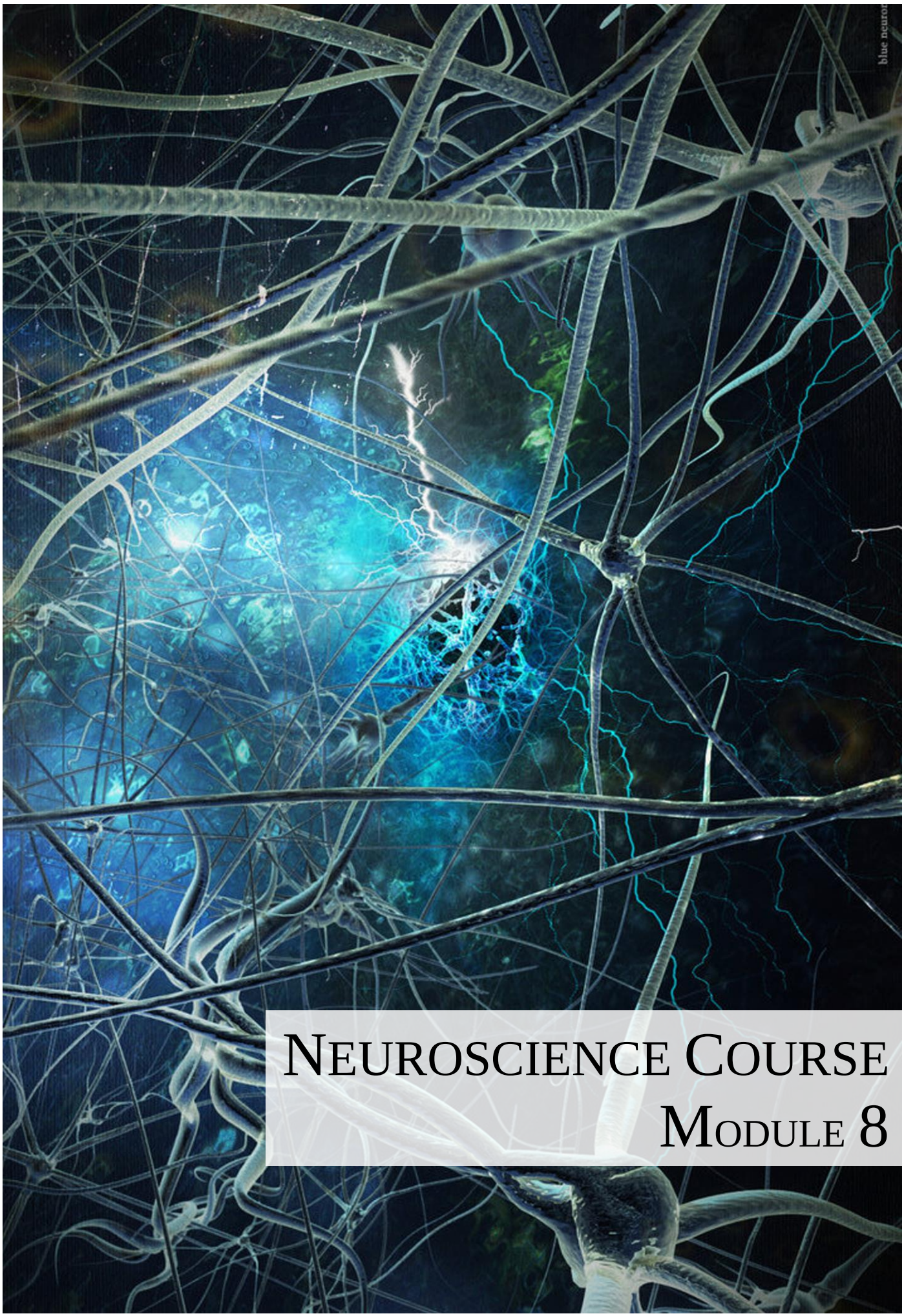


Neuroscience Course
Module 8

Treatment for an addiction does not just happen. Furthermore, it is impossible to rely on the same procedure for several patients. The approach is always individual, hence the importance of careful preparation.

Appropriate treatment requires a proper understanding of the patient's psychological state, but also of the reasons why they have gone down this path. The neuropsychological assessment serves to evaluate the situation. The approach must also take several elements into consideration in order for the treatment to be adapted to the patient.

Assessing the patient

The first phase of the assessment is to take the patient's medical history:

- Their addiction history.
- Reasons why they want to put an end to their addiction.
- Their plans and ambitions for the end of their treatment.
- Their physical and psychological state.

Then come the neuropsychological and psychometric tests:

- Assessment of episodic memory.
- Assessment of visuoconstruction.
- Assessment of working memory.
- Assessment of attention faculties.
- Assessment of executive functions.
- Analysis of the patient's medical record (to detect factors that could potentially complicate treatment, such as deficiencies and psychiatric problems).

Overview of a few tests

Many different tests are used. They are employed as supplements to the discussion the specialist will have with the patient.

Conventional addiction tests

✪ Alcohol addiction tests

The AUDIT (Alcohol Use Disorders Identification Test) questionnaire

This is a relatively simple test developed by the World Health Organization. It is used to diagnose the risks of alcohol addiction.

If the score obtained is less than 8 for men and less than 7 for women, the individual presents no risk of alcohol dependence. If the score is between 8 and 12 for men and 7 and 12 for women, the

individual presents a clear tendency towards dependence. A score higher than 12 indicates a clear alcohol addiction.

	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week
How often do you have a drink containing alcohol?	*0*	*1*	*2*	*3*	*4*

	1 or 2	3 or 4	4 or 5	7 to 9	10 or more
How many units of alcohol do you drink on a typical day when you are drinking?	*0*	*1*	*2*	*3*	*4*

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	*0*	*1*	*2*	*3*	*4*
How often during the last year have you found that you were not able to stop drinking once you had started?	*0*	*1*	*2*	*3*	*4*
How often during the last year have you failed to do what was normally expected from you because of your drinking?	*0*	*1*	*2*	*3*	*4*
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	*0*	*1*	*2*	*3*	*4*
How often during the last year have you had a feeling of guilt or remorse after drinking?	*0*	*1*	*2*	*3*	*4*

How often during the last year have you been unable to remember what happened the night before because you had been drinking?	*0*	*1*	*2*	*3*	*4*

	No	*Yes, but not in the last year*	*Yes, during the last year*
Have you or somebody else been injured as a result of your drinking?	*0*	*2*	*4*
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	*0*	*2*	*4*
You are: ☐ Male ☐ Female			

The CRAFFT test

The CRAFFT test was developed to detect signs of alcohol addiction in adolescents. However, it applies to other psychoactive substances too. It is important to show the patient they can trust you by telling them that the answers they give will remain confidential.

The test is made up of two parts. The most important part is in fact the second. Every "yes" response the patient gives is worth 1 point (and every "no" is worth 0). Any score higher than 2 indicates excessive consumption of psychoactive substances and requires the patient to undergo additional evaluation.

Part A	*Yes*	*No*
During the past 12 months, have you:		
Drunk more than a few sips of alcohol? (Do not count any sips of alcohol you have had during family or religious gatherings.)		
Used any marijuana or hash?		
Used anything else to get high? (Like other illegal drugs, pills, prescription or over-the-counter medication, and things that you sniff, huff, vape or inject.)		

If the person answered "no" to all the questions above, only ask the CAR question, then stop.

If the person answered "yes" to one of the questions above, ask the 6 CRAFFT questions.

Part B		*YES*	*NO*
C	*Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?*		
R	*Do you ever use alcohol or drugs to RELAX, feel better about yourself or fit in?*		
A	*Do you ever use alcohol or drugs while you are by yourself, ALONE?*		
F	*Do you ever FORGET things you did while using alcohol or drugs?*		
F	*Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?*		
T	*Have you ever gotten into TROUBLE while you were using alcohol or drugs?*		

Nicotine addiction tests

Fagerström test

This assesses the intensity of nicotine dependence. A score of 2 or less indicates an absence of nicotine dependence. A score of 3 or 4 indicates a relatively low level of dependence. 5 to 6 represents an average level of dependence, 7 to 8 is strong, and 9 to 10 is extremely strong.

How soon after you wake up do you smoke your first cigarette ?	*Within 5 minutes*	*3*
	6 to 30 minutes	*2*
	31 to 60 minutes	*1*
	After 60 minutes	*0*
Do you find it difficult to refrain from smoking in places where it is forbidden (e.g., in church, at the library, at the cinema)?	*No*	*0*
	Yes	*1*
Which cigarette would you hate most to give up?	*The first one in the morning*	*1*
	Any other	*0*
How many cigarettes per day do you smoke?	*10 or less*	*0*
	11 to 20	*1*
	21 to 30	*2*
	31 or more	*3*

Do you smoke more frequently during the first hours after waking than during the rest of the day?	*Yes*	*1*
	No	*0*
Do you smoke when you are so ill that you are in bed most of the day?	*Yes*	*1*
	No	*0*

Lagrue and Légeron's test

This test does not analyze the degree of nicotine dependence, but rather the patient's motivation to end their addiction. Any score above 6 indicates a satisfactory level of motivation. A score lower than 6 shows minimal motivation.

Do you think that in 6 months' time:	*You will still smoke just as much*	*0*
	You will have reduced your cigarette consumption slightly	*2*
	You will have reduced your cigarette consumption significantly	*4*
	You will have stopped smoking	*8*
Do you currently want to stop smoking?	*Not at all*	*0*
	A little	*1*
	A lot	*2*
	Hugely	*3*
Do you think that in 4 weeks' time:	*You will still smoke just as much*	*0*
	You will have reduced your cigarette consumption slightly	*2*
	You will have reduced your cigarette consumption significantly	*4*
	You will have stopped smoking	*8*
Do you ever feel unhappy about your smoking?	*Never*	*0*
	Sometimes	*1*
	Often	*2*

	Always	*3*

The HONC (Hooked on Nicotine Checklist)

This ten-question test demonstrates the relationship between the individual and nicotine. To be more precise, it reveals their capacity to resist nicotine consumption or not. This test was developed to assess young nicotine users.

The subject has to answer each of the questions with a yes or no. Every "yes" is worth 1 point and any positive response confirms nicotine dependence. The higher the score, the stronger the dependence. A score of more than 7 points indicates total dependence.

	YES	*NO*
Have you ever tried to quit, but couldn't?		
Do you smoke now because it is really hard to quit?		
Have you ever felt like you were addicted to tobacco?		
Do you ever have strong cravings to smoke?		
Have you ever felt like you really needed a cigarette?		
Is it hard to keep from smoking in places where you are not supposed to, like school?		
✪ **When you tried to stop smoking (or when you haven't used tobacco for a while):**		
Did you find it hard to concentrate?		
Did you feel more irritable?		
Did you feel a strong need or urge to smoke?		
Did you feel nervous, restless or anxious?		

The HORN test

The Fagerström test indicates the subject's physical dependence on tobacco. In contrast, the HORN test examines psychological dependence on tobacco. It enables the therapist to understand the reasons why the patient smokes.

	Always	*Frequently*	*Occasionally*	*Seldom*	*Never*

I smoke cigarettes to keep from slowing down.	*5*	*4*	*3*	*2*	*1*
Handling a cigarette is part of the enjoyment of smoking.	*5*	*4*	*3*	*2*	*1*
Smoking cigarettes is pleasant and relaxing.	*5*	*4*	*3*	*2*	*1*
I light a cigarette when I'm upset about something.	*5*	*4*	*3*	*2*	*1*
When I run out of cigarettes, I find it almost unbearable.	*5*	*4*	*3*	*2*	*1*
I smoke automatically without even being aware of it.	*5*	*4*	*3*	*2*	*1*
I smoke to perk myself up.	*5*	*4*	*3*	*2*	*1*
Part of the enjoyment of smoking comes from the steps I take to light up.	*5*	*4*	*3*	*2*	*1*
I find cigarettes pleasurable.	*5*	*4*	*3*	*2*	*1*
When I feel uncomfortable about something, I light up a cigarette.	*5*	*4*	*3*	*2*	*1*
I am very much aware of the fact when I am not smoking.	*5*	*4*	*3*	*2*	*1*
I light up a cigarette without realizing I still have one burning in the ashtray.	*5*	*4*	*3*	*2*	*1*
I smoke to give myself a "lift".	*5*	*4*	*3*	*2*	*1*
Part of the enjoyment of smoking is in watching the smoke I inhale.	*5*	*4*	*3*	*2*	*1*
I want a cigarette most when I am comfortable and relaxed.	*5*	*4*	*3*	*2*	*1*
When I feel blue or want to take my mind off my cares, I smoke a cigarette.	*5*	*4*	*3*	*2*	*1*
I get a real craving for a cigarette when I haven't smoked for a while.	*5*	*4*	*3*	*2*	*1*
I've found a cigarette in my mouth and didn't remember having put it there.	*5*	*4*	*3*	*2*	*1*

Drug addiction tests (heroin, cocaine, cannabis, etc.)

Cognitive scale of attachment to benzodiazepines

This facilitates assessment of the cognitive state of a patient who has been taking benzodiazepines for a while (at least a few months). Patients who get a score of 6 or less are not dependent on these substances. A score above 6 indicates a clear dependence.

	True	*False*
Wherever I go, I need to have this medication with me.	*1*	*0*
This medication is like a drug to me.	*1*	*0*
I often think I will never be able to stop taking this medication.	*1*	*0*
I avoid telling my friends and family that I am taking this medication.	*1*	*0*
Sometimes I feel like I take far too much of this medication.	*1*	*0*
I sometimes feel scared at the thought of missing this medication.	*1*	*0*
When I stop taking this medication, I feel very unwell.	*1*	*0*
I take this medication because I cannot do without it anymore.	*1*	*0*
I take this medication because I feel bad when I stop.	*1*	*0*
I only take this medication when I feel the need to.	*0*	*1*

The CAST (Cannabis Abuse Screening Test)

This is designed to assess the degree of addiction to cannabis. It is a tracking scale and each question makes it possible to identify “cannabis use behaviors or problems that arise in the context of cannabis use”.

A score below 3 indicates that the subject displays no signs of dependence. A score between 3 and 6 shows that there are risks to be taken into consideration. A score above 6 means the individual is dependent.

	Never	*Rarely*	*From time to time*	*Fairly often*	*Very often*
Have you smoked cannabis before midday?	*0*	*0*	*1*	*1*	*1*

Have you smoked cannabis when you were alone?	*0*	*1*	*1*	*1*	*1*
Have you had memory problems when you smoked cannabis?	*0*	*1*	*1*	*1*	*1*
Have friends or family members told you that you should reduce or stop your cannabis consumption?	*0*	*1*	*1*	*1*	*1*
Have you tried to reduce or stop your cannabis use without succeeding?	*0*	*1*	*1*	*1*	*1*
Have you had problems because of your cannabis use (argument, fight, accident, poor results at school...)?	*0*	*1*	*1*	*1*	*1*

The DAST-20 (Drug Abuse Screening Test in 20 Questions)

Developed by the Addiction Research Foundation, a Canadian charity, this test indicates the degree of severity of drug taking. It can be adapted for all psychoactive substances apart from tobacco and alcohol.

A score of 5 or below indicates that the subject does not need help as they are not suffering from addiction. A score between 6 and 10 means the subject's condition merits particular attention, even if they do not present signs of dependence yet. A score between 11 and 15 indicates that the risks of addiction are significant and the individual needs help. A score above 15 means the subject is suffering from severe addiction.

	1	**0**	**Score for this line**
Have you used drugs other than those required for medical reasons?	Yes	No	
Have you abused prescription drugs?	Yes	No	
Do you abuse more than one drug at a time?	Yes	No	
Can you get through the week without using drugs?	Yes	No	
Are you always able to stop using drugs when you want to?	Yes	No	

Have you had 'blackouts' or 'flashbacks' as a result of drug use?	Yes	No	
Do you ever feel bad or guilty about your drug use?	Yes	No	
Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No	
Has drug abuse created problems between you and your spouse or your problems?	Yes	No	
Have you lost friends because of your use of drugs?	Yes	No	
Have you neglected your family because of your use of drugs?	Yes	No	
Have you been in trouble at work because of drugs?	Yes	No	
Have you lost a job because of drug abuse?	Yes	No	
Have you gotten into fights when under the influence of drugs?	Yes	No	
Have you engaged in illegal activities in order to obtain drugs?	Yes	No	

Have you been arrested for possession of illegal drugs?	Yes	No	
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No	
Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No	
Have you gone to anyone for help for a drug problem?	Yes	No	
Have you been involved in a treatment program specifically related to drug use?	Yes	No	

The ALAC test

The ALAC test is particularly effective because it allows the patient to offer an indirect judgement on their own condition. Virtually all tests and questionnaires tend to interrogate the patient, but also judge them in a way. At least, this is the impression that many people invited to take them get.

The ALAC test reduces the probing aspect and gives the patient the possibility to simply share their everyday activities. As they do not feel like they are being criticized, the patient is more open and communicates more freely with their therapist. Three “yes” responses indicate problematic use of cannabis.

	Yes	*No*
Have those close to you complained about your cannabis use?		
Do you have short-term memory problems?		
Have you ever had delusional episodes when using cannabis?		

Do you find it difficult to go a day without smoking a joint?		
Do you lack the energy to do the things you would normally do?		
Have you ever felt worried by the effects of your cannabis use?		
Do you have greater difficulty studying and absorbing new information?		
Have you previously tried unsuccessfully to reduce or stop your cannabis use?		
Do you like being high or stoned in the morning?		
Are you stoned increasingly often?		
Have you felt a very strong desire to use cannabis, had headaches, felt irritable or had trouble concentrating when you reducing or stopping your use of cannabis?		

✪ Behavioral addiction tests

✦ Internet addiction tests – The Bergen Facebook Addiction Scale

Developed by Norwegian researchers, this makes it possible to analyze both the risks of Facebook addiction and the possible degree of dependence.

A score between 6 and 9 points means the subject does not present any signs of dependence to the social media platform. A score of over 9 points means they need expert help.

	Very rarely	*Rarely*	*Sometimes*	*Often*	*Very often*
You spend a lot of time thinking about Facebook or what you are going to do on Facebook.	*1*	*2*	*3*	*4*	*5*
You always feel an urge to use Facebook more and more.	*1*	*2*	*3*	*4*	*5*
You use Facebook to forget about your personal problems.	*1*	*2*	*3*	*4*	*5*
You have tried to cut down on your use of Facebook, without success.	*1*	*2*	*3*	*4*	*5*
You become restless or troubled if you cannot use Facebook.	*1*	*2*	*3*	*4*	*5*
You use Facebook so much that it has a negative impact on your job or studies.	*1*	*2*	*3*	*4*	*5*

The IAT (Internet Addiction Test)

As its name suggests, this test indicates the subject's degree of internet addiction. It addresses all forms of addictions linked to the internet. It is a test composed of 20 questions developed by Kimberley Young. The patient's score can be between 0 and 100.

A score below 50 means the subject does not have an addiction. They may spend more time online than the average person, but no more than that. A score between 50 and 79 indicates that the subject has a complex relationship with the internet. They need expert help. A score of 80 or over indicates that internet usage is already having negative repercussions on the subject's everyday life.

	Never	*Rarely*	*Occasionally*	*Sometimes*	*Often*	*Always*
Do you find that you stay online longer than you intended?	*0*	*1*	*2*	*3*	*4*	*5*
Do you neglect household chores to spend more time online?	*0*	*1*	*2*	*3*	*4*	*5*
Do you prefer the excitement of the internet to intimacy with your partner?	*0*	*1*	*2*	*3*	*4*	*5*
Do you form new relationships with fellow internet users?	*0*	*1*	*2*	*3*	*4*	*5*
Do others in your life complain to you about the amount of time you spend online?	*0*	*1*	*2*	*3*	*4*	*5*
Does your work suffer because of the amount of time you spend online (e.g. postponing things, not meeting deadlines)?	*0*	*1*	*2*	*3*	*4*	*5*
Do you check your email before something else you need to do?	*0*	*1*	*2*	*3*	*4*	*5*
Does your job performance or productivity suffer because of the internet?	*0*	*1*	*2*	*3*	*4*	*5*
Do you become defensive or secretive when anyone asks you what you do online?	*0*	*1*	*2*	*3*	*4*	*5*

Do you block disturbing thoughts about your life with soothing thoughts of the internet?	*0*	*1*	*2*	*3*	*4*	*5*
Do you find yourself anticipating when you will go online again?	*0*	*1*	*2*	*3*	*4*	*5*
Do you fear that life without the internet would be boring, empty or joyless?	*0*	*1*	*2*	*3*	*4*	*5*
Do you snap, yell or act annoyed if someone bothers you while you are online?	*0*	*1*	*2*	*3*	*4*	*5*
Do you lose sleep due to late-night internet use?	*0*	*1*	*2*	*3*	*4*	*5*
Do you feel preoccupied with the internet when not online, or fantasize about being online?	*0*	*1*	*2*	*3*	*4*	*5*
Do you find yourself saying "just a few more minutes" when online?	*0*	*1*	*2*	*3*	*4*	*5*
Do you try to cut down on the amount of time you spend online and fail?	*0*	*1*	*2*	*3*	*4*	*5*
Do you try to hide how long you've been online?	*0*	*1*	*2*	*3*	*4*	*5*
Do you choose to spend more time online over spending time out with others?	*0*	*1*	*2*	*3*	*4*	*5*
Do you feel depressed, moody or nervous when you are not online, and do these feelings go away for a while when you go back online?	*0*	*1*	*2*	*3*	*4*	*5*

Gambling addiction tests

The SOGS-RA test

This test is generally used for adolescents, but it can also work for adults. Developed by Sheila Blume and Henry Lesieur, it helps to diagnose the signs of pathological gambling by focusing on both their family and personal history.

The maximum score is 20. A score of 0 indicates the individual does not have a problem. A score between 1 and 4 suggests the subject presents problematic behavior regarding gambling, but that it is not yet an addiction. A score of 5 or more indicates that the subject has a clear gambling addiction.

	No, never	*Yes, at least once*	*Yes, several times*	*Yes, every time*
Have you ever gone back another day to try to win back money you lost gambling?	*0*	*1*	*2*	*3*

	Yes	*No*
Have you ever told others you were winning money when you weren't?	*1*	*0*
Have your gambling habits ever caused any problems for you, such as arguments with family and friends, or problems at school or work?	*1*	*0*
Have you ever gambled more than you had planned to?	*1*	*0*
Has anyone ever criticized your betting or told you that you had a gambling problem, whether you thought it true or not?	*1*	*0*
Have you ever felt bad about the amount of money you bet, or about what happens when you bet money?	*1*	*0*
Have you ever felt like you would like to stop betting, but didn't think you could?	*1*	*0*
Have you ever hidden from family or friends any betting slips, IOUs, lottery tickets, money that you won, or any signs of gambling?	*1*	*0*
Have you had money-related arguments with family or friends that centered on gambling?	*1*	*0*
Have you ever borrowed money to bet and not paid it back?	*1*	*0*
Have you ever skipped or been absent from school or work due to betting activities?	*1*	*0*

The ICJE test (Canadian index of excessive gambling)

This assesses the subject's dependence on gambling over the past 12 months prior to taking the test. The higher the score, the stronger the dependence.

A score of 0 indicates a non-problematic relationship with gambling. A score of 1 or 2 represents a low-risk relationship with gambling. A score of 3 to 7 indicates a moderate risk, and a score of 8 to 27 reflects a problematic relationship with gambling.

	Never	*Sometimes*	*Most of the time*	*Almost always*
Do you ever bet more money than you can afford to lose?	*0*	*1*	*2*	*3*
Do you need to bet increasing amounts of money in order to feel the same degree of excitement?	*0*	*1*	*2*	*3*
Do you go back another day to try to win back the money you lost gambling?	*0*	*1*	*2*	*3*
Do you ever need to sell or borrow things to get money to gamble with?	*0*	*1*	*2*	*3*
Do you ever feel that you might have a problem with gambling?	*0*	*1*	*2*	*3*
Does gambling cause you health problems, including stress or anxiety?	*0*	*1*	*2*	*3*
Do people ever criticize your gambling habits or say you have a problem with gambling?	*0*	*1*	*2*	*3*
Do your gambling habits ever cause financial difficulties for you or those close to you?	*0*	*1*	*2*	*3*
Do you ever feel guilty about your gambling habits or what happens when you gamble?	*0*	*1*	*2*	*3*

Food addiction tests

The EAT-26 test

This test enables specialists to get an idea of the relationship the patient has with food and detect problematic behavior. A score below 20 means the individual does not have a problem. A score higher than 20 means the patient presents addictive behavior regarding food.

Always	*Usually*	*Often*	*Sometimes*	*Rarely*	*Never*

I am terrified about being overweight.	*3*	*2*	*1*	*0*	*0*	*0*
I avoid eating when I am hungry.	*3*	*2*	*1*	*0*	*0*	*0*
I find myself preoccupied with food.	*3*	*2*	*1*	*0*	*0*	*0*
I have gone on eating binges where I feel that I may not be able to stop.	*3*	*2*	*1*	*0*	*0*	*0*
I cut my food into small pieces.	*3*	*2*	*1*	*0*	*0*	*0*
I am aware of the calorie content of foods that I eat.	*3*	*2*	*1*	*0*	*0*	*0*
I particularly avoid food with a high carbohydrate content (i.e., bread, rice, potatoes, etc.).	*3*	*2*	*1*	*0*	*0*	*0*
I feel that others would prefer if I ate more.	*3*	*2*	*1*	*0*	*0*	*0*
I vomit after I have eaten.	*3*	*2*	*1*	*0*	*0*	*0*
I feel extremely guilty after eating.	*3*	*2*	*1*	*0*	*0*	*0*
I am occupied by a desire to be thinner.	*3*	*2*	*1*	*0*	*0*	*0*
I think about burning calories when I exercise.	*3*	*2*	*1*	*0*	*0*	*0*
Other people think that I am too thin.	*3*	*2*	*1*	*0*	*0*	*0*
I am preoccupied with the thought of having fat on my body.	*3*	*2*	*1*	*0*	*0*	*0*
I take longer than others to eat my meals.	*3*	*2*	*1*	*0*	*0*	*0*
I avoid foods with sugar in them.	*3*	*2*	*1*	*0*	*0*	*0*
I eat diet foods.	*3*	*2*	*1*	*0*	*0*	*0*
I feel that food controls my life.	*3*	*2*	*1*	*0*	*0*	*0*
I display self-control around food.	*3*	*2*	*1*	*0*	*0*	*0*
I feel that others pressure me to eat.	*3*	*2*	*1*	*0*	*0*	*0*
I give too much time and thought to food.	*3*	*2*	*1*	*0*	*0*	*0*
I feel uncomfortable after eating sweets.	*3*	*2*	*1*	*0*	*0*	*0*
I engage in dieting behavior.	*3*	*2*	*1*	*0*	*0*	*0*
I like my stomach to be empty.	*3*	*2*	*1*	*0*	*0*	*0*
I hate trying new rich foods.	*3*	*2*	*1*	*0*	*0*	*0*
I have the impulse to vomit after meals.	*3*	*2*	*1*	*0*	*0*	*0*

The SCOFF questionnaire

Like the previous tool, this also assesses the risks of food addiction. It is a relatively short test made up of five questions. Every "yes" response is worth 1 point. Any score above 2 is considered dangerous.

	Yes	*No*
Do you ever make yourself sick because you feel uncomfortably full?		
Do you worry you have lost control over how much you eat?		
Have you recently lost more than one stone (6 kilos) in a three-month period?		
Do you believe yourself to be fat when others say you are too thin?		
Would you say food dominates your life?		

The EDI-2 (Eating Disorder Inventory-2)

This helps specialists to assess the general condition of a patient suffering from eating disorders. The test has the advantage of addressing all aspects (desire to be thin, body dissatisfaction, bulimia, perfectionism, etc.), which allows the therapist to make the patient's treatment as personalised as possible.

This questionnaire is composed of a total of 91 items. The patient must respond by choosing one of the following options: always, in general, often, sometimes, rarely or never. Based on the item, the answer can be worth between 0 and 3 points.

Here are some examples of items:

- I eat sweets and carbohydrates without feeling nervous.
- I think my stomach is too big.
- I wish that I could return to the security of childhood.
- I eat when I am upset.
- I stuff myself with food.
- I wish that I could be younger.
- I think about dieting.
- I get frightened when my feelings are too strong.
- I think my thighs are too large.
- I feel incapable as a person.
- I feel extremely guilty after overeating.
- I think my stomach is just the right size.
- Only outstanding performance is good enough in my family.
- The happiest time in life is when you are a child.

- I am open about my feelings.

Compulsive buying test

Adès and Lejoyeux's test

Developed by Drs Jean Adès and Michel Lejoyeux, this helps to identify compulsive buying behaviors. The individual is asked to answer each question with a yes or a no. Any score higher than 11 indicates a compulsion for buying. This is not unlike O'Guinn and Faber's test, mentioned in the previous module.

	Yes (1)	No (0)
Have you ever felt an irresistible urge to go and spend your money on buying something, whatever it might be?		
Do you ever buy items that seem unnecessary to you later?		
Have you ever felt aggravated, agitated or irritable when you have not made a purchase?		
Do you ask someone to come shopping with you just to stop you from buying too much?		
Have you ever hidden any purchases from your family and friends?		
Can an irresistible urge to buy things cause you to miss an outing with friends?		
Have you ever missed work in order to make purchases?		
Have any purchases you have made ever triggered criticisms from your family or friends?		

Have any of your purchases led to a prolonged disagreement or separation?		
Has a purchase you have made ever caused you to get into financial difficulties?		
Has a purchase you have made ever been responsible for legal proceedings?		
Have you continued to make purchases in spite of the difficulties (family or financial) they caused?		
Do you regularly regret your purchases?		
Before buying something, do you feel tense or nervous?		
Does buying something relieve your tension or nervousness?		
Do you ever experience periods where you make multiple excessive purchases, accompanied by a feeling of generosity?		
Do you buy something on impulse, without having planned it, at least once a month?		
If you make any impulse or excessive purchases, do they account for at least one-quarter of your earnings?		

Tests for assessing addiction or motivation

Demaria, Grimaldi and Lagrue's test

Like the previous test, this aims to evaluate the patient's degree of motivation. It allows the specialist to assess the patient's success at giving up smoking. The subject has to answer yes or no to 15 questions.

A score of 6 or less indicates very low motivation. A score of 7 to 15 shows a moderate degree of motivation. A score of over 15 is sufficiently high to suggest the chances of success are great.

	Yes	*No*
I have come to the appointment willingly, of my own accord.	*2*	*0*
I have come to the appointment following medical advice.	*1*	*0*
I have come to the consultation following advice from my family.	*1*	*0*
I have already stopped smoking for over a week before.	*1*	*0*
I do not have any problems at work at the moment.	*1*	*0*
I do not have any problems in my family at the moment.	*1*	*0*
I want to free myself from this thrall.	*2*	*0*
I exercise, or I plan to.	*1*	*0*
I want to be in better physical shape.	*1*	*0*
I want to preserve my physical appearance.	*1*	*0*
I am pregnant or my wife is expecting a baby.	*1*	*0*
I have young children.	*2*	*0*
I am currently in good spirits.	*2*	*0*
I am used to succeeding when I put my mind to something.	*1*	*0*
I have a fairly calm, relaxed temperament.	*1*	*0*
My weight is usually stable.	*1*	*0*
I want to have a better quality of life.	*2*	*0*

The RAP (Rapid Addiction Profile)

This helps the specialist to quickly get an idea of the condition of a patient suffering from addiction. It is a recognition test to provide rapid assistance prior to a more comprehensive analysis. It was developed by a team of Swiss researchers.

RAPID ADDICTION PROFILE (RAP) QUESTIONNAIRE

These questions focus on assessing the severity of your patient's problems in 5 dimensions. The clinical descriptions are given as examples ; select the degree of severity that is closest to that of your patient :
1 - no problem, 2 - some problem, 3 - serious problem, 4 - major problem

I - Somatic dimension

- ☐ Good overall condition, negative serology (HIV, hepatitis B and C)
- ☐ Positive serology, slightly diminished overall condition, dental and hygiene problems, uncomplicated abscesses
- ☐ Undergoing triple combination therapy for HIV, chronic hepatitis, somatic comorbidity (diabetes, etc.), complicated abscesses
- ☐ AIDS (disease), endocarditis, pancreatitis, severe neurological impairment

II - Psychiatric dimension

- ☐ No diagnosis other than abuse and dependence according to the ICD 10, DSM-IV
- ☐ Diagnosis on Axis II of the DSM-IV (personality disorder), multiple drug addiction
- ☐ Syndromic diagnosis - Axis I of the DSM-IV (for example bipolar disorder, schizophrenia, depression)
- ☐ Several acute or disabling psychiatric diagnoses

III - Motivational dimension

- ☐ Cooperative patient who is aware of the problem and motivated by treatment
- ☐ Cooperative patient who is partially aware of the problem and ambivalent towards treatment
- ☐ Patient who has come to the consultation under pressure from a third party, partial denial of the existence of a personal problem, reluctant towards treatment
- ☐ Patient is oppositional, under duress, in denial of the problem and does not see the point of treatment

IV - Crisis dimension

- ☐ Supportive partner, family sets clear boundaries and limits, employer is firm and understanding
- ☐ Family is loosely available, partner is co-dependent, employer is cooperative
- ☐ Family rejects the patient, partner is also an addict, no professional lever
- ☐ Conjugal and family violence, severe crisis in the patient's environment

V - Resource-related dimension

- ☐ Salary, housing, no legal issues, active social life
- ☐ Unemployed, insecure housing, legal issues, reduced social life, vocational training
- ☐ Social support, no proper housing, court order, significant debts, no vocational training, no social life other than the vicinity
- ☐ Homeless, complete marginalization, violent crime

The DSM-5 test

This test analyses the degree of severity of addiction to any psychoactive substance. It also draws attention to addictive behaviors. However, it only studies the action of one substance or one behavior at a time. Thus, it is up to the specialist to adapt to meet the patient's needs.

The presence of 2 to 3 criteria indicates a mild addiction. 4 to 5 criteria mean the addiction is moderate. 6 criteria or more indicate that the addiction is considered severe.

	Yes	*No*
The substance is often taken in higher quantities or over a longer period of time than planned.		
There is a persistent desire to cut down or control the use of this substance, or unsuccessful efforts to do so.		
A lot of time is spent on activities trying to obtain the substance, using the substance or recovering from its effects.		
There is a craving to consume the substance.		
Repeated use of the substance leads to the inability to fulfil major obligations at work, school or home.		
The substance continues to be used despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.		
Social, occupational or recreational activities have been abandoned or reduced due to use of the substance.		
The substance is used repeatedly in situations that were physically hazardous.		
Use of the substance is continued despite the person knowing they have a persistent or recurrent psychological or physical problem that is likely to have been caused or exacerbated by this substance.		
There is a level of tolerance, defined by one of the following symptoms: ❖ Need for greater amounts of the substance in order to feel intoxicated or achieve the desired effect; ❖ Effect is significantly reduced in the event of continued use of the same quantity of the substance.		
Withdrawal symptoms are experienced, characterized by one of the following manifestations: ❖ Withdrawal syndrome characteristic of the substance; ❖ The substance (or a similar substance) is taken to relieve or prevent withdrawal symptoms.		

Test of severity of addiction

This indicates the degree of the patient's addiction. It assesses addictions linked to the consumption of psychoactive substances. It is composed of a series of 11 questions which the patient must answer with a yes or a no. The degree of addiction is proportional to the score. When the level of addiction is low, so too is the score. As the latter increases, so too does the level of addiction.

	Yes	*No*
When you started using this substance, did you often consume more than you intended to?	*1*	*0*
Have you tried and failed to reduce or stop your use of this substance?	*0*	*1*
On days when you took the substance, would you spend a lot of time (over 2 hours) trying to get hold of it, taking it, recovering from its effects or thinking about it?	*1*	*0*
Do you sometimes feel a strong urge to use the substance that is very difficult to control?	*1*	*0*
Have you continued taking the substance even though you knew it would cause problems with your family and those close to you?	*1*	*0*
Have you been intoxicated or stoned several times when you had things to do at work/school/home?	*1*	*0*
Have you reduced the amount of activities you do (leisure, work, everyday) or spent less time with other people because you were taking drugs?	*1*	*0*
Have you ever been under the influence of the substance in a situation where this was physically hazardous, for example when driving or using a machine or a dangerous tool?	*1*	*0*
Have you continued using the substance despite knowing it would cause you health or psychological problems?	*1*	*0*
Have you noticed that you need to take higher quantities of the substance to achieve the same effect as before?	*1*	*0*
When you took less of the substance or stopped taking it, did you experience withdrawal symptoms: pain, shivers, fever, weakness, diarrhea, nausea, sweating, increased heart rate, trouble sleeping, or feelings of agitation, anxiety, irritability or depression?	*1*	*0*

For a comprehensive analysis, therapists also use tests that assess the patient's cognitive capacities. These include the MINI test, the MoCA test, the BEARNI test, the STAI-Y test, the DIRECT test and the

BDI test. Only once as much information as possible has been gathered can a suitable action plan be put together to help the patient overcome their addiction.

Treatment of addictions

The treatment of any kind of addiction needs to be personalized. It is dependent on the patient's personality, and the category and type of addiction. The therapeutic approach used for a conventional drug addiction will differ from that taken to treat addiction that does not involve a psychoactive substance.

However, all forms of treatment have one thing in common: psychological therapy. It is not sufficient to put a stop to a dangerous behavior or use of a psychoactive substance. It is also important to encourage and help the patient to control their impulses.

For traditional types of drug addiction, the therapist will center treatment on three aspects:

- **drug treatment**, which needs to help the patient cope better with the negative effects of withdrawal;
- **psychological treatment** to help the patient become aware of their condition and understand their own motivations. They will need to become aware of the reasons why they have found themselves in this situation and make peace with their own demons;
- **the motivational aspect** is the final and most important step. Here, the therapist will need to encourage the patient not only to put an end to their destructive behavior, but also to avoid wanting to start again in the future. The success of the treatment will be largely dependent on the patient's ability to draw a definitive line under their difficult past and avoid relapsing.

Treatment of behavioral addictions, apart from a few exceptions (when the patient suffers from severe behavioral disorders: anxiety, profound depression), focuses primarily on the last two aspects.

Drug treatment

It is undoubtedly important to emphasize a basic notion: drug treatment is not a panacea! It helps the patient to put an end to their addictive behavior and ultimately relieve the inherent negative effects involved in stopping, but no more than this. It is up to the therapist to make the patient understand this. It is also important to note that the effect of drug treatment is not immediate. The addictive behavior does not end for good on the day the treatment begins, and the patient needs to understand this too.

The therapeutic approach to drug treatment has evolved considerably over the past few decades. Initially, drug treatment was considered sufficient. Facing the poor results obtained, and sometimes a worsening of the addiction, drug treatment became a way to offset abstinence. The patient was encouraged to show determination in order to make sure they had the necessary motivation.

Now, the aim has changed once more. Abstinence is no longer a prerequisite for treatment, it is a consequence. Drug treatment begins when the patient needs it most, then is reduced as they regain control of their existence.

This approach might seem less effective than the previous one, but this is an illusion. It is important to remember that the addict, who wants to put an end to their ordeal, needs permanent support. Forcing them to show their motivation openly amounts to leaving them alone with their disorder until they have the strength to face their demons.

However, much willpower the subject may have, this task is far from easy. By offering the patient drug treatment, regardless of their physical and psychological state, the therapist is offering them the support they need.

Drug treatment for addiction is not uniform. It takes place in several phases:

- Withdrawal treatment;
- Treatment to prevent relapse.

Drug treatment can take place at home or on an outpatient basis depending on the severity of the patient's condition. It always begins with a clinical examination. It is a mandatory process to get a precise idea of the patient's physical state and prevent any potential complications.

It is also important to educate the patient (and those close to them). They need to master all the ins and outs of their physical condition and their treatment. They also need to understand the side effects of the medication they will be given. Lastly, they need to be able to recognize withdrawal symptoms and take the necessary measures. This knowledge will also help them to prepare themselves psychologically.

Depending on the type of addiction, the patient will provide the following biological examinations:

- liver function test;
- platelets;
- TP;
- creatinine;
- sodium levels;
- gamma GT;
- potassium levels;
- HIV.

The patient can also be asked to take urine tests so the therapist can get an idea of the concentration of the psychoactive substance. In hospital, all the responsibility for treatment lies with the therapist. The patient simply follows the guidelines that are given to them. At home, however, it is up to the patient to demonstrate personal motivation.

To maximize the chances of success, they need to be able to be in constant contact with their medical team (therapist, psychologist). It is advisable to start treatment on a Monday. This is not obligatory, but it makes it possible to set out a plan of action that is easy to follow.

Before examining the different forms of treatment, it is important to analyze the different types of medication that are used during treatment.

Medication

The medication used to treat addictions is divided into three main categories:

- withdrawal medication;
- substitute medication;
- addiction medication.

Withdrawal medication

The function of this medication is to reduce or suppress all withdrawal symptoms definitively. Taking this medication does not modify the patient's addictive behavior. The implications and agonistic effects vary. In the event of simultaneous consumption of the psychoactive substance, the patient may feel tired and drowsy. Withdrawal medication has no effect on cravings or on the consumption of other psychoactive substances.

For alcohol

Four categories of medication are generally prescribed when weaning off alcohol.

- **Benzodiazepines:** this is the most dangerous category as they can lead to a secondary addiction. Nevertheless, the sedative, anticonvulsant and muscle relaxing effects of this medication make them substances of choice for rapid weaning. They are effective at relieving all withdrawal symptoms, as well as any potential complications.

Table 2: Comparison of the main benzodiazepines used to treat alcohol withdrawal syndrome

Medication	Lorazepam	Diazepam	Chlordiazepoxide
Mechanism of action	Benzodiazepines reduce the hyperactivity of the autonomic nervous system by increasing the inhibitory action of GABA, which is reduced as a result of prolonged exposure to alcohol.		
Administration routes	PO, SL, IV, IM	PO, IR, IV, IM	PO, IV, IM
Dosages	Mild withdrawal: 2 to 4 mg QID days 1 and 2, then 1 to 2 mg QID days 3 and 4, then 1 mg QID thereafter Moderate withdrawal: 2 mg PO q 2 hours or 1 to 2 mg IV or IM q 1 to 2 hours until symptoms disappear	Mild withdrawal: 10 mg TID-QID day 1, then 5 mg TID-QID thereafter Moderate withdrawal: 10 to 20 mg PO q 1 to 2 hours or 5 to 10 mg IV q 1 to 2 hours until symptoms disappear Severe withdrawal: 5	Mild withdrawal: 50 to 100 mg QID day 1, then 25 to 50 mg QID day 2, then 10 mg QID thereafter Moderate or severe withdrawal: 25 to 100 mg PO q 2 to 6 hours or 25 mg IV q 2 to 4 hours until symptoms

	Severe withdrawal: 1 to 2 mg IV q 10 to 15 minutes, maximum 20 mg per hour or 50 mg per 8-hour period	to 10 mg IV q 5 to 10 minutes, maximum 100 mg per hour or 250 mg per 8-hour period	disappear
Equivalent dosages	1 mg	5 mg	20 mg
T1/2	14 +/- 5 hours	43 +/- 13 hours	10 +/- 3.4 hours
Physiological conditions that affect the t1/2	Elderly people: No effect Kidney failure: Increase in t1/2 Reduction in elimination Liver failure: Increase in t1/2 in the presence of cirrhosis	Elderly people and kidney failure: Reduction in protein binding, and therefore increase in the effect of the medication Liver failure: Increase in t1/2 in the presence of cirrhosis or hepatitis	Elderly people: Increase in t1/2 Kidney failure: No effect Liver failure: Increase in t1/2 in case of cirrhosis
Onset of action (hours)	1 to 2 (intermediate)	0.5 to 1 (rapid)	1 to 4 (intermediate)
Duration of action (hours)	10 to 20 (intermediate)	30 to 60 (ad 100) (long)	5 to 15 (ad 100) (long)
Active metabolites	No	Yes – t1/2: 30 to 200 hours	Yes – t1/2: 5 to 30 hours
Comments	Useful in: - Patients who are agitated or who need IM administration because IM absorption is anticipated - Elderly people - People suffering from liver failure - Patients at risk of respiratory depression Disadvantages: - Intermediate onset of action and half-life,	Useful in: - Non-agitated patients, because IM absorption is erratic - Young patients Advantages: - Fast onset of action and long half-life, which can enable a gentler withdrawal process Disadvantages:	Useful in: - Non-agitated patients, because IM absorption is erratic - Young patients Advantages: - Long half-life enables a gentler withdrawal process Disadvantages: - Possibility of toxic buildup in elderly people and those who

	which can sometimes cause inconvenience to the patient (rebound symptoms)	- Possibility of toxic buildup in elderly people and those who suffer from liver failure	suffer from liver failure - Intermediate onset of action

- **Neuroleptics** (such as haloperidol), **anticonvulsants** (such as carbamazepine) and **beta-blockers** (such as propranolol) are prescribed along with the medication in the previous group. Each of them deepens the action of benzodiazepines, thus guaranteeing the treatment has maximum impact.

Vitamin B1 is also prescribed during treatment for withdrawal. It helps to prevent severe neurological problems, such as Wernicke encephalopathy. The same is true for vitamin PP. Indeed, deficiencies in vitamin B1 and PP are relatively frequent in alcoholics and can be the cause of severe neurological problems.

- **For opioids**

The most popular withdrawal medication currently is clonidine (0.15 mg). It must be administered gradually, while always controlling the patient's blood pressure. It is generally used during outpatient treatment, and it is important to warn the patient about the risks of low blood pressure.

Clonidine reduces the sensation of instability and agitation as well as rhinorrhea. If the risks of low blood pressure are very high, it is advisable to replace clonidine with lofexidine. Its action on blood pressure is far gentler.

For a more significant impact, other categories of medication can also be used. These are not withdrawal medication as such, but they help to reduce withdrawal symptoms as much as possible. They include:

- analgesics, which help to reduce (or prevent) pain (such as paracetamol 500 mg);
- antidiarrheals and antispasmodics (such as phloroglucinol, loperamide 2 mg, domperidone 10 mg);
- sedatives: these are myorelaxants, neuroleptics (such as cyamemazine) and hypnotics (zopiclone 7.5 mg).

- **For tobacco**

Very often, people who are addicted to tobacco use substitutes because strict quitting rarely works. Nevertheless, some medication can help patients to resist temptation. The first is an antidepressant, bupropion. Treatment must not last any longer than 7 weeks. If the patient continues to smoke after this time, their therapist will need to consider another form of medication. Note that this is only recommended for patients who are in good health at the beginning of the quitting process.

Another popular form of medication is varenicline. It helps the patient to overcome withdrawal symptoms and reduces all the pleasurable effects at the same time. This medication should only be prescribed for patients with a strong addiction, who have already suffered treatment failure with substitute medication.

The side effects of this medication are somewhat disturbing. When starting to take them, the patient may experience nausea and insomnia. In the longer term, they can lead to mood changes

(depressions, suicidal thoughts, anxiety, etc.). If these symptoms appear, treatment should be stopped immediately.

The unusual case of cytisine

This relatively low-cost medication has been used in eastern Europe since the 1950s and it must be acknowledged that it is very effective. Studies conducted in the West for over two decades show that it is more effective than all the anti-smoking drugs that are currently popular in the West. However, outside of Russia, Bulgaria and Poland, the sale of this product is only permitted in New Zealand.

Substitute medication

Substitute or replacement medication helps the patient to stop taking psychoactive substances without putting an end to the addictive behavior itself. It does not require the patient to make any particular effort.

These drugs can have euphoric effects, just like the psychoactive substance. Like in the previous case, they can have sedative effects if they are combined with the psychoactive substance they are intended to replace. Again, like for withdrawal medication, substitute medication has no effect on cravings.

For tobacco

These come in the form of inhalators, tablets (to be sucked or dissolved), patches and chewing gum. Their mechanism of action is relatively simple. They contain enough nicotine to satisfy the patient's physical needs and prevent direct consumption of cigarettes. However, the prescribed doses need to take into account the amount of nicotine generally consumed by the patient.

For opioids

Two types of medication are currently favored by health professionals: methadone and buprenorphine. Methadone is a synthetic opioid that facilitates the gradual phasing out of consumption of natural opioids. They are prescribed to drug addicts so they can stop taking morphine, heroin and other opioids without having to endure withdrawal symptoms.

In theory, their use is temporary. They need to help the patient gradually reduce their consumption and reach a state of complete abstinence. However, if the patient has trouble achieving their goal, treatment will be continued for as long as possible.

Buprenorphine, like methadone, prepares the patient for a period of complete abstinence. It relieves withdrawal symptoms and helps the patient overcome their dependence. The side effects the patient may experience when taking this medication include headaches, insomnia, dizziness and nausea.

The table below shows the difference between the two types of medication.

BUPRENORPHINE	**METHADONE**
Partial agonist with a ceiling effect = no risk of overdose when used on its own	Pure agonist = lethal dose 1 mg/kg/day for non-addicted patients

BUPRENORPHINE	METHADONE
Limited opioid effect: therapeutic ceiling effect (e.g. pain)	More pronounced opioid effect: dose-dependent effect, morphine-like actions
Random bioavailability, 15% to 60%	High bioavailability, 80%
Little variation in metabolism	High variation in metabolism = methadone plasma concentration
Water soluble tablet (sublingual) = intravenous route possible	Non-injectable syrup

For alcohol

Most types of medication prescribed to treat alcohol addiction are addiction or withdrawal medication. However, nalmefene can be considered a substitute medication. It is prescribed to patients who display a very high level of dependence on alcohol.

It is not prescribed as part of a withdrawal treatment, but rather to help the patient control their urge. It is even advised that the patient does not know any symptoms of alcohol withdrawal when taking it. It is not uncommon for it to be prescribed at the request of the patient themselves.

Addiction medication

This is designed to modify the patient's addictive behavior. It may help to maintain abstinence or encourage them to adopt said behavior. Whatever the case may be, taking this medication is always accompanied by psychological and motivational therapeutic monitoring. Indeed, the success of the treatment depends largely on the efforts made by the patient themselves. The medication does not produce any euphoric effects and has no impact on withdrawal symptoms.

Nevertheless, if the psychoactive substance is taken, the medication neutralizes its strengthening effect and thus also prevents complete loss of control. It also acts on other psychoactive substances by reducing the urge to take them.

For alcohol

In this category, we can include baclofen, acamprosate and disulfiram. Attention must be paid to the side effects. It is highly inadvisable to drive after taking baclofen due to the risks of drowsiness, dizziness and mood disorders.

Acamprosate helps the patient to stay sober. However, it can cause severe diarrhea which can cause the treatment to be stopped permanently. Disulfiram also forces the patient to abstain. It is not the side effects that are controversial, but rather its interaction with alcohol. If the patient consumes alcohol during treatment, they may suffer from rashes, severe headaches, tachycardia, nausea, etc. All these effects can lead to the patient being hospitalized.

For opioids

Some medication is used as both substitute and addiction medication. This is true for methadone and buprenorphine. When administered intravenously, they are substitute medication, but when

administered orally (for methadone) or sublingually (for buprenorphine), they are addiction medication.

Withdrawal treatment

Withdrawal is the most complex phase when treating an addiction. The patient is still fragile and tends to crack when the way their body reacts to the absence of the substance consumed becomes unbearable. It is important to recognize that withdrawal syndrome can be extremely difficult and painful to live with.

Heart palpitations, drops in blood pressure, dizziness, nausea, headaches and a permanent feeling of worry are just some of the common symptoms that can make the patient want to stop treatment for good. Thus, the withdrawal phase needs to put an end to the unpleasant sensations while also allowing the individual to be more resistant against the temptations they will face.

Withdrawal treatment is made up of two phases:

- the withdrawal phase itself;
- the post-withdrawal phase.

The main aim of the medication used for withdrawal treatment is to cut off any unpleasant symptoms. Depending on the type of addiction, analgesics, anti-anxiety medication, antidepressants, etc., will be used. Benzodiazepines are also effective, but their use needs to be controlled, and for good reason: they often lead to secondary addictions.

<table>
<tr><th colspan="2">Indications</th><th colspan="2">Durations</th></tr>
<tr><td>Sleep problems</td><td>BZDs are restricted to severe sleep problems in the following cases: occasional insomnia, transient insomnia.</td><td>From a few days to 4 weeks, including the period during which the dose is reduced.</td><td>Occasional insomnia, for example when travelling, duration 2 to 5 days. Transient insomnia, for example during a serious event, duration 2 to 3 weeks.</td></tr>
<tr><td rowspan="2">Anxiety</td><td>Symptomatic treatment for severe and/or crippling manifestations of anxiety.</td><td colspan="2">The overall duration of treatment should not last longer than 8 to 12 weeks for most patients, including the period during which the dose is reduced.</td></tr>
<tr><td>Prevention and treatment of delirium tremens and other</td><td colspan="2">Brief treatment lasting 8 to 10 days.</td></tr>
</table>

	manifestations of alcohol withdrawal.	

The table above shows the indications for benzodiazepines as well as the maximum durations of treatment. If treatment is taking place in a hospital environment, adrenergic (guanfacine or clonidine) can also be used.

Note that quitting should never be done as an emergency or against the patient's will, unless their life is in danger. The success of treatment is closely linked to the patient's motivation. Given the objectives of withdrawal, treatment should last a limited amount of time, a few weeks at the most. It is then followed by post-withdrawal treatment that will help the patient to avoid relapsing.

✪ Example of treatment for alcohol withdrawal

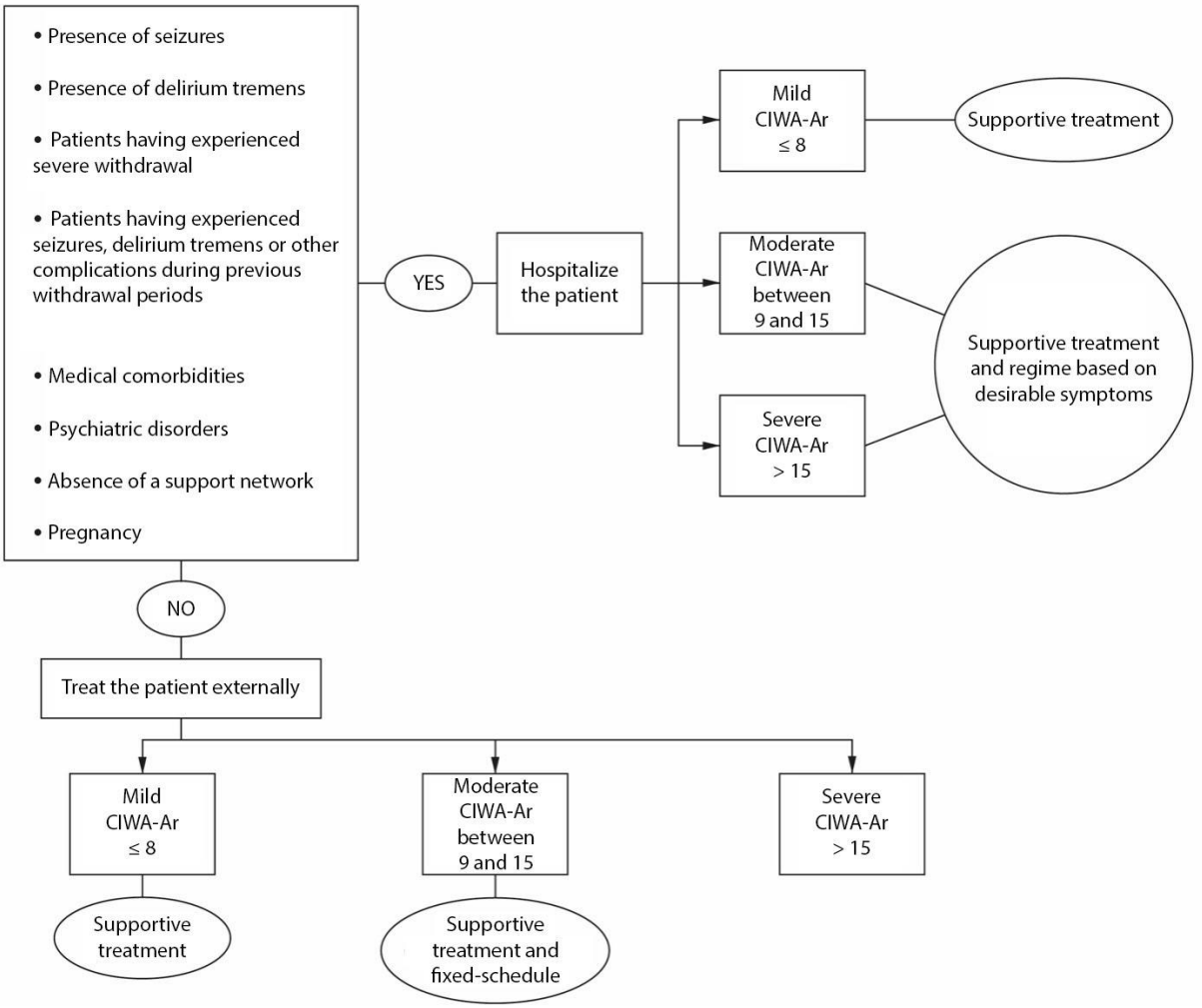
Below is a table indicating the treatment for alcohol withdrawal.

TABLE 1: DESCRIPTION OF LEVELS OF ALOHOL WITHDRAWAL SYNDROME

	Level 1	Level 2	Level 3	Level 4
	Symptoms resulting from hyperactivity of the autonomic nervous system	Hallucinations	Seizures	Delirium tremens
Incidence	100%	10% to 25%	15%	5%
Characteristics of symptoms	Insomnia, tremors, mild anxiety, headaches, diaphoresis, palpitations, gastrointestinal disorders (nausea, vomiting, anorexia)	Hallucinations, generally visual, but sometimes also auditory or tactile	A few grand mal-type seizures (tonic-clonic)	Disorientation, confusion, hallucinations, fever, hyperactivity of autonomic nervous system
Time of appearance	6 to 12 hours	12 to 24 hours	12 to 48 hours	2 to 5 days
Duration	24 to 48 hours	24 to 48 hours	Recurrences occur in the 6 hours following the first seizure	3 to 5 days

			and are limited to 2 to 4 seizures	
Comments	25% of patients will reach a more serious level	N/A	30% of patients will reach the delirium tremens stage	Patient mortality rate (treated or not): 15% Risk factors: age > 30 years, infectious diseases, tachycardia, history of withdrawal or delirium seizures, injuries, surgical intervention

This diagram describes the treatment algorithm based on the intensity of the withdrawal symptoms.



✪ Relapse prevention treatment

In this category, we will classify both post-withdrawal treatment and substitute treatment. Withdrawal and substitution are sometimes wrongly placed on an equal footing. The objectives of the two types of treatment, despite both being non-antagonistic, are not the same.

As indicated, withdrawal treatment is the same as symptomatic treatment. On the other hand, substitution treatment helps subjects who have difficulty continuing a withdrawal phase to stop consuming the active substance. The medication offers them essentially the same effects – at least psychologically – as the psychoactive substance to which they are addicted, without harming their health. In some cases, this can lead the patient gradually towards a withdrawal phase.

Post-withdrawal treatment aims to help the patient to control their impulses. The medication prescribed is of course dependent on the type of addiction:

- Alcohol: the most commonly used medications are naltrexone, acamprosate and disulfiram. Great care should be taken when using the latter.
- Tobacco: bupropion stands out from the rest significantly due to its efficiency.
- Opioids: naltrexone is effective for treating both alcohol and opioid addictions.

The action of medication is however useless when tackling certain addictions. This is true for cocaine addiction, for example. It is possible to use antipsychotic drugs to regulate the effects of cravings, but overall, medication has only a minimal impact.

Behavioral addiction can also be partly susceptible to drug treatment. Antidepressants are very often used to stop the extreme anxiety that patients feel during the withdrawal period. Withdrawal is not particular to conventional addictions. It is also experienced when stopping an addictive behavior.

✪ Substitution treatment

There are cases where it is difficult or indeed impossible to start with complete or partial withdrawal. This is particularly true for patients who are addicted to opioids or tobacco. Substitution is therefore the preferred option, as it at least gives the patient the chance to stop consuming the psychoactive substance even if they are still unable to put an end to the addictive behavior itself. This is a less restrictive method than quitting completely and is often a very long process, but must nevertheless result in complete abstinence.

With good psychological monitoring, the chances of success are relatively high as the withdrawal process is gradual. This treatment has specific characteristics depending on the substance consumed. Nicotine substitution, for example, is a classic type of substitution. This means the medication helps the patient to reduce their tobacco consumption gradually. The therapy can last from a few months to a year at the most.

Substitution of opioids is far more complex. The ultimate goal is sometimes to reduce the dangers faced by the patient. Consumption of opioids is very often linked to criminal activities (theft, prostitution, etc.). Furthermore, it endangers the patient's health, and not necessarily due to the substance but rather due to the conditions in which it takes place.

Thus, substitution of opioids is more similar to rehabilitation than a conventional therapy. If the patient knows they can come and take their "dose" in a clean center where they will be taken care

of, they are less likely to resort to criminal activities to satisfy their addictive behavior. This is why this type of treatment can last years without even leading to complete abstinence.

✪ Treatment of psychiatric comorbidities

We could not end this section on drug treatment without addressing comorbidities. A psychiatric comorbidity is defined as "the presence of two or several disorders in the same individual, which is established through systematic clinical evaluation. The phenomenon of psychiatric comorbidities has been analyzed on general and clinical populations".

The biggest difficulty here is diagnosis. This is largely due to the lack of emotional stability on the patient's part. This leads to frequent occurrences of treatment failure. Treatment of comorbidities aims to reduce these risks as much as possible, as well as the factors that reinforce addictions.

Antipsychotic drugs are used to treat schizophrenic disorders. Second-generation antipsychotics are preferred because they are tolerated better by the body.

Antidepressants will be used to treat depressive states.

Psychological treatment

Psychological monitoring is a long-term task and is again heavily dependent on the type of addiction being treated. There are three therapeutic approaches:

- the individual approach;
- the group approach;
- the family approach.

✪ The individual approach

Here, all the focus is placed on the patient. The therapist needs to build a trusting relationship with the patient so they can encourage them to end their addictive behavior. The approach involves motivational interviews, psychoanalytic therapy or supportive psychotherapy. It is ideal for people whose dependence is the result of a severe psychological trauma.

It allows the therapist to encourage the patient to gradually open up and take stock of their problems. It is also ideal for people who are very shy and who struggle to open up to others. It will be easier for them to talk to someone they trust. The therapist will need to study the causes of the emergence of addiction in the patient in detail in order to help them overcome their disorder.

✪ The family approach

Family-based care depends primarily on the type of family the subject is part of. The therapeutic approach taken with a healthy family and an at-risk family will be completely different.

Family as the origin of addiction

Individuals who grow up in dangerous or high-risk family environments have every chance of becoming addicted to a substance or developing addictive behavior. High-risk environments include violent families, families where one or both parents display despotic behavior, or families where one or several members are addicts themselves. Treatment for "problematic" families is relatively

complex, because its success is dependent on all the family members showing willingness and good intentions.

Determining what type of family the addict grew up in is an important part of treatment. If it was a high-risk family, it will be easier to put together an appropriate form of therapy that will help both the patient and their family.

- **Family as a source of support for the patient**

Many people who suffer from addiction are isolated. They have generally cut ties with their family under the influence of their addiction. Sometimes, their family members have even taken the initiative to do this to avoid suffering the negative consequences of their addiction. The breaking of ties may be temporary, in the hope that the patient regains control of their life, permanently.

When the break is permanent and there is no chance of reconciliation, this approach is of no use because it may aggravate the patient's condition. It is better to get them to follow an individual or group therapy (depending on their psychological state and preferences) so they can re-establish their connection with their family later.

However, when the family wants to offer the patient complete support, it can be very effective. In this case, the therapist's role is to not only understand the patient's psychological state, but also to take stock of the role the family can play in the patient's life.

- **Approach**

Regardless of the situation, treatment begins with a family interview, during which the therapist will establish:

- how many people in the family are affected by the problem;
- what the cause or causes of the problem are;
- how willing each person affected is to recognize and talk openly about the problem;
- what the aggravating factors are and what the positive factors are that could help to improve the situation.

Once all of this has been established, the therapist can create a plan. Note that interviews will be frequent and the therapist will need to put together a treatment protocol each time that is appropriate for the circumstances. Each protocol is made up of six phases:

- analysis of the problem;
- implementation of attempted solutions;
- development of several contexts;
- definition of tasks;
- assessment of changes;
- reappraisal of the previous protocol.

Each session will begin by evaluating the results from the previous one. Each member of the family, as well as the patient, will be invited to share their vision with the others. Openness and frankness are the keys to success in any type of therapy.

✪ The group approach

This is both a combination of the first two approaches, and an extension of them. The group approach offers an incontestable advantage: from the very beginning, the patient does not feel alone. They are surrounded by people who are experiencing or have experienced the same difficulties. As a result, it is easier for them to express themselves. Even if they might struggle to speak in the group, they will be more receptive to the information they receive.

Group therapies are not just for patients. Parents and others close to the patient can also participate. They will have the opportunity to ask questions and find out about all the ins and outs of the disorder affecting their loved one, as well as ways they can help them. Above all, however, they will be able to share their fears and suffering in a friendly setting where they will be understood.

Psychologically, addicts always feel like they are scorned by everyone. Their families have a constant feeling of failure. They feel like they are partially responsible for the state the addict is in, even if this is not the case. Furthermore, by trying to rectify the errors made, they often tend to make things worse. The group, even without its educational aspect, offers a protective environment that facilitates psychological release and unblocking for all those involved.

Motivational treatment

Motivation forms the foundation for the success of any type of therapy. In practice, however, it was not until the early 1980s that the first motivational interviews were used during therapy for addiction. The pioneer in this field was Miller, who published an article in 1983 on the importance of the motivational approach in addiction treatment.

This does not mean that this aspect was of no interest to specialists prior to 1983. Several scientists had addressed it. For example, the notion of decisional balance was developed by Janis and Mann in 1977. In 1981, Brehm published his theory of psychological reactance. Miller was simply the first to develop a practical protocol that is still popular today. Motivational treatment can be summed up in one sentence: “Where there’s a will, there’s a way.”

As Miller and Rollnick pointed out, all patients are faced with a dilemma that is very difficult to resolve. They are split between the need to stop their addictive behavior and return to a ‘conventional’ existence (with all its advantages and problems) and the desire to retain their destructive attitude and exploit the advantages it offers them.

They named their theory “ambivalence”. It is important to understand that addicts also see advantages to their situation. Motivational treatment does not aim solely to encourage the patient to make an effort to overcome their disorder. It is mainly about getting them to understand that abstinence offers far more advantages.

Once the clinician succeeds at this, they need to help the patient to understand that they have everything they need and that, despite the difficulties encountered, they will succeed if they demonstrate willingness.

This treatment can be divided into five main phases: precontemplation, contemplation, preparation, action and maintenance.

Precontemplation

This is the period during which the addict is completely proud of their condition. Even if they are starting therapy, they are probably only doing it because they are being forced. Their involvement is minimal. They hope that if they do what they are asked without thinking, they will be left alone and will soon be able to revert to their initial behavior.

For example, an alcoholic may pretend not to drink in public, but once they are in private, they will indulge. If they get caught, they will justify themselves, for example by saying that they only had a small amount to help them sleep, and that it actually takes a lot more than what they drank to cause problems.

The therapist's objective

The therapist's aim is to teach the patient to become aware of their actions and cast doubt on the logic they use as a shield. To return to the example of an alcoholic, they might remind them that it is all these little "drops" that are the cause of their social failure. If they persist out of ignorance, they need to be shown, with supporting facts, that they are wrong. If they do it out of obstinacy, it is up to the therapist to show them all the misfortune their behavior has already caused.

Contemplation

The patient has finally become aware of their state and sincerely wants to stop it. However, despite all the willingness they display, they do not have the moral and psychological resources to reach the objectives they have set themselves. This is the period of feelings like "I want to, but you know, even my parents have always said I was useless". The patient is looking for excuses in advance to justify their potential failure.

The therapist's objective

Above all, the clinician needs to help the patient take stock of their condition and analyze the advantages and disadvantages. It is important that the patient realizes that the disadvantages are so significant that they have everything to gain by getting rid of them. The subject has to do more than just wanting to stop their behavior; they must see it as an extreme necessity.

Preparation

The patient is finally determined to overcome their addiction, but they are only picturing things in the short term. Sometimes, it seems like even after several weeks or at most a few months, they will succeed. They do not imagine failure; after all, this is something they yearn for.

The therapist's objective

The first thing to do is to bring the patient back to reality. They will need to understand that they will inevitably meet their objectives provided that they do not set themselves colossal goals. Every victory, however small it might be, is still a victory. It will therefore help them to put together an honest plan of the different objectives to be reached and encourage them to set realistic time limits within which to reach them.

Action

The patient finally starts to take action to overcome their dependence. Despite the difficulties, they try as hard as they can to respect the treatment plan.

The therapist's objective

Here, the therapist needs to support the patient psychologically and stay in contact with them. Some days will be more difficult than others. The patient may question their actions completely, doubt their abilities and fear failure. The therapist needs to be someone they trust and to whom they are not afraid to open up. At this stage, sharp criticism from the therapist is not welcome. The patient needs to remain positive the whole time, even when everything is going badly; it is up to the therapist to help them to maintain this state of mind.

Maintenance

The patient has finally overcome their addiction, but dependence does not disappear, even after abstinence. People who have suffered from addiction at least once are more likely to succumb to it again.

The therapist's objective

The aim at this stage is to help the patient resist temptation. They need to not only implement relapse prevention strategies, but also make the patient understand that it is important to remain careful.

For some patients, these five steps are sufficient. However, many patients end up giving in, even if only once. Some consider this a real tragedy and, to avoid a complete failure of treatment, there is another phase.

Relapse

No relapse is spontaneous. All those who manage to put an end to their addiction are particularly proud of it. This victory is the proof that they are very strong both psychologically and physically. But this is precisely why any relapse is catastrophic. After having felt this sensation of personal pride, they realize that they can show weakness again.

The therapist's objective

It is especially crucial not to let the patient lose confidence in themselves. Yes, they gave into temptation. Yes, this is not good. But how did it happen? Why was the patient incapable of saying no this time? Before implementing another approach, it is important to examine the causes of the relapse. Once the patient has become aware of their motivations, they will be able to reclaim their previous victories and understand that nothing is lost yet. They need to be able to use the experience they have obtained to move forward.

Conclusion

Treatment of addictions is crucial to solve the problem of dependence. However, prevention has a more important impact. Not all addicts have the strength to overcome their addiction even if they have permanent support. This is why it is desirable to act early, and there are many success stories.

Unlike in the 1950s and 1960s, the number of tobacco consumers, at least in the adult population, is now much lower. Several countries have managed to reduce alcohol and tobacco consumption drastically. However, it is important to put things in perspective. There is a clear difference between prevention of addictions and prevention of the risk of addictions.

In the first case, a series of measures are developed to inform the population and encourage them to avoid dangerous behavior and offer them rapid, skilled assistance in the event of problems. The problem of addiction is addressed from all angles. Prevention of risks is limited to putting up safeguards to avoid dramatic consequences in the event of a problem. The second approach is not useless, but it is preferable to focus on the first.

With regard to this approach, it is important to start from as early an age as possible. Parents need to set an example and teach their children to develop each action. It will also be important to make them understand that they can always find the help they need from those close to them.

Governments and public authorities have the task of implementing laws and regulations that protect those who are at risk. This is already happening in relation to pornography, alcohol and tobacco. In most countries, minors are not allowed to buy alcohol. However, it is important to go further and focus on areas that still escape strict legislation even today.