

Cognitive-behavioral therapy for alcohol and drug use disorders

Terapia cognitivo-comportamental de transtornos de abuso de álcool e drogas

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Abstract

Objective: Cognitive-behavioral therapies have been successfully used to treat addiction. This article is in part a review on addiction models such as relapse prevention by Marlatt & Gordon, stages of change by Prochaska, DiClemente & Norcross, deriving from motivational interview, developed by Miller & Rollnick, as well as the cognitive models by Beck et al. **Method:** Based on literature evidence for the development of effective treatment programs, we report on a group treatment model used in a group of alcoholics referred by the Department of Worker's Health Surveillance at Universidade Federal do Rio de Janeiro to the Alcoholism Rehabilitation and Research Center. **Results:** Results are presented indicating that this type of treatment could be one alternative to others treatments in use. **Conclusions:** New research is needed to better validate cognitive-behavioral approach to alcohol and drug problems.

Descriptors: Social phobia; Cognitive-behavioral therapy; Shyness; Anxiety; Substance-related disorders

Resumo

Objetivo: Entre os diversos tipos de tratamentos aos quais as terapias cognitiva e comportamental têm sido aplicadas com sucesso encontra-se o uso em problemas de adicção. Este artigo, em parte, revê modelos de adicção como os de prevenção de recaídas de Marlatt e Gordon, o de Prochaska, DiClemente e Norcross sobre os estágios de mudança, com a derivação da entrevista motivacional, desenvolvida por Miller e Rollnick, bem como os modelos cognitivos de Beck et al. **Método:** Com base em evidências da literatura para o desenvolvimento de programas de tratamento efetivos, é descrito um modelo de tratamento em grupo que foi usado com grupos de alcoolistas encaminhados pela Divisão de Vigilância da Saúde do Trabalhador da Universidade Federal do Rio de Janeiro para o Centro de Pesquisa e Reabilitação do Alcoolismo. **Resultados:** Os resultados são apresentados indicando que este tipo de tratamento poderia ser uma alternativa a outros tratamentos em uso. **Conclusões:** Novas pesquisas são necessárias para validar melhor a abordagem cognitivo-comportamental para os problemas de abuso de álcool e drogas.

Descritores: Fobia social; Terapia cognitivo comportamental; Timidez; Ansiedade; Transtornos relacionados ao uso de substâncias

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Introduction

Substance-related disorders often cause major impairment and severe complications, resulting in deterioration of the individual's general health, besides producing negative effects in the personal, social and professional contexts. Repeated consumption of high doses of alcohol may affect nearly all organic systems, especially the gastrointestinal tract, the cardiovascular and nervous systems (cognitive deficits, severe memory impairment and degenerative changes in the cerebellum).

Alcohol dependence and abuse are a major public health problem. Even the best treatments for alcoholism have little favorable prognoses, and the prognosis for patients with increased chronicity is even less favorable.

The American Psychiatric Association (APA) established diagnostic criteria for substance abuse and dependence.¹

DSM-IV substance abuse criteria

A. Substance abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

- recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
- recurrent substance use in situations in which it is physically hazardous
- recurrent substance-related legal problems
- continuous substance use despite having persistent or recurrent social or interpersonal problems

B. The symptoms have never met the criteria for Substance Dependence.

DSM-IV substance dependence criteria

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

- 1) tolerance, as defined by either of the following:
 - a) a need for markedly increased amounts of the substance to achieve intoxication or the desired effect
 - b) markedly diminished effect with continued use of the same amount of the substance
 - 2) withdrawal, as manifested by either of the following:
 - a) the characteristic withdrawal syndrome for the substance
 - b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
 - 3) the substance is often taken in larger amounts or over a longer period than intended
 - 4) there is a persistent desire or unsuccessful efforts to cut down or control substance use
 - 5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects
 - 6) important social, occupational, or recreational activities are given up or reduced because of substance use
 - 7) the substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance (for example, current cocaine use despite recognition of cocaine-related depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)
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Epidemiological data by Carlini et al.,² comparing 107 American and Brazilian cities, described that, concerning any drug, prevalence was 19.4% in Brazil (BR) vs. 38.9% in the United States (USA). Alcohol is the most widely used drug in BR (68.7% of the population vs. 81% in the USA), followed by tobacco (41.1 vs. 70.5%, respectively). Dependence rate for the most commonly used substances is, according to that same study, 11.2% for alcohol, 9.0% for tobacco, 1.1% for benzodiazepines, 1.0% for cannabis, 0.8% for solvents, and 0.4% for stimulants.

In another study, Galduroz & Caetano³ demonstrated that there was a significant increase from 6.6 to 9.4% between 2000 and 2004 for alcohol dependents. They also showed that its use throughout life in 27.7% of the Brazilian population was 68.7%, and that prevalence of alcohol dependence was 11.2%.

Among patients seeking help, major comorbidities are major depressive disorder (MDD) (30-40%), panic disorder (PD) and generalized anxiety disorder (GAD) (15%), and social phobia (20%). Individuals with antisocial personality disorder can reach a 44% rate.⁴

Many traditional treatment programs for alcoholism focus on motivational factors, explaining to the patient *why* he should abstain from drinking alcohol. However, they fail to provide the required skills, since they do not show the patient *how* not to drink, how to quit an old habit and control its occurrence in the future. In that second focus, the individual is given responsibility for problem solving, and not its cause and development.

Some criteria should be met for the development of an effective self-control program:

- 1) Prove to be efficacious in maintaining change for a significant period compared to the best alternative programs
- 2) Improve and maintain adherence to program demands
- 3) Combine cognitive and behavioral techniques with overall changes in lifestyle
- 4) Facilitate motivation and coping skills for continuous changes in life
- 5) Replace usual patterns by other skills
- 6) Maximize generalization
- 7) Teach new forms of dealing with failure
- 8) Use available support systems⁵

The social learning model⁶ considers that learning drinking behavior results from social family and peer influences that shape behaviors, beliefs and expectations regarding alcohol. Parents' attitudes and behaviors toward alcohol are the best predictors of drinking in adolescence. Thus, for example, alcohol can be used by parents to relax after work, and this probably creates in children a model of behavior of using alcohol or cannabis as a relaxant. Extreme attitudes as to abstinent parents' temperance are also increased risk for the development of drinking problems. A major aspect is that such model may not apply only for the drinking behavior, but for the use of a substance that may produce the same effect.

The role of positive reinforcement resulting from alcohol effects cannot be neglected, since it is a powerful social lubricator, facilitating sociability. Negative reinforcement also acts through reduction in tension and negative mood, in pain relief and release of social inhibitions.

The role of Pavlovian conditioning is to strengthen associations between alcohol (and other drugs) and the satisfaction associated with it. Similarly, the operants "ordering alcohol" and "drinking" are strengthened and become more likely to occur in the future.

It is important to stress close emotional and cognitive factors ("this is good," joy, happiness, reduction in negative mood states)

and distant effects (vehicle accident, fights, police, work absence, or academic or school activities).

Inexistence of alternative repertoires is essential, since variety of pleasant reinforcing situations is reduced (no longer goes out with abstemious friends, no longer goes to the cinema, theater and music concerts), and the individual is increasingly restricted to alcohol use.

Cognitive-behavioral approach of alcohol abuse (and other drugs) has a long tradition and integrates varied models to deal with such a severe problem.

Relapse prevention model

There are different models to conceive addictive behaviors, as can be seen in Table 1.

Marlatt⁸⁻¹⁰ also presented data on situations determining relapses in alcoholics (Table 2).

Self-efficacy factors should also be highlighted. The concept of self-efficacy^{11,12} proposes that people tend to repeat given behaviors when they believe in their personal ability to correctly perform these behaviors. However, the predictive power of self-efficacy is limited in alcoholics, since they tend to be self-confident. On the other hand, strengthening self-efficacy of resisting alcohol use diminishes probability of relapses.

This mechanism can be better understood in Figure 1.⁹

Changes in lifestyle are a key element to reduce probability of relapses, such as reducing sources of stress, searching for a balance between pleasures and obligations, doing physical exercises, trying to improve eating through a more balanced diet, doing yoga, meditation or other forms of relaxation, and using techniques of stress inoculation.

Cognitive model of substance abuse

The first intervention attempt using a cognitive model was the SMART Recovery[®] Program, based on the rational emotive behavior therapy by Albert Ellis.¹³ The term SMART stands for Self-Management and Recovery Treatment. It helps individuals achieve independence from their addictive behaviors, whether from substances or activities. The program provides instruments and techniques for four programmatic issues: 1) enhancing and maintaining motivation to abstain; 2) coping with urges; 3) problem solving, managing thoughts, feelings and behaviors; and 4) lifestyle balance, balancing momentary and enduring satisfactions. It helps people recover from all types of addictive behaviors, including alcoholism, drug abuse, compulsive gambling and addiction to other substances and activities. Nowadays, it sponsors more than 300 in-person meetings worldwide and 16 online meetings every week.

Similarly to other disorders, such as depression and anxiety, the cognitive model of substance abuse is based on the assumption that early experiences in life are the foundation for the development of problems of that nature. They favor the development of schemes, basic core beliefs and conditional beliefs.¹⁴

Exposure to and experience with drug use is part of that process, and beliefs particularly related to drug use will be developed, some facilitating and others avoiding its use. At some time continuous use will start, associated with internal/external stimuli of risk of drinking (e.g., at a bar, tired, bored and sad, after many months of withdrawal). This should activate beliefs about substance use (*"I'm more sociable when I drink"*) and certain automatic thoughts (*"Just a little bit;" "Everyone is having fun;" "What the hell, I deserve it!"*). As a consequence, urging will be activated (image of going to the restroom as a ritual; excited! *"A 'line'"*). Activation of facilitating beliefs will then occur (*"Everyone in this town is 'getting crazy' tonight"; "Everyone is doing it; just one line"*). Specific instrumental activities will appear at this moment (search for someone who has cocaine; asking someone for just a *"hit"*). Then the individual goes for a *"line,"* does not enjoy it because he feels guilty: the so-called *"crash."* A new cycle then begins.¹⁵

The basic techniques of cognitive therapy for alcohol-drug abuse demand, in the first place, strengthening of the therapeutic alliance through an empathic understanding of the client's problem, along with unconditional acceptance. Therapeutic relationship and conceptualization of cases play a major role. It is through them that a therapist can understand pain and fear behind the patient's hostility and resistance. It is crucial to explore the meaning and function of the patient's apparently oppositional and self-destructive actions, assessing their beliefs about the therapy, but it is also important to assess the therapist's own beliefs about the patient. Knowing how to use unpleasant feelings in collaboration in the therapeutic relationship as something useful and profitable for the therapeutic process is a much valuable skill.

Activity monitoring or planning is desirable, but hard to be achieved in individuals with complaints of that nature. Therefore, use of a 2 x 2 matrix of advantages-disadvantages can be a good strategy to help strengthen the ambivalence these patients usually experience. It is also important to develop problem solving techniques, so that the patient knows how to deal with risk situations. Daily records of thoughts dealt with alternative rational responses can help manage urges. When dealing with urges, it is recommended to postpone it for 5 minutes, 10 minutes, 1 hour, etc., trying to take the focus off of the urge (watching TV, using the computer, doing some relaxation, talking to someone, cleaning or fixing things at home or at work). Use of confrontation cards containing statements to control beliefs can

Table 1 - Comparison between relapse prevention (RP) and disease models⁷

Topic	RP	Disease
Control locus	The person is able to exercise self-control	The person is victim of forces beyond self-control
Objectives	Choice of objectives: withdrawal of control	Total withdrawal
Work philosophy	The person is distanced from their behavior Educational approach	Person's identification with their problem Medical approach
Treatment procedures	Training of coping skills Self-control groups Cognitive restructuring	Coping and conversion Support groups Cognitive dogmas
General approach of varied addictions	Search of elements common to addictions Addiction based on maladaptive habits	Each addiction is unique Addiction based on physiological processes

Table 2 – Analysis of relapse situations with alcoholics, smokers, heroin addicts, compulsive gamblers and individuals in diet⁹

Intrapersonal determinants	
Negative emotions	35%
Negative physical states	3%
Tests of personal control	9%
Desires and temptations	11%
Interpersonal determinants	
Interpersonal conflicts	16%
Social pressure	20%
Positive emotions	3%

also be useful. It is extremely important to focus on long-term goals instead of searching for immediate rewards. Using dramatizations can also serve as strategy to train drug refusal assertiveness.

Stages of change

Prochaska, DiClemente & Norcross proposed in 1992 that there are several stages related to addictive behaviors that will define an individual's promptness to abandon substance use.¹⁶

According to them, firstly there is a stage called *pre-contemplation*, in which there is a denial of problem existence ("Who has a problem? Not me!"); secondly, there is a *contemplation* stage ("This is starting to bring me problems"); then comes the *preparation* stage (in which the person starts making concrete plans for achieving change); after that moment the *action* stage may start (actual reduction and cessation of substance use); and finally, a *maintenance* stage, in which long-term changes in attitudes and lifestyle will result in ongoing recovery or in a new relapse.

A consequence of that proposal was the motivational interview model developed by Miller & Rollnick.¹⁷ This model supports the idea that pressures to abandon use of a substance only tend to worsen its use and that, alternatively, the therapist working with addicts should conduct non-directive interviews increasing ambivalence as to substance use.

In each session there are actions conceived according to the addict's stage of change. Thus, in the pre-contemplation stage the therapeutic task is to increase doubts. In the contemplation stage, it is desirable to have the therapist point out the lack of balance, providing reasons to change or not. In the preparation for action stage, the task is helping the client determine the best strategy for change. In the action stage, it is desirable to help the client move toward change, valuing their efforts. In the maintenance stage, the therapist is expected to help the client identify strategies to prevent relapses, such as strengthening their self-efficacy.¹¹ In case there are relapses, the therapist should help the client restart the process, assessing whether the patient may not have developed a satisfactory coping response. Their self-efficacy will be lower; therefore, there will be a higher likelihood of more relapses, such as respective violation effects, which include cognitive dissonance, self-attribution/guilt and loss of control.

Treatment

Holder, Longabaugh, Miller & Rubonis¹⁸ reviewed controlled trials including 33 different treatment modalities of alcoholism and concluded that there is good evidence of efficacy for the following therapeutic interventions: social skill training, self-control training, brief motivational interview, stress management, behavioral marital therapy, and community reinforcement. Holder et al. also reported that there is "satisfactory" evidence for covert sensitization and behavioral contracts.^{18,19}

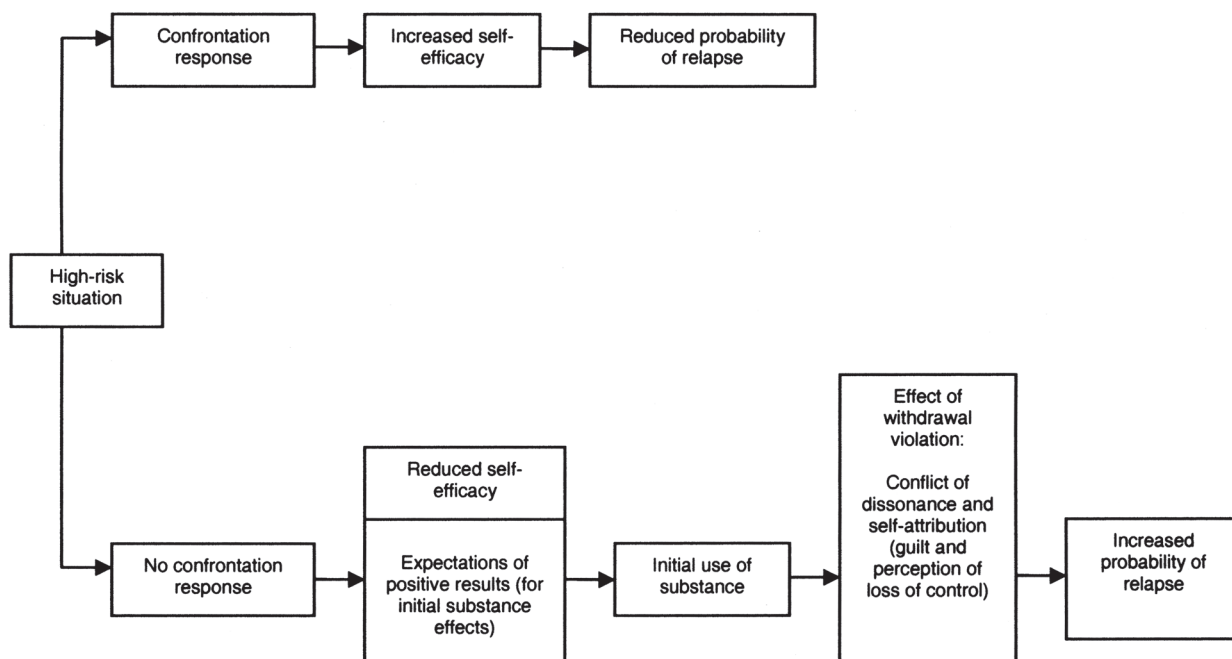


Figure 1 - Cognitive-behavioral model of the relapse process⁹

Many studies have confirmed the effectiveness of cognitive-behavioral therapy in the treatment of alcoholism²⁰ (depression management),^{21,22} (anxiety management),²³⁻²⁷ (intra- and interpersonal skill training, identification of high-risk situations, cognitive restructuring),²⁸ (assertive training),^{29,30} (relaxation training).

The development of skills for effective coping has to involve basic social skills, assertive behaviors and confrontation skills, which include an ability to identify risk situations, to handle emotions and to provide cognitive restructuring.

As a foundation for skill training, two factor categories should be considered as predisposing for alcohol use: interpersonal factors (social support, marital and family relationships, work relationships) and intrapersonal factors (cognitive processes and mood states).

The identification of factors and the ability to deal with them were developed in a group treatment with 27 sessions each lasting 90 minutes and a frequency of twice a week, for patients referred by the Department of Worker's Health Surveillance (DVST) at Universidade Federal do Rio de Janeiro to the Alcoholism Rehabilitation and Research Center, which is now the Center for Alcohol and Addictive Behavior Teaching, Research and Reference (CEPRAL). The objective was to develop a group training program for alcohol dependents based on a cognitive-behavioral approach aiming at initial complete remission of its use.

Specific objectives were to 1) develop learning and practice of new substitute behaviors for the drinking behavior through interpersonal and intrapersonal skill training; 2) teach coping strategies that could be used to deal with high-risk situations (internal and external) that could lead to addictive behavior; 3) establish general strategies of changes in lifestyle; and 4) develop strategies favoring maintenance of the change process in habits produced by the treatment.

Interpersonal skill training involved learning how to recognize social signs; development of the ability to start, maintain and change conversations with friends and strangers; strengthening of assertive behaviors such as "saying no" or "asking for changes in other people's behaviors." Intrapersonal skills were associated with learning muscle and/or respiratory relaxation strategies; anger management; and cognitive restructuring to reduce anxiety and/or depressive mood states. Other skills considered important were the identification of situations of high relapse risk, such as going to a bar on a Friday, depressed and abstinent for several days, and of beliefs that facilitate alcohol use. Actions to encourage increase in frequency of activities, especially pleasant activities, were used as strategies for change in lifestyle, besides stimuli to participate in new social groups.

Hypotheses were that social skill training would be efficacious in the treatment of alcoholism; that it would have alcohol withdrawal, defined as Initial Complete Remission by DSM-IV,¹ as its final goal; that the addictive behavior is functionally associated with deficits in coping skills of everyday problematic situations; and that acquisition of skills to recognize and deal with risk situations contributed to a state of Initial Complete Remission.

Some instruments used for assessment included anamnesis, Anxiety Disorders Interview Schedule for DSM-IV (ADIS-4),³¹ Structured Interview for DSM-IV Personality Disorders (SIDP-IV),³² Beck Depression and Anxiety Inventories,^{33,34} Hamilton Anxiety (HAMA) and Depression (HAMD) Scales.^{35,36} The results of such inventories were compared to applications at the end of the program.

The text below describes a hypothetical group intervention for other groups.

The first session serves to introduce the work plan, rules and norms guiding the group work, presentation of each member, including a brief report of their problem for assessment purposes. The objectives can be to make patients feel comfortable, interacting with each other and being advised about the group's general principles, objectives, procedures, and rules. The relapse prevention model can be introduced, as well as the cognitive model and the social skill training model.

The second session can be used to manage thoughts regarding alcohol, in which, through discussions and group exercises, use of substitute thoughts to drinking thoughts can be encouraged. A matrix of advantages and disadvantages regarding drinking behavior can be performed to make the benefits of not drinking compared to those of drinking more explicit, based on each member's previous drinking experience.

The third session can be dedicated to the development of problem solving strategies, recognizing that problems do exist, but that they can all be solved. The first step is knowing how to identify the problem. A brainstorm should then be performed, in which varied solutions, even those that are apparently weird, are proposed. The pros and cons of each solution should be objectively analyzed and a hierarchy should be established, in which the most promising alternative is selected and used. If it works and solves the problem, then it is good enough; if not, the following should be used, and thereafter successively. Dramatization techniques and group discussions can also be used.

Subsequent sessions can be initially used to social skill training, aiming to establish a conversation to develop the basic communication skills based on the consideration that conversation is the first step in the establishment of interpersonal relationships. With the aim of facilitating the beginning of a conversation, it should be started with a theme that favors an answer, making "open" questions. These questions always include adverbs, such as *when, since, where, what, how, why* etc. The answer will be longer and this may favor the identification of possible experiences in common. Communication techniques recommend that people should speak about themselves, describing facts and experiences in their lives to favor discovery of occasional identities between the speakers. It is extremely important to focus on the development of listening and observation. The conversation can be politely ended, leaving the person with a feeling that it was pleasant speaking to them. The obstacles that can impair an efficient communication in each one need to be identified so that they can be overcome.

The first session in which *assertiveness training* will be started should be performed after the strengthening of basic social skills. Such skills require learning to express one's own feelings directly, honestly and properly, speaking clearly, firmly and decidedly, establishing visual contact and using "I" statements ("I" prefer when you act like this; "I" don't like when you yell at me, etc.). Using dramatizations, debates and exercises, group members will learn to say "no" and to suggest alternatives. They can also learn to require changes in other people's behavior, in case they insist on inviting the person to have a drink. Other sessions in this area can be focused on offering and receiving compliments, receiving criticisms from other people, criticizing other people, refusing alcoholic beverage, etc.

Subsequent sessions can be used to improve intimate relationships, with the aim of developing skills to cope with difficulties and conflicts that occur in the context of intimate relationships. To establish an effective communication it is extremely important to combine skills, such as being assertive, demonstrating knowledge of how to deal

with positive feelings, making and receiving constructive criticisms about other people's disturbing behaviors, before negative feelings are accumulated, complimenting and receiving compliments, listening actively. Being a dynamic listener helps to build proximity, affection, support, and understanding. Directly talking with a sex partner so that they can know what you think, feel and want. Some marital skills, such as expressing feelings empathically and assertively, discussion or negotiation abilities, besides conflict and problem solving, personal change, and help (to make others change) should be stressed. Generalization and transference for everyday situations will depend on each one's consistent understanding and training to reach this objective.

The importance of nonverbal communication must be pointed out as there should be a correspondence between verbal (*what* is said) and nonverbal (*how* it is said) behavior. To do so, the different components of nonverbal behavior should be discussed: posture, space (distance) between two people, visual contact, head signs, facial expression, tone of voice, gestures and mimics. Dramatizations can be performed so that these exercises can be modeled.

Respiratory and muscle relaxation training, besides use of imaginary techniques should be started considering that many drinkers use alcohol as a type of self-medication to relax and control tensions, stress and anxiety. It is important to learn to be aware of body tensions and learn to relax, tensioning and relaxing eight specific muscle groups. Such progressive muscle relaxation was proposed by Jacobson and has been widely used in CBT since the 1950's.³⁰ Muscle relaxation exercises can be performed in groups, mixing suggestive techniques taken from autogenous training³⁷ and exercises of imaginary techniques of positive visualization. Another type of relaxation that can be trained in this session is respiratory technique exercises, described as diaphragmatic breathing, such as those performed in yoga and/or meditation classes.

With regard to learning intrapersonal techniques, the first could be focused on anger prevention, since anger is the main factor related to relapses. Therefore, learning to discriminate stimuli causing anger and knowing how to function under the effect of that emotion is very important. It is thus worth trying to define anger and point out its positive and negative effects. It is essential to discriminate which situations cause anger, directly and indirectly, and which responses manifest it (internal reactions). It is very important to stress that anger, as every emotion, has a lasting period, and that, throughout time, it will necessarily be reduced. In this sense, it should firstly be explained that the first thing a person can do when feeling anger is doing *nothing*. Secondly, the person should start diaphragmatic breathing. Thirdly, they should reflect about the interpretation made of the fact that can be originating anger to verify whether it is a correct evaluation, whether there are distortions or whether other interpretations can be provided. Finally, if the person has already calmed down, they can start talking assertively to the one whose behavior triggered anger. Situations causing anger in group members can be analyzed, and stress inoculation exercises can be used to help group members learn how to manage anger.

Sessions can also be focused on achieving reversions of negative thoughts. Learning to identify negative or pessimistic thoughts is important to change them and being more able to perceive how they influence our feelings. Being able to learn to restructure these thoughts by replacing them by other more realistic thoughts is useful and necessary to fight sad feelings, which are another source of relapses. Therefore, that skill can be incorporated through practical exercises using record sheets for dysfunctional thoughts and group dramatizations. More specifically, it may also be necessary to try

to change irrational and unrealistic nuclear beliefs, replacing them by more realistic beliefs.

After some time there may be a review of the relapse prevention and cognitive models (automatic thoughts and beliefs), of social skill training (assertiveness, nonverbal behavior, receiving and making criticisms, negotiating) and of the importance of empathy in intimate relationships. Relaxation training can be practiced again, as well as the problem solving training. Closer attention should be paid to the management of feelings such as anger, fear, tension, sadness, and joy.

Increase in pleasant activities with the aim of encouraging the importance of the amount of time dedicated to leisure and activities that provide pleasure is a form of avoiding negative thoughts. Attempt to develop a range of pleasant activities should be made using the "pleasant chart" technique³⁸ and a wish list, stressing the identification of obstacles. Increase in social support network is a required objective to develop and maintain interpersonal relationships that can provide the support for an individual to feel more confident in their skills. Trying to identify how interactions can be a source of support: 1) who can provide help? 2) what kind of support is desired? 3) how to get the help one needs? Efficacious (direct and specific requests) and inefficacious (indirect or unspecific requests) ways to ask for help should be demonstrated, aiming at a model.

It is also essential to draw some attention to emergency plans for a range of stressful situations that can arise unexpectedly and to include strategies to solve them. In addition, it is necessary to deal with persistent problems, considering changes occurred since the group was formed and identifying problems that are still present.

The last session is again focused on a conversation about relapse prevention to increase awareness that (apparently) irrelevant decisions can cause relapses. It is important to stress the ability of thinking about each choice, anticipating risks and analyzing the relapses and the apparently irrelevant decisions that may have led to this. A treatment analysis should be performed for a proper group farewell, including a feedback for therapists.

Conclusions

Working with individuals that have alcohol and/or drug abuse problems is usually little gratifying, but perhaps that is why it is stimulating. When dealing with addictive patients, it is important for the therapist to be "focused," trying not to demonstrate hopelessness and despair, but at the same time, not expecting constant progress. While therapists should provide their patients with feedback, education, techniques and support, they cannot take responsibility for the patient's problems. Therapists should always try to remain calm in a crisis situation and help the patient in their problem solving, knowing that they should not solve the crises for their patients.

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Writing group member	Employment	Research grant ¹	Other research grant or medical continuous education ²	Speakear's honoraria	Ownership interest	Consultant/ Advisory board	Other ³
Bernard P Rangé	UFRJ	---	---	---	---	---	---
G Alan Marlatt	University of Washington	---	---	*	---	---	---

* Modest

** Significant

*** Significant. Amounts given to the author's institution or to a colleague for research in which the author has participation, not directly to the author.

Note: UFRJ = Universidade federal do Rio de Janeiro.

For more information, see Instructions for authors.

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