From addiction to control

Motivational interviewing as a technique for leading the sceptical heroin addict towards self-control

Although behavioural self-control training has proven to be one of the most effective methods for creating change in addictive behaviours, it is not as widely used as it could be. Motivational interviewing could perhaps act as a go-between – a link between clients engaging in high-risk behaviour and a method that could help them become responsible heroin users. Two case examples are presented.

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MANY PEOPLE FIRMLY believe that heroin and some other controlled drugs can only be used in an uncontrolled and addictive way. 'Chipping' – limited and controlled use – is looked upon as merely a phase leading from abstinence to addiction, and an impossibility for the former addict.

This prejudice hampers motivation for change in people suffering from addictive behaviours, as one of the beliefs that promotes change is that *the desired change is actually possible*.[1,2] In our present decade it is even more important than in the past to exclude all change-hampering aspects of treatment: the AIDS problem forces society and treatment services to reconsider options and common practices. The fact is that *all behaviours* that can become excessive can also be untrained and enjoyed again in moderation. Let us take a closer look at the case of heroin.

"All behaviours that can become excessive can be untrained and enjoyed again in moderation"

The first research on occasional heroin use was published in 1973.[3] Twelve people questioned about their heroin use revealed a varied pattern of use including once a week or once every two or three months, averaging once a month. Sometimes heroin was used two to three times a week followed by a period of two or three months' abstinence.

In an extensive series of studies, Zinberg and Harding have tried to answer the question of whether controlled, limited heroin use is possible and how long people can maintain it (see references 4-9). Controlled heroin use was defined as regular heroin use but without physical dependence or interference with personal or social functioning. In some of the research, information given by users was cross-checked.[10] The average length of controlled use was found to be three to six years, but some had been using in this way for more than ten years.

Research in the early '70s in Detroit found that 37 per cent of a group of 60 young male heroin users used every day, 40 per cent used in a limited way, and 23 per cent had used regularly in the past year but not in the previous month.[11]

What this research proves is that a small group of people manage to use heroin in a controlled way: the population of heroin users consists only in part of addicts. Estimates of the size of the addict group vary from 50 per cent[12] to 20 per cent of all heroin users.[13]

Harding moved one step further when he concluded that addicted heroin users can return to non-addictive, controlled use.[14] A study of a small group of ex-addicts showed that six were now controlled users – five following therapy. They were using heroin no more than twice a week and had been for at least two years – in fact, on average for longer than they had been addicted.

How did these users control heroin? The researchers found that controlled, moderate use of heroin, integrated into rather than dominating the user's life, was possible whenever a small subculture developed social sanctions and rituals that limited use. Examples of such social sanctions and rituals are:

- rules limiting the frequency of use, eg, not more than twice a week or not more than a certain amount;
- rules allowing use only on certain occasions with certain groups of friends but never alone;
- rules that take into account the variable quality of street heroin by first 'tasting' a

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Case One: HARRY HEROIN

Facts

- Age: 29 years
- Length of drug use: 12 years
- Amount of heroin use: one gram a day
- Personal circumstances: single, a loner, no job, has no contact with his parents, leads a 'good' life as a successful dealer of drugs

Treatment process

Harry came to see me because he had received some warning signals that the police were on his tracks because of his dealing. The only way he would be able to stop dealing was to regain some control over his heroin use. He had tried several other treatment centres but these refused to help him because he wanted to become a recreational heroin user rather than abstinent.

At first Harry set an ultimate goal of a maximum ½gm a week, five heroin-free days, and a maximum ½gm on any one day. Treatment sessions were every other day but after the fifteenth session they were held weekly.

Harry decided to decrease his heroin use gradually. At about the fifteenth session, he became unsure whether it would be wise for him to maintain the goal of recreational use (being on the dole it would be very expensive). Re-negotiation resulted in the ambitious goal of complete abstinence. His reward at the very end of treatment was to buy a second-hand bike with a very good lock – "These junkies will steal anything, you know".

Outcome

- Number of sessions: 30
- Length of sessions: in total, 24 hours client-therapist contact
- Goals at the end of treatment: abstinence
- Situation 12 months after end of treatment: abstinent, two lapses of ½gm each after being refused entry to some training

"Harry' became abstinent from heroin, 'Mona' became a weekend user. Both achieved their own form of self-control through motivational interviewing techniques

Case Two: MONA MULTIPLE

Facts

- Age: 29 years
- Length of drug use: 5 years
- Amount of heroin use: two grams a day plus various other substances in large quantities
- Personal circumstances: married, rich and suffering from depression since childhood – drug use was a medicine for her depression

Treatment process

Mona was forced to come and see the therapist by her family (husband and parents). Their instructions to the therapist and Mona were that she should stop using any drugs.

The motivational process for Mona consisted mainly of boosting her self-esteem and self-efficacy. One way of doing this was to create a negotiation process between Mona and her husband concerning her use of heroin. Mona decided that she would like to become a recreational user of heroin and remain abstinent from all other drugs. She succeeded in convincing her husband and the self-control training could begin.

Training was aimed at controlling two behaviours: drug use and depressed moods. Mona's ultimate goal was to use one gram of heroin every other weekend; out of 14 days, she intended to remain abstinent for 12. She decided to work gradually towards this goal, stopping use of the other drugs (amphetamines, cocaine, crack, etc) immediately. After the functional analysis a mood-improvement programme was introduced.

Outcome

- Number of sessions: 60
- Length of sessions: about 60 hours' client contact
- Situation 12 months after end of treatment: ½gm of heroin used during one month, only at the weekends

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Five phases to self-control

PHASE ONE: Introduction. In this phase objective information about heroin and heroin addiction is given, the possibility of personal choice is stressed, and examples of successful clients are discussed. Instructions for self-observation are given and from the first session clients are trained in recording their heroin use.

The clients then evaluate their heroin use and set standards for future use – the treatment goals. Goals are set for the maximum amount of heroin use in a week, maximum use during one day, and number of heroin-free days in a week. The therapist takes on an advisory role in the client's decision-making process – for instance, informing them that using heroin two days in a row is more difficult to control than using on alternate days. A reward is discussed for the client to give themselves if they achieve or comply with their goal.

After clients have set themselves their ultimate goal, therapist and client negotiate how this is going to be achieved: will the client gradually reduce use, or change in one big step? The client is then asked to set goals for their use in the period until the next session. For every intermediate goal, small rewards are negotiated for the client to give to themselves. Setting realistic intermediate goals is very important – goals which both client and therapist are confident of achieving. A typical client with sessions every two days might set the following goals: maximum use two days a week, using no more than half a gram a day, and no use between 1pm and 6pm.

PHASE TWO. Say no to heroin. This consists of training in saying no to drugs that are offered. Client and therapist engage in role play tailored to the client's needs, during which the client learns various ways to say no.

PHASE THREE. Rules and regulations. A list of rules on heroin use is given to the client, who at each session is expected to choose a new rule to apply to their heroin using behaviour. Examples could be: never use heroin in the living room/kitchen/bedroom/ etc; before use, have a short brisk walk around the block; phone parents/friends before every use; leave at least x hours between every use; etc.

PHASE FOUR. Functional analysis. Based on the client's self-monitoring, a 'functional analysis' is presented, analysing which situations, emotions and thoughts elicit uncontrolled heroin use, and what situational, emotional and cognitive goals the client is seeking to achieve by this use.

PHASE FIVE. Planning new behaviour. Based on the functional analysis, plans are made and evaluated to engage in new non-drug-seeking behaviours. The functional analysis helps client and therapist become aware of the high-risk situations for this client and which skills they lack to engage in self-control.

small part to assess its strength and prevent overdose (comparable with wine tasting);

◆ other rules reinforcing the view that heroin use takes only a minor place in life and supporting obligations and relationships that have nothing to do with heroin.

Self-control – the ability to "refuse that offer one couldn't possibly refuse" – involves doing something which will result in immediate punishment or diminish short-term rewards, but which will instead gain longer term rewards. The short-term loss of positive feelings may be quite extreme, as in the heroin addict who decides not to take their next hit: they must be able to withstand withdrawal symptoms in exchange for vague promises of a better life in the future.

Self-control in addictive behaviours has two options. Either the person can abstain from the behaviour, or they can decrease its frequency in order to eliminate problems while maintaining the joys of successful moderation. Behavioural self-control training with addictive behaviours has been successful, especially with problem drinking.[15,16]

Training people for self-control consists of three steps:[17]

◆ **self-observation:** being aware of what you are doing;

◆ **self-evaluation**: evaluating your behaviour against certain standards or norms and based on this setting yourself behavioural goals;

◆ **self-reinforcement**: reinforcing and maintaining the behaviour needed to achieve these goals.

Based on various sources,[18,19,20] we have developed a behavioural self-control programme for heroin which is individually tailored to each client. The programme is structured into five phases consisting in total of 24 sessions each lasting between 15 minutes and one hour. Depending on the client, the frequency of sessions could vary from once a day to once a week. Common practice is to start with a high frequency and to fade out towards the end, perhaps down to a session a month.

Motivating self-control

The problem with self-control therapies is that, while highly successful, they are difficult to 'sell' to clients and professionals because of the widely held belief (prejudice) that heroin is a 'demon drug' which can only be controlled by 'curing the disease'. Motivational interviewing is a therapeutic approach that might act as a link between sceptical clients and an effective treatment approach.

Basically this approach aims to help the client to make wise decisions about their situation.[21,22] Making use of techniques derived from various therapeutic schools, motivational interviewing tries to help clients make a firm commitment to change. Behavioural psychotherapy, Rogerian psychotherapy and strategic psychotherapy are combined in an approach which:

– raises the client's awareness of their problems;

– increases their concern about these problems;

– raises self-esteem ('a good person like me should not have these problems'); and

– increases their feelings of competence to change.

THESE TECHNIQUES are based on the firm belief that people can regain control over addictive behaviours. In an atmosphere of empathy, the client's responsibility is stressed. Instead of diagnosing a client and giving them instructions to enter a certain treatment, a treatment goal and method is negotiated with the client based on their preferences and the objective facts of their personal situation. ■