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Psychosocial Treatment of Substance Use Disorders in Adolescents

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"Medication treatment can only 'level the playing field'. Psychosocial treatment, group therapy, and individual counselling do the actual treatment to prevent relapse" (James Halikas, 1993).

Psychosocial treatment for substance use disorders is a broad "umbrella" term that brings under its folds a diverse array of ***non-pharmacological interventions*** for effective and global management of drug abuse. The common thread underlying these interventions is that they do not involve prescribing medicines in any form. This does not mean, however, that psychosocial treatment has any conflict with pharmacological treatment. Quite on the contrary, it has been documented that each modality of treatment helps the other. Specifically, psychosocial interventions can ***enhance*** pharmacological treatment efficacy by increasing medication compliance, retention in treatment, and acquisition of skills that reinforce the effects of medications.

Other than this short-term goal of strengthening pharmacological efficacy, psychosocial treatment serves the even more important long-term goal of ***abstinence maintenance***. Getting detoxified from an abused drug is relatively much easier than staying away from the drug in the long run, as evidenced by the world-wide high rate of relapse of treated drug addicts. Psychosocial treatment aims to overcome, or approximate, this difficult challenge. Staying drug free for a long period of time may be practically impossible for a substance abuser living a particular life style, often in a drug-using "sub-culture", where the primary preoccupation's and themes of living revolve around drugs. Thus, long-term abstinence also necessarily implies, ultimately, a ***change of life style*** and adoption of a more ***productive life*** style. Accordingly, it follows that these are also the ultimate goals of psychosocial treatment for substance use disorders.

Treatment for specific drugs can differ depending on the characteristics of the patient, and the problems associated with an individual's drug addiction. The main goals of psychosocial treatments are- to enhance efficacy of pharmacotherapy, to achieve a sustained drug free status, a change of life style, and have an improved quality of life. In keeping with these goals, the short- term goals are- increasing medication compliance, increasing retention in treatment, and acquisition of skills that reinforce the effects of medication. The long-term goals are- maintenance of abstinence, a change of life style, and corresponding adoption of a productive life style.

Reasonable degree of success has been achieved in terms of- reduction of drug use by 40-60%, reduction of risk taking and criminal behavior, and also improving the prospects of employment. However, the outcome depends on the - extent and nature of the patient's presenting problems, the appropriateness of the treatment components, related services used to address those problems, and the degree of active engagement of the patient in the treatment process.

Modalities of delivering psychosocial therapies can be either therapist mediated or non-therapist mediated.

Therapist mediated:

These can be of two types i.e. [a] Brief Interventions (BIs) and [b] Extended Interventions (EIs).

BIs are characterized by involving 1-4 sessions. They improve staff efficiency and are generally cost effective. The main characteristics of BI are: keeping the goal of reduced or non-problem alcohol/drug use as opposed to abstinence; generally delivered by a non-specialist; generally directed at non-dependent rather than dependent individuals; addressing the person's motivation to change habits; being self-directed; and having certain key components/ingredients (feedback of risk involved, encouraging responsibility for change, advice, alternative options, enhancing self-efficacy). BIs have demonstrated a 20-30% reduction in excessive drinking of alcohol. However, evidence points towards it being more effective for early stage, non-dependent drinkers in primary care/community rather than dependent drinkers or treatment seeking groups where extended interventions are generally more helpful. In patients with nicotine dependence, Brief Advice (BA) has been used considerably. It is defined as- verbal instructions to stop smoking with or without added information about the harmful effects of smoking. It is conceptually similar to BI and all published guidelines recommend that health professionals should give BA routinely to all smokers they encounter. BA has been shown to be one of the most cost-effective interventions in medicine, but with a modest success rate.

EIs are characterized by involving 5-12 sessions, which are carried out either in a group or alone. The type of intervention delivered depends upon the aims of the treatment, and can be- relapse prevention programs, cognitive behavior therapy, behavioral interventions, social skill training, supportive-expressive psychotherapy etc. Varied types of EIs have been found to have similar benefits- results being similar across both inpatients and outpatients. However, it has been seen that it is necessary to address problems with psychiatric illness and lifestyle concurrent with drug/alcohol abuse.

Non-therapist mediated:

These are essentially Self-Help Groups (SHGs); the commonest and popular ones being- Alcoholic Anonymous (AA), Narcotic Anonymous (NA), Cocaine Anonymous etc. The SHG is a group of individuals with similar problems who meet voluntarily to help each other to help themselves. The common theme of all SHGs is of mutual aid- of individuals

helping each other by offering friendship and sharing common experiences.

AA is a voluntary; supportive fellowship; founded in 1935 by two alcoholics: Bill Wilson and Dr. Robert Smith. At present approximately 9000 AA groups exist in 134 countries. The essential components are that- alcoholics help one another to stay sober, weekly meetings are held, there is verbal sharing of experiences and feelings, 24 hours support, empathic understanding, and there is self-dedication to being abstinent from alcohol. All of these are based on the 12-step model. It has been shown to be reasonably effective in reducing alcohol (or drug) use.

NA is an international fellowship for recovering addicts who meet regularly to help each other stay off drugs, and is open to anyone with any type of drug problem. The only requirement for membership is a desire to stop using drugs. The 12-step programme includes: [1] admitting that one is an addict and powerless over one's drug/alcohol-taking; [2] acknowledging that only a power greater than oneself (God) can help, and turning one's life over to Him; [3] making a fearless moral inventory, recognizing defects of character and asking God to remove them; [4] admitting previously committed wrongs and trying to make amends for them; [5] carrying the spiritual message of AA/NA to addicts and practicing its principles in all aspects of daily life.

However, it is important that professionals do not become directly involved in SHGs; as they then no longer remain 'self-help'. Also, there had been recent evidence to suggest that patients should be just introduced to (and encouraged to attend) the AA groups, but it should not be forced (or made compulsory) on them, as this can lead onto poor outcomes.

IMPORTANT PSYCHOSOCIAL INTERVENTIONS

Individual psychotherapy and group psychotherapy: In this, the common issues and strategies include- setting the resolve to stop, teaching coping skills, changing reinforcement contingencies, fostering management of painful affects, improving interpersonal functioning and enhancing social support.

The treatment goals are- establishing abstinence, establishing stable functioning, preventing relapse, addressing psychological issues, and managing care considerations.

Family and marital therapies: In this, one has to define the problem, and it involves negotiating the contact, establishing the context for a drug free life, ceasing substance abuse, managing the crisis and stabilizing the family, and family reorganization and recovery.

Relapse Prevention: This involves specific techniques of - exploring the positive and negative consequences of continued use, self-monitoring to recognize drug cravings early on and identifying high-risk situations for use, and developing strategies for coping with and avoiding high-risk situations and the desire to use. The central element involves anticipating the problems patients are likely to meet and helping them develop effective coping strategies.

Supportive-Expressive Psychotherapy: This has two main components i.e. supportive techniques to help patients feel comfortable in discussing their personal experiences, and expressive techniques to help patients identify and work through interpersonal relationship issues.

Individualized Drug Counselling: This focuses directly on reducing or stopping the addict's illicit drug use. It also covers other related areas of impaired functioning like-employment status, illegal activity, family / social relations, and content and structure of the patient's recovery program. Through its emphasis on short-term behavioral goals, it also helps the patient to develop coping strategies, tools for abstaining from drug use, and maintaining abstinence.

Motivation Enhancement Therapy: This approach employs strategies to evoke rapid and internally motivated change in the client. The first treatment session focuses on providing feedback generated from the initial assessment battery to stimulate discussion regarding personal substance use and to elicit self-motivational statements. In subsequent sessions the therapist monitors change, reviews cessation strategies being used, continues to encourage commitment to change or sustained abstinence, and sometimes encourages the clients to bring a significant other to the sessions.

Behavioral Therapy for Adolescents: Therapeutic activities include fulfilling specific assignments, rehearsing desired behaviors, recording and reviewing progress, with praise and privileges given for meeting assigned goals. Urine samples are collected regularly to monitor drug use. The therapy aims to equip the patient to gain three types of control viz. stimulus control, urge control, social control.

Multidimensional Family Therapy (MDFT) for Adolescents: This is an outpatient family-based drug abuse treatment for teenagers. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations. During individual sessions, the therapist and adolescent work on important developmental tasks like developing decision-making, negotiation, and problem-solving skills. Parallel sessions are held with family members. Parents examine their own particular parenting style, and learning to distinguish influence from control, and to have a positive and developmentally appropriate influence on their child.

MultisystemicTherapy (MST): This addresses factors associated with serious antisocial behavior in children and adolescents who abuse drugs. These factors focus on the characteristics of the adolescent (favorable attitudes toward drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward drug use), school (dropout, poor performance), and neighbourhood (criminal subculture).

Combined Behavioral and Nicotine Replacement Therapy: This has two main components. First, the transdermal nicotine patch or nicotine gum, which reduces symptoms of withdrawal, producing better initial abstinence; and second, the behavioral component, which concurrently provides support and reinforcement of coping skills,

yielding better long-term outcomes.

The patients practice skills in treatment, social, and work settings. They learn other coping techniques like cigarette refusal skills, assertiveness, and time management.

Community Reinforcement Approach (CRA) Plus Vouchers: This involves an intensive 24-week outpatient therapy. The treatment goals are two-fold i.e. to achieve abstinence long enough for patients to learn new life skills that will help sustain abstinence, and to reduce alcohol consumption for patients whose drinking is associated with drug use. Patients attend one or two individual counselling sessions per week, where they focus on improving family relations, learning a variety of skills to minimize drug use, receiving vocational counselling, and developing new recreational activities and social networks.

Day Treatment With Abstinence Contingencies And Vouchers: For the first 2 months, participants must spend 5.5 hours daily in the program, which provides lunch and transportation to and from shelters. Interventions include individual assessment and goal setting, individual and group counselling, multiple psycho-educational groups, and patient-governed community meetings. Individual counselling occurs once a week, and group therapy sessions are held three times a week. After 2 months of day treatment and at least 2 weeks of abstinence, participants graduate to a 4-month work component that pays wages that can be used to rent inexpensive, drug-free housing. A voucher system also rewards drug-free related social and recreational activities.

The Matrix Model: This provides a framework for engaging stimulant abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction. The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behaviour change. The interaction between the therapist and the patient is realistic and direct, but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is a critical element for patient retention. Treatment materials draw heavily on other tested treatment approaches. This approach includes elements pertaining to the areas of relapse prevention, family and group therapies, drug education, and self-help participation.

One of the main concerns of psychosocial treatment of substance use disorder is maintenance of abstinence. Thus it is important to focus on `relapse' and related issues.

PREVENTION AND MANAGEMENT OF RELAPSE

Attempts to prevent and manage relapse are based on a common understanding of the concept and mechanisms of relapse. Relapse may be defined in several ways: a) the resumption of drug use after a period of abstinence; b) return to previous levels of use; c)

return to full-blown dependence; and d) an unfolding process in which the resumption of substance use is the last event in a long sequence of maladaptive responses to internal or external stressors and stimuli. All of these definitions reflect the same essential concept: a resumption of frequent, perhaps uncontrolled, substance use after a period of non-use.

Most treatment specialists distinguish between a lapse and a relapse. A ***lapse*** is considered a single incident of drug use. A lapse (or "slip") may or may not result in a relapse (regular, heavy use), depending upon how the patient responds to the initial incident. If the response is pessimistic, it may actually lead to a full-blown relapse as a self-fulfilling prophecy. A lapse should instead be viewed more productively as a mistake and an opportunity for intervention and further learning. Even a full-blown relapse may not be accompanied by the complete resumption of a "drug abuse lifestyle" but may instead result in the drug user seeking renewed treatment.

Common contexts/reasons for relapse

Understandably, a protracted or difficult withdrawal syndrome may send a patient back to drugs. The initial few days of withdrawal are especially painstaking, both physically as well as emotionally. But this period is usually covered by anti-withdrawal medication. As the medicines are tapered off over the days, a protracted abstinence state often ensues (e.g., mild aches, fatigability, sleep problems), which is less amenable to pharmacological treatment. This state may even last for months. Along with this there is a persistent craving that may become further accentuated in certain "high-risk" situations. This combination of events provides the commonest context of a lapse and subsequent relapse.

The "high-risk" situations or factors preceding relapse include:

Stress. Whether due to discrete negative life events or everyday hassles, stress greatly increases vulnerability to relapse.
Negative emotions. A wide range of `negative' emotional states can precipitate relapse. These include anger, anxiety, depression, frustration, or even boredom.
Positive emotions. Good feelings that come from socializing can sometimes trigger relapse. In other cases, drug use might be used as a reward or a means of celebration.
Interpersonal conflict. Relapse is often associated with conflict with family members and other individuals. This may particularly manifest as lack of trust by family members despite the patient being drug free for a period of time. The resultant anger or frustration may act as a strong precipitant for relapse.
Social pressure. Sometimes social pressure is overt, as and when someone offers the addict a drug. Often it is more indirect. Being enmeshed in a social network in which other people abuse drugs is especially risky.
Use of other substances. Use of any one intoxicant drug can trigger cravings for the primary drug of abuse or undermine self-control.
Presence of drug-related cues. Environmental cues (e.g., drug paraphernalia) elicit strong craving in some people who are trying to maintain abstinence, and may even cause a `conditioned' withdrawal syndrome.

The importance of each of these precipitating factors varies from person to person. In addition, relapse is often the result of several of them acting in combination.

General measures of intervention

Three major strategies are used in current relapse prevention and intervention programmes:

Social support approaches. These focus on the patient's need for emotional support from family members and friends. Support from family, friends and other recovering addicts can play a vital role in relapse prevention and intervention.

Lifestyle change approaches. These focus on helping patients develop and sustain new social identities as drug-free individuals, including breaking ties with drug users, developing new interests, pleasures and social contacts.

Cognitive-behavioral approaches. These emphasize identifying internal and external cues associated with craving, and then learning how to avoid them, or, if they do occur, to prevent them from turning into a full-blown relapse.

The common and popular approaches are- cognitive behavior therapy (CBT), behavioural self- control training (BSCT), motivation enhancement therapy (MET), coping skills training, and cue exposure (CST & CE). CBT generally tends to incorporate many interventions in its fold and is effective. BSCT focuses on controlled drinking and has been found to be effective. MET has recently become a very popular mode of treatment that involves a less directive, non-confrontational approach wherein the aim is to make the patient understand the negative effects of alcohol/drugs with feedback about various options for change. It has been found to be as an effective adjunct to the more extensive psychosocial treatment package. CST & CE involve persons being able to identify internal/external factors that can trigger a lapse/relapse and ways of countering them effectively. Jointly they have been found to be efficacious, especially for alcohol abuse.

In spite of the best preventive measures, relapse can and does happen to an appreciably large number of recovering patients. The therapist can then play a pivotal role by persuading the patient to enter into active treatment again. Earlier treatment and relapse precipitants need to be reviewed carefully. A follow-up plan needs to be devised and implemented stringently. The most important role of the therapist perhaps is to induce optimism in the patient and his family. Relapses always arouse powerful negative emotions in the family members, ranging from confusion, perplexity and helplessness to anger, frustration and rejection. Thus, the psychosocial therapist must involve the family members in dealing with a relapse.

Specific measures for intervention

The first specific measure in handling a relapse is to clearly ***delineate the contexts/causes for relapse*** in that particular case, keeping in view the common situations and reasons

discussed above. Often a combination of internal and external factors (e.g., chronic boredom plus invitation from a drug using peer, or, unhappy mood plus a nagging family member) is responsible for the relapse.

The second step, then, is to ***reformulate the treatment plan i***n accordance with these factors. The patient may be taught coping skills for "high-risk" situations, communication skills training, relaxation techniques, distraction techniques, using social or self-help networks for help, or assertiveness training, depending on the pertinent factors responsible for relapse. Behavioural interventions such as cue conditioning and extinction may be done, but they often require a trained therapist. Family or marital counselling helps a lot in preventing further relapse. At times, referral to a long-stay residential care programme is needed.

Again, despite best treatment, a substantial minority of patients tend to relapse again and again. This phenomenon of ***recidivism*** can be frustrating for the patient, his family, and the therapist all alike. Other than pharmacological strategies like maintenance on an agonist drug (e.g., methadone) in such circumstances, the psychosocial strategy adopted may be that of ***harm minimization***. In brief, this means that even if the basic condition of drug dependence cannot be cured, the harm (physical and social) accruing from it can be reduced to a minimum. This strategy has become especially relevant in the context of HIV infection in injecting drug-abusers. Examples are syringe (needle) exchange schemes, condom distribution, counselling on safe sex techniques, counselling on safe injecting and sterilization procedures, etc.

AFTERCARE AND REHABILITATION

Aftercare suggests different things to different people, and even treatment specialists are often unclear as to what the term means. In a basic sense, it simply refers to whatever follows a given form of treatment. But it can also be understood with reference to the process of recovery itself. Recovery is not just the cessation of drug use, but it also adjustment to a new way of life within the culture of the larger community. The challenges to such adjustment come from: a) persistent drug craving, b) need for establishing a new social network, c) need to derive satisfaction from drug-free activities and lifestyle, and finally, d) dealing with the risk of relapse. Thus, despite a successful detoxification and inpatient treatment, patients can, and do, go back to their earlier drug using lifestyle and subculture, unless active efforts are made to prevent them from doing so. ‘Aftercare' refers to these efforts and processes to address the issues (a-d) mentioned above. Aftercare can be provided in the de-addiction clinic as follow-up patient visits, or it can be provided by follow-up home visits. A proper ***follow-up*** is essential to and for all aftercare activities.

With efficient aftercare, the patient gradually moves toward ***rehabilitation***. This involves, in practical terms, the following: a) listing of the patient’s assets and building upon them, b) listing of handicaps and ways of improving or coping, c) tapping the social resources available, e.g., family, dedicated organizations, d) restoration to an earlier level of functioning, and e) restoration of social skills. In this regard, it is most important to remember that drug dependence does ***not*** lead to loss of skill, in contrast to the situation

encountered in other severe chronic mental disorders. Accordingly, intense vocational rehabilitation (VR) is often not needed for recovering drug addicts. Developing regular habits and restructuring of life are often sufficient. A minority may need formal help. Wherever required, VR encompasses a whole range of skills that contribute to the individual's ability to get a job and then keep it. As mentioned above, many of the patients with drug/alcohol dependence do not actually loose their skills, and their problems are no different from those people who are long-term unemployed.

During aftercare and rehabilitation, psychosocial and pharmacological treatments are given as described earlier. Most rehabilitation efforts, residential or outpatient, be they through individual, group, or family therapy; over weeks or even years, try to assist patients in eliminating or reducing the initial causes of the compulsion to use drugs. Physiological, psychological, and social factors are addressed, with some variations in emphasis depending upon the treatment modality. Such treatment must address any resistance to change. Patients may need help in ending an intimate relationship or starting one. They will often need help in relinquishing long-held ideas, attitudes, tastes or habits. For many addicts, particularly for those who live overwhelming addictive forces and whose personal styles are deeply entrenched, nothing short of residential programmes may be needed for a long time. Other settings in which rehabilitative efforts may be employed include day care centres, and community outreach services. Patients may also be referred to appropriate non-governmental organizations (NGO) in the town or city.

ROLE OF FAMILY IN OVERALL MANAGEMENT

Throughout the preceding sections, `family' has featured in various contexts. Indeed, the role of family traverses genesis, maintenance, treatment seeking, recovery as well as relapse of substance abuse. Conversely, drug abuse in one family member pathologically influences others' well being and taxes their coping resources. Thus, the entire family may become dysfunctional and burdened. This burden and dysfunction may evoke strongly negative responses from the family members towards the drug addict who, in turn, perceives the family as cold, hostile, non-supportive or even rejecting. This often sets up a vicious cycle where the addict and his family go on aggravating each other's problems. Whatever be the individual family scenario, the reaction of family members to the drug/alcohol abuse often seems to be to maintain the drug/alcohol-taking maladaptive behaviour, whether or not there was a causal role in its initiation. This is especially relevant in the Indian situation because: a) family systems are much more intact than in Western countries, b) the family has an important say in the matters of an individual, unlike that in many developed countries, and c) interpersonal problems peculiar to this society that may act as stressor for the recovering addict (e.g., conflicts between the wife and mother-in-law adversely influencing the husband's drinking or abstinence pattern). Thus, the family becomes an integral component in the focus of psychosocial treatment of substance abuse, more so in the Indian situation.

Help needed for the family

The family needs help during a crisis, such as an exacerbation of the drug problem, a drug-related crime committed by the addict, etc. The problem needs to be clarified. Very

often, the family is quite ignorant of the nature of drugs and of those who take them. Family members may have a "moral" model of drug addiction, which states that drug taking is immoral, sinful, and antisocial and implies lack of will-power in the addicts. These notions impede recovery, as discussed above. Hence, there are different ways by which the family can be helped. Firstly, education regarding the "medical" model of substance use disorder is important. Such education, stressing on the medical nature of the disorder and its undulating course, can do much to reduce the undue worries and apprehensions of the family and to rope in family support. Practical solutions to day-to-day problems in handling drug addicts can be given. The family can be further useful for mobilizing new resources and getting a medication/therapeutic contract. Secondly, family therapy, in which the therapist works along with patient and rest of the family members jointly so as to influence the rest of the family to help the patient with his/her problem, can be tried out. Alteration of the present situation and not exploration of the past events is the goal of treatment. Thirdly, another variation has been tried i.e. multiple-family therapy, in which a number of drug/alcohol addict's families are treated conjointly. Lastly, family SHG (i.e. Families Anonymous, Al-Anon) is allied to NA and aims to help the relatives of drug-dependent individuals. These are based on openness and honesty. They offer opportunity to share; offer social acceptance and relief from social isolation; and the accumulated experience of members helps in providing constructive advice and handling of situations. Members may attend these groups even if the drug abuser does not attend the SHG.

Family involvement during treatment

The family should be involved from the early stages of therapy, but is maximally helpful during follow-up. Family members can ensure compliance to medication (especially long-term, such as disulfiram for alcoholism) or other forms of therapy. Family members can provide assistance in the patient maintaining contact with the treating team. They can also provide information about lapse or relapse of a treated patient. In all these endeavours, trust development is a key issue. Such trust should be nurtured in a tripartite system - the patient, the therapist, and the family. This triad can be successful in the phases of recovery through aftercare and rehabilitation. In this regard, clear suggestions should be given both to the patients and to their family members regarding the "do"s and "don't"s, as shown in the accompanying table.

Table 1: Suggestions for the Recovering Family*

For the recovering person	For the other family members
You have earned distrust - expect it.	Expect ups and downs; recovery takes years.

Help your family learn about recovery and your major issues, such as your dangerous situations, what your support group is like, and so on.	Get outside support, perhaps through other recovering families, and develop outside interests.
Invite your family to join you at group meetings and make opportunities for them to meet some of your positive new friends.	Learn about recovery and how it can affect families.
Be open to yourself to meeting family members again, because you may be seeing them in a new light, seeing they have strengths and weaknesses you never noticed before.	Make your expectations and rules clear and confront problems honestly, but avoid giving lectures.
Try to make at least one family member a partner in recovery, someone you can be fully open with and rely on.	Be open to meeting some of the recovering addict's new friends and joining in some recovery group activities.
Do as much for yourself as you can without relying on family, but when you have a legitimate need, do not be too proud to ask them for help.	Do not try to protect the recovering person from normal problems or provide help where it is not really needed.
Remember: Your recovery depends on you, not on the attitudes and actions of your family.	**Remember**: You cannot make someone recover. Offer the support and love you can and keep yourself well. That is the best and most that can be done.

* (Source: Zackon F, et al., 1993)

Conclusion

Psychosocial treatments, in the form of advice and counselling, psycho education, interactive sessions, role-playing, feedback, skills training and providing emotional and social support, can be very useful for both the patient of drug abuse and his family. Such treatments may be meted out in professionally guided brief or extended interventions, or in the self-help approaches. All these, taken together, can be instrumental in achieving maintenance of abstinence, return of the drug user to the mainstream of life, and promotion of well being in the patient and his family. However, it needs to be kept in mind that pharmacological and psychosocial approaches to the management of alcohol/drug abuse tend to go hand in hand i.e. they are complementary to each other, and

the best results have generally been obtained by a combined approach. Hence, in the treatment of patients with alcohol/drug abuse (or dependence), psychosocial management of the patient (and related family) is of equal, if not less, importance as pharmacological management.

References

Alcoholics Anonymous (1973) The Big Book. New York: Alcoholics Anonymous World Services.

American Psychiatric Association (1995) Practice guidelines for the treatment of patients with substance use disorders: alcohol, cocaine, opioids. American Journal of Psychiatry, 152 (Suppl.), 5-59.

Bien, T.H., Miller & W.R. & Tonigan, J.S. (1993). Brief interventions for alcohol problems: a review. Addiction, 88, 315-336.

Coleman, T. (2004) ABC of smoking cessation. Use of simple advice and behavioural support. British Medical Journal, 328, 397-399.

Department of Health (1999) Drug Misuse and dependence- Guidelines on clinical management. London: Her Majesty's Stationery Office.

Gelder, M., Mayou, R. & Cowen, P. (2001) Shorter Oxford Textbook of Psychiatry- Fourth edition. Oxford: Oxford University Press.

Ghodse, H. (1995) Drugs and addictive behavior: A guide to treatment- Second Edition. Oxford: Blackwell Science.

Halikas, J.A. (1993) Treatment of drug abuse syndromes. Psychiatric Clinics of North America, 16(4), 693-702.

Health Education Authority (1997) Health Update: Alcohol. London: Health Education Authority.

Kadden, R, Carroll, K, Donovan, D. & et al (1994) Cognitive-behavioural coping skills therapy manual. NIH Publication No. 94-3724. Rockville, MD: NIAAA.

Lingford-Hughes, A.R., Welch, S., Nutt, D.J. (2004) BAP Guidelines. Evidence-based guidelines for the pharmacological management of substance misuse, addiction and co-morbidity: recommendations from the British Association of Psychopharmacology. Journal of Psychopharmacology, 18 (3), 293-336.

Malhotra, A., Basu, D. & Mattoo, S.K. (1996) Alcoholism and substance abuse: recent trends in intervention. NIMHANS Journal, 14(4), 275-283.

Marlatt, G.A. & Gordon JR, et al (1985) Relapse prevention: maintenance strategies in the treatment of addictive disorders. New York: Guilford Press.

McLellan, A.T., Arndt, I.O. & Metzger D.S., et al (1993) The effects of psychosocial services in substance abuse treatment. Journal of American Medical Association, 269: 1953-1959.

Miller, W.R., Zweben, A., DiClemente, C.C. & Rychtarik, R.G. (1994) Motivational enhancement therapy manual: NIH Publication No. 94-3723. Rockville, MD: NIAAA.

Miller, W.R. & Rollnick, S. (1991) Motivational interviewing. New York: Guilford Press.

Nowinski. J., Baker, S. & Carroll, K. (1994). Twelve step facilitation therapy manual. NIH Publication No.

94-3722. Rockville, MD: NIAAA.

O'Malley, S.S. & Carroll, K.M. (1996) Psychotherapeutic considerations in pharmacological trials. Alcoholism: Clinical and Experimental Research, 20(7) Suppl., 17A-22A.

U.S. Department of Health and Human Services (1994). Relapse prevention. Clinical report series. National Institute on Drug Abuse. NIH Publication No. 94-3845. Rockville, MD: NIDA.

World Health Organization (1986). Drug dependence and alcohol-related problems. A manual for community health workers with guidelines for trainers. Geneva: WHO.

Zackon, F., McAuliffe, W.E. & Chien, J.M.N. (1993) Recovery training and self-help: relapse prevention and aftercare for drug addicts. National Institute on Drug Abuse. NIH Publication No. 93-3521. Rockville, MD: NIDA.

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