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Change in paradigms in addiction therapy

Abstract: Paradigms constitute a model description of problems and their solutions. They are important as certain methods of work, ideas for interpreting e.g. behaviour of people in need for help, criteria for success or failure come from them. Recent years have brought an important change of paradigms, which can still be seen happening in therapeutic rehabilitation in the area of understanding addicts as well as the understanding of addiction itself.

The change influences the occurrences of new therapeutic programs, which are no longer focused on sobriety itself, but it also has a huge influence on alcohol abuse and harm reduction programs. It must be emphasized that these are programs that are not designed for everyone and each of them is dedicated to strictly defined group of people with an addiction in a broad sense.

Keywords: Paradigms, addiction, motivation, alcohol abuse programs, harm reduction programs.

The notion of a paradigm

In helping other people, including in the profession of a probation officer, the key is the personality of the assistant, which consists not only of their qualities, but also their attitudes and beliefs about the sources of human problems and possible ideas for solving them, as well as the competence to understand and be able to influence the process of change. It all starts with how we understand reality, i.e. what constructs and thinking patterns we use to interpret information and facts. This trivial sentence is a reflection of what scientists call the conceptualization

of a problem or, in other words, a paradigm. The latter concept was introduced to philosophy by Thomas Kuhn (Kuhn 2001), and it means a model description of problems and solutions, a way of seeing phenomena and their interpretation. Paradigms are a kind of software with which we process the collected data.

If we learn something in a given scientific field, we are learning paradigms, i.e. a certain way of thinking with which we interpret emerging facts. In our understanding and interpretation of various phenomena there is a source of working methods, ways of evaluating them, successes and failures. That is why it is so important to see things and phenomena in science as they are, not as we would like them to be. This is an interesting and responsible task and a challenge at the same time, as it obliges us to constantly expand our knowledge and learn about new discoveries and research results, because nothing is permanent in science. Paradigms are not dogmas that are unchangeable, rather evolving interpretations of the world and phenomena around us. Science develops on the basis of research and the theoretical concepts derived from it, which sometimes contradict the previously adopted way of thinking about a given topic. In this way, new knowledge often leads either to the verification of existing views or to the adoption of a completely new paradigm, and sometimes to the coexistence of different interpretations of reality. We experience this because our knowledge is not only made up of facts, but also of different and changing over time ways of interpreting them, which aim to organize our experiences. In the modern world there is no one true concept that has a monopoly on the truth. De Barbaro described it in a very interesting way, calling this mental construct a „theory filter" (2007). Helping other people always involves adopting a certain „filter", or paradigm of thinking. It contains beliefs about what a person is like, the source of his/her difficulties, what, for example, an addiction, its nature is, i.e. whether it is a curable or incurable disease and so on. Some of them become a 'limitation' over time because they impose a certain interpretation of reality for many years and decide, for example, on the content of drug addiction treatment, rehabilitation programs, etc.

Humanism, but also post-modernity, is strongly associated with emphasizing the client's subjectivity. In therapy, it means that assistants cease to be an experts, do not propose ready-made solutions, but together with their client search for the interpretation and method most useful for the client, which means that they take into account the motivational aspects of the change and the client's predispositions, which are non-specific therapeutic factors in therapy. This therapeutic approach is related to two aspects thereof: to the therapist assuming the client's subjectivity as a certain foundation for therapeutic interventions and to the client's experience, who can develop his/her sense of subjectivity in such a relationship.

It also means that the client:

— may have doubts about the need to make changes in his/her life,
— wants to decide for himself/herself and he/she has the right to do so,

— can make choices that are disadvantageous to himself/herself,
— does not want prescriptions and answers,
— in a situation where his/her freedom of choice is being restricted, he/she may rebel against it, etc. (Głowik 2017a).

Subjectivity also assumes that we do not treat these states and behaviours of the client as manifestations of pathology, but as 'normal' reactions. It also assumes that in case of bad choices the client will bear the consequences.

Resistance to change can therefore be treated as a consequence of objectifying the client and depriving him/her of the possibility to co-decide on his/her fate. The expression of our subjective attitude is e.g. focusing on quality and not on quantity of relations, trying not to label clients as 'hopeless', 'disturbed', and the need to understand their world and what influenced them, etc.

The above thoughts are only an attempt to draw attention to the importance of our fundamental beliefs and attitudes in the area of court probation, therapy and assistance. In different periods of our lives these attitudes evolve, but it is difficult to determine in which direction. This is influenced by our beliefs about people, our experiences with clients, our personal life stories, successes and failures, etc.

In their work, probation officers often meet women and men for whom the problem of addiction to alcohol or other substances is the main symptom or manifestation of other life problems and/or difficulties. Inconsistent educational methods, the disintegration of intra-family relationships, an atmosphere of danger and uncertainty, FAS, violence, crime, interpersonal aggression are just some of the examples of alcohol and/or other substances abuse by persons under guardianship or supervision. That is why it is so important to understand what is changing in our thinking about addicts and their therapy, because it can significantly affect the work of guardians or probation officers.

Directions of change

The changes in addiction therapy concern three important directions:
— differentiation between the phenomena,
— 'demystifying' the beliefs about a person with an alcohol problem and what we attribute to the phenomenon of addiction, and
— introduction and integration of new working methods.

In the general population, addicts account for about 2-3% of our society, but there are several times as many hazardous and harmful drinkers and for this reason they generate much more health, material and financial harm than addicts. In clinical populations, this percentage is much higher. For example, in the population of inmates with whom probation officers meet before or after the sentence, the percentage of addicts is about 23–24%, and the problem

with alcohol and drugs is seen by about 48% of convicts.[1] Not all of them are addicted and therefore not all of them need long-term interventions, such as addiction therapy in an inpatient or outpatient addiction treatment centre. The first significant change in addiction therapy is to pay attention to and address the methods of therapeutic and preventive work also to people who are not yet addicted, whose drinking pattern is harmful, both in health and social terms, to themselves and their relatives. This differentiation of drinking patterns also allows for different goals of therapeutic work to be set.

For many years now, the diagnostic criteria of disease classifications have been under revision in an attempt to create the most objective symptoms of addiction, the identification of which would separate addicts and non-addicts. With all the symptoms, i.e. the so-called full-blown addiction, to alcohol for example, this does not seem to be a problem, but when you weigh the fate of the third symptom, which would tip the diagnosis towards addiction, you start to realize the importance of such a model. However, addiction is a heterogeneous phenomenon and its course may vary. Researchers such as Jellinek, Clonninger, Lesch and others differentiate addiction by creating typologies of addicts and take into account criteria such as age, gender, personality traits, co-occurring problems, drinking patterns and e.g. severity of addiction symptoms. The often expressed belief that 'all addicts are similar to each other' contains something untrue, and this is because there is no single true diagnostic criterion for addiction (Hughes 2007). When we compare diagnostic classifications such as DSM IV and ICD 10, we see significant differences in the identification of dependence, e.g. in the number of diagnostic symptoms and their differences (e.g. hunger). The new American DSM 5 classification suggests that, for example, alcohol dependence should be seen as an 'alcohol-related disorder', and its severity should be determined by the number of prevalent symptoms. The disorder may be:

— Mild – 2–3 symptoms,
— Moderate – 4–5 symptoms
— Severe – 6 and more.

If in some people the alcohol use disorder may have a mild course and in some people a severe one, it may mean that for both groups we should differentiate the aims of the therapeutic work, that it does not have to be, for example, complete abstinence.

Even today there are many false stereotypes and myths about the personality traits of addicts, about resistance and denial as attributes of addiction, according to which addicts do not see the need for change and most often do not want it (Miller 2009). Many of them seem to be a common-sense reflection of probation and therapeutic considerations. The concept of psychological mechanisms of

[1] The data comes from unpublished research by the author of the article carried out within the research project.

addiction (Mellibruda, Sobolewska-Mellibruda 2006), referring to cognitive distortions and emotional functioning of a person, tries to explain this 'trait' of addicted persons and the attributes of addiction. Meanwhile, motivation deficits do not concern only, nor mainly, alcohol or drug addicts. They apply to numerous groups of people with broadly understood health problems, including mental health problems. Narrowing the lack of motivation mainly to addicts and creating their image as people who are not susceptible to any influence is nothing more than creating another myth about them, like: 'An alcoholic must drink every day'. We deal with deficits in the area of motivation in numerous groups of people (e.g. people suffering from hypertension, infarcts, people with mental health problems, etc.). Besides, the motivation is shaped by various factors, not just what we call 'the desire to change'. Miller and Rollnick (2010) differentiate between variables that affect the motivation to change and propose a break with a zero-one approach. Division into those who have and who have no motivation to change has no grounds. In their opinion, three variables influence motivation. These are: the importance of change, readiness for it, and trust, i.e. the sense of client/patient self-efficacy. None of us will make a decision to change if its goal is not important to us. For others, the goal is important, but they still give themselves time to change, i.e. they think that this is not the moment to change something, they are not 'ready'. This last variable is about whether the patient trusts that he/she will manage if he/she decides to change. The latter element of motivation is particularly important for people who feel 'lost'. It concerns a large group of penitentiary recidivists, people who have repeatedly tried, unsuccessfully, to make changes in their lives, who have given up because they do not believe they have any influence on their lives. This simple distinction of factors influencing motivation allows to normalize this phenomenon and not to pathologise it, because this description concerns a specific group of people, but can also be applied to all those who have difficulty in changing destructive behaviours. That is why current therapeutic programs break with Minnesota's understanding of the process of motivation formation (Dodziuk 1993). In the 1940's and the 1950's it was believed that at the beginning of treatment, motivation was not essential for the effectiveness of the therapy (...) and it was assumed that motivation would appear during the course of the therapy. These are, among others, the roots of judicial obligation to treat addicts. Contrary to the 'past', shaping motivation to change has 'today' become an element of the therapy and change process, and studies show a relationship between the effectiveness of therapy and the level of client/patient motivation (Miller, Rollnick 2010). The transtheoretical model of behaviour change has become an invaluable help in understanding change as a process. (Prochaska et al. 2008). It shows a very simple truth that all people change in a similar way, regardless of whether they change on their own or as a result of various external interventions. As we change, we go through different stages of change, and it is natural to doubt whether it is worth changing, because

each of us has to find our own reasons for change. These doubts are an expression of the ambivalence that results from the dilemma between what benefits and losses a person has suffered because of his/her drinking or drug use. Ambivalence is a normal state that one can and should work over. Another conclusion is relevant for the work of probation officers and therapists, i.e. that certain methods of intervention and therapeutic work are effective only in certain stages of change, and therefore the methods and techniques of probation and therapeutic work should be adapted to the client's/patient's situation. Otherwise, our interventions, e.g. convincing a person being in the stage of pre-contemplation or contemplation (because this is what the first two stages of change are called) to change may turn out to be counterproductive and alienate him/her. In this sense, the phrase that sometimes 'helping harms' seems to be very appropriate. Interventions that are not appropriate to the client's/patient's situation can alienate him/her from the change even more.

The phenomenon of reactance is known in psychology (Brehm, Brehm 1981). It means the desire of man to restore freedom of choice while being reluctant to the source of its absence/restriction. This is a phenomenon that is characteristic of all those institutions, places and situations in which a person's ability to make choices is taken away or limited. Roberts (2003) conducted a study on the effectiveness of the accredited social rehabilitation program 'Think First' for offenders. It showed that detainees who were induced to participate against their will returned to crimes more often than those who did not participate in any social rehabilitation program. This is a typical example of a time-stretched phenomenon of reactance, the subjective treatment of recipients of social rehabilitation measures and the omission of such important issues as the level of motivation in the process of change.

The literature on the efficacy of therapy contains references to the 'Emrick's Rule' (1974). Based on a meta-analysis of 113 studies, he created the **'rule of the thirds'**, which means that after therapy:

— 1/3 of the clients/patients continue drinking and drink the same as before treatment,
— 1/3 of clients/patients maintain abstinence,
— 1/3 of clients/patients drink less than before the therapy ('show improvement in drinking and functioning')

Süß (1995), in turn, noted that the number of people maintaining complete abstinence is decreasing over time, but at the same time the number of people who have experienced improvements in their functioning is increasing.

People who drink less after therapy are also addicts. For many people, of course, a very important question arises about who, despite a diagnosis of addiction, has a chance to reduce drinking and who does not? Can or should the therapist agree to such a goal knowing that he/she is dealing with an addicted patient? Can the probation officer use this knowledge to build up the motivation of his/her wards to change?

The above research results show again that addiction is a heterogeneous phenomenon and that in the group of addicts, perhaps depending on the type of addiction, there are people who will never be able to reduce their drinking and people who can do so, and this changes our previous view of addiction as an incurable disease.

People who encounter the phenomenon of addiction in their work are often convinced that 'an addicted person cannot cope without therapy'. However, there are many studies (Blomquist 1998, Klingemann, Klingemann 2013) whose authors describe the phenomenon of self-healing, i.e. so-called spontaneous remission. One of the possible and documented effects of such a change is the reduction of drinking to a low level of risk and this occurs more often in the group of 'self-healed' addicts than in the group of those who have completed addiction therapy. These research results pose a very interesting question: Can therapy, by imposing on clients/patients the paradigm of addiction as an incurable disease, hinder the shift towards reduced drinking?

Alcohol abuse programs

The vast majority of us share the opinion that abstinence is the optimal and most desirable goal for addicts. But it does not have to be the only goal. Lilienfeld et al. (2011) cite research findings that indicate that moderate drinking as a therapeutic goal is appropriate for harmful drinkers or addicts with less severe symptoms of addiction and for those who reject abstinence as a therapeutic goal and the associated diagnosis of being an 'alcoholic'. In the opinion of the authors of the publication, the belief that abstinence is the only appropriate goal in working with addicts is not empirically confirmed by science. Many studies confirm that alcohol/drug abuse programs or behavioural self-control training are effective methods in working with people with addiction problems in the broad sense. The content of these programs varies. Some focus on increasing self-control over drinking, some on learning to control negative emotions, and some of them develop coping skills in situations where one used to drink/take drugs. These programs evoke and probably will continue to evoke a lot of emotions, but their message fits in with the need to deal with the situation of the client/patient "as is" (Głowik 2017a).

There is nothing overtly complicated about the structure of alcohol abuse programs, but they are an important step in our thinking about people with alcohol problems. If we recognize them, we believe that reduced drinking is an achievable goal for people with alcohol problems. The guidelines for the development of alcohol abuse programs[2] have been developed in Polish rehabilitation medicine, and are published on the PARPA website.

[2] www.parpa.pl/index.php/lecznictwo-odwykowe/programy-ograniczania-picia

They refer to the concept of a disciplined drinking according to a predetermined drinking plan. When setting the goal, it is worthwhile to agree and define with the client/patient the following:

— frequency of drinking,
— type and quantity of alcohol,
— drinking on special occasions,
— situations in which the client will remain abstinent.

Their agreement is not related to the control over the client/patient, but to making the goal real. These programs are absolutely not less demanding for the clients/patients, rather the opposite. For many of them, participation in these programs is a natural step towards a decision of complete abstinence. Research shows that many clients/patients choose to be completely abstinent over time because it is easier for them than to follow the recommendations (created by themselves) resulting from their decision to reduce drinking. They require some basic and useful information and skills:

— knowledge of standard drinks,
— knowledge of the possible health effects of drinking alcohol,
— knowledge and skills to differentiate alcohol use patterns,
— the ability to agree and specify the purpose of therapeutic work,
— the ability to use screening tools, if needed in the treatment process.

In the literature on the subject the concept of a standard drink can be found. It is a measurable portion of pure alcohol amounting to 10 g. This amount of pure alcohol is contained in 30 ml of vodka, 100 ml of wine or 250 ml of beer, which means that when drinking 30 ml of vodka one drinks the same dose of pure alcohol as when drinking 100 ml of wine or 250 ml of beer. There is also a number of well-described studies stating, for example, that a certain number of portions of alcohol drunk in one day or in one week carries a low or high risk of health damage or is simply harmful (Głowik 2017b).

Standard drinks are also helpful in differentiating drinking patterns. For example, they are used in the WHO recommended AUDIT screening test. These patterns are: low-risk, risky, harmful and addictive drinking.

However, it is worth emphasizing again that alcohol abuse programs do not fit all patients. This is very important because in some addicts, and especially in the case of severe alcohol-related disorders, it may not be possible to achieve this goal because every person changes according to his or her abilities, which are determined, among other things, by the disease severity degree and, consequently, the neurobiological mechanisms of addiction. It is also not about the therapist making decisions for the patient, but about sharing his/her expertise wisely with the patient. An important element influencing the effectiveness of therapeutic programs is to address them to appropriate groups of recipients. And so it is in this case. Agreeing to work on reducing drinking when working with an addicted patient with a history of several years of destructive drinking and numerous attempts to reduce it is unlikely to be a good idea, and work based on so-called

exceptions may turn out to be a trap for the therapist and the patient. A similar trap may be to work on reducing drinking in the case of a patient who has been suspended by the court on the condition of complete abstinence and not only on reducing drinking, or to work with a patient who has health contraindications to participate in such a program (serious liver, cardiovascular, neurological, mental, digestive and other disorders). That is why, and it is worth remembering, alcohol abuse programs are dedicated:

— to harmful drinkers,
— alcohol addicts, especially those:
  • without any health contraindications for alcohol use,
  • in the initial phase of addiction,
  • with better social skills,
  • with less severe symptoms of addiction,
  • not accepting permanent abstinence as the goal of therapy,
  • experiencing fewer drinking problems,
  • younger.

Harm reduction

Harm reduction programs have a hundred years of tradition to them (Gaś 2002). In the vast majority, these programs are aimed at severely dependent people, for whom reduced drinking or abstinence are very distant, if not unrealistic goals. Here, harm reduction is a public health measure, aimed primarily at reducing the harmful effects of the use of psychoactive substances, rather than reducing their use. Their aim is, among other things, to reduce the risk of death, severe health complications, prevent social exclusion and increase the sense of security in the local community. Often a more appropriate place for such programs will be social welfare or non-governmental organizations (nutrition, maintenance of shelters or accommodation for the homeless, restoring life skills, medical assistance, saving from frostbite, etc.), because social welfare can reward participation in such programs with various benefits. However, drug treatment can provide space for meetings aimed at solving current health, social and other problems, motivating severe addicts to drink alcohol in a less harmful way, e.g. by giving up drinking non-food alcohol, seeking help in case of severe abstinence syndromes, not mixing alcohol with medication, etc.

The paradigm shift in addiction therapy results, and will continue to result, in inclusion of harmful drinkers in the target group, the emergence of new proposals for therapeutic work with addicts, the development of different methods of therapeutic work and a different role of the therapist in the process of change. More and more studies indicate, for example, the high effectiveness of short motivational interventions, skills training, therapies for couples in which one person abuses alcohol or Internet-delivered behaviour change interventions.

This change in thinking also becomes a challenge for the probation officers' work, because it makes them ask themselves questions about understanding addiction and the whole process of change, the method of therapeutic work, their own beliefs about addicts and so on.

Bibliografia

[1] Blomquist J., 1998, *Beyound treatment? Widening the approach to alcohol problems and solutions*, Departament of Social Works, Stockholm Univeristy, Stockholm.
[2] Brehm S.S., Brehm J.W., 1981, *Psychological Reactance*, New York.
[3] De Barbaro B., 2007, *Po co psychoterapii postmodernizm*, „Psychoterapia", 3(142).
[4] Dodziuk A. (ed.), 1993, *Wybrane spojrzenia na alkoholizm i jego leczenie*, IPZiT, Warszawa.
[5] Emrick C.D., 1974, *A review of psychologically oriented treatment of alcoholism: I. The use and interrelationships of outcome criteria and drinking behaviour following treatment*, „Quarterly Journal of Studies on Alcohol", 35.
[6] Gaś Z.B., 2002, *Redukcja szkód a profilaktyka uzależnień*, „Remedium", lipiec–sierpień.
[7] Głowik T., 2017a, *O podmiotowości pacjenta, psychoterapii w terapii uzależnień i innych*, „Terapia Uzależnienia i Współuzależnienia", 2.
[8] Głowik T., 2017b, *Zmiany w leczeniu osób uzależnionych w Polsce*, „Świat Problemów", listopad.
[9] Hughes J.R., 2007, *Defining dependence: Describing symptom clusters versus central constructs*, „Addiction", 102(10), 1531–1532.
[10] Klingemann H., Klingemann J., 2013, *Czy terapia jest koniecznością? Samowyleczenia a system lecznictwa*, [in:] *Terapia uzależnień. Metody oparte na dowodach naukowych*, (ed.) Miller M. Peter, Warszawa.
[11] Kuhn T., 2001, *Struktura rewolucji naukowych*, wyd. 2, Warszawa.
[12] Lilienfeld S.O., Lynn S.J., Ruscio J., Beyerstein B.L., 2011, *50 wielkich mitów psychologii popularnej. Półprawdy, ćwierćprawdy i kompletne bzdury*, Warszawa–Stare Groszki.
[13] Mellibruda J., Sobolewska-Mellibruda Z., 2006, *Integracyjna psychoterapia uzależnień. Teoria i praktyka*, Warszawa.
[14] Miller M.P. (ed.), 2013, *Terapia uzależnień. Metody oparte na dowodach naukowych*, Warszawa.
[15] Miller W.R., Rollnick S., 2010, *Wywiad motywujący. Jak przygotować ludzi do zmiany*, Kraków.
[16] Miller W.T., 2009, *Wzmacnianie motywacji do zmiany w terapii nadużywania substancji*, Warszawa.
[17] Prochaska J.O., Norcross J.C., DiClemente C.C., 2008, *Zmiana na dobre*, Warszawa.
[18] Roberts C., 2003, *The emerging what works evidence and its implications for practice in the National Probation Service, National Probation Service What Works Conferencje 2003 pack. A whole service approach to delivering interwention 8–10 December*, Nottingham.
[19] Süß H.M., 1995, *Zur Wirksamkeit der Therapie bei Alkoholabhängigen: Ergebnisse einer Meta-Analyse*, „Psychologische Rundschau", 46.