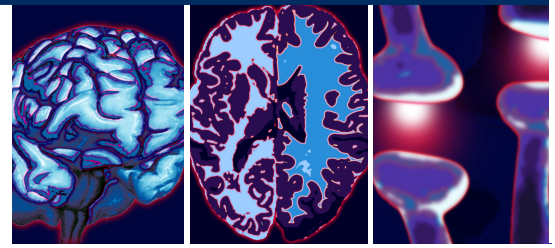


REVIEW



Reduction of harmful consumption versus total abstinence in addiction treatment

Michael Musalek*

Practice points

- For alcoholics with a severe physical and/or psychological dependence, reducing intake to a moderate level of consumption is not worthwhile and can be dangerous (due to the occurrence of a withdrawal syndrome).
- In the early stages of alcohol addiction, however, without indications of severe physical or psychological dependency, minimizing the consumption of alcohol to a moderate level can be a possible alternative to total abstinence for many patients.
- In patients with severe addiction, reducing alcohol consumption can be a first step to abstinence-supported treatment (however, occurrence of a withdrawal syndrome limits such a reduction).
- As addictions are chronic, highly complex disorders with a multifactorial genesis that are embedded in manifold psychological and physical comorbidities, and social handicaps, addiction treatment that focuses exclusively on the pattern of consumption and pays less heed to or even ignores the pathogenic importance of the 'comorbidities' cannot be effective in the long term.
- An effective treatment of addiction must always be oriented towards the constellation of conditions in which the addiction develops and starts with a dynamic, multidimensional, differential diagnostic investigation that takes into account all those pathogenic and pathoplastic factors that cause and influence the course of the disease.
- Only if the goal of the treatment appears to be both attractive and attainable for the patient will he or she be willing to actively and consistently participate in the chosen program.
- In multidimensional integrative treatment of addiction, abstinence, drug substitution or reduced consumption are only subgoals on the road to a life that is essentially self-determined, full and rewarding.

SUMMARY Drug consumption-oriented treatment goals, and, in particular, abstinence-oriented treatment goals, remain the treatment of choice in the field of addiction treatment research. Treatment programs that focus only on reducing intake to a moderate level of consumption are not effective for alcoholics with a severe physical dependency. In

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the early stages of an addiction, however, when the first signs of addiction are present but there are no indications of severe physical or psychological dependency, minimizing the consumption of alcohol to a moderate level can be a possible alternative to total abstinence for many patients. Addictions are chronic, highly complex disorders with a multifactoral genesis. No addiction treatment that focuses exclusively on the pattern of consumption and pays less heed to or even ignores the pathogenic importance of the 'comorbidities' can be effective in the long term. The attractiveness of a treatment goal or a therapeutic action is the chief motivator for long-term treatment.

Addictions are considered as the most common psychiatric disorders after depression and anxiety disorders. If nicotine is included then addictive disorders could be considered the most common psychiatric illnesses [1,2]. Addictive disorders currently include substance-related addictions (e.g., alcohol, nicotine, tranquilizers, amphetamines, cannabis, heroin and cocaine) and nonsubstance-related forms of addiction (e.g., addictions to gambling, shopping, the Internet and work). The International Classification of Diseases-10 diagnostic tool classifies addictive disorders in the mental and behavioral disorders owing to psychoactive substance use category into the subcategories: alcohol dependence; opioids dependence; cannabinoids dependence; sedatives or hypnotics dependence; cocaine dependence; dependence on other stimulants including caffeine; dependence on hallucinogens; dependence on volatile solvents and on other psychoactive drugs; and tobacco dependence [3]. The nonsubstance-related forms of addiction are classified as impulse control disorders. Accordingly, this article will only deal with the treatment of substance-related addictions. These individual substance-related addictive disorders can, in turn, be subdivided into addictions to legal substances (e.g., alcohol and tranquilizers) and to illegal substances (e.g., heroin and cocaine). While these addictions differ in terms of the effects and side effects of the individual substances, withdrawal symptoms and psychosocial consequences, there is no difference in terms of the diagnostic criteria. Nor for many decades did the primary treatment goals differ. Historically, the treatment of patients suffering from addiction has been completely dominated by an abstinence goal.

The spectrum of treatments for patients suffering from addiction was broadened to some degree in the 1960s and 1970s, initially with the introduction of substitution programs for morphine drug addicts. The basic aim was to reduce or suspend the harmful consumption of heroin or morphine [4]. The first main focus

was to include those patients in treatment programs for whom an abstinence-oriented program was – for whatever reason – not (yet) possible. Today, many people forget that when substitution therapy was introduced, it was still dominated by the final goal of total abstinence. The belief was that administering substitutes would be a first step to gain access to those patients who were at risk of infection and who rejected an abstinence-oriented treatment. In a second step, they would be linked up to a treatment facility with appropriate motivation work and preparation by means of reduced consumption, leading to abstinence [5]. Today, most experts in the field of substitution therapy no longer consider abstinence to be a desirable ultimate goal. The original drug substitution therapies directed towards an abstinence goal increasingly developed a momentum of their own and eventually evolved into counseling and treatment programs that are now grouped together under the heading 'harm reduction' [4,101]. 'Harm reduction' in this context usually has a dual meaning, namely a reduction in the level of harm to the addict and a reduction in the level of harm to society by, for example, protecting it against patients who are infected with HIV or contagious hepatitis.

At about the same time, an effort was made to replace the stigmatized and stigmatizing terms 'addiction' and 'addicts' with the terms 'dependence' and 'dependent'. Thus, the two major classification systems of our time, the International Classification of Diseases-10 and the DSM-IV (now DSM-V) of the American Psychiatric Association now only refer to addiction or addictive disorders using the diagnostic classes 'substance use disorder' (e.g., DSM-V) or 'dependence syndromes' [3,6,7]. However, such efforts at removing this stigma must be considered to have failed. Addictions, irrespective of whether they are now called dependence disorders or something else, still carry a great deal of stigma. Moreover, the new nomenclature has led to a watering down of the designation of the disorder. Terms such as dependence and dependency, and even more so

‘maladaptive pattern of consumption’, represent a very broad semantic field, which also embraces conditions that should certainly not be considered as serious illnesses. Who does not recognize their own forms of excess, which might also be viewed as dependence? The dilution of the term today goes so far that in the public discourse (and even occasionally in specialist discussions) we come up against terms such as ‘chocoholic’, ‘telephone addiction’ and even ‘tanning addiction’, although none of these should of course be considered as serious illnesses. This puts problematic behaviors on the same terminological level as addictions, with the inevitable consequence that the latter are no longer taken as seriously as they deserve to be as severe forms of illness. This is also the reason why in this article I have chosen to use the traditional terms ‘addiction’ and ‘addictive disorders’ that communicate the serious nature of the disorder and to refer to those suffering from these disorders as ‘addicts’ (derived from the Latin word ‘addictus’ – the debt slave). The term ‘dependence’ is only used where it is unavoidable in order to faithfully render a quotation.

Addictions are chronic, highly complex disorders with a multifactoral genesis that are embedded in manifold psychological and physical comorbidities [8,9]. While the overwhelming majority of physical comorbidities are consequences of the addiction, it is far harder to evaluate the pathogenesis of the psychological disorders that so often present in conjunction with addictive disorders. In many cases, they are not merely consequences, but the starting points and promoters of the addiction dynamics or at least act as catalysts. Even where they only appear over the course of an addiction, they often subsequently act as disease-perpetuating factors and, thus, as constitutive elements of the addictive disorder itself. Many researchers today even go so far and no longer talk about comorbidities of the addictive disorder but instead interpret the addiction itself as a comorbidity of other psychiatric disorders, such as in the final analysis as a secondary disorder that virtually grafts itself onto other mental illnesses [10,11]. Irrespective of whether we continue to regard addictions as primary disorders, which just happen in many cases to be accompanied by comorbidities, or as secondary disorders in the sense of sequelae from other mental health issues such as depression, anxiety disorders, bipolar disorders (and in particular bipolar II disorders) or

serious personality disorders to name just several of the most frequent, these ‘comorbidities’ must always be included in the treatment plan as crucial issues that need to be dealt with if treatment is to be successful, if only owing to their manifold interactions in the pathogenic structure. No addiction treatment that focuses exclusively on the pattern of consumption and pays less heed to or even ignores the pathogenic importance of the ‘comorbidities’ can be effective in the long term.

Finally, in any discussion about forms of addiction treatment it must always be remembered that it is not the disorder itself that is to be treated but only ever the individual who is afflicted by it [12,13]. Diseases are constructs that humankind has created in order to cope better with the suffering encountered in the natural world. However, the categories created in this way should not prevent us from seeing that it is always the ‘sick person’ and not just the ‘illness’ that is the focal point of our therapeutic considerations and thus our therapeutic choices. At the same time, however, this clearly shows that therapeutic goals that focus solely on the symptoms of the addiction and lose sight of the person with all his or her potential and limitations must always fall short [14]. Nor, according to the most recent publications on human-based therapeutic approaches, are they ultimately very well suited to serve as guidance for effective and sustainable treatment planning [15,16].

Drug consumption-oriented treatment goals

Nonetheless, drug consumption-oriented treatment goals, and, in particular, abstinence-oriented treatment goals, remain the treatment of choice in the field of addiction treatment research. Thus, research in the field of alcohol addiction treatment that is committed to evidence-based medicine still prefers to measure the success of a treatment in terms of the number of days that a patient has remained abstinent in a set period; or *vice versa*, the failure of a therapy is measured above all by how many days an individual has failed or fails to maintain abstinence [17,18]. However, despite the supremacy of abstinence-oriented approaches to research and treatment, there have been numerous attempts to deviate from the central paradigm of absolute abstinence in the history of alcoholism treatment – but not in drug treatment.

The use of substitute substances as widely practiced in drug treatment today did not

naturally suggest itself in the field of alcohol addiction treatment, and instead a variety of concepts for so-called 'controlled drinking' or 'moderate' drinking were developed. A variety of completely different therapeutic approaches are covered by the term 'controlled drinking', which in turn can mean anything from the scrupulously preplanned consumption of small quantities of alcohol at carefully set times to the mere attempt to desist from the uncontrolled consumption of large doses of alcohol. Between these two extremes, a range of therapeutic approaches have established themselves that focus on 'mild' or 'moderate alcohol consumption', whatever one understands by 'mild' or 'moderate', from small quantities to less than regular consumption [19–22].

Long-term studies showed that, measured by the recurrence of severe alcoholism, controlled or moderate drinking could achieve results that are equivalent to those achieved by permanent abstinence [17,23,24]. At least some of these 'therapeutic successes', however, are nothing more than methodological artifacts from long-term studies that were not based on a careful assessment during monitoring periods but on group comparisons at successive points of observation, which were then extrapolated to the entire period. In a long-term study that was not based on group comparisons but on the progress of individual alcoholics, Vaillant and his coworkers demonstrated that adding up the figures for those who are 'relapsed', 'moderate drinkers' and 'abstinent' at specific points in time can create the impression that these are groups that remain stable over long periods of time [25]. However, if one views the progress of individual patients, it becomes clear that the members of these groups move in and out of different patterns of drinking over different study periods. Thus, Vaillant showed that over several years many alcohol patients fell into very different groups; for example, one individual who belonged to the 'abstinent' group at the first point of examination had, by the second point of examination, moved into the group of 'moderate' or 'controlled' drinkers and, by the third point of examination, belonged to the group of 'heavy drinkers' or 'seriously relapsed' because he was unable to drink moderately in the long term [25]. Another test person was initially unable to achieve the required abstinence and, at the first point of examination, belonged to the group of 'heavy drinkers', with a great deal of effort he managed to become abstinent by the

second point of examination but, at the third point of examination, belonged to the group of 'moderate drinkers' owing to several minor relapses. This instability on the part of individual alcoholics measured in terms of membership of consumption groups over a lengthy period must of course be taken into account when interpreting the results of treatment studies that are based on group comparisons [25]. It invalidates the excessively optimistic evaluations of certain long-term scientific studies with regard to the potential of long-term moderate drinking as a good alternative to abstinence among severely dependent drinkers in line with the clinically observable reality.

Even if most studies about controlled or moderate drinking are by no means as convincing once their positive results have been critically weighted in the long term, reduced consumption is nevertheless particularly significant for alcoholics. Unlike morphines and also cocaine, which, except in cases of significant overdosing are relatively well tolerated by the human body and only cause marginal physical harm, alcohol is an agent that is extraordinarily harmful to the human body even medium doses. Alcohol damages virtually all body systems: the central and peripheral nervous systems (e.g., organic psychosyndrome, Wernicke's encephalopathy, epileptic seizures and polyneuropathy), the digestive tract (e.g., gastritis, colitis, cirrhosis hepatitis and pancreatitis), the cardiovascular system (e.g., hypertonia, heart arrhythmia and dilative cardiomyopathy), the skin (e.g., acne rosacea, psoriasis and spider naevi) and the bones (e.g., toxic osseous edema) to mention just the most important [8]. However, in addition to the potential for the development of an addiction, alcohol also causes a host of psychological disorders, such as alcoholic hallucinosis, alcoholic psychoses, withdrawal delirium, depression and dysphoria, among others [26]; and as alcohol crosses the placenta it can also harm the fetus (e.g., alcohol embryopathy). The type and extent of all this harm of course depends significantly on the intake and it is clear that in addition to the quantity of the individual intake, the regularity of consumption over a long period of time plays an eminently important role.

For this reason alone it makes sense to reduce alcohol intake in order to minimize the risk of secondary physical or psychological disorders caused by alcohol. A limiting factor in efforts to reduce intake in the case of a manifest alcohol

addiction with a pronounced physical addiction is the occurrence of an alcohol withdrawal syndrome. This always arises when the level of alcohol in the blood falls below a critical value. This 'critical value' is not a general value, but varies sharply from one individual to another. Where a massive tolerance has developed (in the case of chronic consumption the psychotropic effects of alcohol are achieved only with ever-increasing dosages), such a withdrawal syndrome can occur even when alcohol is drunk in significant quantities so that even small reductions in the quantity (to values that would still be considered high in comparison to moderate drinking) lead to withdrawal symptoms. Besides the occurrence of epileptic seizures induced by withdrawal, the greatest danger in alcohol withdrawal is the transition into a delirium tremens, which, notwithstanding the use of the intensive medical measures that are available today, can still result in the death of a patient [27].

For this reason, treatment programs that focus only on reducing intake to a moderate level of consumption are not effective for alcoholics with a severe physical dependency [28]. In the early stages of an addiction, however, such as when the first signs of addiction are present but there are no indications of severe physical or psychological dependency, minimizing the consumption of alcohol to a moderate level can be a possible alternative to total abstinence for many patients. In DSM-V several of those stages in the development of an addiction, which in the past were not regarded as elements of addiction but were classified as 'abuse', are now seen as early stages of addiction [7]. This finally makes it possible to treat the development of an addiction at an early stage and at the same time opens up new goals in addiction treatment. Especially for those patients who are in the early stages of developing an addiction, moderate consumption is a much more attractive goal than lifelong total abstinence.

The attractiveness of the treatment goal and the belief that it can be attained are directly and positively correlated with the likelihood of a successful treatment outcome [29]. People are generally (and also independently from the development of an addiction) always highly motivated to achieve a goal when the goal is perceived to be both attractive and attainable. In such circumstances they are willing to make great efforts over long periods of time, which of course increases the likelihood that they will indeed

attain the goal. By contrast, our motivation is poor to nonexistent if both the goal and the path to achieving it are unattractive and we do not really believe that we can attain it. What is true of motivation in general is of course also true in addiction treatment. For many people, neither abstinence nor the road to it, namely through the traditional forms of treatment offered at addiction treatment centers, are appealing propositions, and furthermore, many addicts simply do not (yet) believe that they can achieve lifelong abstinence. Abstinence is not necessarily correlated with improvement in other areas of overall adjustment, such as emotional, interpersonal and vocational health [30]. All these reasons appear to leave little incentive to participate in abstinence-oriented treatment programs. In this context, reducing intake as an initial incentive and as a first step towards doing something about the illness, before taking the next step and switching to an abstinence-oriented treatment program, can also be a constructive move for those patients whose addiction is already so far advanced that they display signs of both severe physiological and psychological dependence and thus do not fall into the primary target group for intake-reduction programs. However, in such cases, care must always be taken that the intake reduction does not bring the patient into the danger zone of 'cold turkey'. Last but not least, any discussion about the usefulness of intake-reduction programs must also include those patients who are suffering from severe addiction, but who for whatever reasons or circumstances are a long way from being able or willing to undergo an abstinence-oriented treatment. It is neither medically nor ethically acceptable to leave these patients untreated. An attempt to reduce intake with the aim of 'harm reduction' is appropriate in such cases.

If one sums up all that has been said about intake-reduction programs so far, it becomes clear that these do have a place, especially in the treatment of alcohol addiction. For patients with a severe physiological and psychological dependence, permanent abstinence is undoubtedly the primary treatment objective. However, this can no longer be considered a '*conditio sine qua non*' of addiction treatment [31]. In the early stages of an addiction, intake reduction is not only a sensible course of action; in many cases it can also sometimes be enough to halt the development of the addiction. Even in late-stage addictions, it can help prepare addicts for abstinence or, in

cases with an extremely poor prognosis, can act as a last resort at least prevent or minimize even greater suffering or consequences as part of a 'harm-reduction' strategy. In clinical practice, this means that the focus of the treatment must be flexibly adapted to the particular stage of the illness (Figure 1).

Abstinence-supported & reduced consumption-supported approaches

Alcohol consumption-reduction programs cannot and must not be satisfied with administering psychopharmaceuticals to reduce the quantity of alcohol consumed – not even today, when we have nalmefene at our disposal, a substance that in studies has impressively demonstrated that it is highly effective at helping people with problematic or addictive consumption patterns reduce the amount that they drink [32,33]. Like all other addictive disorders, alcoholism is a highly complex process. It is never the result of a single cause; it is always a complex bundle of causes in which physiological and genetic factors and environmentally related physiological, psychological and social factors are interactively interwoven. During the development of the addiction that was triggered by these factors, a number of secondary illnesses or secondary disorders develop, which in turn act as disease-perpetuating factors in the pathogenic process and thus enormously increase the complexity of the disease process. Some of these disorders become apparent as so-called 'comorbidities' or psychosocial disorders; others, although pushed into the background of the pathological process by the primary problem of the addiction, remain concealed and in many cases unrecognized over a long period of time, but still nevertheless have a pathogenic and pathoplastic effect.

In the final analysis, an effective treatment must always be oriented towards the constellation of conditions in which the addiction develops. It must, therefore, start with a dynamic, multidimensional, differential diagnostic investigation, which takes into account all those pathogenic and pathoplastic factors that cause and influence the course of the disease [34–36]. Simple behavior pattern analyses or simplistic biological or psychological preconceptions regarding the causes of addiction do not do justice to the complexity of the addiction process. Of course, modifying consumption, be it towards reduced intake or permanent abstinence, is an important step in the treatment of addicts. However, it is always only one of the many steps that have to be taken to help the addict recover. Accordingly, we should today no longer talk about 'abstinence-oriented' or 'intake-reduction-oriented' treatment programs, but of 'abstinence-supported' or 'intake-reduction-supported' treatment so that the terminology we use makes it clear that these programs are far more than just behavior-modification treatment programs.

Nondrug consumption-oriented treatment goals

This and similar considerations led several groups of researchers to start thinking about what the actual final goal of addiction treatment should be [37,38]. Of course, the prime goal of medicine is usually 'healing' the patient. But what does 'healing' really mean? Is it merely the elimination of symptoms or is it reflected in the complex and dynamic concept of 'recovery'? Is healing simply to be equated with the absence of disease or is it an improvement in the pathogenic process in those cases where an elimination of symptoms cannot be achieved? Or has it much more to do with the definition of health put forward by WHO back in 1949 [39,102], namely as reaching a state of complete physical, mental and social wellbeing? And if so, what does wellbeing mean in this context? Is social wellbeing simply recovering the ability to work that has been lost or reintegration into the life of our society or does it perhaps reach further, something that was developed in the 1980s as quality-of-life concepts? Should psychological wellbeing be equated with wellness or is it to be found in what we call a full and rewarding life? And should physical wellbeing simply be equated with physical wellness or is it much more wellbeing in the sense of becoming one with oneself in

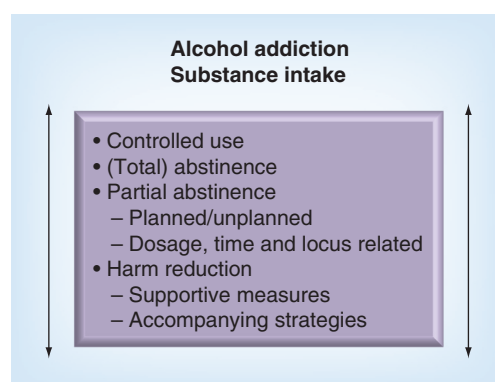


Figure 1. Dynamic treatment plan goal.

one's corporeality? And is all this sought-after wellbeing an intended or desired end point or is it a process of events in all its plasticity with an open end? Or is it even sufficient to minimize the harm that arises for the individual and for our society without striving for complete health of the individual? All the answers to these questions are not only politically and economically explosive, they are also essential for planning effective treatment measures.

It is crucially important to carefully define the goal of treatment before commencing a treatment program, if for no other reason than because a treatment goal can only be achieved if it is known as such in all its details and boundaries. However, this extremely banal connection between the definition of a treatment goal and its attainment is all too often neglected in clinical practice. It is not uncommon for treatment goals to remain unarticulated or for several treatment goals to be pursued simultaneously, even though these goals cannot be achieved simultaneously, to say nothing of those frequent cases where the treatment goal sought by the therapist is not congruent with that of the patient, thus giving rise to the risk that neither goal will be achieved. In many cases, however, the definition of the treatment goal simply remains vague, there is no finishing line so to speak, which demonstrates quite clearly to all parties that the goal has been reached when the line has been crossed. This, and similar deficiencies in developing treatment goals, inevitably lead to uncertainties and disappointments that pose a grave threat to the success of the treatment.

Quality-of-life & recovery approaches

It has been the quality-of-life concepts and the so-called recovery concepts that have attracted the most attention among experts. Most of the objective quality-of-life concepts focus mainly on reintegrating addicts into what we in western middle-class society call 'normal life': an ability to work, somewhere to live, social contacts and financial security; while the subjective parameters of a quality of life refer mainly to a feeling of wellbeing or contentment [40–42]. The advantage of these concepts is that fundamental aspects of life, which go far beyond substance-consumption patterns, are incorporated into treatment planning. The disadvantage is that in the case of the objective approaches in particular, external sources prescribe what the addict should understand as a high quality of life; however, this

is often a far cry from how patients define a good or better quality of life.

In contrast to quality-of-life concepts, recovery concepts are not end point oriented but process oriented. They are concerned less with achieving a predefined end condition that is regarded as optimal, but instead with initiating a process of development directed at improving the general condition but without being fixated on an end point [43–45]. This is the strength of these approaches, as they take much better account of the individuality of the patients with all their potential and limitations than traditional end point-fixated quality-of-life approaches do. Yet at the same time, this is also their weakness: most recovery approaches lay down the direction of travel within certain confines, but lack a finishing line to be crossed, with – as discussed earlier – not infrequent consequences of disappointment and demotivation.

Human-based medicine approaches

In recent years, a human-based medicine [36,46] has been developed that focuses on the human being in his individuality, corporeality and aesthetic aspects, and, in particular, aspects of beauty and attractivity have increasingly been incorporated into treatment concepts that look further than the quality-of-life and recovery approaches. The attractiveness of a goal of action or an action, together with its perceived attainability, are the chief motivators for long-term action. This general principle also applies to treatment measures. The more attractive the goal of a treatment and the treatment itself, the greater the chance of a successful outcome. As a comprehensive analysis of addiction treatment studies carried out by Bottlender and Soyka showed, the prognosis for an addiction depends less on the particular form of treatment than on whether someone manages to remain in treatment for a long period of time or not [47]. In this context, motivational interviewing techniques play a central role [48–50]. Treatment plans and goals, which are perceived as attractive by patients, significantly increase the treatment outcome [29]. This was what prompted the Anton Proksch Institute (Vienna, Austria) to develop a treatment plan entitled the Orpheus program, which focuses on (re)gaining an autonomous and joyful life [29].

An autonomous and joyful life is nothing more than the concrete embodiment of what

people usually call a life that is worthy of affirmation because it is beautiful. What people call a beautiful life is in turn nothing else but a life that is characterized by physical, mental and social wellbeing, such as a 'healthy life', as defined by WHO in 1949 [102]. In the Orpheus program, individuals learn to develop and unfold these sources of strength in keeping with their own possibilities and capabilities in a variety of treatment modules that include awareness and mindfulness modules, modules that enable patients to experience nature and art, body perception and body awareness modules, life and self-reflection modules, as well as pleasure-intensification modules [29]. Abstinence, drug substitution or reduced consumption are then only subgoals on the road to a life that is essentially self-determined, full and rewarding. In contrast with earlier moralizing therapies [51,52], the specific form that this 'healthy life' can and should take is no longer determined by the therapist, but by the patient himself; the therapist supports this development and unfolding of a beautiful and healthy life by contributing expertise as an advisor, promoter, catalyst and as a stabilizer who offers a sense of security [15].

Summarizing all that has been discussed so far, it becomes clear that even before treatment is started both therapists and patients today have to face decisions that are far from simple. The days when the only available choices were abstinence as the all-dominant goal or no treatment at all are over [30,31]. Today there is an abundance of drug consumption-oriented treatment goals and nondrug consumption-oriented treatment goals to choose from, and based on the experience we have today, focusing solely on drug abstinence or intake reduction cannot be considered effective [38]. Both approaches should always be integrated into an overall treatment plan, which takes account of all the physiological, psychological and social factors that play a role in the pathogenic process and yet that is ultimately directed towards the convalescence or recovery of the individual, such as toward their physical, mental and social wellbeing. The diversity of the treatment goals and therapeutic possibilities should not, however, detract from the fact that we do not always and in every case have complete freedom of choice. Some treatments, as explained earlier, are only appropriate or suitable in certain phases or stages of addictive disorders. In any case, the choice of the treatment goal and form of treatment depend to a very large extent

on the potential and limitations of the individual in its particular phase of life. Thus, the foundation for planning an effective treatment must always be a weighing-up of which treatment goal (or subgoal) is currently feasible for that patient at that stage of their addiction and this of course requires comprehensive specialist knowledge.

The professional opinion is set against the needs and wishes of the patients, who of course must also be involved in the decision-making process. Only if the goal of the treatment appears to be both attractive and attainable for the patient will he or she be willing to actively and consistently participate in the chosen program [29]. At the same time, it should not be forgotten that patients on the whole now demand greater self-determination. A monolog by the therapist can, therefore, no longer be accepted as state-of-the-art practice. Nor, however, can a monolog by the patient be considered productive. A great deal of specialist knowledge and considerable experience as a therapist is required to choose the optimal treatment goal that is attainable for the patient at the present point in time. Simply leaving it up to the patient to decide whether he would rather choose an abstinence-supported treatment program or intake-reduction program as has recently been suggested by some groups of researchers is thus not really constructive [53–57].

Conclusion & future perspective

What is needed in the future is to establish treatment programs based on a constructive medical dialog between patient and therapist. In this context, a simple 'explanatory consultation' is not enough. All too often, such consultations end in a monolog for two, in which one party not only wishes to persuade the other that his point of view and intentions are the right ones, but also seeks to impose his own aspirations. To establish a treatment plan according to what an addict considers as a 'full and rewarding life' and what he or she is capable of living, requires a genuine dialog in which the therapist can bring in his specialist knowledge regarding the possibilities and impossibilities of attaining particular treatment goals and the possible paths towards it. However, also the needs and wishes of the patient must be respectfully taken into account so that in a joint dialog-based therapeutic process, all that is needed for the addict to enjoy a full and rewarding life can be developed and unfolded.

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