4. Psychiatric and psychological brief psychotherapy for chronic alcoholism

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Abstract
Brief Psychiatric Psychotherapy (PKP) for alcohol dependence covers all the important evidence-based therapeutic strategies for treating alcoholism. It can be used in individual and group settings. The PKP manual is a safe guide that helps to master even difficult passages of treatment. The therapy consists of three pillars (modules) - symptom therapy, skills training and replacing the dysfunctional overriding rule with a new permission-giving rule of life as an elegant way of dealing with therapeutic resistance in addiction. The evaluation shows encouraging interim results.

Keywords
Alcoholism therapy - psychotherapy of alcohol dependence - craving - abstinence violation - relapse prevention - symptom therapy - skills training - survival rule - reaction chain to the symptom - therapy motivation - therapy goals - therapy plan - mentalisation support - emotion regulation

The three pillars of PKP alcohol dependence

Pillar 1: Dealing with the symptom module

PKP primarily includes psychotherapeutic strategies and assumes that detoxification has already taken place. This is not addressed in PKP. It starts with the joint psychoeducational development of basic knowledge about the patient's alcohol dependence. This ensures that the patient is not simply addicted, but that they consider and reflect on their addiction (mentalise it in Fonagy's sense). He goes to a meta-level and metacognition takes place (thoughts about thoughts) and even this brief distancing is the beginning of self-control ability.
Let's take a look at the PKP manual for the treatment of alcohol dependence, which consists of 85 therapeutic instructions. The first (and most important) pillar is the symptom therapy module:

Analysing the origins of my alcohol dependence
When did the disease begin? Pathogenic lifestyle and relationships. And now I analyse how exactly it happened that I became an alcoholic. Triggering life conditions (S = situation) . Triggering life event. How the survival rule influences the reaction chain to the symptom.

Symptom therapy
First we learn to deal with the symptom (craving):
Learning to deal with my symptom: EXPOSITION
My own reaction chain up to the symptom
Symptom therapy step by step: Recognising the primary emotion. Control the primary impulse. Achieve a realistic expectation of effectiveness. Delete the secondary emotion. Build up masterful behaviour

What maintains the symptom? Consequences of alternatives to symptom formation

Relapse prevention: Recognising relapse-triggering situations. Recognising early relapse reactions. Relapse prevention through lifestyle - how, when, where? Relapse prevention by organising relationships - how, when, where? When an abstinence violation has occurred. Emergency card

Utilising the time between conversations
My project/task card
Energising rituals (in the group)
Final thanks at the end of a group evening

Pillar 2: Emotion exposure and skills training module
The second pillar supports the development of skills on a cognitive, emotional and behavioural level. This module contains a selection of proven interventions for alcohol dependence:

Clarifying the motivational stage
Where do I currently stand with my decision to abstain? Motivation building: What makes it difficult for me to motivate myself? Motivation for and against. What are the advantages and disadvantages of drinking and abstinence? Motivation building: helpful thoughts. What thoughts help me to motivate myself? Building motivation: Other people. What feedback helps me to motivate myself?

Utilising offers of help from other people
Who can help me to stay abstinent? What sources of strength do I have? External sources of strength in your living environment. Inner sources of strength (qualities, abilities). How can people help me to stay abstinent? Who can help me HOW to stay abstinent? How can I say what help I need? How can I (re)gain friendships? How can I win (back) my partner? How can I regain my strength? How can I get my life in order?

Determine goal orientation and goal alignment every 3 months (weekly in the clinic): My personal goals - goal alignment - What am I doing to achieve my goals?

Getting to know my feelings - learning to deal with my feelings
Model of emotion regulation in addiction disorders - An emotion theory of alcohol addiction. Feelings help people ... 43 Feelings. My feelings of sadness. My feelings of joy. My feelings of fear. My feelings of anger. How I have dealt with my feelings so far. Disorders of emotion regulation. Moods and their function. Expressing feelings. Emotional communication. When a feeling completely determines my actions: Emotion exposure. If a feeling is not/hardly perceptible: feeling discovery. Functional handling of feelings

Use the time between conversations
My project/task card. Energising rituals (in the group). Final thanks at the end of a group evening

Pillar 3: Module Working with the dysfunctional survival rule/motive clarification
The therapy instructions of the 3rd pillar dissolve the patient's motives that stand in the way of therapy and strengthen his motives for change. This involves working with the central feelings that control behaviour (fear, anger, rage, etc.), central needs and dysfunctional personality traits. The personality trait's own survival rule (the master plan of his life internalised

since childhood) is developed on the basis of the learning history. The 3rd pillar ends with the patient's new experience of "living instead of surviving": by practising living, the symptom loses its function.
We begin by working on the survival rule: the patient's central needs - the patient's central fear. His personality traits based on ICD-10. His learning history. Formulate his survival rule. Contract: Act against the survival rule. Living instead of surviving. My new rule of life.

A mental model of alcohol dependence - how alcohol dependence can develop.
The interaction between the parents with their parental behaviour and the child with its innate characteristics and temperament leads not only to satisfaction but also to frustration and threats, which permanently bring certain needs to the fore, e.g. the need for security or the need for attention. It also leads to a person permanently focussing on avoiding specific threats or fears and thus building up an individual profile of avoidance actions. Another important result of his childhood is the inhibition of his feelings and aggressive tendencies towards members of his social community. The content of the anger tendencies is characteristic of a person and is also the result of the interaction between parents and child or between the child and other important attachment figures (e.g. brother, sister, grandparents). The permanent blocking of the tendency to rage and attack is an important task of self-regulation. Many people go so far as to become insecure and anxious. Psychological homeostasis (a control loop that tries to keep everything in balance) can be understood as a set of rules and the most important rule is the one that ensures survival. The processes are preconscious, i.e. the arbitrary (conscious) psyche is unaware of these connections.
Relationships are usually only about emotional survival, i.e. preventing psychological damage. A survival rule that is optimally tailored to the social environment in childhood becomes unsuitable (dysfunctional) in adult life if it is not changed. Patients have dysfunctional survival rules that ensure that their experiences and behaviour do not lead to the desired results, i.e. are detrimental to the person concerned. They also prevent the relationships of their adult life from remaining supportive and satisfying for both sides. In our observations, we are therefore initially concerned with the personality traits that prevent success. The survival rule and the sub-optimal experience and behavioural stereotypes defined by the personality restrict a person's active behavioural repertoire considerably in some cases. As a result, they are less able or unable to cope with difficult problems. The triggering life situation, for example, can only be responded to by the development of symptoms. Experiences and behaviours that would have led to mastering the problem are forbidden. They would violate the survival rule and jeopardise emotional survival. Which life situation leads to the

formation of symptoms is therefore also determined by the personality of the person affected. Therapeutic change of these personality traits and behaviours is therefore of great importance in the definition of psychotherapeutic goals and treatment planning

How to use the PKP manual - A look into practice: Practical work with the PKP modules

Symptoms of alcohol dependence

Which of these symptoms do I have?
( ) I drank too much alcohol or too often
( ) I could not suppress my craving
( ) I drank more and more over time
( ) My life was significantly affected
(job, relationships)
( ) My physical health was significantly affected (liver values etc.)
( ) My mental health deteriorated
( ) Withdrawal symptoms appeared

Recognising that it is a disease

Both the patient and those around him are convinced that his alcohol dependence is a weakness of character for which he himself is responsible.
It is therefore necessary to declare that it is an illness. Illness is not something you can cause yourself and is therefore not your fault. Illness can be treated and must be treated. However, treatment is only successful if the patient actively co-operates.
Dependence means that you can't get away from it without outside help. You have to seek help. It is therefore your own responsibility to actively seek help.

Clarifying the motivational stage: from unintentional abstinence to resolute abstinence

It is not a waste of time to precisely analyse the patient's current stage of motivation for therapy.
This is not about paying lip service, which we are quick to do ourselves.

Rather, it is about the emotional attitude, the question of whether there are already tangible energies that want to move away from the current state.
Although the patient has already arrived at our therapy centre, their innermost being is often not yet ready for change. Therapist and patient need to realise this and accept it first. Only then can they work together to create willingness.

Anti-motivations
Some patients are not yet aware of their own addictive behaviour. There is no reason for them to change it.
Others cognitively recognise that things can't go on like this, but this doesn't get through to their feelings. They do not feel affected.
Still others are aware of the problem and are emotionally affected, but there is no motivational force, no willingness to change.
A final group is aware of the problem, is affected and willing to change, but is so hopeless that any initial energy immediately dries up.
We follow the concept of the "motivational interview" by Miller and Rollnick (1991, 2009)*,
by working out which thoughts help to build up motivation to change:
A thought that builds awareness of the problem
A thought that helps to feel affected
A thought that expresses willingness to change
A thought that promotes confidence and self-confidence.
It is important that these are the patient's own words, even if the therapist helps to develop ideas: "How would you say it?"

Who can help me stay abstinent?
Once detox has taken place, it is important to

- Maintain abstinence,
- and to do everything that contributes to this;
- First and foremost, mobilise helpers.

First and foremost, the specialised addiction therapist is responsible,
and the addiction therapy group,

then the self-help group
and finally the natural attachment figures (family, circle of friends, profession) - even if the relationships have become highly ambivalent in the meantime.

External sources of strength in your living environment
What opportunities do you find in your living environment to do something that gives you strength, joy, self-confidence, relaxation, variety or recreation?
What do you still do?
What did you do until recently?
What did you do in the past and could you do it again?
What is on offer that you could easily try out?
What would you really like to do?

In general: Who can help me HOW to stay abstinent?

( ) By not drinking alcohol themselves
( ) By confirming my abstinence
( ) By being present
( ) By listening to me
( ) By showing me understanding
( ) By supporting me in my endeavours
( ) By appreciating me
( ) By showing me that he/she likes me
( ) By being honest and open with me

How can I get my life in order?
If many areas of life are in a desolate state, there is no good basis for therapy. Therefore, they must be put in order - the problem must be turned into a resource. What needs to be done,

- so that the professional situation becomes stable?
- so that the marriage becomes supportive again?

- so that the family gives more strength than it takes?
- so that the body is healthy and feels good?
- so that you feel a sense of belonging to your circle of friends?
- so that nice leisure activities can be reported?

The S-O-R-C behavioural model
Situation S: How drinking occurs.
Organism O: Which person this happens to.
Reactions R: The (ineffective) reactions that preceded the symptom.
Symptom: The whole behaviour around the drinking.
Consequence C: what keeps the drinking going - why it doesn't stop.

How the survival rule influences the reaction chain to the symptom
The symptom-triggering situation usually involves a severe frustration/hurt that leads to anger (primary emotion) and the impulse to fight back (primary impulse).
However, the survival rule developed in childhood, which has become dysfunctional in adult life, prohibits this feeling and this impulse, so that an anticipation of negative consequences of defensive action arises, which triggers fear or a feeling of guilt etc. (secondary feeling), which leads to compliant or capitulating behaviour. The dangerous residual anger is neutralised by the symptom so that the relationship with the person involved is spared.
Only a new rule of life that gives permission opens the door to the necessary resilience and social competence.

My own reaction chain up to the symptom
A typical observable situation (which is extremely frustrating, for example):
The primary emotion in response to this situation (e.g. anger):
The primary impulse to act that results from this emotion (e.g. attack):
The thought: Considering the consequences of my actions
(e.g. Then I will be rejected):
A counteracting secondary feeling (e.g. guilt, powerlessness):
My observable behaviour (e.g. doing what my counterpart wants):

Symptom formation (e.g. dejection : depressive syndrome):

Perceiving the primary emotion
The therapist allows the patient to experience the situation so that they can feel the emotion as intensely as possible during the therapy session (if necessary, the situation and the other person's behaviour are exaggerated so that the emotion becomes more tangible, e.g. "If the other person reacts even more inconsiderately and selfishly, what emotion do you feel? How strong is the feeling now?"). If this is successful, you can ask whether the feeling is justified. Is it permissible, is it right to feel this way at this moment? And: Am I already causing harm just by feeling it? The aim is for the patient to give themselves permission to have this feeling.
He should also be able to recognise and appreciate the important function of this feeling. This feeling helps them to stand up for their interests.

Controlling the primary impulse
The primary impulse can be coping appropriate to the situation or an uncivilised impulse that really should not be acted out. Great anger can lead to the impulse to want to slap the other person or push them away or even kill them. It is absolutely necessary to allow these uncivilised impulses to become conscious, as they are there anyway and have a very strong effect on the patient's psychological process. Only if I become aware of them can I learn to deal with them consciously. It is important for the patient to realise that he is not the only one who has such impulses, but almost everyone. Then the sentence "I'd love to smack him against the wall!" is liberating for him. In the therapy session, trust should be built up that allowing the impulse does not automatically lead to it being carried out. The patient experiences that they are a controlling entity that can decide freely and responsibly which impulse to follow and which not.

Achieving a realistic expectation of effectiveness
If, on the other hand, the primary impulse is appropriate to the situation and is only held back by irrational fears, the way must be cleared for the corresponding action. The unrealistic anticipations can be corrected through Socratic questioning, so that in the patient's new assessment the positive effects of his action outweigh the negative ones. He should also be able to realise that the positive consequences of his actions are so important to him that he is prepared to accept the resulting disadvantages.

As it is not enough to take this anticipation ad absurdum just once, the patient should regularly imagine their primary action and the overall favourable, satisfying outcome of the situation - in the sense of mental training.

Delete the secondary feeling

The secondary counteracting feeling wants to prevent the primary action (e.g. defensively asserting a central concern) from being carried out. Even if this action is already being practised, it still occurs, e.g. a feeling of guilt or shame. There is a high risk that the patient will abandon their defensive behaviour as a result. Dealing with this secondary feeling should therefore be practised separately. The motto - limited to the agreed situation - could be: "Do what makes you feel guilty until it no longer makes you feel guilty!" This includes refraining from behaviour that this secondary feeling would like me to do, e.g. giving in, apologising, hiding, making amends, etc.

The patient exposes himself to the feeling until he has learned to let it go without showing the behaviour that ends the feeling.

Building masterful behaviour

If the primary impulse to act was appropriate to the situation, we already know what the mastering behaviour is in this situation. Role-playing can help to shape this behaviour and increase the likelihood that it will occur next time.

If, on the other hand, the primary impulse to act was inadequate, an adequate coping behaviour must first be sought and developed. When selecting a behaviour that the patient has found, the therapist makes sure that the behaviour is not still half an avoidance behaviour. On the other hand, a coping behaviour may be the most appropriate for the situation, but the patient is not the kind of person who can manage to behave in this way in the long term.

In addition to the possibility of building up the patient's situational competence through skills training, consideration should be given to initially selecting a behaviour from the patient's current repertoire so that there is an immediate possibility of mastering the symptom-triggering situation.

What changes have occurred since the onset of symptoms?

What changes have occurred in the relationship to the various areas of life since the onset of symptoms? At work, e.g. an end to exploitation, with superiors.

Z. e.g. consideration, with colleagues e.g. a new willingness to help, in public e.g. complete withdrawal with avoidance of frightening encounters, with friends e.g. deeper friendship with those who have been through something similar, with

hobbies e.g. more time, with friends e.g. loving care, with relatives e.g. end of recriminations, with family e.g. release from sins. e.g. letting go of the scapegoat role, in marriage e.g. an end to the cold marital war, with children e.g. greater closeness, with yourself e.g. less self-criticism, with your body e.g. less exhausting performance, with the future e.g. letting go of a goal that you have long since stopped longing for but thought you had to achieve.

My personal goals - <u>what do I do to achieve them?</u>
You can't achieve a goal without movement/change
We are on our way and we are moving on.
Which steps are next for which goal?
A step - albeit a small one - is determined for each goal.
Easier to achieve goals create a quicker sense of achievement, which is urgently needed.
This provides strength for more difficult goals that require more persistence.
Once the steps and activities have been identified, a contract is made with the patient and the therapist about what is to be done when, how and in which situation with which people. This strengthens the will and promotes willingness.

Recognising typical relapse situations
Information about dangerous external and internal situations should be collected throughout the therapy: Birthday parties, company outings, New Year's Eve, Christmas, weekends alone, contact with certain friends, holidays, the cigarette machine right next to the former favourite pub, the host's home bar, failures, rejections, injustice, feelings of guilt).
These are reaction-triggering stimuli in the sense of behavioural theory and they are dealt with through stimulus control. If the stimulus can be prevented or minimised, the risk of relapse is reduced. An agreement should be reached on how to deal with each situation. However, this is only the second step after recognising the situation in the current field of vision (i.e. it is coming towards me and I may be unprepared).

If an abstinence violation has occurred
According to Marlatt and Gordon (1980), the experienced abstinence violation effect leads to
1. the cognitive dissonance between the self-image of having "managed to stay sober" and the relapse behaviour leads to an affective tension that is alleviated by continuing to drink.

2. in contrast to the "wet self-lie", the relapse is attributed internally and evaluated as one's own inability to ever make it. This ends in a standard feeling of hopelessness that can only be endured under alcohol.

Emergency card
The use of the emergency card must be practised, like first aid on a first aid course or a fire drill.
Regularly. After all, this emergency is much more likely to occur than an accident or a fire.
The emergency is simulated and the emergency behaviour is automated as much as possible.
The problem with this is that the simulation is performed by a sober brain and in an emergency the brain is alcoholised.
It is also very important here to take into account the shame and distress of not wanting/being able to show oneself drunk under any circumstances.
This requires self-instructions such as: "Showing my weakness is my greatest strength" or "I stand by my weakness, which ultimately makes me strong."

Emotion regulation

Recognising and expressing feelings
One of the most important steps towards drinking is escaping from unbearable feelings.
That's why we have to learn to endure even very bad feelings
This works better if I allow, feel and express them
It doesn't get better straight away, but gradually.
This is so important that every therapy session must be used to recognise and express feelings.
With every thought that I express, I can mention the feeling that I am currently experiencing.
This is why the therapist will very often ask me:
"What feeling do you have at the moment?"

Feelings help people ...
Feelings help people
- recognise the meaning of situations for them and
- mobilise them to find and show the behaviour that is right for them.

Every person has different feelings that belong to them. We recognise a person by their preferred emotional reactions, among other things.
And you only really get to know yourself when you get to know your feelings:
What feelings do I have frequently or intensely? What feelings do I have frequently or intensely, so that they are my companions and belong to me, even if they are unpleasant?
Which feelings do I only have weakly or rarely?

Emotional communication
Talk about your feelings by saying which aspect of the other person's behaviour triggered which feeling in you.
Talk about your feelings/thoughts by saying which aspect of the other person's behaviour has triggered which thoughts in you.
Talk about your hopes/wishes for the other person by saying what you want from your relationship with them, what you want from them now in this situation.
Talk about your fears by saying that it is not easy for you to express your feelings openly, what fear/worry makes it difficult for you to express your feelings openly.
Talking about feelings should be distinguished from expressing stronger feelings.
With the former, the other person should understand me; with the latter, my feelings should have an effect on them**.**

Using the time between conversations
Overcoming alcoholism does not happen in the therapy sessions, but between them.
In other words, when the therapist is not present.
So you have to do all the therapy work yourself.
Only what you do between therapy sessions will move you forward.
This is why your "interval work" or your "project" - some also call it "homework" - is discussed well in advance during the therapy sessions. This also includes completing a project card.

My project/task card
Even if it is annoying to keep the project card, it helps you to stay on the ball.
It reminds you of your goal. And every time you read this line, you can say to yourself: Yes, that's what I want.

It defines the situation, so it's not so easy to let opportunities pass you by.
And you focus on the person, usually the problem person, with or on whom you want to try out the new behaviour.
Then there is the recording of the implementation of the activity, experiment or task.
Your signature at the end creates a commitment that has a supportive effect.

Energising rituals (in the group)

It may seem surprising that this topic has a place in such a rational therapy programme.
However, we know that irrationality has power and we are pragmatic enough to utilise this power, which we ourselves experience time and again.
Therapists should therefore overcome their inhibitions and do what they and some patients may find embarrassing.
Stand in a circle in the group, shake hands and say these words in chorus, the thanks and the abstinence affirmation:

I thank you

- *for coming together*
- *for listening*
- *for the feedback*
- *for our common goal*
- *for the strength I take with me today*

I am and will remain abstinent!
We are and will remain abstinent!

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