

Effectiveness of Self-Help Groups and Psychotherapy: Self-Assessment of Patients With Substance Use Disorders

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Summary. *Background and Objective.* The basis of substance use disorders (SUD) is formed with regard to biopsychosocial aspects. By following the SUD biological model exclusively, the effectiveness of treatment is limited since all the formation aspects of SUD are not taken into account. By using the psychosocial model, however, the understanding and treatment of a substance use illness becomes enhanced and is more effective. A key role in this model is played by self-help groups and psychotherapy.

The aim of this study was to determine the viewpoint of patients with substance use disorders in terms of the number of visits, duration of treatment, efficacy of self-help groups, and individual and group psychotherapy in different treatment methods.

Material and Methods. The participants were approached by researchers at two drug and alcohol services in Latvia. In total, 587 patients received questionnaires developed by the authors of the study.

Results. All the 587 questionnaires of both outpatient respondents ($n=200$, 34.1%) and inpatient respondents ($n=387$, 65.9%) were analyzed. Of all the outpatient department respondents, 41.5% ($n=83$) attended self-help groups, 28.5% ($n=57$) individual psychotherapy, and 14.5% ($n=29$) group psychotherapy; the inpatient department respondents were 2 to 4 times less often involved in the measures.

Conclusions. The outpatient respondents were more frequently employed. They attended self-help groups and psychotherapy and obtained longer remission comparing with inpatient respondents. This study has shown that patients had a greater success rate in staying in remission, maintaining outpatient care and shedding the need of inpatient care.

Introduction

The basis of substance use disorders (SUD) is formed with respect to biopsychosocial aspects. The factors of chemical addiction formation are created by individual psychological personality traits (subjective factors) and environmental social traits (objective factors). The reasons why the individual uses psychoactive substances include not only the characteristics of the substance, but also his/her own social-psychological and psychological problems and his/her difficulties in solving these problems in constructive ways. The use of psychoactive substances leads to the destructive development of a personality and brings it to its logical conclusion; it reveals a nonconformist personality and its character flaws. There are several psychiatric areas that are associated with the use of psychoactive substances: self-confidence pathology (1, 2), self-cognition, social competence, the “ability-to-cope” deficiency (3–5),

narcissism (6), effective mental defense mechanism deficiency, and inability to solve common everyday problems (7). SUD patients have difficulty dealing with anxiety, stressful situations, pain, disappointment, and expectation. Often, a lack of emotional maturity, an incomplete psychosexual organization, impulsiveness, a tendency to regressive behavior, difficulty in interpersonal relationships, a cognitive deficiency, and a weak ability to socialize were observed (8, 9).

By following the SUD biological model exclusively, the effectiveness of treatment was limited since all the formation aspects of SUD were not taken into account. By using the psychosocial model, however, the understanding and treatment of a substance use illness became enhanced and were more effective (10, 11). As the illness progressed, the impact of the psychosocial aspects was not mitigated and remained significant, while the biological aspects came to the forefront. The lessening of physical symptoms by pharmacological means exposed

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psychological problems. These psychological problems were the root cause of the use of psychoactive substances and relapse outbreaks and compelled one to seek psychotherapy, which was logically followed by the help using pharmacological means. Unfortunately, psychotherapy in Latvia is only available to wealthy patients. Psychotherapy is not included in the state reimbursement list of Latvia (12). Even so, many have access to self-help groups, especially in large cities and in regional centers. If an addict does not improve his/her own personal functionality, psyche defense mechanisms and ability to understand himself/herself, communicate, and work together with other people, then the addict has a greater risk of relapse. Cohen et al. (13) points out that patients have to be educated and informed in order to reduce their stigmatization caused by treatment.

The aim of this study was to determine the viewpoint of patients with SUDs in terms of the number of visits, duration of treatment, efficacy of self-help groups, and individual and group psychotherapy in different treatment methods.

Material and Methods

Participants. From January 2010 until October 2011, the data of 587 patients were analyzed. These patients were treated in the outpatient department of addiction disorders and in 2 inpatient departments: detoxification and Minnesota Program (MP), which is a psychotherapy treatment based on a 12-step philosophy. Addiction was diagnosed in all the patients according to the ICD-10 classification (F10.2–F19.2) (14). The inclusion criteria were the following: the patients had a SUD diagnosis; were at least 18 years old; were not in an acute condition; and agreed to give full disclosure and fill out research questionnaires.

The exclusion criteria were the following: the patients did not have an addiction diagnosis (but F10.1–19.1 instead); were younger than 18 years old; refused to take part in the study or fill out the questionnaire completely or at all. The ability to get consent to take part in the study did not affect the treatment of patients. In the detoxification department, the treatment typically lasted for 5 to 10 days. These patients, therefore, filled out their forms at the end of the treatment once the acute symptoms had disappeared. Patients with 5-day abstinence entered the treatment in a 12-step program. This is why they filled out their forms at the beginning of the treatment. The outpatients (with at least 5 to 10 days of abstinence) filled out their forms when visiting the doctor in their outpatient department.

Research Instruments. The qualitative method, i.e., the questionnaire worked out by the author of this article, validated in a previous pilot research project, was used in this study. The form contained

24 questions and had a social/demographic information section and the main section. In the social/demographic section, the respondents had to fill in the data about their gender, age, education, employment, family status, and number of offsprings (if any). In the main section of the form, they had to answer the questions concerning their experience on alcohol/drug use initiation, substance abuse consequences, the kinds of substance abuse help sought, as well as about their self-help groups, individual and group psychotherapy, the length of attending therapy, remission time, and degree of improvement after each kind of therapy. The form was set up for the respondents to answer “Yes” or “No” to the following: employment, education, family status, consequences, improvements, and methods. The respondents provided written responses to the questions about the use of psychoactive substances, remission time, and number of treatment sessions. In the study, only answers regarding the demographic data and psychotherapy and self-help group attendance were analyzed.

This research was conducted after the official approval from the Ethical Committee, Riga Stradins University, had been received.

The data were processed with the Microsoft Excel and SPSS 16.0 for Windows programs using descriptive statistics and a frequency analysis. As per the Kolmogorov-Smirnov Z test, the respondent groups conformed to the standard allocation. In order to calculate and compare the respondent average ages, the t tests were implemented. In order to determine the correlation between the patients' groups, the Spearman correlation was applied.

Results

A total of 587 completed questionnaires were analyzed: 200 (34.1%) were filled out by outpatient department patients and 387 by hospitalized patients, among which there were 188 (32.0%) after the detoxification treatment and 199 (33.9%) starting the 12-step treatment program (MP). There were 66.4% of men and 33.6% of women; the mean age was 39.6 years (SD, 11.3). Only 238 (40.5%) of the respondents were employed. However, 378 respondents (64.4%) had high school education or specialized high school level education; there were 89 university-educated respondents (15.2%). Moreover, 170 respondents (29.0%) lived in a registered relationship, 155 (26.4%) lived in an unregistered relationship, and the rest lived alone or were divorced. Of all the respondents, 396 (67.5%) had children. The sociodemographic data of the respondents are summarized in Table 1. Of the questioned respondents, 97.4% ($n=572$) admitted to using alcohol, 33.7% ($n=198$) admitted to using narcotics, and 29.3% ($n=172$) said they gambled in casinos. There were

460 respondents who (78.4%) saw themselves as alcoholics, 130 (22.1%) who thought they were drug addicts, 55 (9.4%) who thought they were addicted to gambling, and 48 respondents (8.2%) thought that they were not addicts.

The outpatients and detoxification respondents were significantly older than MP respondents (40.3 [SD, 11.1] and 41.7 [SD, 11.1] versus 36.9 years [SD, 11.2]; t test $P=0.003$ and $P<0.001$, respectively). The statistically significant correlation when comparing outpatients and inpatients manifested itself only in existence of employment ($P<0.001$), but not between the genders or in any of the following: education, family status, or existence of children ($P>0.05$) (Table 1). There were 56.0% of the outpatients who were employed; meanwhile, only 1 in 3 inpatients was employed.

There was a statistically significant correlation between self-help group attendance and the respondents' place of treatment (Table 2). The outpatient respondents had a 41.5% attendance rate of self-help groups, including a 35.0% attendance rate of alcoholics anonymous (AA) groups, a 15.5% attendance rate of narcotics anonymous (NA) groups, and a 5.0% attendance rate of gamblers anonymous (GA) groups. In the treatment group of inpatients, the attendance rates of the respondent had been

shown before, i.e., 24.1% for MP and 12.2% for detoxification; the AA attendance rate was 21.1% for MP and 11.7% for detoxification respondents; the NA attendance rate was 6.0% for MP and 1.1% for detoxification respondents; but the GA attendance rate was 1.5% and 0.0%, respectively.

There was a statistically significant correlation between the respondent place of treatment and the duration of self-help group attendance, duration of remission and improvements in the most important life areas (Table 3). In the inpatient clinical treatment group, both MP (70.8%) and detoxification (65.2%) respondents attended self-help groups for up to 1 year, but the outpatients showed only a 42.2% attendance rate. In the treatment group of outpatients, the respondents showed a 20.5% attendance rate of self-help groups for up to 3 years, 12% for up to 5 years, and 24.1% for more than 5 years ($P<0.001$). The MP patients showed the attendance rates of 16.7%, 4.2%, and 2.1%, respectively ($P<0.001$). The detoxification patients showed 17.4%, 0.0%, and 4.3%, respectively.

Among those patients who attended self-help groups, 12.9% of the outpatients, 19.0% of the MP respondents, and 18.2% of the detoxification respondents had the remission of up to 1 year ($r_s = -0.295$; $P<0.001$). There were 44 outpatients (53%), 30 MP

Table 1. Respondents' Sociodemographic Data

Sociodemographic Data		Outpatient (N=200)		MP (N=199)		Detox (N=188)		r_s	P
		N	%	N	%	N	%		
Gender	Male	138	69.0	120	60.3	132	70.2	-0.008	0.848
	Female	62	31.0	79	39.7	56	29.8		
Employed	Yes	112	56.0	61	30.7	65	34.6	0.181	<0.001
	No	88	44.0	138	69.3	123	65.4		
Education	Elementary	37	18.5	54	27.1	29	15.4	-0.009	0.837
	High school	62	31.0	57	28.6	63	33.5		
	Specialized professional	64	32.0	60	30.2	72	38.3		
	University	37	18.5	28	14.1	24	12.8		
Family status	Married	62	31.0	54	27.1	54	28.7	0.010	0.812
	Unregistered	51	25.5	59	29.6	45	23.9		
	Live alone	87	43.5	86	43.2	89	47.3		
Children	Have	134	67.0	131	65.8	131	69.7	0.002	0.965
	Do not have	66	33.0	68	34.2	57	30.3		

Table 2. Self-Help Group Attendance as Assessed by Respondents

Attendance of Self-Help Groups		Outpatient (N=200)		MP (N=199)		Detox (N=188)		r_s	P
		N	%	N	%	N	%		
Self-Help Groups	Attend	83	41.5	48	24.1	23	12.2	0.187	<0.001
	Do not attend	117	58.5	151	75.9	165	87.8		
AA	Attend	70	35.0	42	21.1	22	11.7	0.226	<0.001
	Do not attend	130	65.0	157	78.9	166	88.3		
NA	Attend	31	15.5	12	6.0	2	1.1	0.222	<0.001
	Do not attend	169	84.5	187	94.0	186	98.9		
GA	Attend	10	5.0	3	1.5	0	0.0	0.139	0.001
	Do not attend	190	95.0	196	98.5	188	100.0		

patients (62.6%), and 17 detoxification patients (73.9%) who had remission for more than 1 year. The improvements in the most important life areas were noted by both outpatient and inpatient respondents (Table 3). A larger proportion of outpatient respondents (83.1%) and MP respondents (64.6%) noted improvements in the emotional area ($r_s=0.255$; $P<0.001$), but 78.3% of the detoxification respondents noted improvements in both the emotional area ($r_s=0.255$; $P<0.001$) and health area ($r_s=0.207$; $P<0.001$). Still, some 16.7% of the MP respondents noted that nothing improved in their

lives following the attendance of self-help groups. This was also true for 7.2% of the outpatients and for 4.3% of the detoxification respondents ($r_s=0.062$; $P=0.135$). There was no statistically significant correlation between the respondent place of treatment and the fact that there were no improvements.

In Table 4, the statistically significant correlation between the respondent place of treatment and the attendance rate of individual psychotherapy, its duration, duration of remission, and improvement in the most important life areas are shown. What concerns individual psychotherapy, there were 57

Table 3. Duration of Attendance of Self-Help Groups, Duration of Remission, and Improvements in the Most Important Life Areas as Assessed by Respondents

Attendance, Remission, Improvements		Outpatient (N=83)		MP (N=48)		Detox (N=23)		r_s	P
		N	%	N	%	N	%		
Duration of attendance	Up to 1 year	35	42.2	34	70.8	15	65.2	-0.305	<0.001
	Up to 3 years	17	20.5	8	16.7	4	17.4		
	Up to 5 years	10	12.0	2	4.2	0	0.0		
	More than 5 years	20	24.1	1	2.1	1	4.3		
Remission	Up to 1 month	9	12.9	11	26.2	2	9.1	-0.295	<0.001
	Up to 6 months	13	18.6	8	19.0	10	45.5		
	Up to 1 year	9	12.9	8	19.0	4	18.2		
	Up to 3 years	25	30.1	27	56.3	16	69.6		
	Up to 5 years	6	7.2	0	0.0	0	0.0		
	More than 5 years	13	15.7	3	6.3	1	4.3		
Improved	Health	57	68.7	25	52.1	18	78.3	0.207	<0.001
	Employment	45	54.2	23	47.9	15	65.2	0.171	<0.001
	Relationships	60	72.3	25	52.1	15	65.2	0.240	<0.001
	Emotional functioning	69	83.1	31	64.6	18	78.3	0.255	<0.001
	Sexual functioning	37	44.6	17	35.4	9	39.1	0.181	<0.001
	Morality	55	66.3	28	58.3	12	52.2	0.234	<0.001
	Legal problems	27	32.5	11	22.9	5	21.7	0.170	<0.001
	Financial	42	50.6	27	56.3	14	60.9	0.158	<0.001
Nothing improved		6	7.2	8	16.7	1	4.3	0.062	0.135

Table 4. Duration of Individual Psychotherapy, Duration of Remission, and Improvements in the Most Important Life Areas as Assessed by Respondents

Individual Psychotherapy		Outpatient (N=200)		MP (N=199)		Detox (N=188)		r_s	P
		N	%	N	%	N	%		
Individual psychotherapy	Attended	57	28.5	30	15.1	22	11.7	0.177	<0.001
	Did not attend	143	71.5	169	84.9	166	88.3		
Duration of attendance	Up to 6 months	28	49.1	21	70.0	20	90.9	-0.187	<0.001
	Up to 1 year	11	19.3	2	6.7	1	4.5		
	Up to 3 years	7	12.3	3	10.0	1	4.5		
	More than 3 years	11	19.3	1	3.3	0	0.0		
Duration of remission	Up to 1 month	11	19.3	6	20.0	4	18.2	-0.197	<0.001
	Up to 6 months	13	22.8	9	30.0	5	22.7		
	Up to 1 year	3	5.3	5	16.7	3	13.6		
	Up to 3 years	9	15.8	0	0.0	2	9.1		
	Up to 5 years	5	8.8	2	6.7	0	0.0		
	More than 5 years	8	14.0	0	0.0	1	4.5		
What improved?	Health	31	54.4	14	46.7	13	59.1	0.119	0.004
	Employment	29	50.9	14	46.7	9	40.9	0.140	0.001
	Relationships	40	70.2	20	66.7	15	68.2	0.148	<0.001
	Emotional functioning	45	79.0	21	70.0	13	59.1	0.187	<0.001
	Sexual functioning	19	33.3	11	36.7	5	22.7	0.118	0.004
	Morality	35	61.4	16	53.3	13	59.1	0.140	0.001
	Legal problems	15	26.3	7	23.3	1	4.5	0.146	<0.001
	Financial	23	40.4	13	43.3	5	22.7	0.141	0.001
Nothing improved		7	12.3	3	10.0	1	4.5	0.089	0.030

outpatients (28.5%), 30 MP respondents (15.1%), and 22 detoxification department respondents (11.7%) who attended it ($r_s=0.177$; $P<0.001$). In the inpatient clinical treatment group, 2 MP respondents (6.7%) and 1 detoxification respondent (4.5%) attended individual psychotherapy for up to 1 year, but there were 11 such outpatients (19.3%). There were 7 outpatients (12.3%), 3 MP patients (10.0%), and 1 detoxification patient (4.5%) who attended individual psychotherapy for up to 3 years, and there were 11 outpatients (19.3%), 1 MP patient (3.3%), and no detoxification patients who attended individual psychotherapy for more than 3 years ($r_s=-0.187$; $P<0.001$). Three outpatient respondents (5.3%), 5 MP respondents (16.7%), and 3 detoxification respondents (13.6%) who all attended individual psychotherapy had remission of 6 months to a year ($r_s=-0.197$; $P<0.001$). There were 22 outpatient respondents (38.6%), 2 MP respondents (6.7%), and 3 detoxification respondents (13.6%) who had remission of more than 1 year. Improvements in the most important life areas were noted by both inpatient and outpatient respondents (Table 4). Of those who attended individual psychotherapy, 79.0% ($n=45$) of the outpatients and 70.0% of the MP respondents noticed improvements in the emotional area ($r_s=0.187$; $P<0.001$). There were 59.1% of the detoxification respondents who noticed improvements in the social and relationship areas ($r_s=0.148$; $P<0.001$). Nonetheless, 7 outpatients (12.3%), 3 MP patients (10.0%), and 1 detoxification patient (4.5%) noticed no improvement in any life areas after attending individual psy-

chotherapy ($r_s=0.089$; $P=0.030$).

There was a statistically significant correlation between the respondent place of treatment and the attendance of group psychotherapy, its duration, duration of remission, and improvements in the most important life areas (Table 5). Group psychotherapy was attended by 29 outpatient respondents (14.5%), 8 MP respondents (4.0%), and 4 detoxification department respondents (2.1%) ($r_s=0.199$; $P<0.001$). Among the inpatient clinical treatment respondents, group psychotherapy was attended for up to 1 year by 3 MP respondents (10.3%) and by 2 detoxification respondents (25.0%), but only by 2 outpatient respondents (50.0%). Group psychotherapy was attended for more than 1 year by 13 outpatient respondents (44.8%), none of the MP respondents, and 1 detoxification respondent (25.0%) ($r_s=-0.191$; $P<0.001$). Three outpatient respondents (10.3%), 1 MP respondent (12.5%), and 1 detoxification respondent (25.0%) who attended group psychotherapy had remission of 6 months to 1 year ($r_s=-0.223$; $P<0.001$). Remission of more than 1 year was shown by 15 outpatient respondents (51.6%) and none of the MP or detoxification respondents who attended group psychotherapy. Improvements in the most important life areas were noted by both inpatient and outpatient respondents (Table 5). There were 23 outpatient respondents (79.3%) who attended group psychotherapy and noted improvements in the emotional area ($r_s=0.202$; $P<0.001$) and 3 MP respondents (37.5%) who noted improvements in the health area ($r_s=0.183$; $P<0.001$), emotional area, and moral area ($r_s=0.189$; $P<0.001$). Two detoxification re-

Table 5. Duration of Attending Group Psychotherapy, Duration of Remission, and Improvements in the Most Important Life Areas as Assessed by Respondents

Group Psychotherapy		Outpatient (N=200)		MP (N=199)		Detox (N=188)		r_s	P
		N	%	N	%	N	%		
Group psychotherapy	Attended	29	14.5	8	4.0	4	2.1	0.199	<0.001
	Did not attend	171	85.5	191	96.0	184	97.9		
Duration of attendance	Up to 6 months	11	37.9	5	62.5	1	25.0	-0.191	<0.001
	Up to 1 year	3	10.3	2	25.0	2	50.0		
	Up to 3 years	4	13.8	0	0.0	1	25.0		
	More than 3 years	9	31.0	0	0.0	0	0.0		
Duration of remission	Up to 1 month	3	10.3	0	0.0	0	0.0	-0.223	<0.001
	Up to 6 months	5	17.2	5	62.5	0	0.0		
	Up to 1 year	3	10.3	1	12.5	1	25.0		
	Up to 3 years	3	10.3	0	0.0	0	0.0		
	Up to 5 years	5	17.2	0	0.0	0	0.0		
	More than 5 years	7	24.1	0	0.0	0	0.0		
What improved?	Health	18	62.1	3	37.5	1	25.0	0.183	<0.001
	Employment	17	58.6	2	25.0	1	25.0	0.181	<0.001
	Relationships	21	72.4	2	25.0	0	0.0	0.223	<0.001
	Emotional functioning	23	79.3	3	37.5	2	50.0	0.202	<0.001
	Sexual functioning	11	37.9	1	12.5	1	25.0	0.139	0.001
	Morality	21	72.4	3	37.5	2	50.0	0.189	<0.001
	Legal problems	8	27.6	1	12.5	0	0.0	0.134	0.001
	Financial	11	37.9	2	25.0	1	25.0	0.134	0.001
Nothing improved		1	3.4	0	0.0	0	0.0	0.050	0.226

spondents (50.0%) reported improvements in the emotional and morality areas. Nonetheless, there was 1 outpatient respondent (3.4%) who claimed that nothing in his life had improved after attending group psychotherapy ($r_s=0.050$; $P=0.226$). There was no statistically significant correlation between the respondent place of treatment and the fact that there was no improvement.

Discussion

In the treatment of SUD patients, the main approach involves a combination of different treatment options (10, 11). It is necessary to use a drug-related therapy as well as psychosocial treatment for SUD patients in order to reduce the negative consequences of addiction and help patients change their attitude toward themselves and their illness.

The mean age of respondents was 37–41 years. This is in agreement with other research data in which SUD patients typically seek treatment between 35 and 55 years of age (15–17).

The male-to-female ratio in the study groups was 2:1 even though this ratio is 4:1 in the general population in Latvia (18). This ratio remains the same for both inpatient and outpatient men and women. Compliance and responsiveness of women in filling out the research forms, however, were better than those of men. This perhaps has to do with the women's social role in society (empathy, compliance, responsiveness, helpfulness, etc.).

A statistically significant number of outpatient respondents were employed. The ratio of employed to unemployed patients was 1.5:1, but it was 1:2 for inpatient respondents. Does this mean that employed addicts choose outpatient care instead of inpatient care or is the opposite true and employment inhibits drug use? Research has shown that stable employment can facilitate abstinence, and pressure at work can instigate seeking help sooner (19). Even so, some studies have reported that individuals seek help with a greater frequency if they face legal difficulties and problems at work (15, 20).

The outpatient respondents were more likely have a university education than the inpatient respondents although the difference was not statistically significant. This in turn confirms a number of previous studies that people with higher levels of education and income tend to seek better treatment options. Still, there are other studies revealing that men have a greater tendency to seek help if they are worse educated and unmarried (13).

The outpatient respondents previously sought self-help group, individual, and group psychotherapy sessions statistically significantly more often than the inpatient respondents. The group psychotherapy data for inpatient respondents should be assessed cautiously due to a small size of the respondent

group (only 12 patients). The respondents more often choose self-help groups rather than psychotherapy. In addition, Grant et al. (21) makes the point that three-fourths of those who at one time sought treatment had attended alcoholics anonymous groups. Comparison of the attendance of individual therapy sessions and group psychotherapy showed that respondents preferred individual psychotherapy. The outpatient respondents were 2 times more likely to choose individual therapy sessions, but the inpatient respondents chose it 4–5 times more frequently than group therapy.

The inpatient respondents tended to begin attending self-help groups or psychotherapy, then interrupted attending, and the vast majority ceased therapy in the first year. This is confirmed in related literature (22). Contrary, the outpatient respondents continued to attend self-help groups and psychotherapy for extended periods. It is possible that the attendance of self-help groups and psychotherapy and employment caused them to remain as inpatients. Even so, some studies have reported (23, 24) that patients with more severe addiction and more severe psychosocial disorders have a greater tendency to form an attachment with these self-help groups and to continue attending them for extended periods. Patients who had more pronounced adherence to the group showed better results (25) as well as by those patients who feel noticeable improvements and are able to devote enough time to therapy (26). Ouimette et al. (27) found that patients who approved the 12-step philosophy and the self-help view as the illness model were more involved in self-help groups.

The inpatient respondents attending self-help groups were in remission mostly for up to 3 years, and those following psychotherapy for up to a year. Nearly 16% of the outpatient respondents attending self-help groups were in remission for more than 5 years; the corresponding percentages of those attending individual therapy and group psychotherapy were 14% and 24.1%, respectively. This is confirmed in the relevant literature that self-help groups and psychotherapy help maintain and sustain remission (26, 28–30).

According to Johnson and Zlotnick, group psychotherapy in comparison with individual psychotherapy is more effective in SUD patients (29). This depends on inborn sensitivity to the surrounding opinion of others. The opinion of the group has a tremendous influence on an individual's behavior. Other important factor is the processes that take place within the group (31, 32). The abilities to identify one's emotional experiences and emotions, empathy, as well as how an individual may experience a catharsis, how to find more effective behavior patterns, and how to practice to use them are

trained. It is important to begin within the group and later outside it.

Except for the detoxification, the respondents who showed most improvement in personal relationships following individual psychotherapy, the most important improvement was emphasized in their emotions and emotional area of life no matter what kind of therapy was used. SUD patients experience pronounced disorders in their emotional lives. These disorders are associated with the feelings of guilt, shame about one's behavior, remorse, and condemnation of oneself, which lessen once the patient stays sober (33). By overcoming alexithymia, which is typical of SUD patients, during psychotherapy patients learn to identify their experiences, organize and verbalize these experiences, and solve conflicts in relationships. This is confirmed by the relevant literature sources referring to the effectiveness of psychotherapy on SUD patients (29, 30).

The respondents also showed significant improvements in their relationship, social, moral, and physical health areas. However, patients often tended to confuse 2 areas, the emotional and the moral; the feelings of remorse, guilt, or anger at oneself for things done to themselves and others were named by patients as "moral hangover," but not the emotional one. There was a definite improvement in the respondents' health since the use of drugs and alcoholism lead to serious health problems. It was surprising that these improvements were not most important to the respondents. This is possible perhaps because addicts do not associate turning to a psychotherapist or attending a self-help group with physical health ailments. In addition, it is possible that it is related to the rapid reduction of physical symptoms of withdrawal. It is possible that defense mechanisms work to obstruct addicts from serious health ailments (chronic pancreatitis, stomach and intestine illnesses, neuropathy, hypertension, etc.) associated with the consequences of drug use (34, 35).

Nevertheless, part of the respondents claimed that no benefit was gained in their lives following the attendance of self-help groups and psychotherapy. Even after the attendance of self-help groups and psychotherapy, there was a proportion of respondents that mentioned no improvement at all. It is possible that this is related to the premature ceasing of therapy sessions and the fact that psychotherapy did not provide immediate results, which SUD patients often expect. It is possible that patients fear the openness of therapy and better use the mechanism of avoidance of those things that are hurtful.

Further studies are necessary to continue this

research of the influence of psychotherapy and self-help groups on SUD patients in Latvia by expanding the study group and revising the respondent's questionnaire form.

Study Limitations. Since only the accessible respondent group was used for this study from the population of the 2 largest cities in Latvia, the actual results as they relate to the entire population as a whole remain limited. It would be necessary to expand the research respondent group to reflect all the regions of Latvia.

The study questionnaire was compiled by the author of this study. Even though the questionnaire had been deemed valid in a prior pilot-research project, it is possible that this may have influenced the results. Therefore, it would be necessary to improve this form by providing answers in the format of the Likert scale as well as by including questions pertaining to the various psychotherapy methods.

In this study, a patient self-assessment questionnaire was used and the remission periods provided by the patients themselves were used, which could have possibly influenced the accuracy of the results.

Nevertheless, all the questionnaires were given individually maintaining strict confidentiality. In this way, it reduced the patient's desire to hide information of their personal lives or their treatment.

Conclusions

The research has shown that by continuing to attend self-help groups and with the aid of psychotherapy patients had a greater success rate in staying in remission, maintaining outpatient care, and shedding the need of inpatient care.

The outpatient respondents tended to keep their job and attend self-help groups and psychotherapy sessions more often and maintained remission longer. On the other hand, the inpatient respondents tended to discontinue attending self-help groups and psychotherapy sessions within the first year, while outpatient respondents continued to attend these groups and sessions for more than 3 years.

The attendance of group psychotherapy sessions provided most respondents with the remission periods of more than 5 years. A minority of respondents noticed little or no improvement in their most important areas of life following group psychotherapy. Nevertheless, the respondents stressed that the main improvement was in their emotional state.

Further research is needed by expanding the study sample size and by including all regional SUD patients in Latvia.

Statement of Conflict of Interest

The authors state no conflict of interest.

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