranged in stages of rehabilitation in a hierarchical order. The extent of freedom that patients enjoy depends on the rehabilitation stage. Patients receive more freedom and responsibility the higher the stage attained. Patients can be moved between these stages depending on their progress of rehabilitation. The more that patients are trusted, the more rights and responsibilities they get. Thus, some patients from the third group (see below) are more trusted by the team and have responsible assignments.

- *Motivation stage:* The patient is not allowed to leave the facility. Even if the patient is not suffering from withdrawal, his will is still paralyzed by psychological dependency. If he returns to his environment, he will again start seeking drugs and justify it using protective psychological mechanisms. It takes time and substantial effort both by the patient and the team members to overcome these mechanisms. The patient learns how to adapt an objective view on himself and to call things by their proper names. The consultant on chemical dependency plays the main role in this stage by being both the judge and the friend who gives psychological support.
- *Limited functional mode stage:* After some time the patient earns more freedom, that is, he lives in a *limited functional mode*. He is allowed to go outside with relatives, and later on with other patients and groups. The patient obtains this stage if he complies with the ten specified criteria of expected behavior and actively cooperates with the team members. Most of the patients are allowed to spend weekends at home on the condition that they go to Narcotics Anonymous meetings (NA, 2008) when they are outside the clinic.
- When the discharge time approaches, the patient starts looking for a job and is allowed to travel to interviews. Two weeks before the discharge, the patient is allowed to spend all night at home but is expected to attend all group sessions at the clinic.

- *The follow-up stage:* The psychosocial follow-up is performed by the consultants after the discharge, within a time frame of up to 8 months. At this stage, the patients sign the "family agreement" which is similar to the therapeutic agreement (see assignments). The patient is expected to have a job and, by the end of the period, to have found an adviser/instructor in NA. The adviser is typically a person with a very long period of abstention from drugs/alcohol who regularly attends NA groups and plays a supporting role. It is recommended to attend the NA sessions daily for the first 3 months after discharge.

Groups

Patients who are at different stages participate in the program and are placed in a group.

The aim of participating in the *motivation group* is to go through detoxification and to be qualified for the rehabilitation program.

The *rehabilitation group* is a model of the society, and the therapeutic agreement is a model of the law. Therefore, to keep the agreement means to train to keep the social norms, which is of most importance for these patients. The patient learns how to predict consequences of his behavior and be responsible for them; every act leads to well-known and immediate consequences. The patients' hierarchy is reflected by badges of different colors that the patients carry; the motivation group carries white badges, and patients in the rehabilitation group carry yellow or red badges depending on the advancement of the rehabilitation process.

Assignments

A newly enrolled patient starts by signing a therapy agreement. It contains the behavioral norms for the group to which he/she belongs.

The following behaviors are prohibited:

- Use of any drugs except for tobacco and prescribed medicines
- Sexual relations, physically or verbally aggressive behavior, use of slang, displays of alcoholic or drug subculture and symbols
- Use of mobile phones

Permitted behavior include:

- Keeping the daily routines
- Maintaining personal hygiene

It is every patient's responsibility to make sure that all patients keep these norms and do not enter any "contract relations," that is, bribery is not allowed. Keeping these rules helps to avoid conflicts in the group.

Encouragements and Punishment

The correlation between behavior and consequences is defined in a document entitled "Classification of Encouragements and Punishments." It describes in which situation

a patient can earn (1) more rights and privileges, or (2) a promotion, or, on the other hand, (1) lose some or all of his privileges, or (2) be required to do extra work such as dish washing. The worst punishment is to be expelled from the group, and the money paid for rehabilitation is not returned.

Contents of the Intervention

Duties

The patients are engaged as instructors for supporting other patients who are still at a lower stage. An instructor has the responsibility for the other patients' behavior and follows them everywhere, even to the restroom. This creates a kind of surrogate family, where the newly arrived patient has the role of a younger brother or sister, the instructor has the role of an older brother/sister, and the medical team plays the parents' role. Thus, the training of everyday live and social roles is conducted. In this way, the patients earn more responsibilities for themselves and other patients, which is aimed at increasing continually during the rehabilitation program.

Duties that are part of the rehabilitation program include training of responsibility, honesty, organizational skills, and ability to resolve conflict situations.

Every patient has certain duties at all stages of the program. The duty tasks are defined by the patients themselves at the morning meeting. Usually it is different kinds of homework, such as cleaning and dish washing. For example, more advanced patients may become training instructors and also work as volunteers after their own program has ended. All these duties are elective, and the patients have to be rated by other patients on four parameters: trust, discipline, contactability, and knowledge of the program.

Habits and Daily Routine

A typical day involves several blocks of duties:

- Occupational performance of morning and afternoon housework at the ward and outside the premises
- Group therapy conducted by an instructor
- Performing small individual daily tasks, such as discussing current psychological problems.
- Participating in individual consultations.
- Free time for walks, watching TV, movies, etc.

There are several daily features of the program:

- Morning meetings under the supervision of the consultant. The purpose is to teach the patients to act together and to define the day's focus. The participants discuss the news, encountered problems, and individual problems in the context of the "here and now," such as the use of drugs or alcohol, resolving conflicts inside the group, insults, etc. Housework for the day is also planned during these meetings. The philosophy of the group is discussed constantly.
- Meetings are conducted under direction of the patients at a higher stage.
- Afternoon discourses are conducted by the consultant. The participants discuss their performances of the housework; make comments and apologies, express

gratitude, and read the Diary of Feelings that every patient has to keep constantly. The participants fill the Mirror of Recovery ("what I did today for my recovery"), discuss the Focus of the Day, and their feelings of the moment. Every participant gets feedback and reasonable social pressure.

- A weekly meeting is held similarly to the daily meeting. A team member helps to set up the coming week's activities. The patients can apply for a leave of absence or participating in a group activity, such as going to the theater. If the group accumulated too many demerits for the week, they are made public and the corresponding measures are announced. The meeting's secretary collects applications and follows up the announced measures.
- Special discourses are conducted when necessary. Here the patients can comment on other patients' behavior. The aim is to get feedback to the patients and serve as a "valve" for socially acceptable feelings or for aggression. The instructor is usually an advanced patient and the team members are present.
- Approximately once a month the speakers' meetings are held with participation of persons with long periods of sobriety (more than 1 year) who once were patients at this clinic, or persons from one of the NA groups. They discuss their own experience of abstention from drugs/alcohol. Thus, the participants of the program can see successful cases from people from outside and thus can objectively judge their own problems and the possibilities of resolving them.

Evidence-Based Practice

The figures for the last 2 years show that 23% of the patients at the clinic who fulfilled the program have a remission period longer than 1 year. About 8% to 10% of patients return for an antirelapse treatment, and 15% have periodic relapses but with longer periods of sobriety and a better quality of life. There is no available information about 10% to 15% of the patients.

Generally speaking, the results of rehabilitation are better if the patient is connected to the clinic and participates in rehabilitation for a longer time; however, there are also some exceptions.

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References

Dalziel, S. (2002). Alarming rise in Russia drug abuse. BBC News World Wide. http://news.bbc.co.uk/2/hi/europe/2176504.stm.

Karvasarsky, B. Psychotherapeutic encyclopedia, 2007. Б Д. Карвасарский. Психотерапевтическая энциклопедия (in Russian). http://vocabulary.ru/dictionary/6/word/%C1%C8%D5%C5%C2%C8%CE%D0%C8%C7%CC.

Narcotics Anonymous Word Wide (2008). 1999–2008 NA World Services, Incorporated. http://www.na.org.

Order of the Health Ministry of Russian Federation No. 500. Dated Oct. 22, 2003. Regarding treatment of people with substance abuse. Приказ Минздрава РФ 22.10.2003 N 500 об утверждении протокола ведения больных "реабилитация больных наркоманией (z50.3)" (in Russian). http://lawrussia.ru/bigtexts/law_1776/index.htm.

Tschurkin and Martushov. (1999). Short guidance regarding the use of International Classification of Diseases (ICD-10) in psychiatry and narcology. Russian translation. Moscow: Triada-X, pp. 1–232. Чуркин, А.А. и Мартюшов А. Н. Кратқое руководство по испольэованию МКБ-10 в психиатрии и нарколоии. – М.: Изд-во «Триада-Х», 1–232 с (in Russian).

Wallen, M.C., Weiner, H.D., Mansi, A., and Deal, D. (1987). Utilization of 12-step theme groups in a short-term chemical dependence treatment unit. *J Psychoactive Drugs*, 19(3), 287–290.