

Psychological Management of Craving

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Abstract

Drug addiction constitutes a chronic central nervous system disorder and one of the most serious public health problems globally, not only because of their high prevalence and impact on the personal, family, occupational and social spheres, but also because of their economic and medical consequences. Most prominent features of addictive behavior are craving which can be described as the psychic pain of addiction. It is an intractable obstacle confronted by addicts attempting to achieve abstinence. Craving is the key in evolving drug-taking behavior into compulsive drug-taking behavior. Cravings for food are similar to substance cravings in their maladaptive potential to cause eating disorders. Direct relationship between craving and relapse, though not easily established, appears to occur through intermediate factors. Incorporating craving measurements in routine clinical practice can increase the patient's capability to know and monitor his internal states that are related to substance intake and this can be used in recommending appropriate treatment. Craving seems to be a non-unitary phenomenon, and different kinds of craving with different mechanisms have been proposed, so it is conceivable that different drugs (including proposed immunotherapy) can be more or less effective on different kinds of craving. Hence there is great need for psychological management as augmented and maintenance strategy.

Keywords: Craving; Addiction; Psychological management; Therapy

Management

Approach to management

Psychological treatment procedure for reducing craving can be placed in broadly two categories:

- Procedures that are designed to decrease the likelihood of the onset of craving that include stimulus control, cue exposure, aversion therapy, coping imagery, self-monitoring, and skill training for avoiding situations in which craving is likely to occur.
- Procedures that are designed to decrease the intensity and duration of craving that include cognitive and behavioral skill training.

There are different ways to address craving. The identification of triggers or precipitants is the most important step in dealing with craving in Motivational Enhancement Therapy (MET) and Relapse Prevention Therapy (RPT). Described below are a few common ways effective in handling craving used in MET and RPT.

- **Stimulus control:** The frequency of externally triggered urges and craving can be reduced by using stimulus control techniques designed to minimize exposure to the cues. In some circumstances, simply avoiding the situation is the best strategy, especially in those filled with multiple cues for indulgence. This means that before coping responses are strong, certain activities should be curtailed until exposure to these cues can be mastered without precipitating a lapse [1].
- **Cue exposure:** Cue exposure involves repetitive exposure to cues, a procedure that is assumed to produce extinction of craving responses. Cue exposure is most effective when exposure to alcohol or drug cues is paired with strategies and techniques designed to prepare clients to cope with the kinds of temptations they will encounter in the course of their everyday lives. Cue exposure treatments have shown some efficacy in reducing relapse to alcohol, nicotine, opiates, and cocaine [2].
- **Aversion therapy:** Aversion therapy involves pairing of alcohol

cues with an aversive stimulus, a procedure by which alcohol cues come to elicit an aversive reaction rather than craving. In contrast to cue-exposure, the goal of aversion therapy is to increase reactivity to alcohol cues, because such cue reactivity is assumed to reflect conditioned nausea. Increase bodily reaction following aversive reaction should be associated with successful outcomes [3].

- **Coping Imagery:** A person experiencing a craving for some substance or activity has a tendency to feel as if the pressure is building up inside them and that it will mount precipitously until they resolve to abstain and their resistance collapses under the overwhelming pressure of a rapidly inflating balloon that will eventually explode. Using a wave metaphor developed Coping Imagery technique, "Urge Surfing", can be used to help the client gain control over these seemingly unmanageable events.
- **Urge surfing:** In this technique, the client is first taught to label these internal sensations and cognitive preoccupations as an urge or craving that is beginning to develop and to foster an attitude of detachment and dis-identification regarding this wave of desire. Clients are initially taught the urge surfing technique through guided imagery and then to try it on their own whenever they are exposed to substance cues. One advice that works very well in clinical situations is that of **HALT**, which include four D's. If one avoids these situations, the likelihood of craving decreases [1]

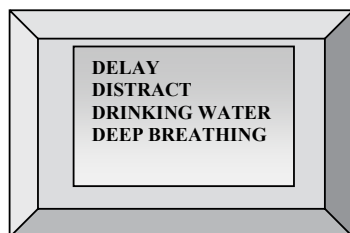
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The 4 D's:



- **Self-monitoring of urges and craving** – The Craving Diary: Another way to foster detachment from urges and craving is to have clients use Self-Monitoring Procedures to keep track on these experiences. The client is asked to keep track of the internal and external cues that stimulate the craving, their mood, the strength of the craving, how long it lasted, coping skills such as urge surfing used to cope with the craving, and how successful or unsuccessful these coping strategies were [1].
- **Social skill training:** These include learning to refuse like patient refusing a real glass of beer, thereby learning to emit an appropriate response under realistic condition, others being like asking a friend to forego drinking in one's presence [3].
- **Behavioral strategies:** These include consumption of non-alcoholic drinks or food, call a friend to discuss the craving, get some physical exercise, read, particularly about recovery, keep busy, distract oneself with an activity, avoid high-risk people, places, and events, be firm when refusing offers to use substances [3].
- **Cognitive strategies:** These include remembering the consequence of consuming or not consuming, reappraisal of the situation, remembering one's commitment to abstinence, remembering that cravings and desires for substances eventually go away, thinking positive and tell oneself that she/he can fight off craving, talking oneself through the craving, praying or asking for strength from a higher power, practicing ahead of time how to refuse substance offers³. Cognitive changes associated with cue elicited craving and suggestive that craving for alcohol is followed by guilt/ loss of confidence, along with emotions which usually result from unsuccessful coping and relapse. It is as if craving itself represented failure. These findings imply that goal of treatment should be to help patients see craving as normal and view resisting craving as an example of successful coping [3]. The cravings usually do not operate at a conscious level, but are likely to be masked by the cognitive distortions and defense mechanisms. As such, these dimly perceived sensations and strong emotions filled with forbidden desires set-up the possibility of relapse by bringing the person closer to exposure to a high-risk situation. Teaching patient to become vigilant for these early warning signals and to engage in explicit self-talk which questions their motivations and intentions can help them to recognize and acknowledge the direct relevance of these "Apparently Irrelevant Decisions" to the increased risk of relapse. This may allow the patient to begin to see through their rationalization and denial by recognizing the true meaning and likely outcome (relapse) of the decisions they may not be taking responsibility for making [1].

Cognitive behavior therapy in craving

Behavioral techniques primarily focus on avoidance of stimulating situations, different response to these stimulants and offering new

appropriate reinforcements. Cognitive techniques help patients to recognize thoughts which precede drug use and replace them with healthier thoughts. In this way, patients learn to look at situations and relations in a different way [4].

Pollack et al. (2002) [5] studied the efficacy of cognitive behavior therapy on decreasing craving and suggested that cognitive behavior therapy works through helping the patient recognize external and internal stimulants and apply effective strategies. This intervention is also effective in breaking the link between negative mood and drug use.

Craving as metacognition

Construing cravings as metacognition is an indication that the individual is experiencing cognitive events, such as discursive thinking, feelings, memories, perceptions, sensations, dreams, or images, and appraises as aversive and wishes to modify as rapidly as possible. A metacognitive analysis of craving stresses the quickness with which drugs and alcohol can impact on subjective experience because the modification of conscious experience is one of the most reliable and psychologically meaningful effects of psychoactive substances, often occurring within seconds or minutes [6].

Exposure response prevention (ERP) in craving

Marlatt and Witkiewitz (2005) [1] the effectiveness of exposure response prevention (ERP) in reducing the psychological and physiological response to drug stimuli. Subjects in the study experienced a significant increase in both biometric ratings and self-reported cravings after being exposed to stimuli related to their drug use. When the average craving at the peak of the initial two sessions was compared with the average craving at the peak of the final two sessions, the cravings at the final two sessions were found to be significantly lower, indicating that the subject's experienced expected reactions to drug stimuli and that those reactions decreased over a number of sessions. Unlike traditional treatment modalities that leave the patients vulnerable to the effects of cue reactivity after treatment, ERP extinguishes the conditioned physiological and psychological responses that occur when addicts are confronted with drug cues.

Craving identification and management (CIM)

In the CIM Model given by Stalcup et al.(2006) [7], which states that the treatment interventions are referenced to craving by helping the clients to identify their craving level and equipping them with strategies to avoid use. At its core, the CIM Model asks clients to be aware of craving, analyze its causes and based on those causes, implement specific strategies to prevent and manage craving. The CIM Model combines several treatment components, including control of exposure to environmental cues, establishment of a daily schedule, the use of behaviors that dissipate craving (tools), and treatment (with medications when appropriate) of mental health and withdrawal symptoms. The CIM Model is a client-derived approach to achieving and maintaining sobriety based on a process of analyzing craving and managing it with an individualized program of recovery activities.

The four causes of craving are identified:

- Environmental cues (triggers): Exposure to people, places, and things associated with prior drug-using experiences that may cause immediate and overwhelming craving;
- Stress: Addicted persons experiencing stress as a craving;
- Mental illness;
- Drug withdrawal: Symptoms of both mental illness and

withdrawal lead to craving if clients associate use with relief of these symptoms.

The CIM Model incorporates four service delivery elements:

- Relapse Prevention Workshop,
- Individual counselling,
- Medical/psychiatric services,
- Screening for ongoing drug use.

Issues in psychological management of craving

Individuals with a conditioning history of repeatedly experiencing the potent psychopharmacologic effects of drugs and alcohol on consciousness have learned that psychoactive substances are reliable, rapid and effective means by which cognitive discomfort can be relieved [5]. The greater the discomfort, the greater the desire to escape discomfort, hence stronger the craving. Thus, the aversive cognitive experiences can be viewed as a punishing event, the removal or attenuation of which is experienced as negatively reinforcing. Due to the habitual character of long-term substance use, experienced substance users may not be always highly aware of the precise nature of the cognitive experiences that they may be almost automatically self-regulating and thus relatively unaware of the cognitive basis of their craving.

This also may be the result of chronic modification of cognitive events with psychoactive substances whereby drugs and alcohol are skillfully used to avoid fully experiencing cognitive events even when anticipated to be unpleasant or noxious. In this case, the substance is used not only to escape aversive conscious experiences but also to avoid them. As a result, directly asking a substance user why he or she craves alcohol or drugs may be unproductive. By redefining craving statement, characteristics of the cognitive experience (i.e., thoughts, feelings, sensations, memories, and images) modified by substance use can be made explicit. Such information can elucidate the psychological basis of drug effects, drug preferences, and drug expectancies and highlight deficiencies in nonpharmacological coping skills and cognitive self-

regulation [8].

Conclusion

There is a need to move away from clinically based and simplistic pharmacological management of craving, and move towards a holistic team approach. Advances in understanding of the nature of craving are allowing further development of promising new treatments. With the arrival of new, promising management strategies aimed at preventing relapse, there is greater hope for better and sustained management of craving substance use disorder. Resulting in better adherence to treatment, lesser relapse and cost burden on patients. There is also need for more research with large population sample on the lines of psychological management to prove its efficacy.

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