從臨床心理知識澄清對毒癮者的非理性信念

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DRUGS, BRAINS, AND BEHAVIOR

THE SCIENCE OF ADDICTION

NIDA
NATIONAL INSTITUTE ON DRUG ABUSE

National Institutes of Health
U.S. Department of Health and Human Services

我們從臨床心理學的角度看毒癮

- 治療的效果
- 心理分析對藥癮或毒癮的看法
- 共病的現象
  - 精神疾病
  - 人格疾患
- 神經心理學的角度

治療的效果

MEDICATIONS USED TO TREAT DRUG ADDICTION

- **Tobacco Addiction**
  - Nicotine replacement therapies (e.g., patch, inhaler, gum)
  - Bupropion
  - Varenicline
- **Opioid Addiction**
  - Methadone
  - Buprenorphine
  - Naltrexone
- **Alcohol and Drug Addiction**
  - Naltrexone
  - Disulfiram
  - Acamprosate

PSYCHOSOCIAL TREATMENT USED TO TREAT DRUG ADDICTION

- ***Cognitive Behavioral Therapy.*** Seeks to help patients recognize, avoid, and cope with the situations in which they are most likely to abuse drugs.
- ***Motivational Incentives.*** Uses positive reinforcement such as providing rewards or privileges for remaining drug free, for attending and participating in counseling sessions, or for taking treatment medications as prescribed.
- ***Motivational Interviewing.*** Employs strategies to evoke rapid and internally motivated behavior change to stop drug use and facilitate treatment entry.
- ***Group Therapy.*** Helps patients face their drug abuse realistically, come to terms with its harmful consequences, and boost their motivation to stay drug free. Patients learn effective ways to solve their emotional and interpersonal problems without resorting to drugs.

毒癮的治療有效嗎?

- 請大家想一想下面幾個問題的答案：
  - Q1：毒品犯的再犯率有多高?
  - Q2：毒品犯不是都有強制治療嗎?
  - Q3：強制治療倒底有沒有成效？

人類行為原因的複雜性

- 自由意志
  - 個人可以選擇與決定

- 司法上行為責任的界定—『自由意志』
  - 在自由意志下，人必須為選擇或決定去負責

- 心理治療常處理的是非自由意志的部份

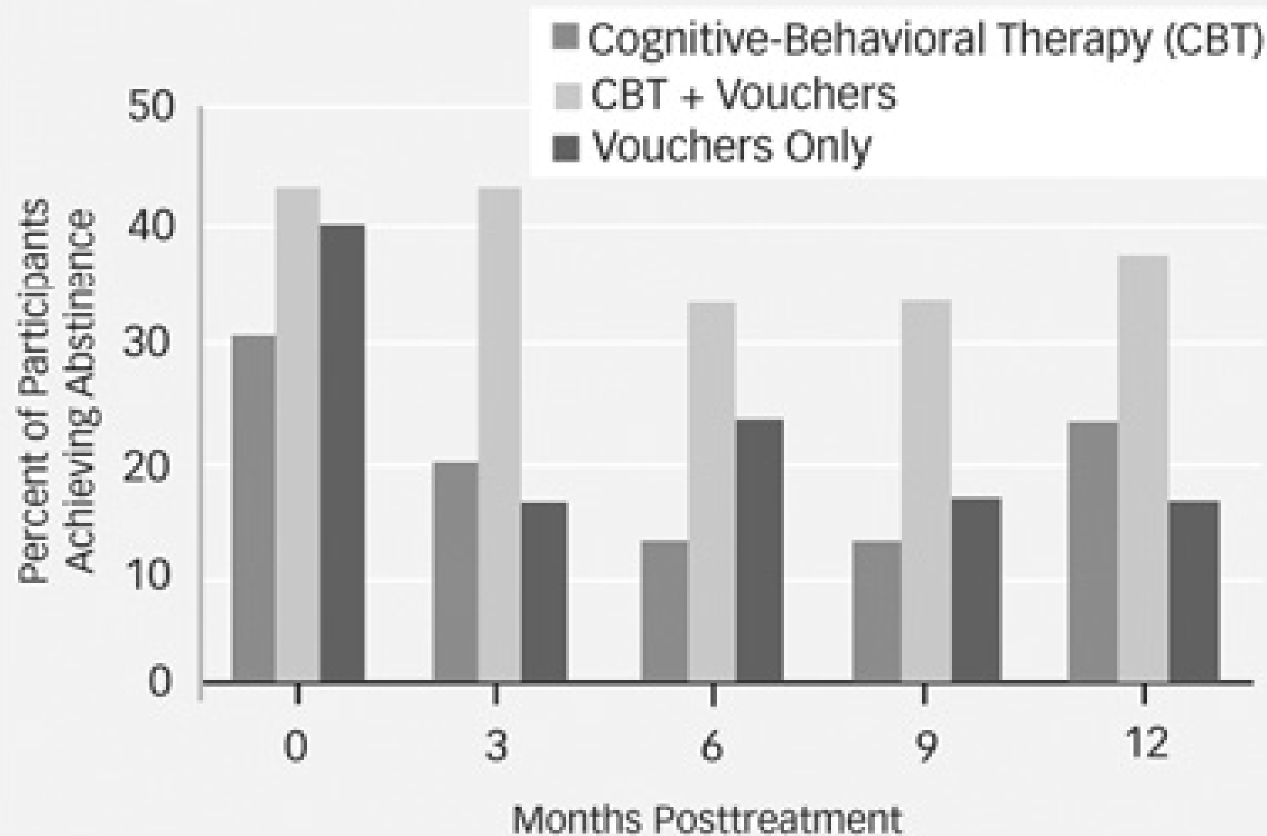
台灣司法的強制治療

- 台灣司法上需要強制治療的罪犯有：
  - 毒品犯
  - 性侵害犯
  - 家庭暴力犯
- 這些司法強制治療效果有多大???
  - 行為出現的原因出自於自由意志的部份以及非自由意志的部份

藥癮治療有效嗎?

- 從研究來看，是有效的!
  - RCA
  - RP
  - MI
  - DBT
  - MBCBT

COMBINED TREATMENT HELPS MAINTAIN ABSTINENCE Over the 12 months following treatment, abstinence levels for all treatment conditions tended to decline, but levels for the combined treatment remained consistently higher than those for CBT or vouchers only.

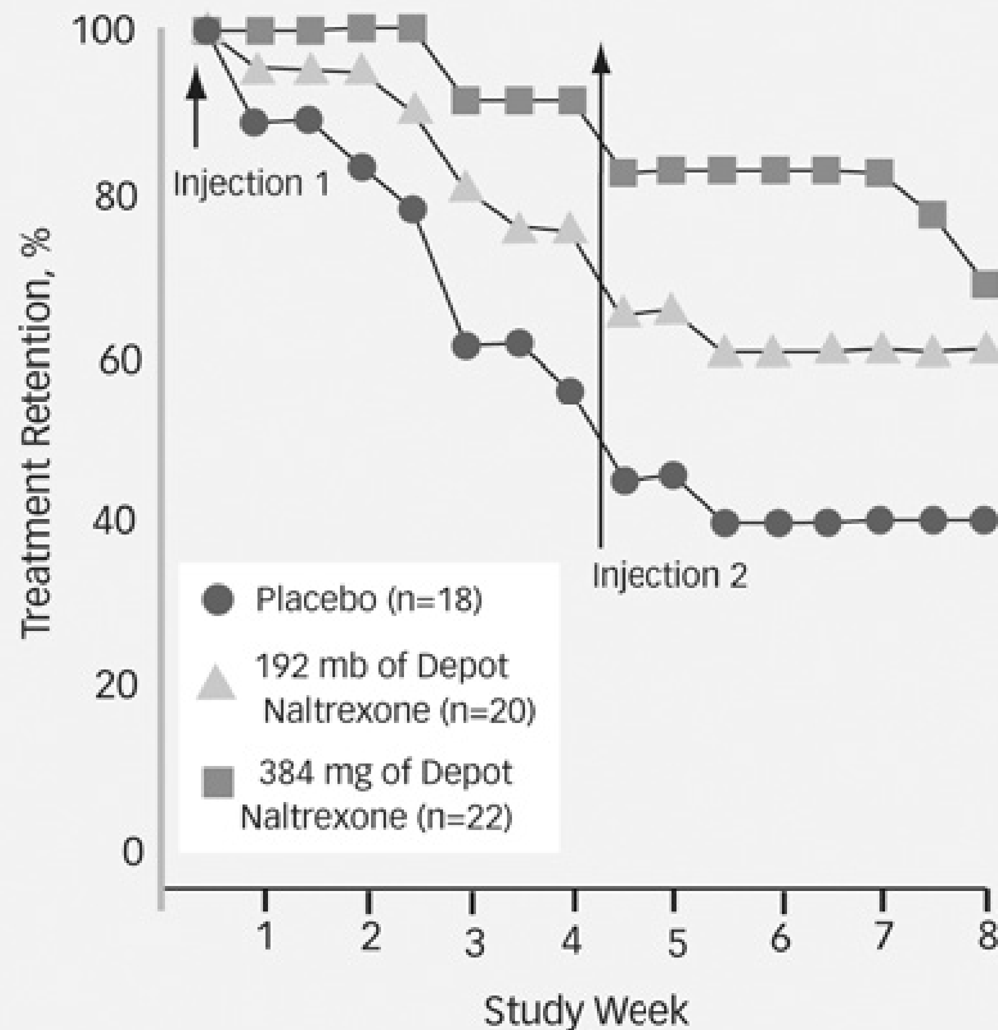


VOUCHERS BOOST ABSTINENCE RATES DURING TREATMENT Participants in the vouchers-only group had better abstinence outcomes than those in the combination or CBT-only groups during treatment. All three groups reported substantial improvements over the 14-week period, but no significant intergroup differences, on measures such as the number of days participants used marijuana and how often they experienced marijuana-related problems.

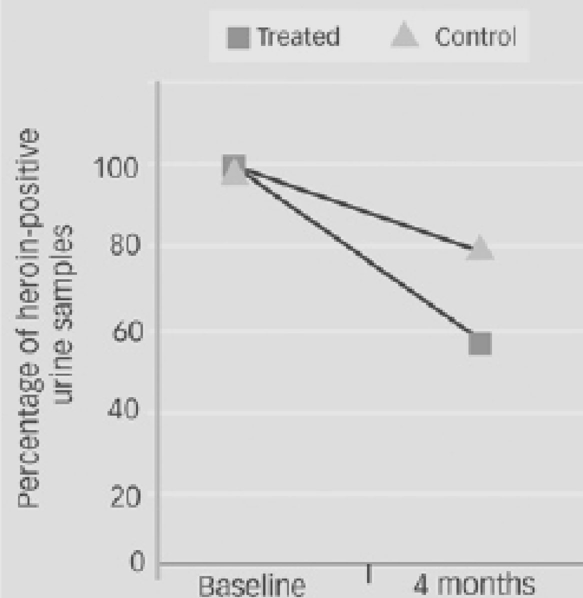
	CBT	CBT+V	V
Primary abstinence outcomes			
Mean weeks of continuous abstinence [a]	3.5	5.3	6.9
% of participants who achieved 6 or more weeks of continuous abstinence [a,b]	17.0	40.0	50.0
% marijuana-negative urine specimens	32.0	43.0	55.0
Secondary self-report measures			
Number of days marijuana used during prior month [c]			
Intake	26.1	24.8	25.8
End of treatment	8.6	9.7	11.3
Number of times marijuana used per day [c]			
Intake	3.7	4.2	3.8
End of treatment [a]	1.6	2.7	2.6
Marijuana Problem Scale [c]			
Intake	7.9	7.8	7.8
End of treatment	5.1	3.6	4.1

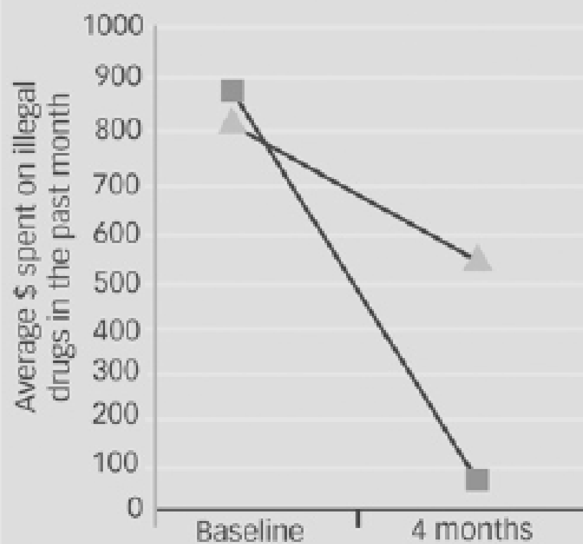
Data for all analyses were based on all participants (n = 30 per treatment condition).
Mean data reflect means adjusted for abstinence prior to treatment.
[a]CBT vs. V, comparison $p < .05$
[b]CBT+V vs. CBT, comparison $p < .05$
[c]Significant main effect for time, $p < .01$

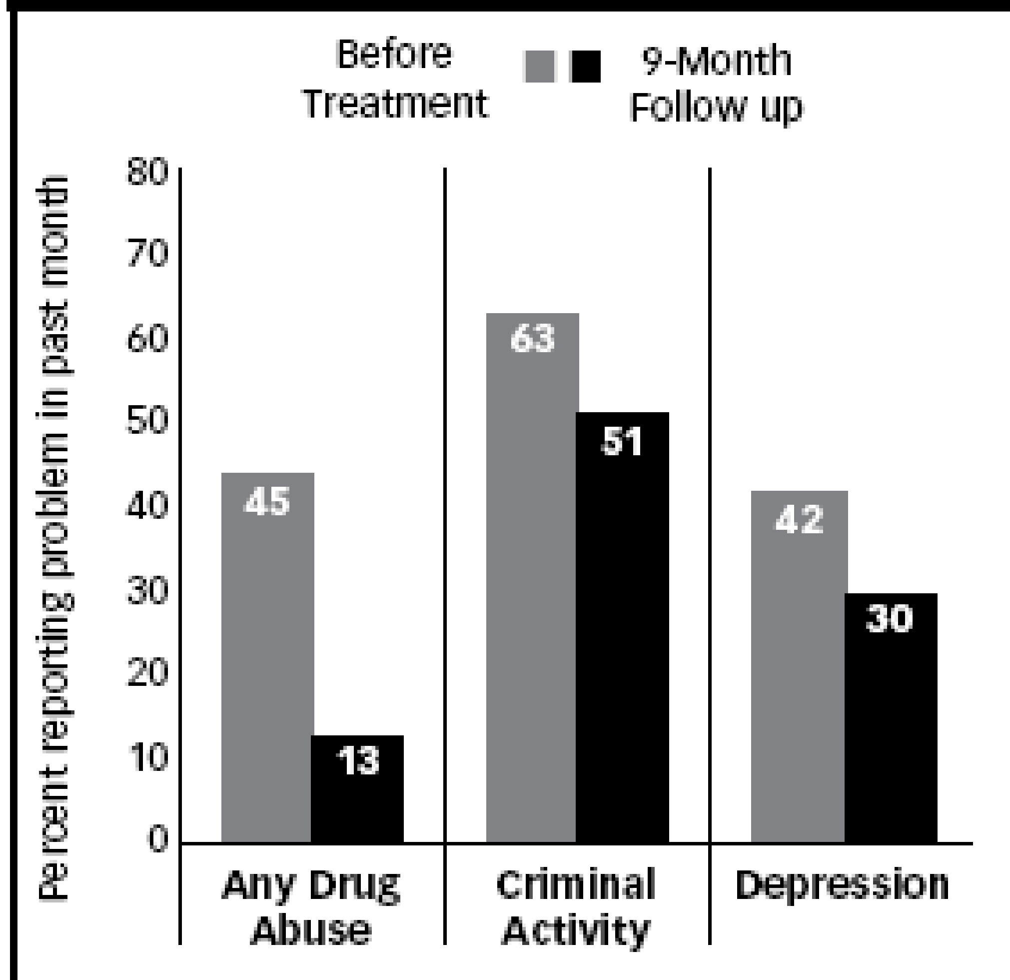
NALTREXONE HELPS PATIENTS STAY IN TREATMENT More patients receiving 384 mg of depot naltrexone attended each weekly treatment session, compared with those receiving a smaller dosage of depot naltrexone or those who received placebo.



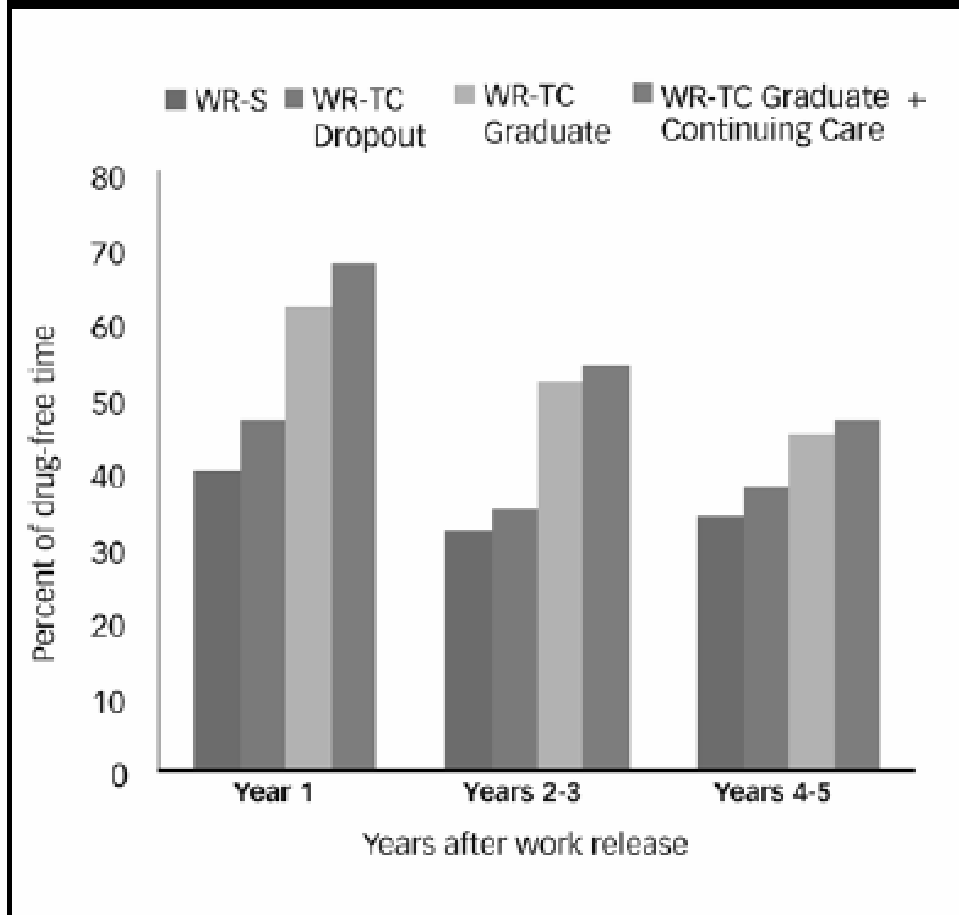
HEROIN USE AND MONEY SPENT ON ILLEGAL DRUGS AMONG PATIENTS RECEIVING INTERIM METHADONE TREATMENT COMPARED TO CONTROLS





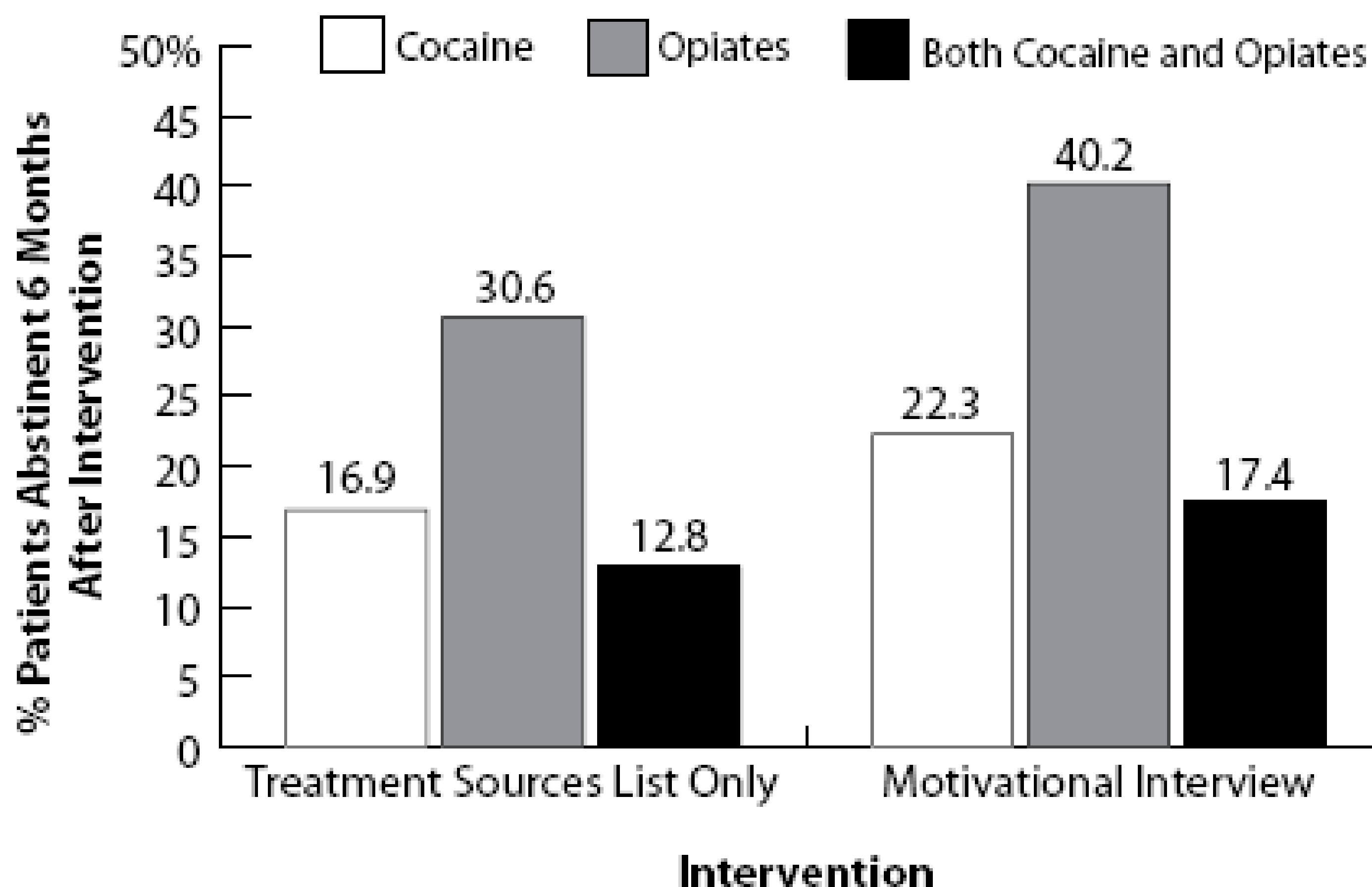


Nine months after methamphetamine abusers began addiction treatment, they had reduced past-month drug abuse and criminal activity, and fewer reported depression.



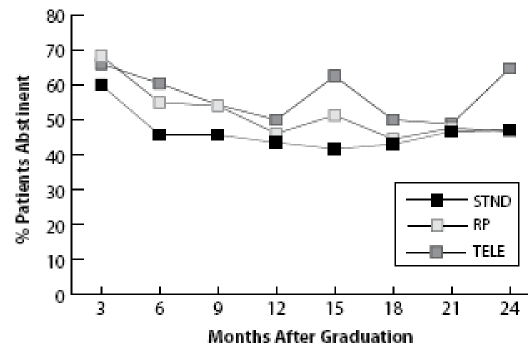
During the 5 years after prison release, Delaware offenders receiving treatment in a work-release therapeutic community (WR-TC) demonstrated more drug-free time than those in the standard work-release program (WR-S). For the first two followup periods, percentage of drug-free time increased with greater participation in treatment. Beginning 3 years after treatment, the four groups were not significantly different from each other; however, participants in WR-TC demonstrated more drug-free time than those in WR-S.

Motivational Interview During Routine Medical Visit Reduces Drug Abuse

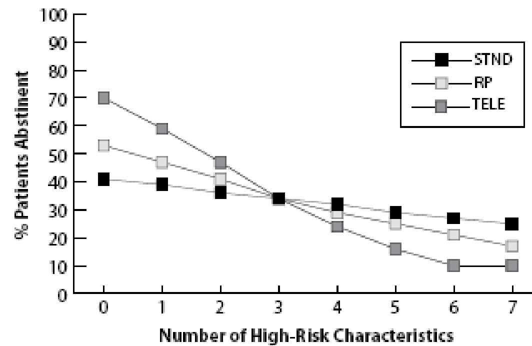


Six months after meeting with a peer addiction educator during a routine medical care visit, patients who participated in a motivational interview had higher rates of abstinence than patients who received a treatment sources list only.

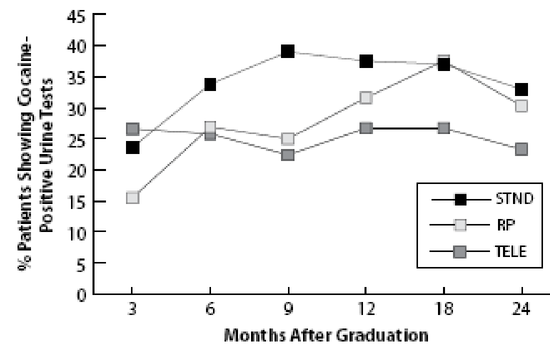
Telephone Counseling Helps Outpatient Treatment Graduates Stay Abstinent



Two years after graduating from intensive outpatient treatment, more patients who participated in telephone-based continuing care (TELE) had maintained abstinence during the previous 3 months than those receiving standard group counseling (STND). The percentage of abstinent patients did not differ between TELE and relapse prevention (RP) continuing care.



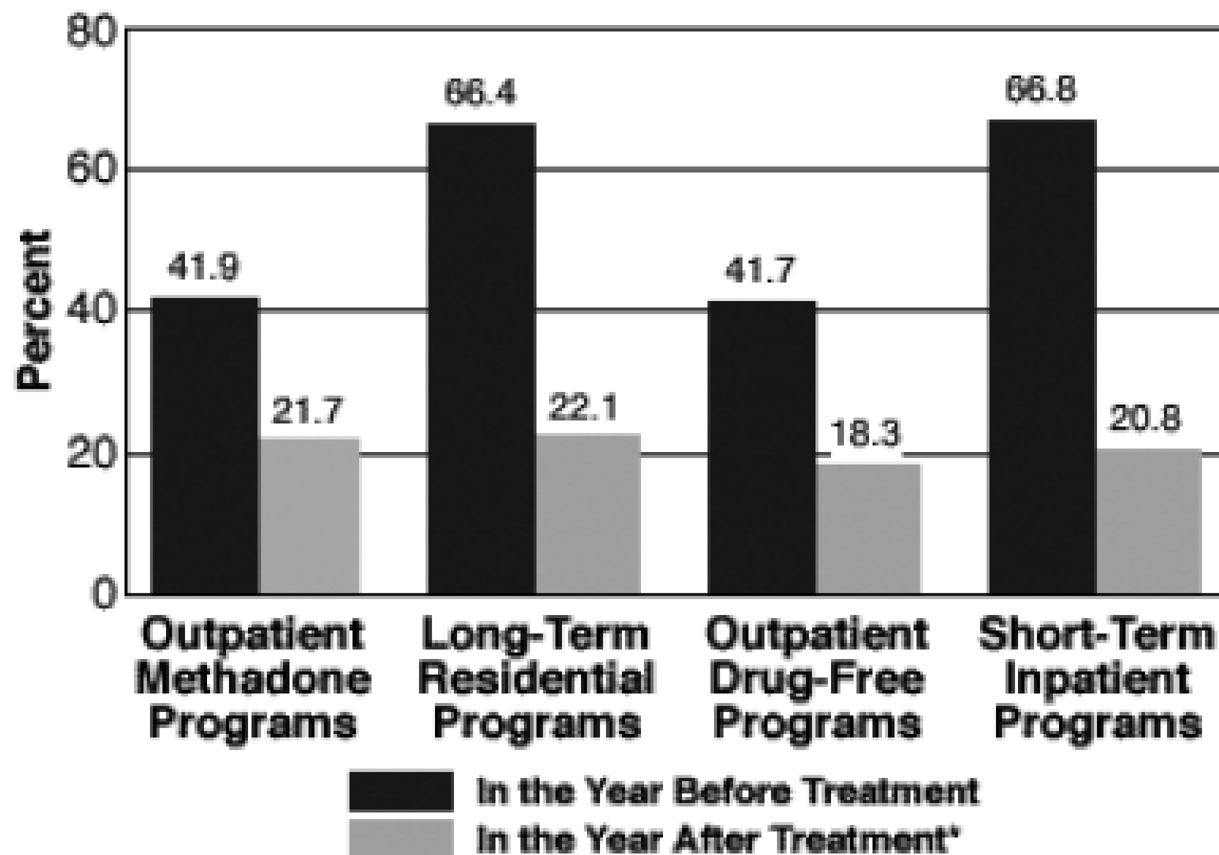
Throughout the study, patients with four or more characteristics reflecting severe addiction were better able to maintain abstinence if they participated in STND compared with TELE.



The percentage of cocaine-positive urine samples did not increase as quickly during the followup for TELE patients as it did for those who participated in RP, with a similar trend for TELE compared with STND.

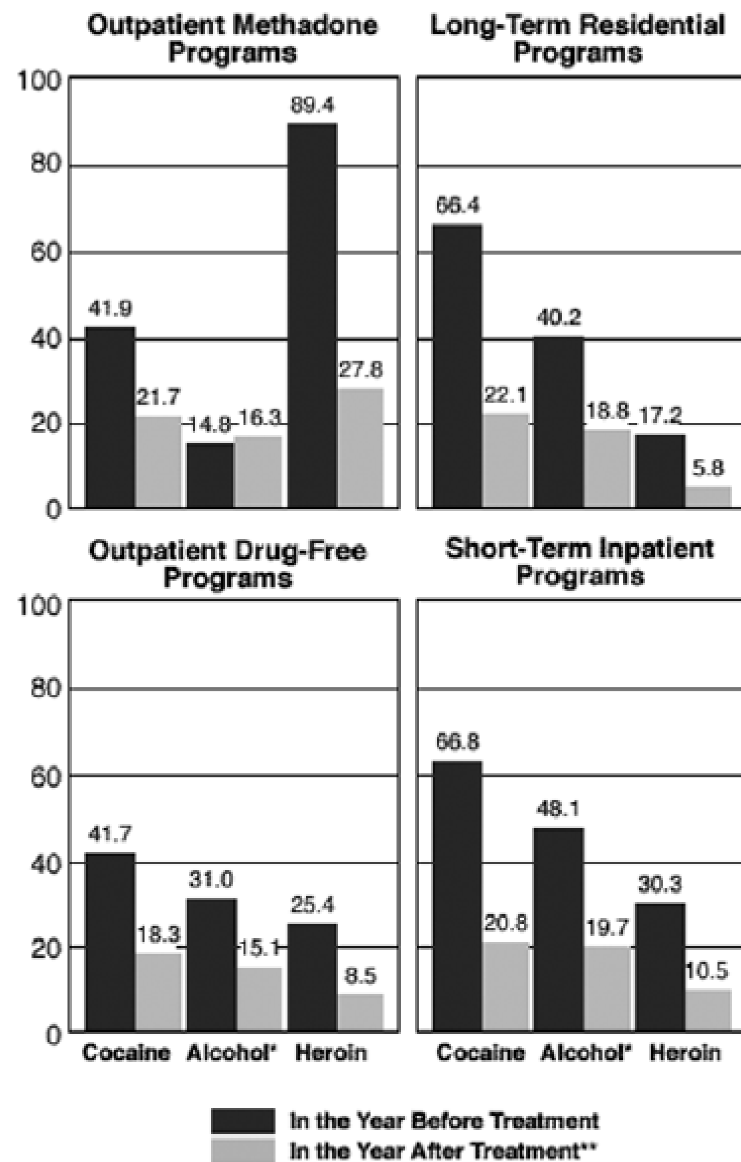
All patients participated in 12 weeks of continuing care after completing a month of intensive outpatient treatment, and reported outcomes every 3 months during the 2-year followup.

Percentage of Patients Reporting Weekly or More Frequent Cocaine Use Before and After Treatment



* Outpatient methadone patients still in treatment were interviewed approximately 24 months after admission.

In all four types of treatment programs that the Drug Abuse Treatment Outcome Study examined, the percentage of patients reporting frequent use of cocaine dropped dramatically after treatment.

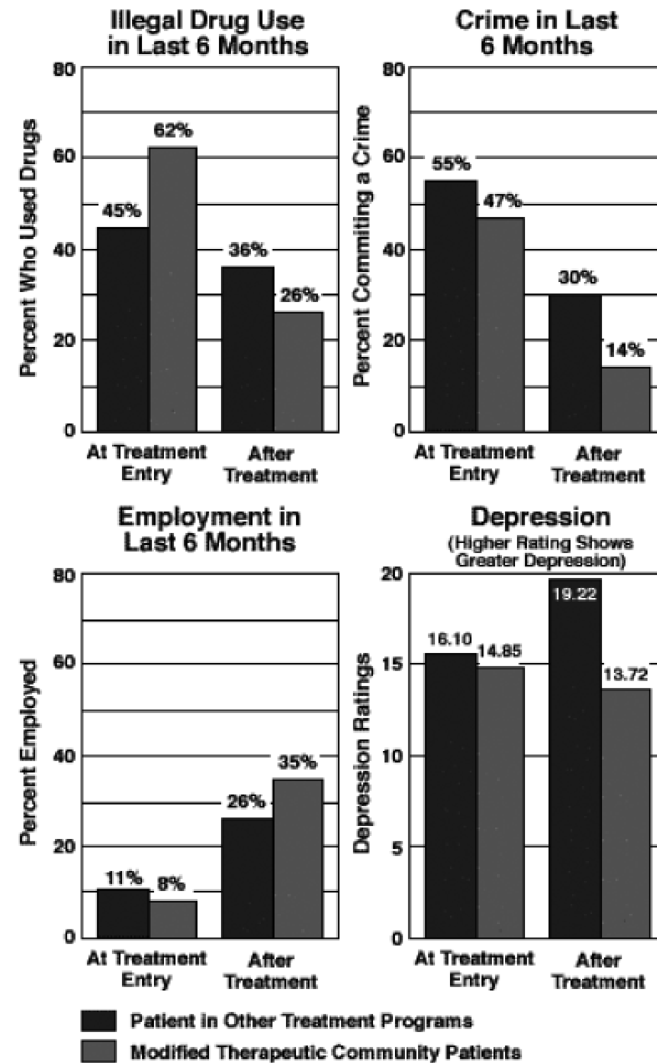


* Weekly or more frequent use with 5 or more drinks at a sitting.

** Outpatient methadone patients still in treatment were interviewed approximately 24 months after admission.

Changes in Outcomes After Treatment

(Measured an Average of 750 Days After Patients Entered Treatment)



Homeless mentally ill patients in a modified therapeutic community in New York City who were treated for both substance abuse and psychiatric problems had more successful outcomes after treatment than did patients with similar disorders in other treatment programs.

經驗與學術研究上的衝突!

- 臨床經驗與研究結果的衝突!!!
- 為何會這樣呢? Why?其實很多原因造成這樣的結果…
  - 1.個案的特徵
  - 2.有效的標準
  - 3.…

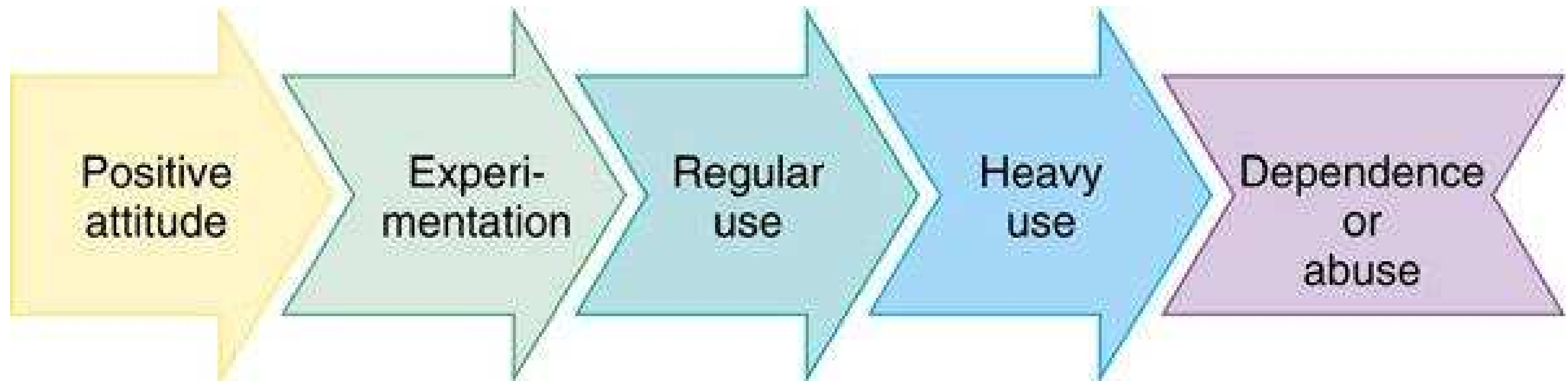
1. 個案的特徵

- 研究的個案是被必須能配合研究要求，而臨床個案部份來自於應付法律要求。
- 治療時必須考慮個案的『動機』或『配合程度』—進行心理治療時應該要評估的

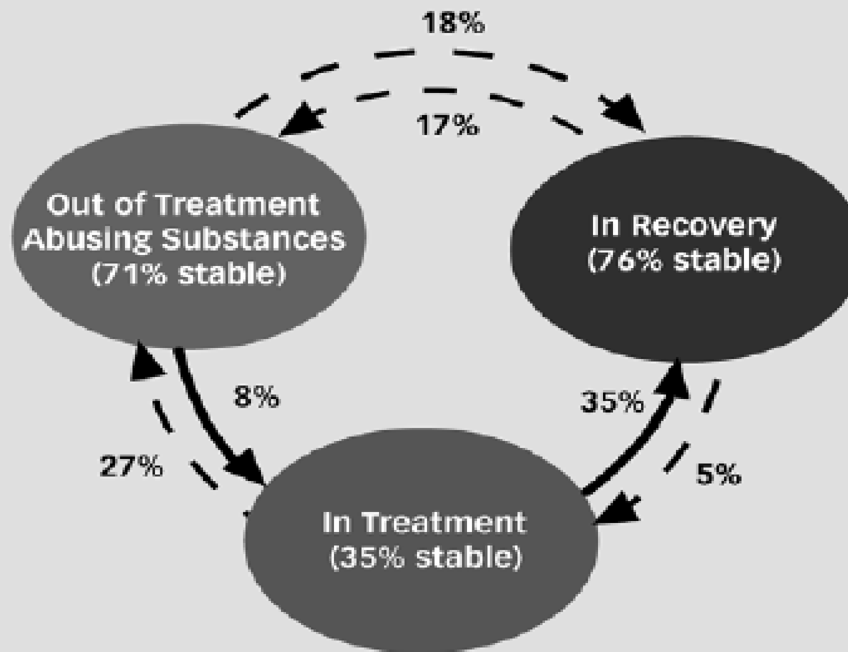
2.療效有效的判斷標準

- 法律的標準是『不再用藥』或『禁絕』，臨床上的標準是『改變的程度』，包括使用藥物的量的改變、頻率的改變、維持禁絕時間的長短…
- 治療的進展多數是一小步、一小步的進展，小心現行台灣的制度很容易把治療所建構的關係與進展一下子完全抹煞了
- 藥癮個案是犯人還是病人?

藥物的使用或依賴的歷程



藥物的戒治則是循環的



治療是肯定有效!但不是每一位個案!

藥癮就像頭痛一樣，這次治療好了，還是會頭痛的!!!

事實告訴專業人員的是－請不要懷疑，就是盡力去協助這些需要幫助的人

心理分析的角度

心理分析的角度

- 有許多的理論模式。有趣的現象是多數理論模式都支持Wurmser的看法，認為藥癮者的『超我』太過嚴苛、太具破壞性。因此，自我選擇用逃避的方式面對內在的衝突。

"Very well, I'll introduce you. Ego, meet Id. Now get back to work."

對毒癮者的心理治療

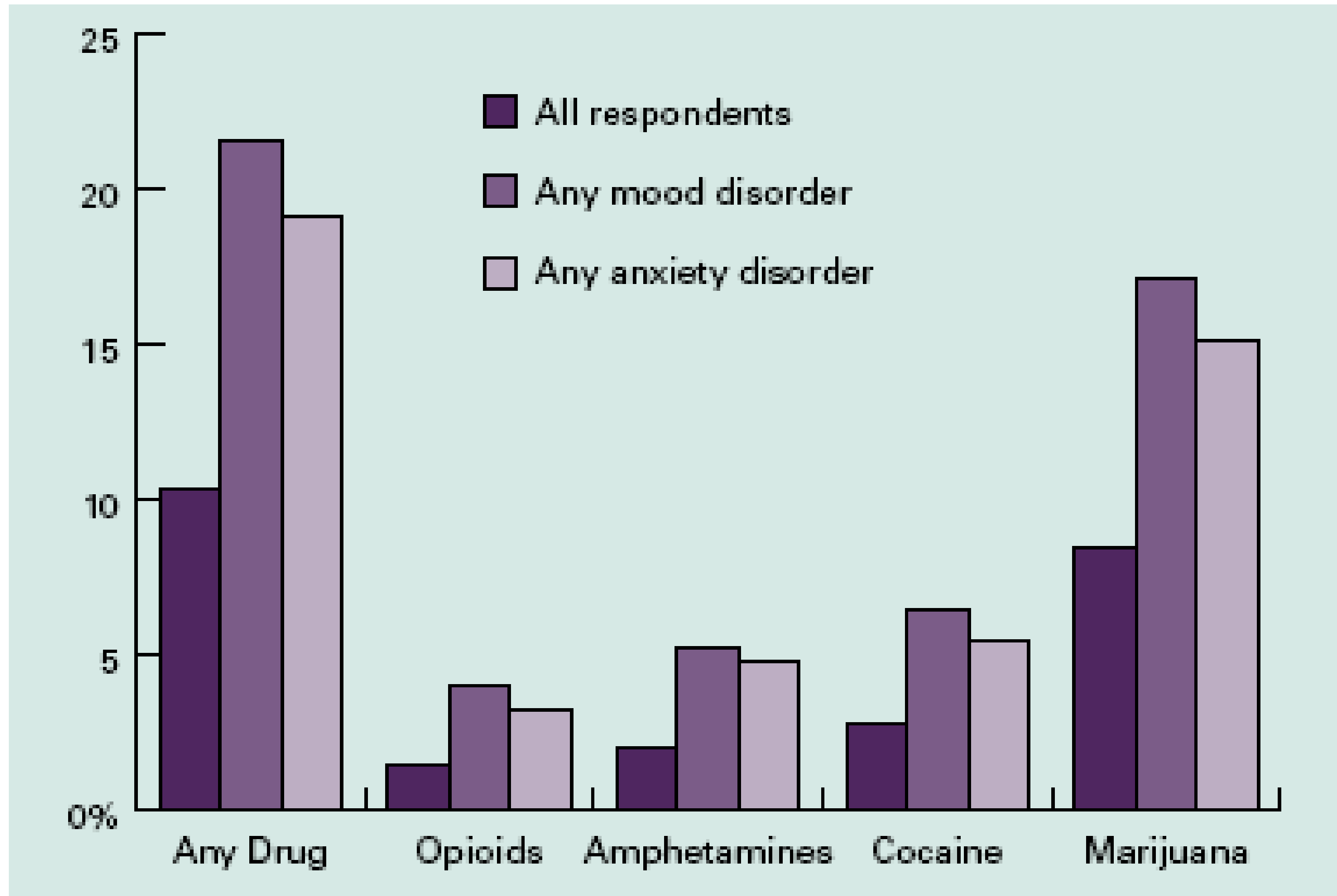
- 意指治療者應該能提供情緒經驗的存在感以及彈性、溫暖與仁慈的態度。

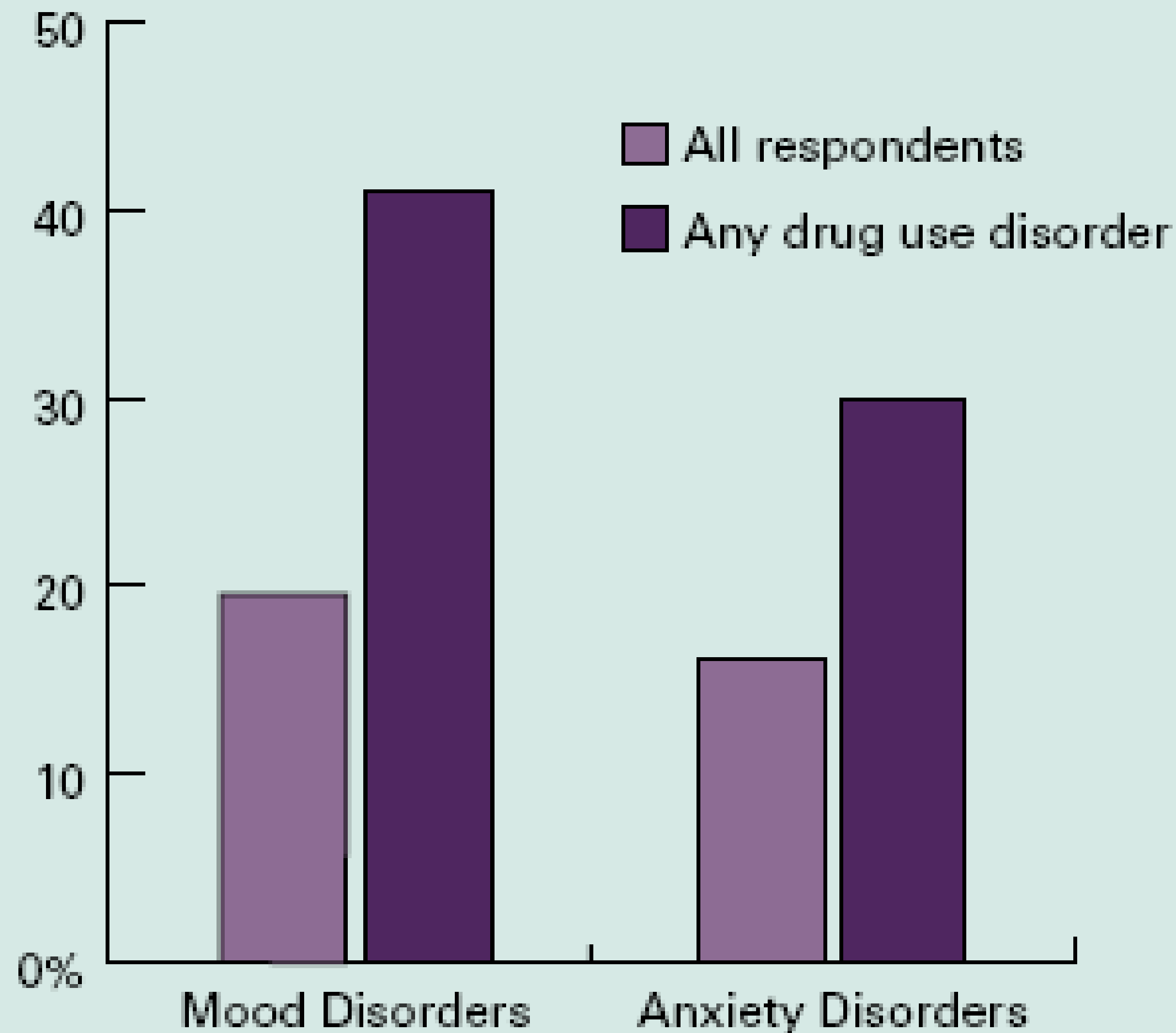
共病的現象

共病

- 共病是精神疾病獨特的現象
- 目前精神病理的模式是描述性的
  - 描述精神疾病病人的困擾或問題
- 上癮者除了傳統物質濫用與依賴外，常同時呈現著許多問題
  - 與其他疾病共病
  - 與其他人格疾患
  - 心理診斷是很重要

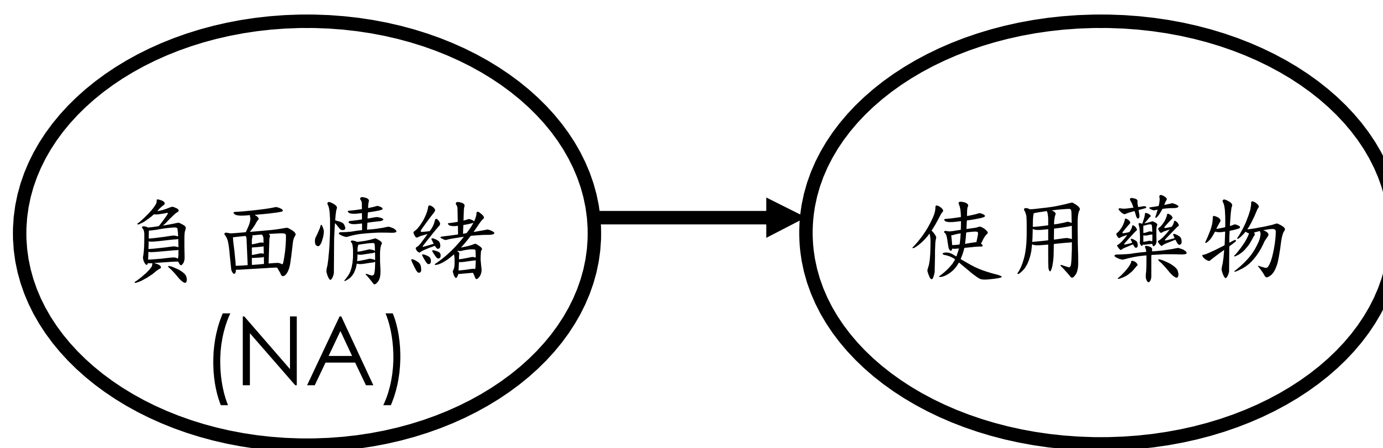
藥癮與焦慮、憂鬱症高共病




Higher Prevalence of Mental Disorders Among Patients With Drug Use Disorders
50
40
30
20
10
0%
All respondents
Any drug use disorder
Mood Disorders
Anxiety Disorders

藥癮與焦慮、憂鬱症高共病

- 藥物有其功能性－"為何要使用藥物"?



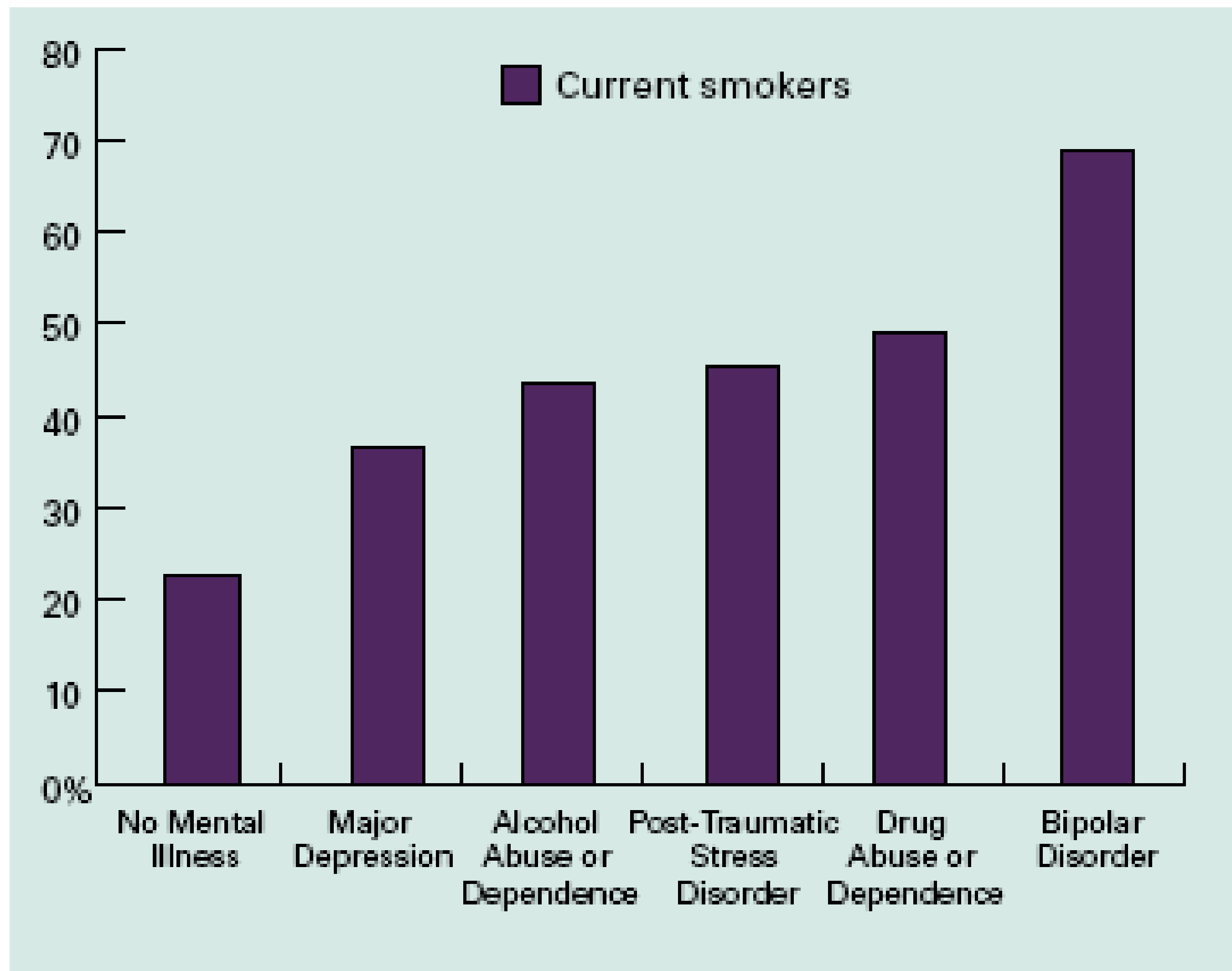
行為學派的制約理論

- 雙面向理論(biphasic theory)
  - 正增強：得到正向愉悅的感受
  - 負增強：逃避不舒服的感受

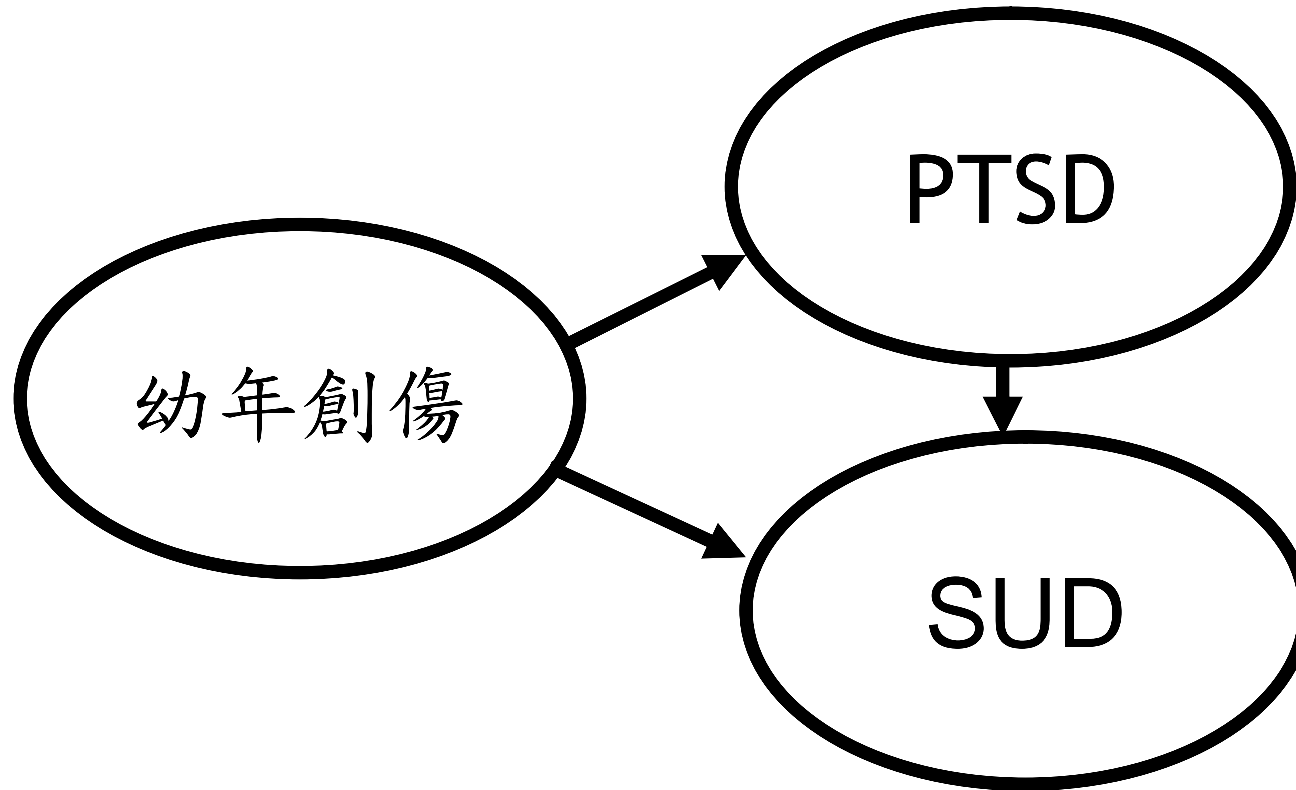
雙面向理論

- 藥物使用初期
  - 雙面向理論
- 藥物上癮後
  - 逃避戒斷與耐受性不舒服的感覺
- 雙面向功能的評估與處置

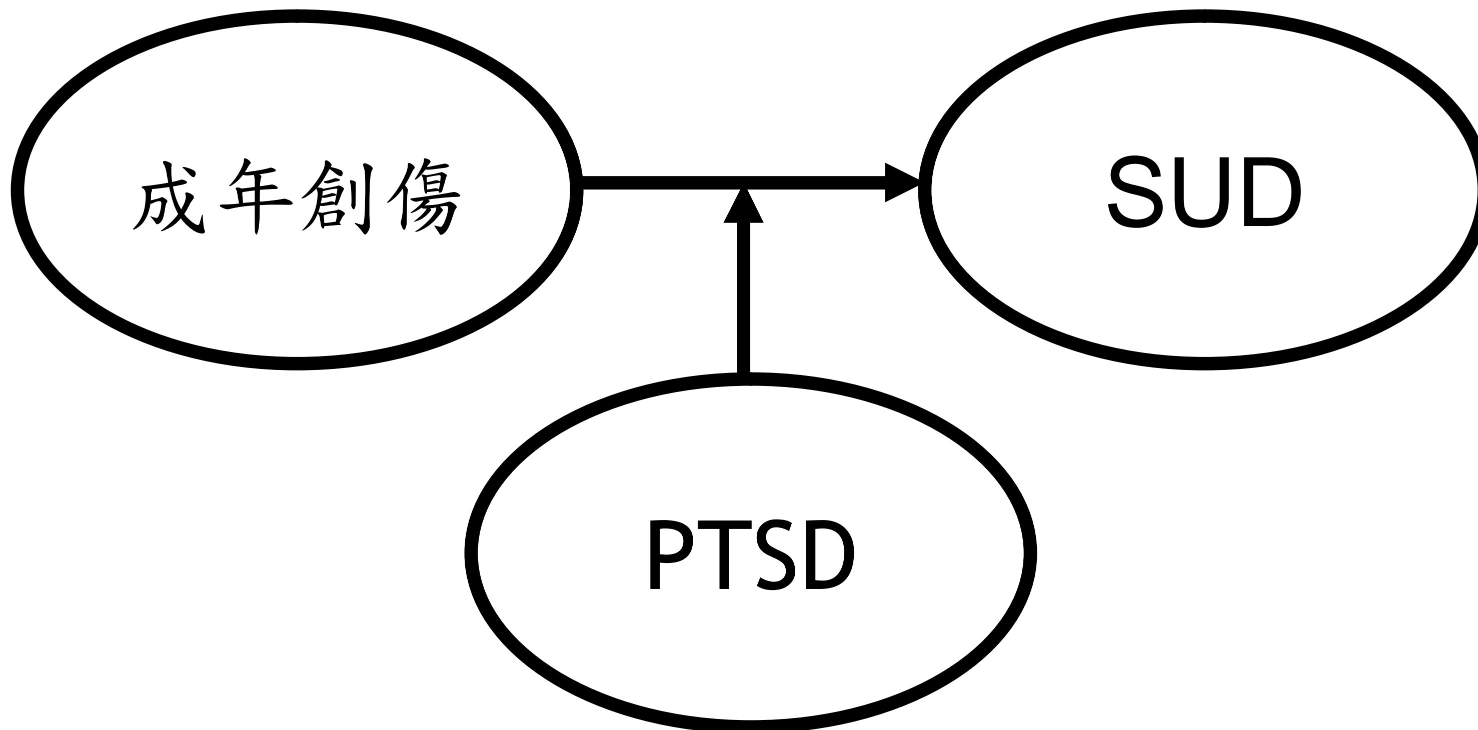
藥癮與創傷後壓力疾患的高共病



自我醫療理論(一):幼年創傷
Self Medication Theory (Khantzian,1985)



自我醫療理論(二):成年創傷
Self Medication Theory



藥癮與人格疾患的共病

- 在男性方面與反社會性人格疾患高共病
- 在女性方面與邊緣性人格疾患高共病

- 心理病態
  - 男性：嚴重的反社會性人格違常
  - 女性：邊緣性人格違常

心理變態

- 在西方社會是一般人朗朗上口的字
- 香港翻譯為「心理變態」
- 日本翻譯為「心理变态」

- 在我們文化中最相近的字眼是『變態』或『心理變態』，但這個字眼負面意味太濃厚。所以採取原意，譯為『心理病態(者)』

心理病態診斷的重要貢獻者(一)

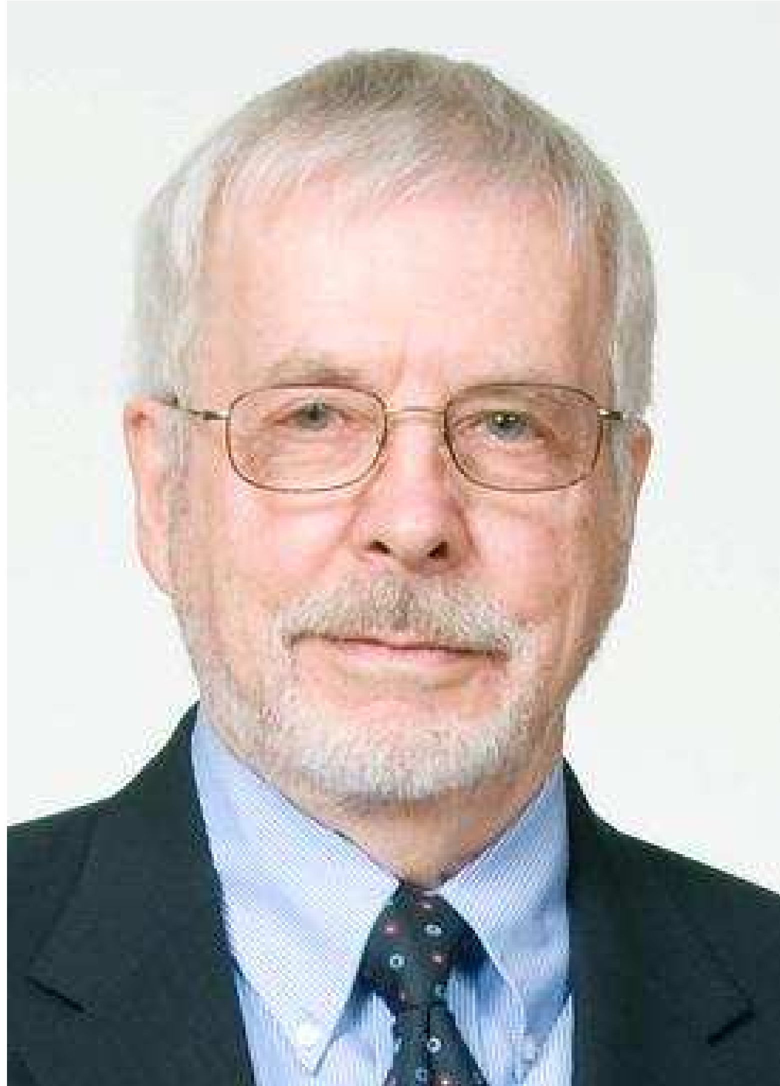
- <u>**Dr. Cleckley**</u> (1941)
  - **A psychiatrist in U.S.A**
  - **Book "The Mask of Sanity"**

Cleckley's Psychopathy

Cleckley 心理病態 16 項特徵

特徵	Characteristics
01.表面魅力且良好智力	01.Superficial charm and good "intelligence"
02.沒有妄想且不合理思考	02.Absence of delusions and other signs of irrational thinking
03.不會緊張或沒有心理神經症的表現	03.Absence of "nervousness" or psychoneurotic manifestations
04.不可靠、無法被信任	04.Unreliability
05.不真實且不真誠	05.Untruthfulness and insincerity
06.缺乏悔恨與羞恥	06.Lack of remorse or shame
07.不當動機的反社會行爲	07.Inadequately motivated antisocial behavior
08.判斷失常以及無法從經驗中學習	08.Poor judgment and failure to learn by experience
09.病態性自我中心且無法愛人	09.Pathologic egocentricity and incapacity for love
10.主要情感反應上的大致貧乏	10.General poverty in major affective reactions
11.缺乏特定的自我覺察	11.Specific loss of insight
12.一般人際關係缺乏反應性	12.Unresponsiveness in general interpersonal relations
13.有時無預期而且狂歡式的飲酒行爲	13.Fantastic and uninviting behavior with drink and sometimes without
14.鮮少有自殺行爲	14.Suicide rarely carried out
15.性生活沒感情、膚淺且整合不佳	15.Sex life impersonal, trivial, and poorly integrated
16.無法遵循任何人生規劃	16.Failure to follow any life plan

心理病態診斷的重要貢獻者(二)



- <u>**Dr. Hare**</u> (1985, 1991, 2003)
  - **A clinical psychologist (Forensic) in Canada**
  - **Test "Psychopathy Checklist (PCL)"**

Hare's Psychopathy

Hare 心理病態 20 項特徵

Hare's PCL-R ITEMS	**特徵**
01.Glibness/superficial charm	01.口若懸河/表面魅力
02.Grandiose sense of self worth	02.誇大的自我價值感
03.Need for stimulation / proneness to boredom	03.需要刺激/易於無聊
04.Pathological lying	04.病態說謊
05.Conning / manipulative	05.欺騙/操縱性
06. Lack of remorse or guilt	06.缺乏悔恨或罪惡感
07.Shallow affect	07.淺薄情感
08.Callous/ lack of empathy	08.無感受/缺乏同理
09.Parasitic lifestyle	09.寄生式的生活方式
10.Poor behavioral controls	10.行爲控制不佳
11.Promiscuous sexual behavior	11.雜亂隨意的性行爲
12.Early behavioral problems	12.兒童行爲問題
13.Lack of realistic, long-term goals	13.缺乏實際長期的目標
14.Impulsivity	14.衝動(做事不計後果)
15.Irresponsibility	15.無責任感
16.Failure to accept responsibility for own actions	16.缺乏接受自己行爲的責任
17.Many short-term marital relationships	17.許多短期婚姻關係
18. Juvenile delinquency	18.青少年犯罪
19.Revocation of conditional release	19.假釋撤銷
20.Criminal versatility	20.犯罪多樣

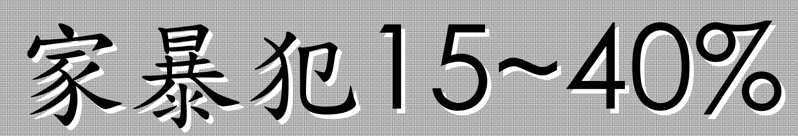
心理病態的流行率

- 一般人口約佔1-2%
- 在監獄或矯治機構約佔15%~30%
  - 性侵害犯15%~30%
  - 暴力犯15%~30%
  - 毒品犯12%
  - 家暴犯15~40%

暴力犯15%~30%

性侵犯15%~30%

毒品犯12%


家暴犯15~40%

再犯罪犯兩人中一人是心理病態

- 心理變態罪犯釋放五至六年的再犯率約為非心理變態罪犯的四至五倍(Quinsey, Harris, & Rice, 1995; Serin & Amos; 1995)
  - 以性侵、家暴罪犯來說，20%是心理病態
  - 再犯率是四倍計算
  - 20%×4(心理病態)：80%×1(非心理病態)=1:1
- 一個可怕的數據，更可怕的是他的治療
  - Later~~

心理病態的法律處遇

- 法律處遇
  - 加重刑期
  - 單獨監禁➔請參考療效研究的"監獄教育"
  - 法律監護➔社區治療中最需要的
- 由於心理病態的診斷會影響法律判決
  - 所以在USA與UK體系，可以使用此量表來進行診斷的人員是極度受限制的。

目前心理治療的成效(1)

- **Thornton & Blud (2007)**

(1)以一般學界與實務界認為個別認知行為治療可能是有效治療心理病態成人個案的方法，這個看法不一定是對的。對高心理病態性的成人個案，短期個別認知行為治療反應不佳。長期認知行為治療療效研究呈現衝突結果：密集性長期認知行為治療有降低再犯的效果，但一般長期認知行為治療卻出現增加再犯的情況。

(2)治療社區(therapeutic community，一種團體心理治療)會增加高心理病態性成人個案的再犯。

目前心理治療的成效(2)

(3)監獄教育(Prison Education)會增加將近快一半的高心理病態性成人個案的再犯。

(4)表達性心理治療(expressive psychotherapy)對高心理病態性成人個案不會增加再犯。

(5)高頻率的折衷心理健康服務(eclectic mental health services)對高心理病態性成人個案有些許的行為療效，但沒有針對再犯進行統計。

(6)上述這些療法或處遇對低心理病態性成人個案均有降低再犯的效果。

一些學者的看法

- Hare(1996)認為由於心理病態在團體中會學會更多操弄他人的方法與能力，因此建議<u>不應進行團體心理諮商與治療</u>以及<u>也不應進行領悟性(**insight**)取向的心理治療</u>
- Rice et al (2001)建議應該採用<u>個別心理治療</u>，而且必須在<u>法律監護下進行</u>
- Meloy (1998, 2002) 建議採用個別深度心理動力性心理治療(沒有實證)
  - ➔對PCL-R>30以上的個案不建議治療

心理病態目前心理治療的成效(3)

- Thornton&Blud(2007)也針對兒童與青少年個案的治療研究回顧，做下列暫時性的結論：

(1)密集長期認知行為治療對於心理病態性得分高與得分低的兒童及青少年罪犯有同樣的效果，且可降低再犯。而且並無任何資料可以支持密集長期的認知行為治療會對兒童及青少年罪犯有負面影響。

(2)其他處遇，如法律監護與家長管束，均會增加高心理病態性兒童與青少年個案增加再犯；而同樣的這些非認知行為治療的處遇，對於低心理病態性之兒童及青少年個案卻有助於降低再犯率。

法律監護下進行心理治療

採用密集、長期個別心理治療

不要用團體心理治療

不要用領悟式心理治療

採用表達性心理治療或認知行為心理治療

團隊

必須從兒童、青少年期就開始治療

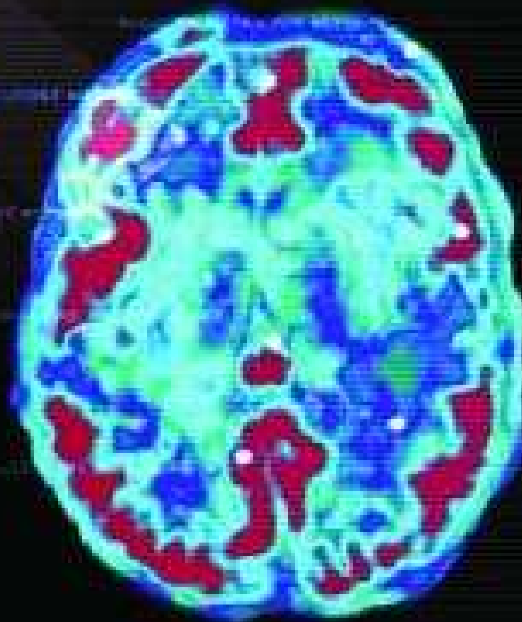
治療方向與方式(一)

- 應在法律監護下進行心理治療
  - 多利用轉移性機構來延長法律監護
- 採用密集、長期個別心理治療
  - 不要用團體心理治療
  - 表達性心理治療或認知行為心理治療

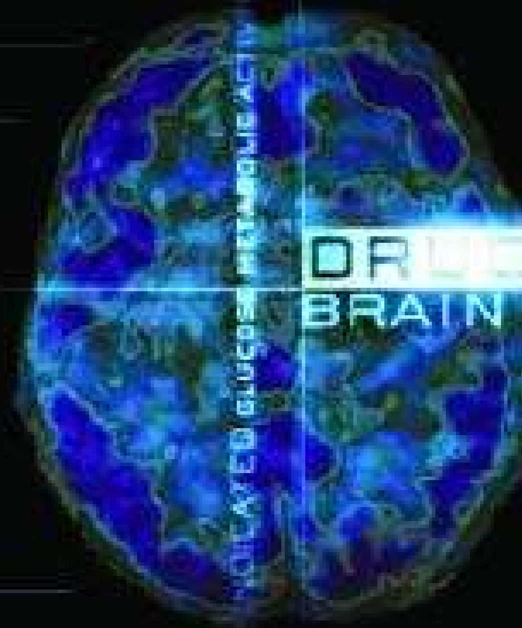
治療方向與方式(二)

- 不要去治療心理病態有關的特質
  - 去治療與心理病態無關卻與臨床問題有關的變項
  - 去處理心理病態在治療中出現的干擾行為
- 團隊教育、督導以及定義清楚的操作程序用以維持界線以及避免被操弄
- 必須從兒童、青少年期就開始治療

神經心理學的角度



HEALTHY BRAIN ACTIVITY



BRAIN ACTIVITY

"Drug addiction is a brain disease that can be treated."

Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse

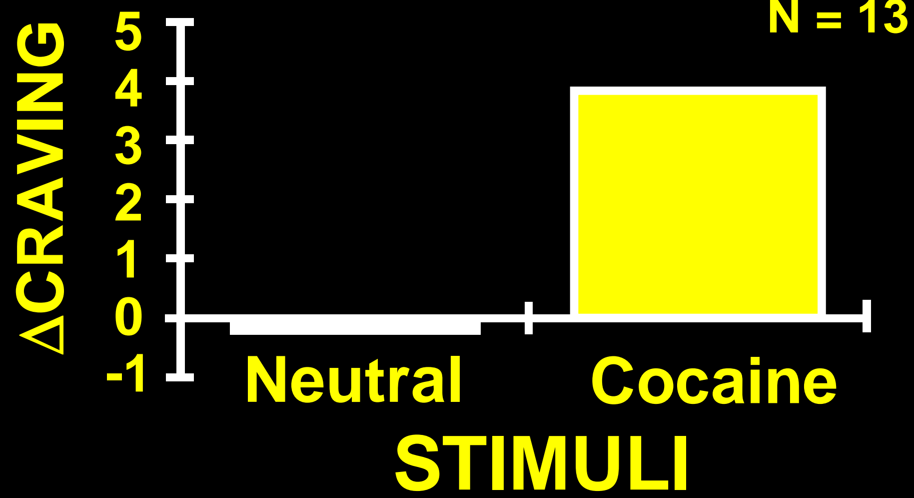
神經心理學

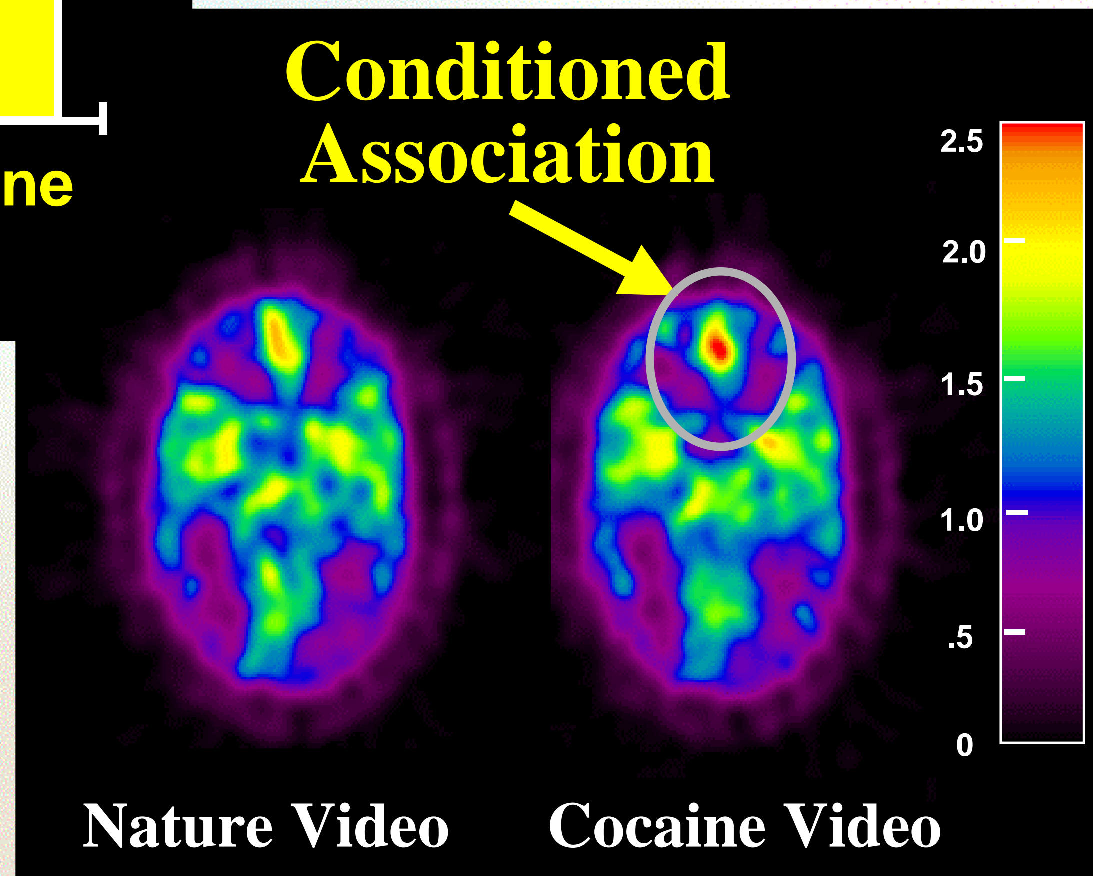
- 『癮』是有生理基礎
  - 這個癮是可以由許多刺激所誘發出來
  - 這個癮也可以是自發性出現的
- 藥物對大腦功能的影響
- 停藥之後認知功能逐漸恢復，但需要一段長時間
- 恢復期間的心理治療

渴求(craving)

- Incentive-sensitization theory (Robinson & Berridge, 1998, 2003)
  - Distinguish
    - *Wanting* (craving for drug)
    - *Liking* (pleasure obtained by taking the drug)
  - **Dopamine system** becomes sensitive to the drug *and* the cues associated with drug (e.g., needles, rolling papers, etc.)
  - Sensitivity to cues induces & strengthens *wanting*

CRAVING INDUCTION IN A PET SETTING

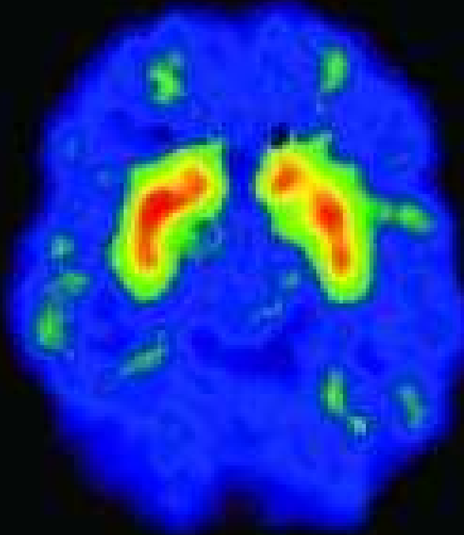




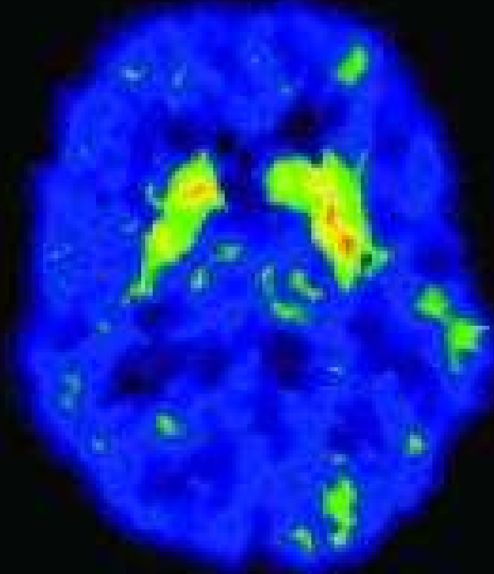
Childress et al., Am. J. Psychiatry, 1999

多巴胺(DA)的活動減少

DECREASED DOPAMINE TRANSPORTERS
IN A METHAMPHETAMINE ABUSER



Healthy Control

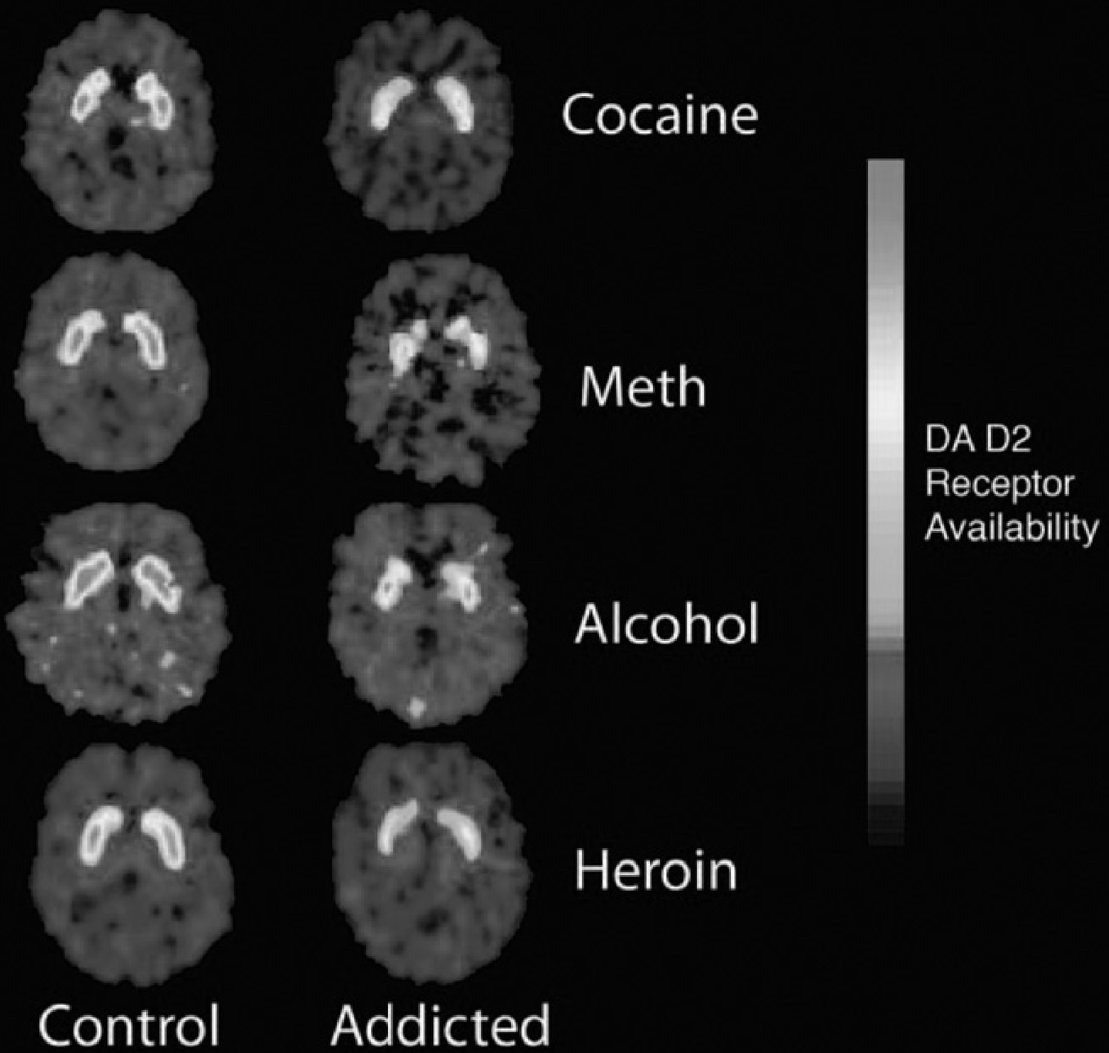


Drug Abuser

Methamphetamine abusers have significant reductions in dopamine transporters.
Source: Am J Psychiatry 158:377–382, 2001.

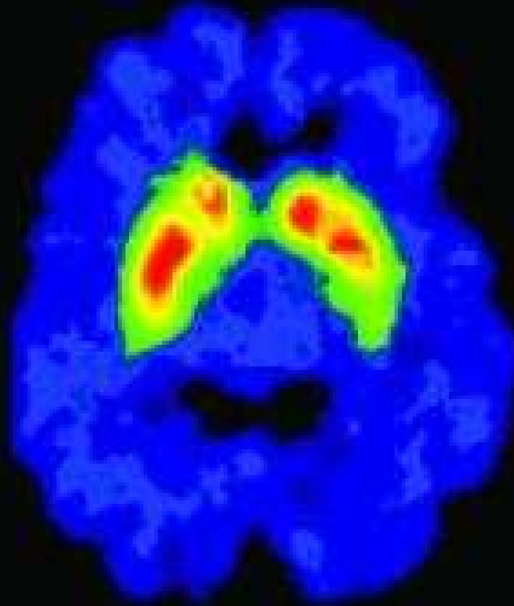
BRAIN IMAGING IS A KEY TOOL IN STUDIES SPONSORED BY THE DIVISION OF CLINICAL NEUROSCIENCE AND BEHAVIORAL RESEARCH

The images below—used in a recent Division presentation—show that repeated exposure to drugs depletes the brain's dopamine receptors, which are critical for one's ability to experience pleasure and reward.

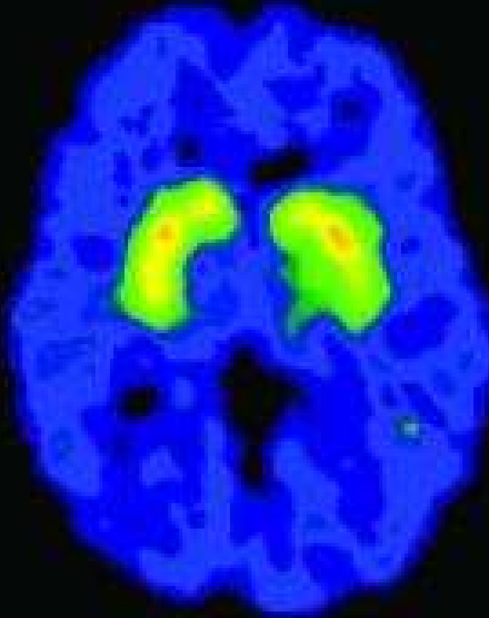


禁絕後多巴胺活動的恢復

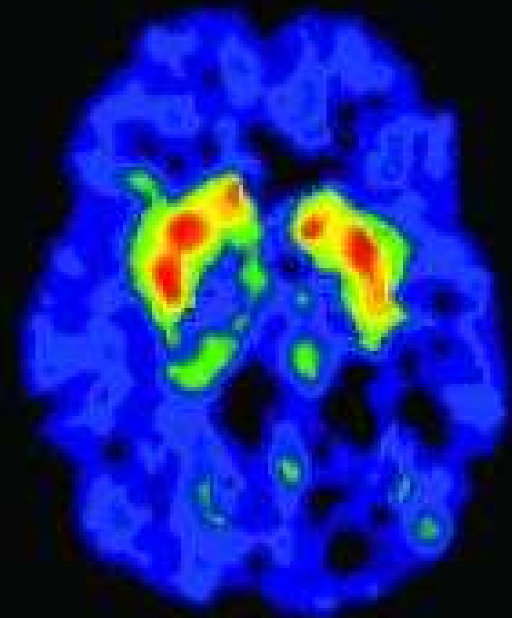
BRAIN RECOVERY WITH PROLONGED ABSTINENCE



Healthy Person

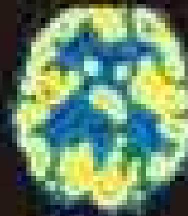
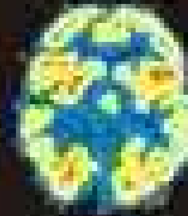


METH Abuser
1 month abstinence

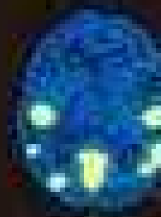
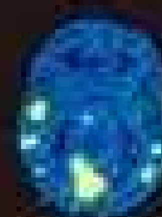


METH Abuser
14 months abstinence

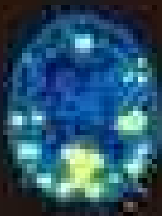
正常的大腦

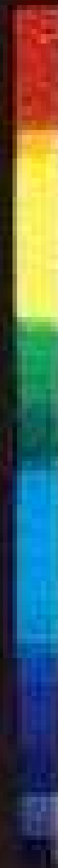



古柯鹼濫用者
（停用10天後）

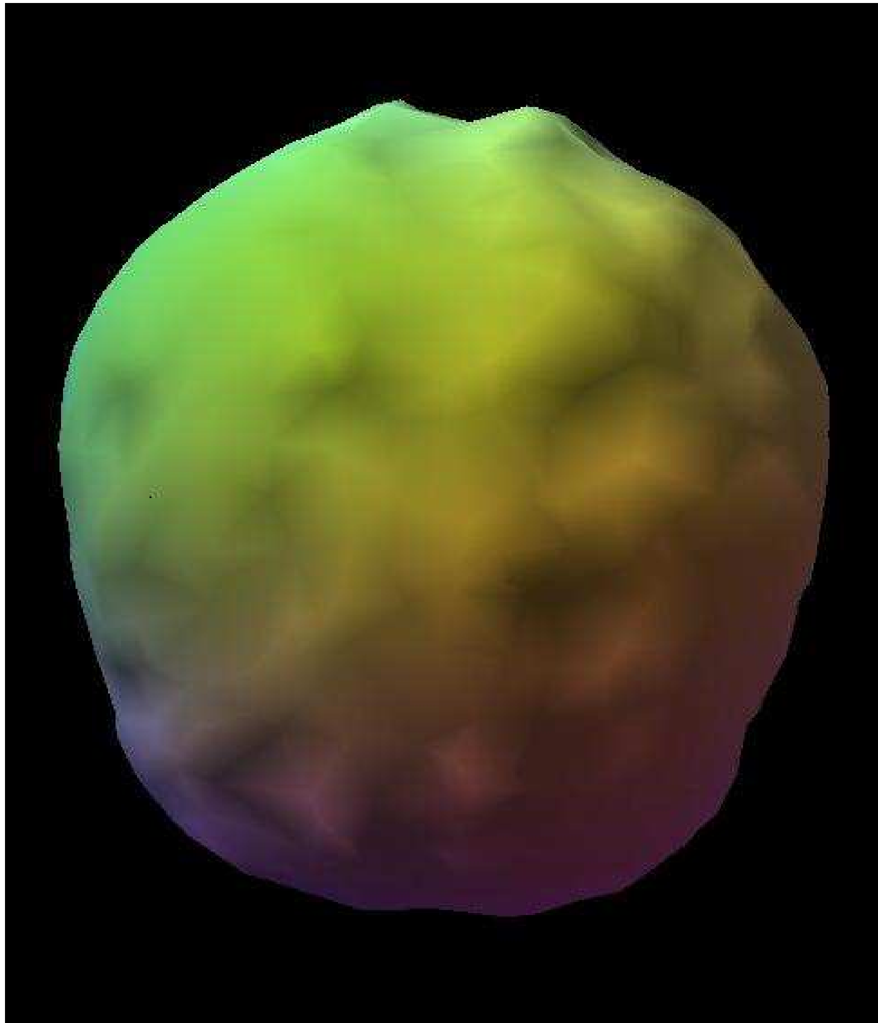



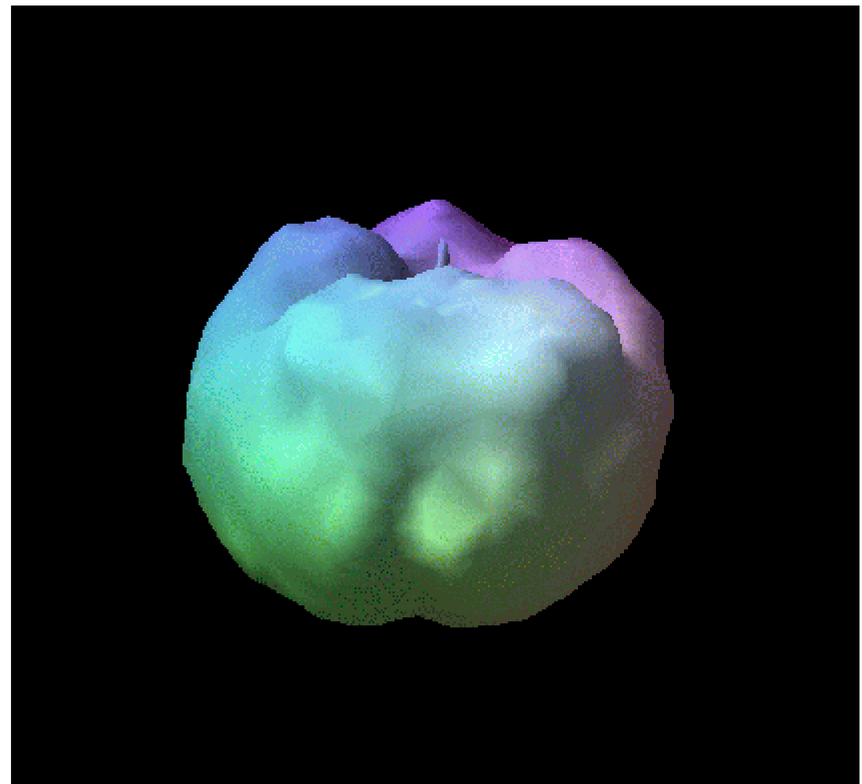
古柯鹼濫用者
（停用100天後）

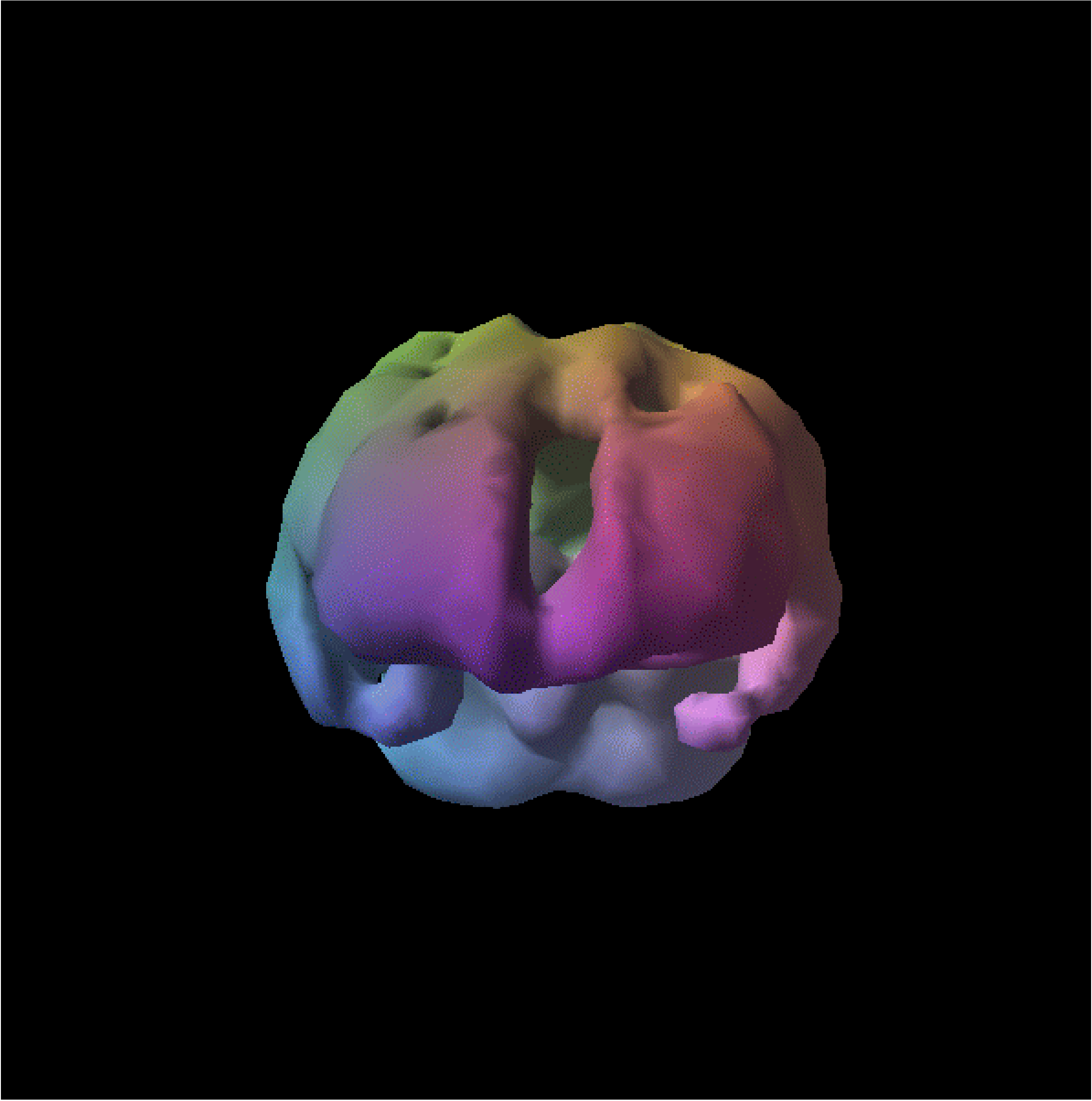




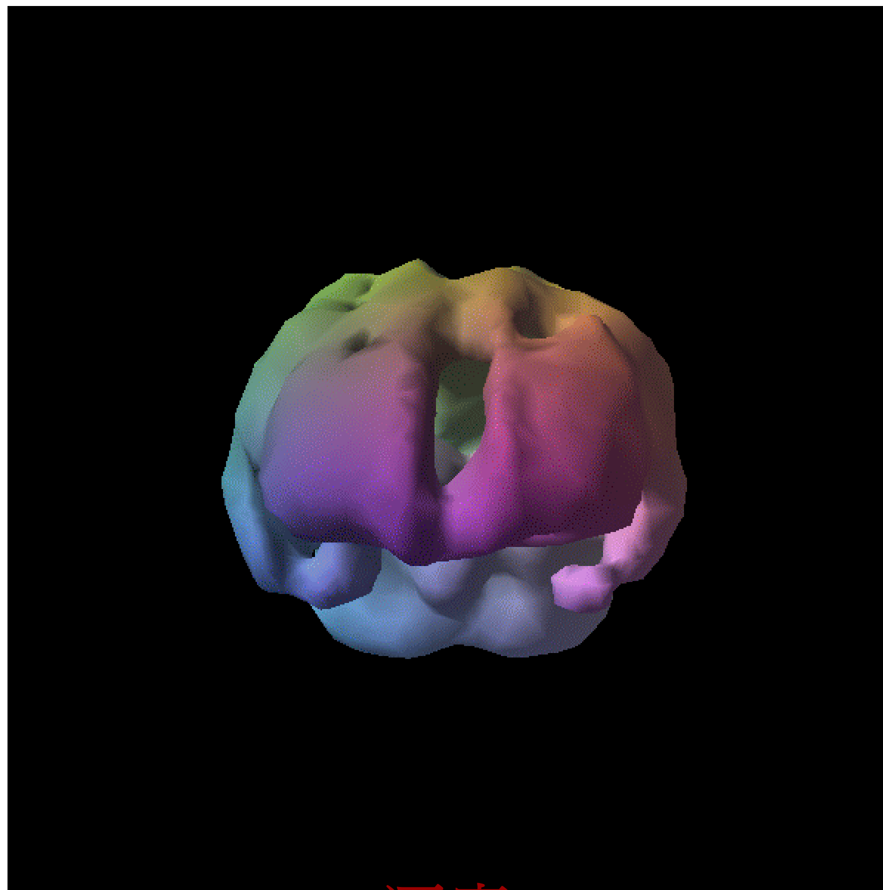
SPECT-正常大腦



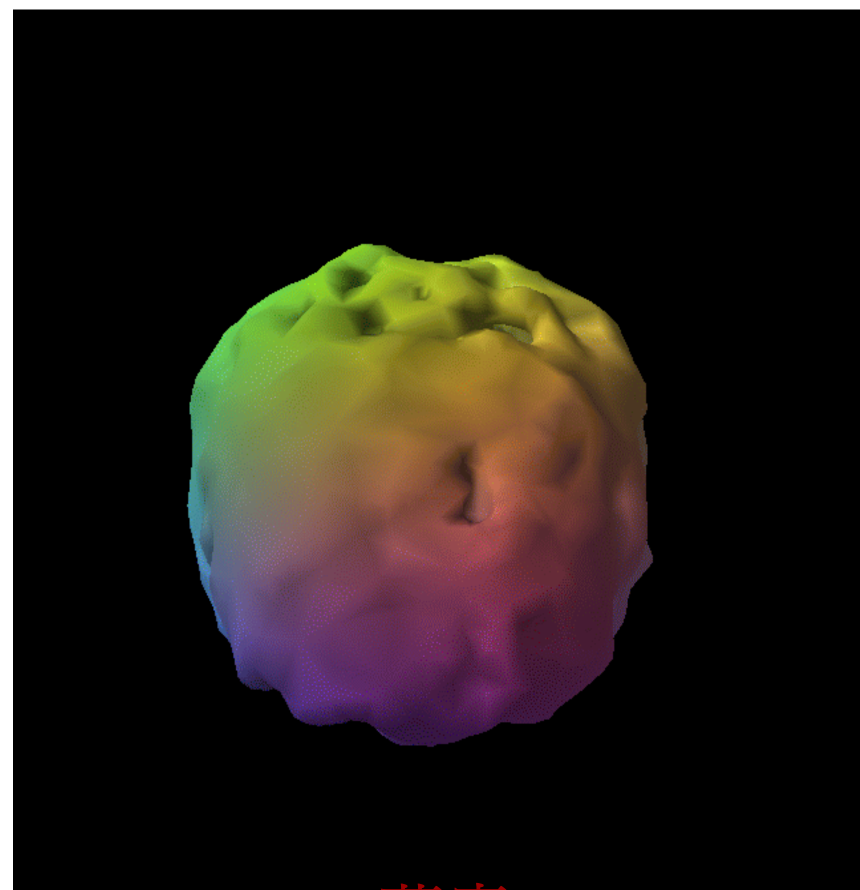




物質成癮者的大腦

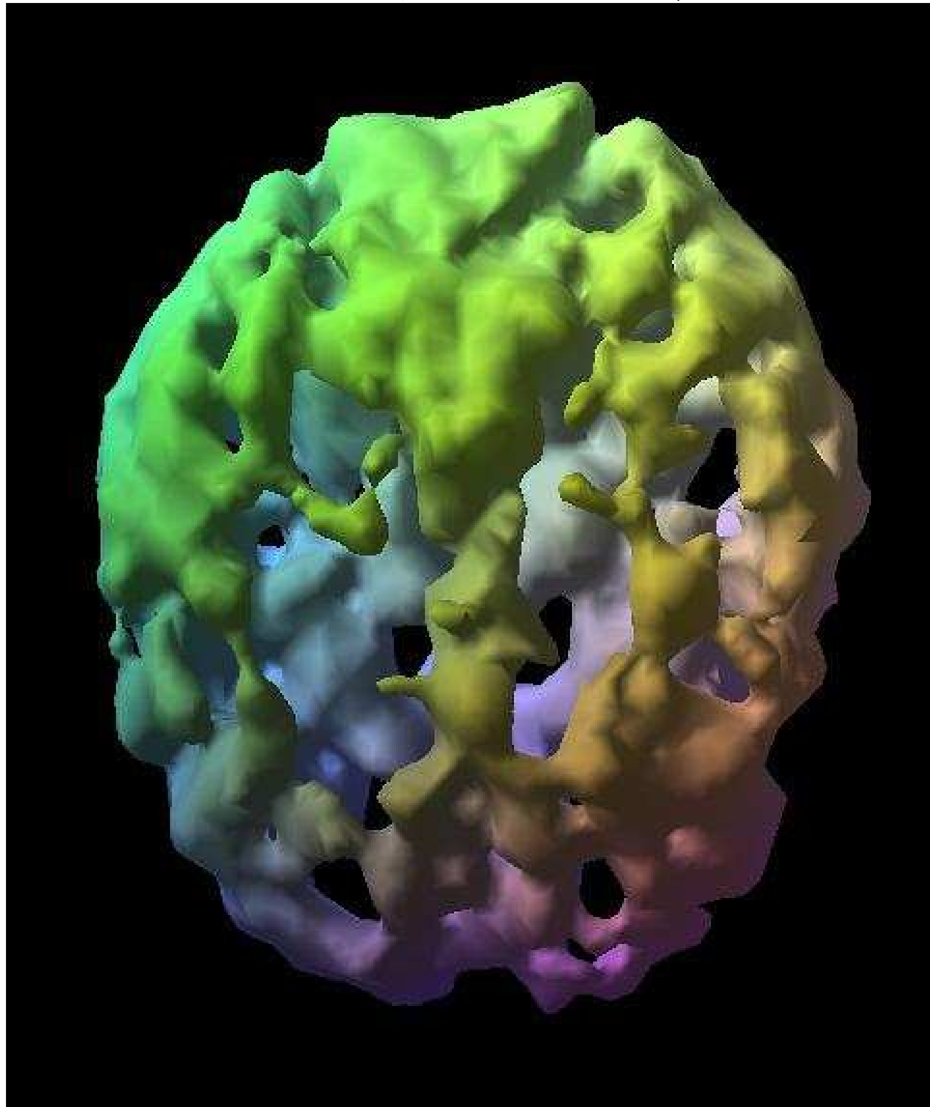


酒癮



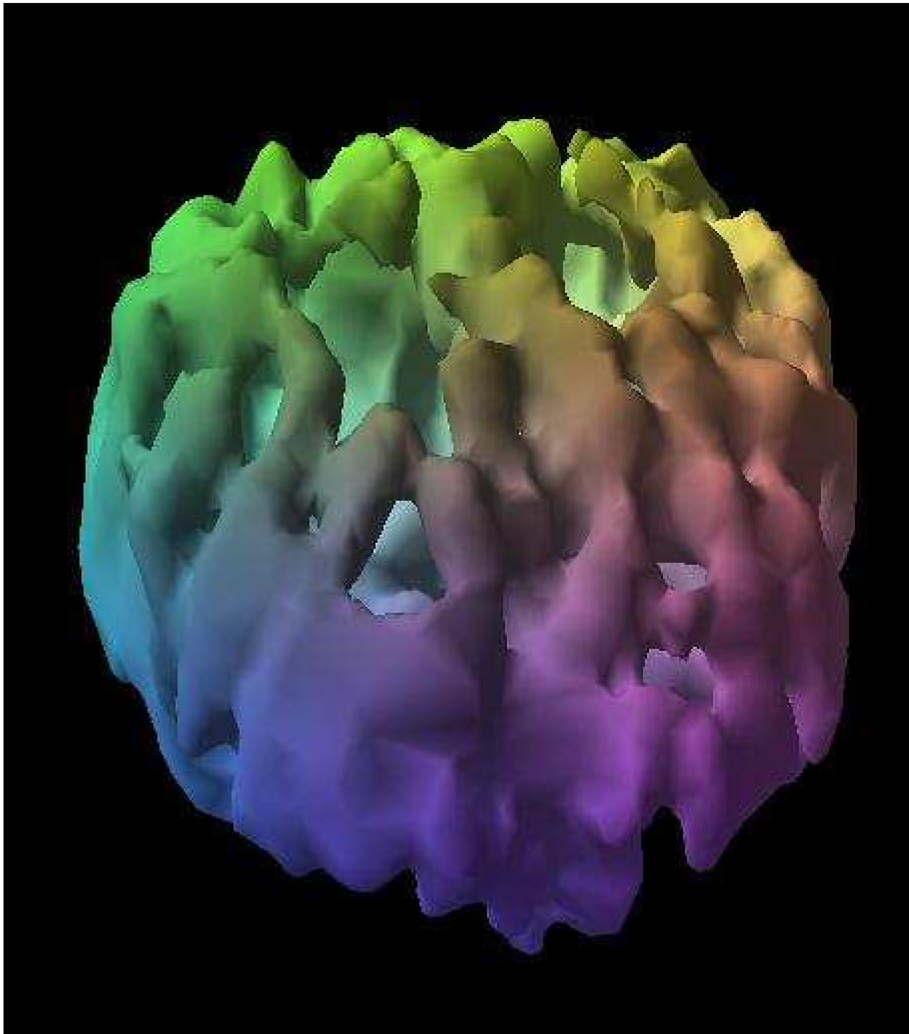
藥癮

海洛因成癮-1（融化的腦）



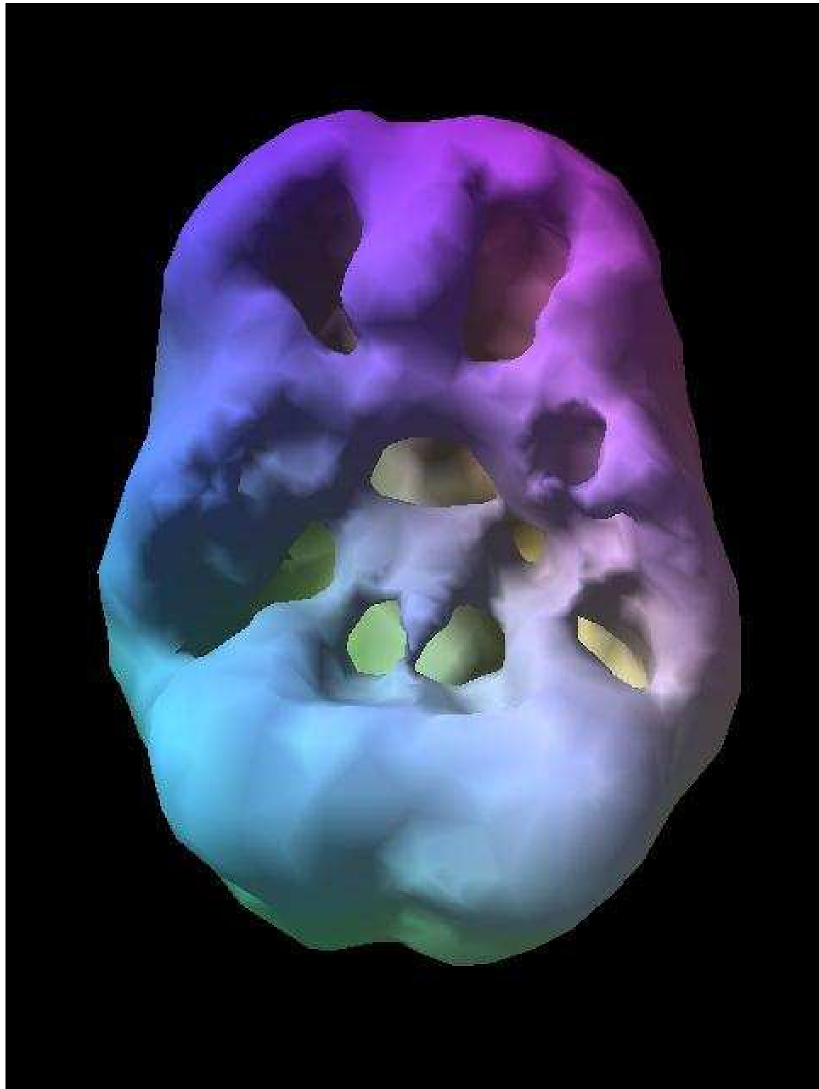
- 40 歲。
- 7 年的美沙酮 (methadone)與 10 年海洛因的使用歷史。
- 整體腦部功能活動下降。

海洛因成癮-2（融化的腦）



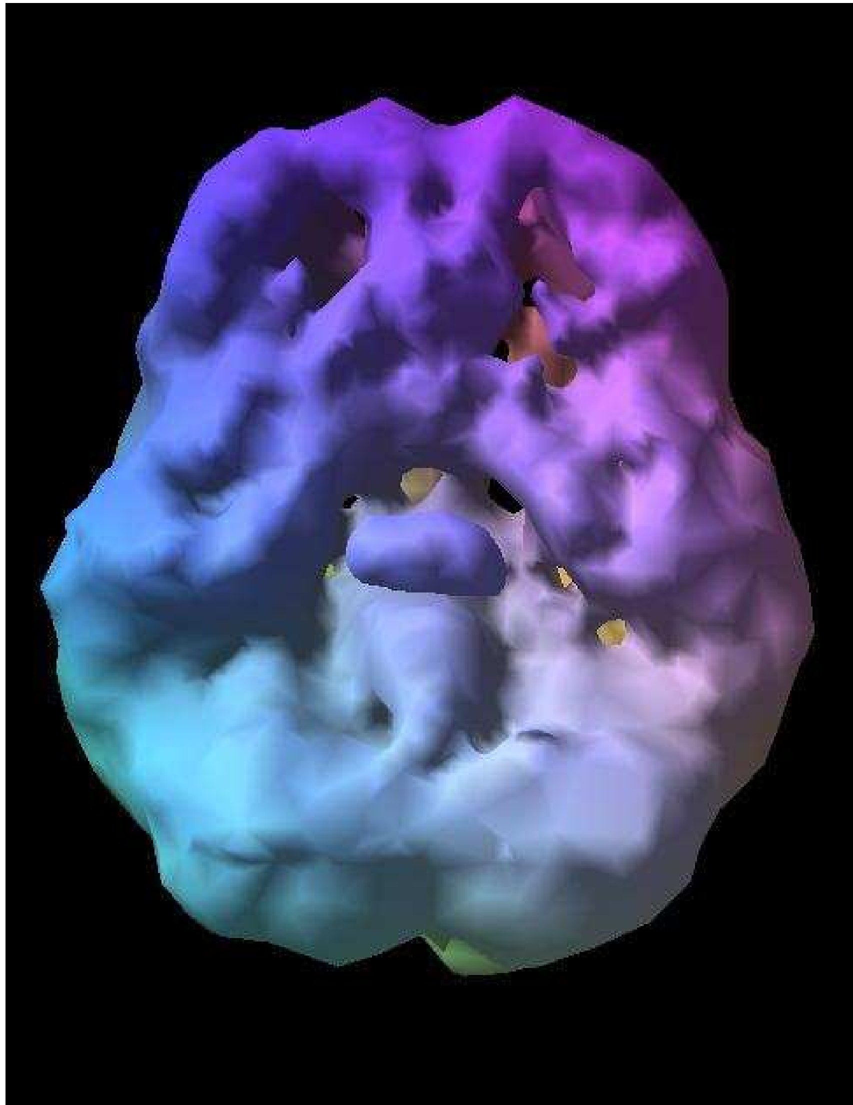
- 39 歲。
- 25年 來經常使用海洛因。
- 腦部功能整體下降。
- 大腦大片區域的活動減退。

吸食大麻-1



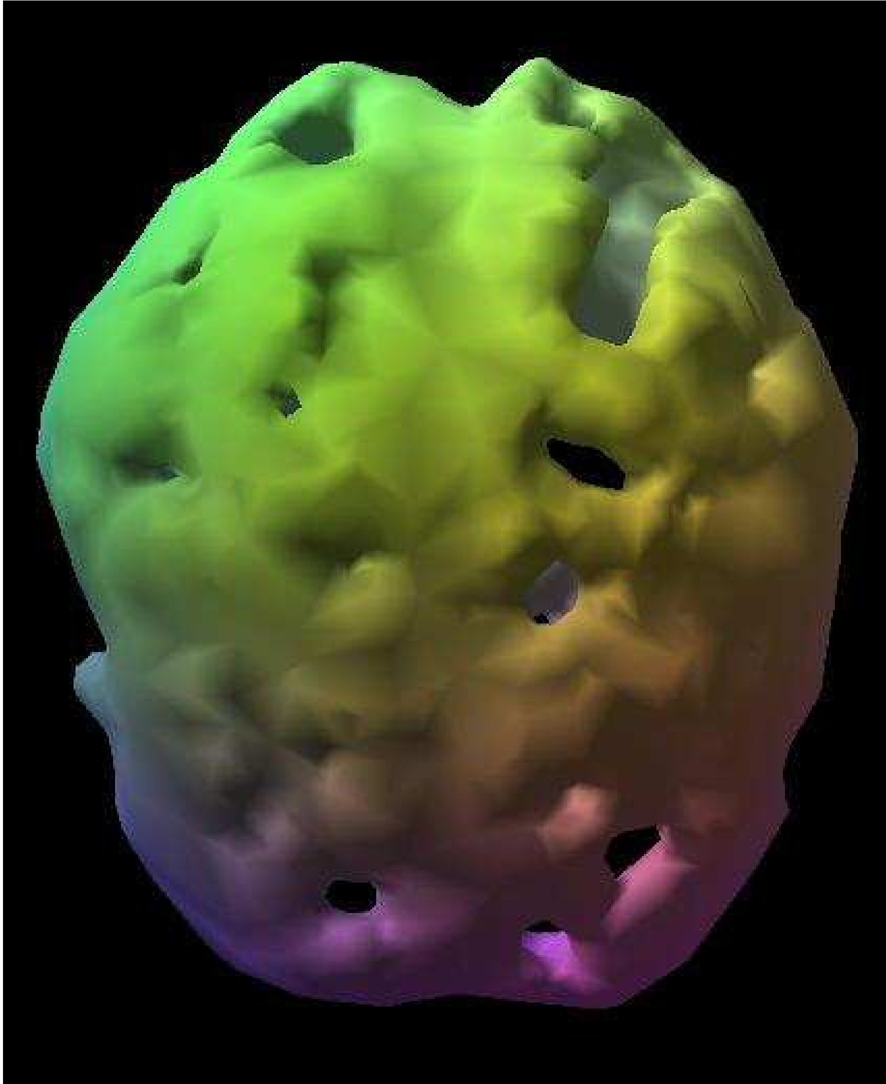
- 16歲。
- 每天吸食大麻2年，高二時被學校退學。
- 額葉與顳葉活動異常。
- 造成無動機症候群，嚴重缺乏興趣、動機、精力、注意力，有語言、學習、記憶障礙。

吸食大麻-2



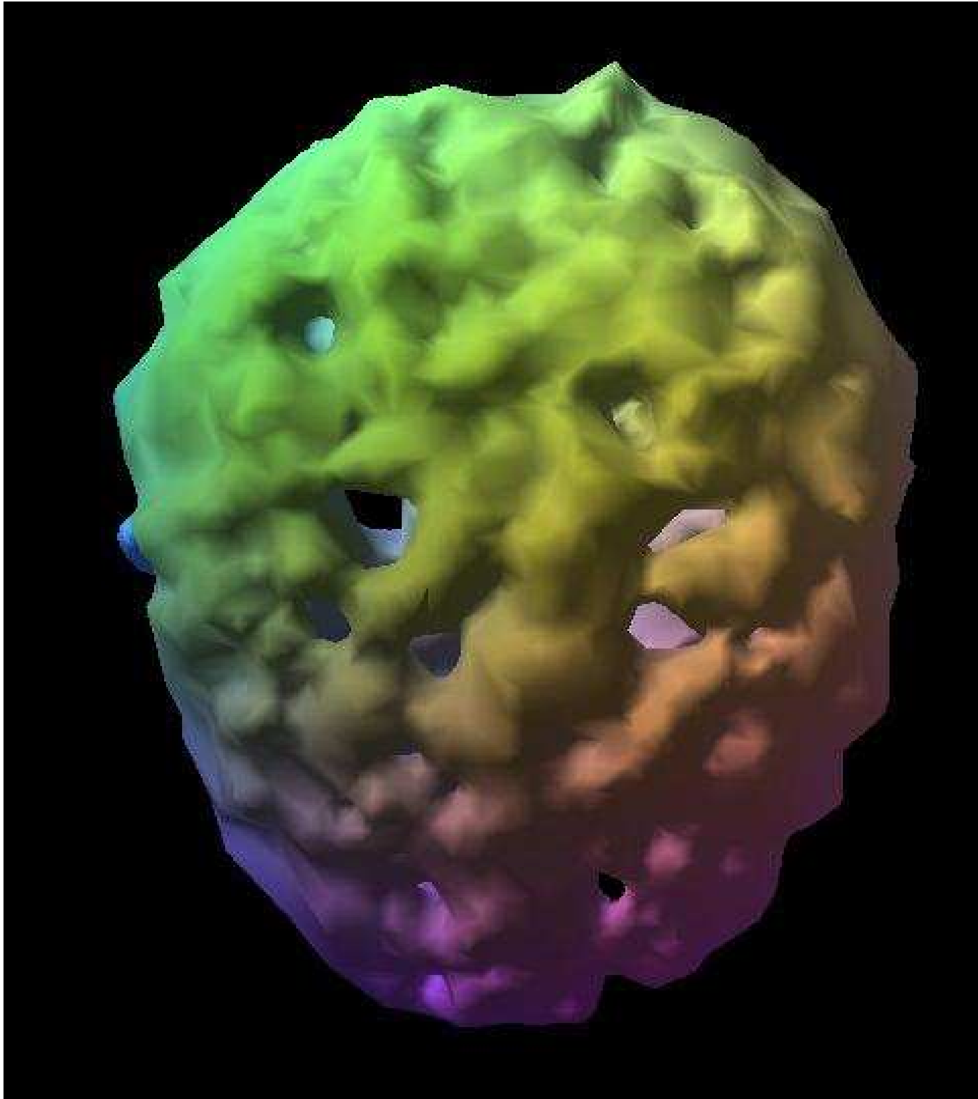
- 28歲
- 吸食大麻10年。
- 幾乎每個週末都有吸食。
- Journal of Psychoactive Drugs, Volume 30, No. 2 April-June 1998. Pgs 1-13

安非他命成癮-1



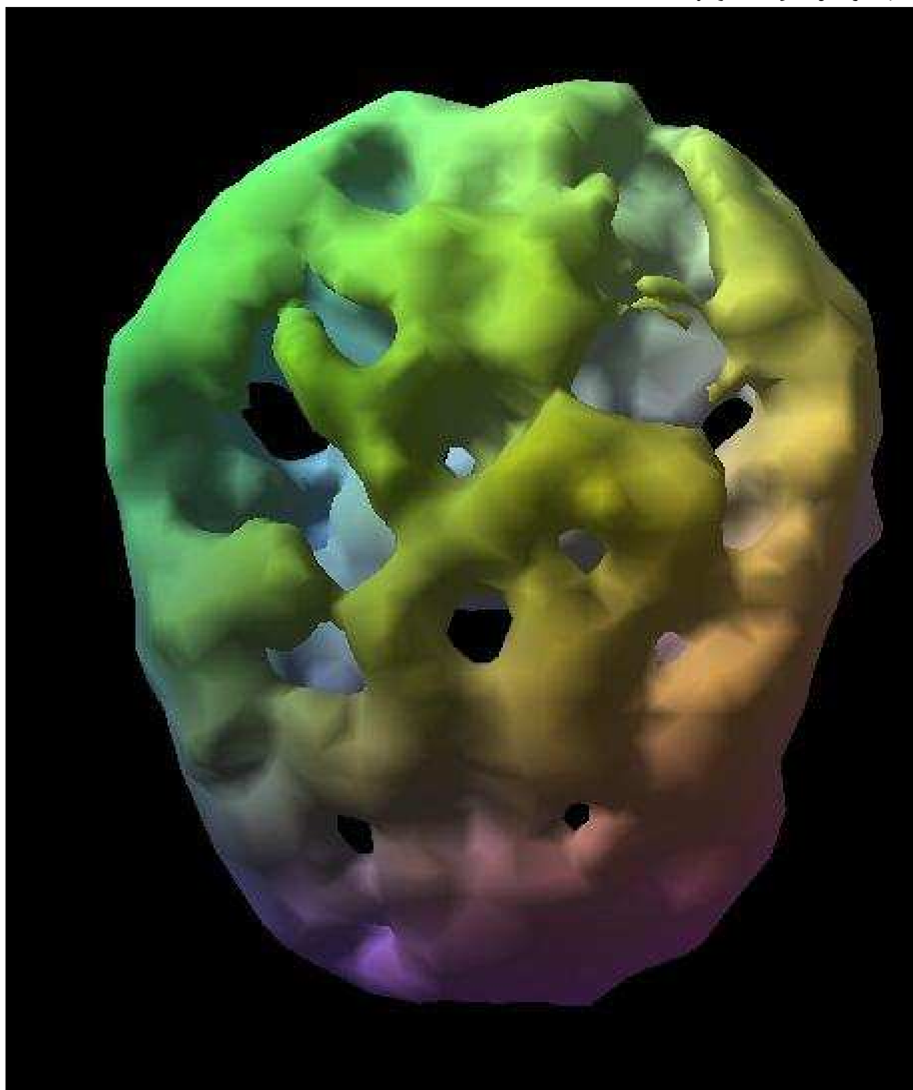
- 36 歲。
- 10 年用藥史。
- 經常使用甲基安非他命。
- 大腦皮質有多個破洞。

安非他命成癮-2



- 28 歲。
- 8 年用藥史。
- 重度使用甲基安非他命。

酒精濫用



- 38 歲
- 17 年來每個週末酗酒。
- 大腦看起來相當乾癟

對毒癮者的非理信信念

- 只要再吸毒，治療就是無效的
- 戒毒的目標就是不再吸毒
- 上癮的治療方法是沒有效的
- 毒癮者就是縱容自己吸毒，是沒救的
- 毒癮的治療只要治療上癮就好了
- 心理治療與諮商是不會有壞處的
- 毒癮是心理的病

Treatment
is the Key
drugabuse.gov

NIDA上癮治療的13項指引 (NIDA)

1. 上癮是一種複雜但可以被治療疾病，這種疾病會影響腦部功能以及行為。
2. 沒有任何單一的治療方法適用所有上癮者。
3. 治療需要隨時可及。
4. 有效的治療會注意個案的多重需要，而非僅考慮藥物的依賴與濫用。
5. 持續維持在治療中一段時間是關鍵。
6. 心理治療－個別或是團體－以及其他行為治療是最常使用的處遇方法。

NIDA上癮治療的13項指引 (NIDA)

7. 藥物治療是處遇許多患者的重要因素，特別要併入心理治療與行為治療之中。

8 患者的處遇與服務計畫是需要持續地評估與調整，且必須確保符合患者不斷改變的需求。

9. 許多藥物上癮的患者也有其他精神疾病

10 藥物上的解毒只是藥癮治療的初步階段，僅是藥物解毒很難改變長期的藥物上癮與濫用。

NIDA上癮治療的13項指引 (NIDA)

11. 藥癮的處置不需要是自願的才會有效。
12. 處置中要不斷地監督個案上癮藥物的使用，治療過程中的確會發生再度使用上癮藥物。
13. 治療計畫應該評估患者的HIV/AIDS、B型與C型肝炎、結核病以及其他感染性疾病，並且提供高風險行為的心理治療以協助患者改變或調整會讓患者感染或散播疾病的高風險行為。