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GROUP COGNITIVE BEHAVIOUR THERAPY FOR ALCOHOLISM

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ABSTRACT

The purpose of the present study is to replicate the effectiveness of group cognitive behaviour therapy, which is known to be cost effective as well as emerging as an appropriate non-pharmacological intervention in India. Close homogeneous group of 15 alcoholics were formed and alcohol dependence scale (ADS) was administered on them before (baseline) and after (follow up) group cognitive behaviour therapy. Results showed the difference in scores on alcohol dependence scale for baseline and follow up assessment to be statistically significant; indicating that group cognitive behaviour therapy is an effective non- pharmacological treatment for alcoholism.

Key Words: Alcoholics, ADS, Baseline and Follow up assessment, Group cognitive Behaviour therapy.

Alcoholism is an addictive dependency on alcohol characterised by craving, loss of control, physical dependence and withdrawal. Alcoholics need to be helped to identify situations and feelings that trigger the urge to drink and to find new ways to cope without alcohol use. Such type of treatment modality comes

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under non-pharmacological intervention. Studies have shown alcoholism as a burning problem in India and also emphasised on the importance of non-pharmacological interventions in abstinence maintenance (Robin, Thomas, & Jorgen, 2005). The purpose of psychosocial intervention is to achieve a sustained drug free status, a change in life style, and to have an improved quality of life. The goals of short- term psychosocial interventions are increasing medication compliance, increasing retention in treatment, and acquisition of skills that reinforce the effects of medication, whereas the goals of long-term psychosocial intervention are maintenance of abstinence, a change of life style, and corresponding adoption of a productive life style. Psychosocial intervention for alcoholism is a broad "umbrella" term that brings under its folds a diverse array of psychotherapy, counselling and rehabilitation for effective and global management of alcohol (Malhotra, Basu & Gupta, 1996).

The purpose of the present study is to call attention to group cognitive behaviour therapy and its practical utility in psychosocial intervention for alcoholics' treatment. From the perspective of cognitive-behaviour therapy, alcohol abuse and dependence are viewed as learned behaviours that are acquired through experience. If alcohol provides certain desired results (e.g., good feelings, reduced tension, etc.) on repeated occasions, it may become the preferred way of achieving those results, particularly in the absence of other ways of meeting those desired ends. Cognitive-behavioural approaches include cognitions, thoughts, and emotions among the factors that are considered to precipitate or maintain drinking behaviour. On the other hand behavioural methods (e.g., repeated practice, reinforcement) are used to modify cognitive and emotional processes. Cognitive-behaviour therapy (CBT) is used for conceptualizing drinking problems, and on the basis of that we can design psychosocial interventions that focus on developing effective coping skills. The cognitive-behavioural model incorporates two major types of learning: learning by association and learning by consequences (Morrison, 2001). A main advantage of CBT over other forms of therapy is that it has a tendency to be short, taking an hour long session each week for about 3 to 6 months. During this time, the therapist and the client work towards understanding what the problems are, and the therapist discusses new strategies for tackling them.

Recent researches have suggested that group cognitive behavioural therapy (GCBT) is more efficacious for alcoholism in comparison to individual therapy. Group therapy has been associated with many advantages, such as potential time and cost savings per patient, the possibility of treating a greater number of people and reducing waiting lists (Jeffrey, 1999; Lewinsohn & Clarke, 1999;

Morrison, 2001; Vinogradov & Yalom, 1994). The effects of group cohesion, imitative behaviour, interpersonal learning, opportunity for group members to serve as co-therapists and offer mutual support are claimed as positive by-products of group treatment (Lewinsohn & Clarke, 1999; Morrison, 2001; Spence, 1989; Toseland & Siporin, 1986; Vinogradov & Yalom, 1994). Group settings are also said to provide group members with the opportunity to recognize common experiences shared among other group members (Lewinsohn & Clarke, 1999; Morrison, 2001; Toseland & Siporin, 1986; Vinogradov & Yalom, 1994). These non-specific factors of the therapeutic relationship have repeatedly been shown to produce equivalent improvements in client outcomes (Corey & Corey, 2002; Horvath & Bedi, 2002; Oei & Browne, in press).

METHOD

Sample

The subjects of the present study were patients undergoing treatment for alcoholism while admitted in De-addiction Ward of the Central Institute of Psychiatry (C.I.P., Ranchi). A group of 15 alcoholics that had given consent and met the inclusion and exclusion criteria was selected for group cognitive behaviour therapy.The following inclusion criteria were : 1) age 20–50 years, 2) meeting the DSM-IV-TR criteria for alcohol abuse, with or without physiological dependence, 3) on an average consumption of three or more drinks per day during last 30 days, and 4) all the patients were under regular pharmacological management at CIP. The exclusion criteria were: 1) previous history of brain organic problem, 2) any other current drug abuse or dependence (including tobacco), 3) a current major psychiatric disorder as determined by Clinical Interview, and 4) a serious or unstable medical condition. Brief description of this group is presented in Table 1. Table 2 gives the general description of social demographic and clinical characteristics of the group.

TABLE 1

Descriptive features of the alcoholic group.

Number of patients	15
Total number of sessions	18
Time taken	1 hour and 30 minutes per session
Duration	4 months
Ward	De-addiction ward
Therapy/ intervention	Group Cognitive Behaviour Therapy
Type of the group	Close and homogeneous

TABLE 2

Social, demographic and clinical characteristics of the alcoholic group.

Social and clinical variables		Mean ± SD / n = % (N=15)
Age (years)		36.67± 5.802
Present duration of alcohol intake (years)		4.27± 2.764
Education	<9th class	1(6.7%)
	High school	4(26.6%)
	Inter mediate	3 (20.0%)
	Graduation	4 (26.7%)
	>Graduation	3 (20.0%)
Occupation	Business	8 (53.3%)
	Service	6 (40.0%)
	Student	1 (6.7%)
Marital status	Married	11 (73.3%)
	Unmarried	4 (27.7%)
Religion	Hindu	9 (60%)
	Muslim	2 (13.3%)
	Christian	4 (26.7%)
Region	Rural	9 (60%)
	Urban	6 (40%)
Sexual abnormality	Present	4 (26.7%)
	Absent	11 (73.3%)
Past history of alcohol	Present	5 (33.3%)
	Absent	10(67.7%)

Procedure

Initial Phase

In the very first session, all alcoholics were rated on alcohol dependence scale (ADS) which was developed by Skinner and Horn (1984), and this assessment was considered as baseline assessment. After that the therapist introduced herself to the patients of alcohol dependence and explained the purpose and rationale of the therapy sessions. This was followed by a formal introduction of all the participants, including their family background, interest and hobbies. This was done in order to make the patients feel comfortable and participative. In the next session the main target was to elicit from patients their reasons for taking substance and taking treatment as well as to assess the current level of motivation. In order to achieve this purpose, the participants were divided into pairs. Each pair was allotted 10 minutes during which time the members would talk with each other by focusing primarily on 3 questions (i) Reason for taking treatment. (ii) Assess their level of motivation on a 5 point

rating scale ranging from least motivated (1) to highly motivated (5). (iii) Reasons for taking the substance and sharing their feelings during the intoxicated state.

This situation not only enabled the patients to interact with each other but also helped them to assess their own standing in terms of their rating.

Middle phase

After initial introduction and the assessment of the level of motivation, the therapeutic targets were identified as follows:

Psycho-education regarding the effects of alcohol dependence

Psycho-education was given to the patients about how their dependence pattern affects their physical and psychological health.

- Physical problems: Here, the impact of repeated alcohol consumption on physical health was discussed. The patients were told how their alcohol intake could affect their body systems and how alcohol could be fatal for them, i.e., each lead to death.
- Mental problems: Here, patients were told about delirium, depression, mania, Korsakoff psychosis, etc.

Coping skills training

This was selected as the next target because it came out through discussion that alcohol was often consumed because patients did not have alternatives to deal adequately with stressors and they preferred this short-term relief from the problem situation.

Mode of therapy

An open discussion was conducted in order to identify the potential triggering situations for alcohol intake. To teach the client how to develop adequate coping skills, the following pattern was developed:

1. **Intra personal skills.** Intra personal skills training were thought to be crucial because patients had to be taught how to control craving, how to engage in alternative activities, and how to control their anger and anxiety, etc.
2. **Managing thoughts and craving for use.** Thoughts about drinking or drug use and craving are common among people with alcohol abuse. Thus, the patients were taught how they could control themselves, like challenging such thoughts, recalling unpleasant memories resulting from using alcohol, distracting techniques like drinking water or chewing gums, and leaving the situation, etc. Along with this the cue exposure technique was explained to them in which they were supposed to take the help of their family members. Family members should keep the alcohol in front of the patient and the patient have to control himself from not taking the alcohol.

3. **Anger management.** Anger is a very common antecedent to alcohol. Clients were taught about the warning signs of anger, both external and internal so that they can calm down themselves. Skills for managing anger like use of calm down phrases, identifying aspect of an anger provoking situation, considering other options, deep breathing techniques, backward counting, etc. were taught to the patients.
4. **Relaxation training.** Patients were also given relaxation technique (deep breathing) in order to control both anxiety as well as anger because both are frequent triggers for substance intake
5. **Inter personal skills.** These skills were taught to the patients for coping with situation in which other people are an important factor.

Assertiveness training

Assertiveness training targeted four aspects.

A. **Substance refusal.** Here, patients were taught how to say 'no' convincingly when any type of substance was offered to them. Clients were taught not to give double meaning to the person offering the substance or to change the topic of conversation. A few instances of role playing of refusal were also practiced.
B. **Refusing requests.** Patients often reported discomfort when refusing other's requests for favour and, therefore, they did not do so. Thus, they were taught how to refuse unwanted requests by first acknowledging the requesting person's position and feelings, and then by making firm and calm statement of refusal.
C. **Handling criticism.** Criticisms from other people are often taken very harshly by such patients. So they were taught how to handle criticisms without getting angry and aggressive. They were taught how to calm down, evaluate the opinion of the other person, and try to clarify it.
D. **Myths about social status.** Many of the patients expressed their opinion that taking alcohol contributed to their social status. Thus, they were explained that drinking or taking any substance would not enhance any one's social status. They were also explained that social status was related to what one has achieved in one's life, not to such factors as taking any substance. Thus, corrections of various misconceptions were undertaken.

Termination phase

In this phase, 'relapse prevention' was targeted. The main focus of relapse prevention is the development of strong self control in order to avoid relapse. Specific relapse prevention strategies discussed were the following:

(i) Helping the patients identify high risk relapse factors, such as intrapersonal and inter- personal situations and strategies.

(ii) Helping the patients understand relapse as a process and as an event.
(iii) Helping the patients understand and deal with triggers for substance intake as well as its craving.
(iv) Helping the patients understand and deal with social pressure for the use of the substance.
(v) Helping the patients develop and enhance a supportive social network.
(vi) Helping the patients develop methods of coping with negative emotional states.
(vii) Explaining the patients the importance of follow up.

The issues, which were already targeted in the middle phase, were also summarized and reviewed in this phase. After this, some patients were asked to speak about the positive effects of taking alcohol or other substance, and some were asked to speak about the positive effects of not taking alcohol or other substance. In this way, a decision making matrix was proposed highlighting the long-term negative consequences of alcohol consumption. These were developed as pamphlets and the patients were told to stick it at some place such as on the door, or table where they could be seen every day. Booster sessions were given to them as per their convenience. Few sessions were given in groups and few individually.

RESULTS AND DISCUSSION

After 4 months (during booster sessions) the patients were again rated on ADS. The purpose of further assessment was to examine their improvement objectively. Table 3 clearly indicates that all alcoholics who were involved in this GCBT had low scores on their follow up assessment in comparison to baseline assessment. Paired t test indicated that the difference in scores between the two conditions was statistically significant. This proves the importance of GCBT as a non-pharmacological treatment for alcoholism.

TABLE 3

Mean score and SD on Alcohol Dependence Scale (ADS) at baseline and follow up.

Treatment Conditions	*Mean*	*SD*	*t*	*df*	*p*
Baseline assessment	30.80	6.82	20.086	14	*0.000
Follow up assessment	6.07	5.71			

P = .01*

Holder and his colleagues (1992) have reported that cognitive behaviour therapy is an effective treatment for alcoholism. It has been one of the therapies used during the Project MATCH, a large multisite study of 1,726 alcoholics that has attempted to match alcoholic characteristics to therapy response (Project MATCH, 1997). In that study manual-guided cognitive behavioural therapy

(Kadden, Carroll, Donovan, Cooney, Monti P, Abrams, Litt & Hester, 1992) was found to lead to a marked reduction in both drinking days and drinks per drinking occasion for up to 15 months after the initiation of treatment. It was reasoned that cognitive behavioural therapy, which addresses issues of craving, management of slip drinking, reduction of relapses, and other similar techniques, would be particularly amenable to augmentation with naltrexone (O'Malley, Jaffe, Chang, Schottenfeld, Meyer & Rounsaville, 1992). The present study brings out the effectiveness of group cognitive behaviour therapy for alcoholics. The results showed clearly that alcohol dependence can be effectively treated even without using medicine.

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