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EC NEUROLOGY
Case Report

Two-Year Case Study Shows Short-Term, and Long-Term, Impact of Integrating Spirituality and Motivational Interviewing for Treatment of Alcohol Use Disorder (AUD)

Eugene J Koprowski*

Georgetown University, Washington D.C. USA

***Corresponding Author**: Eugene J Koprowski, Georgetown University, Washington D.C. USA.

Received: February 08, 2017; **Published:** February 20, 2017

Abstract

A two-year long case study with an elderly female patient shows the short-term, and long-term, impact of integrating spirituality and motivational interviewing for treatment of alcohol use disorder (AUD) and relapse prevention. Close to 7.2% of American adults, age 18 and over, were diagnosed with AUD in 2012, according to the National Institute of Alcoholism and Alcohol Abuse, a division of the National Institutes of Health. Criteria for AUD come from the Diagnostic and Statistical Manual (DSM-5), and include continuing to drink even though it causes social problems, and continuing to drink even though it caused neuropsychiatric problems, including sleeplessness, anxiety, irritability, restlessness and depression. Results of this case study suggest that the therapeutic combination of spirituality and motivational interviewing may be effective in the short-term, but evidence for its efficacy in the long-term is uncertain.

Keywords: *Integrating Spirituality; Motivational Interviewing; AUD*

Introduction

The short-term impact of integrating spirituality, praying, along with Motivational Interviewing (MI), and Cognitive Behavioral Therapy (CBT) is quite effective in producing short-term remission for alcohol use disorder. But over the long-term, the course of two years, questions remain about its efficacy. Two years ago, a then-63-year-old female, divorced, with two adult children was treated with this therapeutic strategy. She had relapsed into alcohol abuse after a purported 15-year period of being sober, and accomplished a one-month remission at follow-up. That was during 2014.

An array of psychosocial stressors had generated the relapse. These included midnight telephone calls from her ex-husband, as well as financial problems in putting her children through college. The patient admitted she was self-medicating with red wine, every evening. She suffered total blackouts as a consequence of the relapse.

Methods

As the clinician handling the case, I interviewed the patient and discerned, among other psychosocial factors, that she was a Roman Catholic (Latin Rite). Based on the evidence in the addictions literature of the value of spirituality as an adjunct to psychological counseling in patients with AUD, I asked her if she would like to pray, as well as continue talk therapy regarding her emotional issues. With the permission of the patient, we incorporated three prayers into her therapy session, the Lord's Prayer, The Ave Maria, and the Glory Be to God from a traditionalist Catholic prayer book. These prayers were said at the beginning of the session and at the conclusion of the 50-minute session.

During the weekly therapy sessions, Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) techniques were also used therapeutically to help her clarify her life goals, and see what she wanted out of life now in her sixth decade. Additionally, Zen-based mindfulness techniques were used to help her discern what her internal and external stressors seemed to be.

What is more, the patient also went to church daily, every morning, for social and spiritual support. The mixed mode intervention employed here resulted in a one-month remission, at follow-up.

Discussion

Two years ago, when the patient encountered a huge stressor during her initial weeks of therapy, e.g. her ex-husband asking her on telephone to come reunite with him in California, she relapsed, for 24 hours, as she did not utilize the prayer, mindfulness techniques, nor did she go to church. She slipped quite easily into her old social environment and its well-known triggers.

An emergency intervention, with reminders of the principles of mindfulness, and with prayer, halted the relapse, at that time.

However, the patient did not manage her stressors well, over the long-term, i.e. two years.

Twenty-four months after the successful interventions, the patient returned to psycho-therapy. She had taken a year off, claiming she was well and could handle her disease by simply attending Alcoholics Anonymous meetings, and without weekly therapy sessions.

Upon return to therapy, triggered by the death of her ex-husband, who had been a potent stressor in the past, the patient announced to the practitioner that she was also now "engaged" to be married to another, fellow, former alcohol abuser, who had also served a federal prison term for felony embezzlement. She had met the fiancée during an Alcoholics Anonymous meeting.

The stress from this engagement resulted, during the summer of 2016 and fall of 2016, in a number of reported alcohol-consumption binges, resulting in blackouts, hospitalization, and neuropsychiatric complaints once again. During one incident, the patient assaulted a paramedic, kicking him while in transit to hospital in the ambulance, and was informed by the police that she would be arrested and placed in jail, if she repeated the illegal behavior. She denied recall of the incident when queried the next day.

After reporting feelings of "being stuck," the patient was encouraged to enter into neuro-psychoanalysis, as well as use the previous mindfulness training, spirituality, etc., to cope with her daily life. But the patient's fiancée discouraged the patient from engaging in therapy during this multi-month period, and stated that he viewed her moves to maintain emotional and spiritual autonomy as an existential threat to him and the planned marriage. The patient reported intense, disturbing dreams during this period, suggesting alcohol-related stimulation of the mesolimbic-mesocortical dopaminergic system of the brain. Patient refused prescription of SSRIs. The wedding ceremony was cancelled, subsequently, and the patient ended her relationship with the former felon [1-5].

Conclusion

Additional study is required to see how the integration of prayer with psychosocial therapies can help other patients with alcohol use disorder (AUD). Therapeutic vigilance is key here. Relapses can occur as a result of old stressors re-emerging, or of new stressors appearing, and previously underlying, undisclosed psychological issues emerging.

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Volume 5 Issue 1 February 2017