Group psychotherapy with alcoholic patients: some theoretical and clinical issues

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Abstract
With this article we hope to illustrate how changing theoretical views within the psychoanalytic understanding of the mind and psychopathology of the alcoholic patient have lead to a shift in our clinical approach of these difficult patients. Starting from a more object relational approach we have integrated important contributions from self psychology and recently also from the work of Monjauze on the alcoholic part of the personality. Furthermore, we are thinking of ways in which we could apply the work of René Kaës in our group psychotherapeutic work with this population. His description of the psychic formations in the three psychic spaces, and especially his concept of the phoric function within a group has caught our attention. It is our hypothesis that in a group of alcoholic patients the group psychotherapist is confronted with a specific kind of phoric function. We see it as an inherent part of the alcoholic group that one of the group members chooses to be, and at the same time is chosen by the other members to be, the bearer of the alcoholic part of the group.

Keywords: psychoanalytic group psychotherapy, addiction, alcoholic part, phoric function.

Introduction
Over the past 25 years our unit for the treatment of addicted patients has undergone a gradual transformation in the type of patients we are treating as well as in our approach towards these patients. Our unit is part of a regional psychiatric hospital and has a capacity of some thirty patients. Most of them have an alcohol problem; a limited number of patients is addicted to psychotropic medication or illegal drugs. Occasionally we also treat patients with gambling problems or one of the new types of addiction e.g. Internet or game addiction. We are also confronted with a growing number of patients who are addicted to more than one substance and with more double diagnoses. In the initial years of working with addicted patients the therapy programme of our unit mainly consisted of individual cognitive behavioural therapeutic sessions and social skills training. It was only when the unit adopted a psychodynamic approach to addiction that group psychotherapy became an integral part of the treatment.

Group psychotherapy and the treatment of addictions
Group psychotherapy has since long been considered to be the treatment of choice for addictive pathology (Cooper, 1987; Flores, 1988) and this can be easily explained. Known curative factors in group psychotherapy such as the instalment of hope, universality, altruism, support, catharsis and interpersonal learning experiences (Yalom, 1995) contribute to a great extent to the double task each addict in treatment is confronted with, namely detaching himself from his addictive substance and forming an attachment to a group of recovering addicts.

Already in 1918 Freud seemed to be convinced of the importance of a psychoanalytic approach in the domain of addiction. In a lecture he made to the psychoanalytic congress that year, Freud focused on all the neurotic misery that up till then had been out of reach of psychoanalysts. But “some day, the conscience of society will awaken and admonish it that poor man has just as much right to health for his mind as he already has to life-saving surgical help, and that neuroses threaten the health of the people no less than tuberculosis. As soon as this has been recognized, there will be public institutions employing psychoanalytically trained physicians to aid men who would otherwise succumb to alcoholism.” (Gay, 1988, pp. 278).

In 1974 Yalom wrote an article in which he gave an account of his long year attempts to treat alcoholics in heterogeneous therapy groups. He admitted at once that most of the time he quickly became disappointed and gave up his efforts, leaving these patients to the AA (Alcoholics Anonymous). But then he began to adapt his interactional group dynamic approach to the treatment of alcoholics. His central premise was that investigating one’s feelings and interpersonal relations in a group forms a powerful means to psychological change.

Yalom began forming his groups as an supplement to participation in AA meetings. Whereas AA works on becoming sober and maintaining abstinence, Yalom started to focus on the working through of the interpersonal pathology lying at the root of conflicts and problematic behaviour such as alcoholism. At first his approach and strategy didn’t seem to be a big success in homogeneous groups of alcoholics. He even held these groups up to his students as an example of how groups can fail. But after a while this initial contrast seemed to disappear and there wasn’t much difference anymore between the groups of alcoholics and the groups of neurotic patients. Yalom since long ceased to write about alcoholics but his pioneer work did influence much of the literature in this field.

Treating addicted patients in groups has many advantages (Levine & Gallogly, 1985; Flores & Mahon, 1993).

1. A group offers more support and pressure to achieve and maintain abstinence. Often this pressure is better accepted when presented by peers than from a professional counsellor. When working with semi-open groups members with a relatively stable abstinence offer a powerful and hopeful model for group members who still struggle with parting from alcohol. In this way a group will contribute towards the commitment to change and adherence to therapy.
2. In a group, the alcoholic patient quickly experiences that he is not alone in his struggle against addiction. He becomes part of a wider group of recovering alcoholics. In addition, a group of peers (all potential self-objects) can respond more easily to the need for an idealized parent figure in the person of a member who has been abstinent for a longer time.

3. Working in a group, addicted patients have the opportunity to gain insight into the specific experiences, relationship style and defences by first observing these in others before recognizing and accepting them within themselves.

4. The group experience also facilitates relinquishing pathological defences (denial, avoidance, rationalization) that cause dysfunctional interpersonal relationships.

5. And finally, a group offers an actual situation in which addicted patients can learn how to use defences in a positive way by experimenting with and learning new behaviours in the group as demonstrated by more experienced members.

On the other hand, there are also some limitations to group therapy for addicted patients. Group therapy on analytical lines is certainly not appropriate for all addicted patients (American Psychiatric Association, 1995). Adequate diagnosis and considering indications and contra-indications are necessary. There isn’t a single therapeutic approach which suits every addicted patient. The more expressive approach is not appropriate for patients with severe psychiatric disorders (psychosis, severe personality disorder) (Lindström, 1992). Patients with few or no sociopathic tendencies do well in interactional group therapy, patients with a higher degree of sociopathy and psychopathology are better helped with cognitive-behavioural therapy groups (APA, 1995).

Moreover, only group therapy is insufficient in the initial phase of treatment. In order to help addicted patients to stop their substance abuse additional tools are needed. Medical-psychiatric management and daily active support within a sufficiently restrictive and facilitating environment is certainly a necessity. This can be offered in optimal conditions a residential setting.

**Psychoanalytic views on addiction**

We approach the problem of addiction from a psychoanalytic point of view but one shouldn’t imagine this theory as clear and unchanging. There are many different views that sometimes seem to be contradictory. Good summaries of psychoanalytic views on addiction can be found in Levin & Weiss (1994), Yalisove (1997), Rost (2001), Weegmann & Cohen (2002) and Bilitza (2008a). Various psychoanalytic
contributions to the understanding of addictive phenomena can be divided into two main models.

In the *conflict model* (e.g. Fenichel, 1946) alcohol abuse is understood as a compromise solution to the conflict between the various intrapsychic agencies, and as the result of the dynamic struggle between the expression of and defence against forbidden wishes.

Drive theory, ego psychology and object relational theory can be placed under this heading. Wurmser (1984), a prominent author within the conflict model of addiction, agrees with the idea of treatment of addiction being a multimodal enterprise but adheres strongly to a more traditional psychoanalytic approach in which therapeutic action is directed towards helping the addicted patient to get out of the externalization and getting in touch with his inner world of affects, cognition and fantasy. In Wurmser’s view the focus of any psychoanalytic treatment of addiction must be on the conflict and not so much on any deficits.

He proposes that much of what seem to be structural deficits are essentially defences against an intrapsychic conflict. He has an eye for narcissistic vulnerabilities but his focus remains on uncovering the unconscious conflict as an objective in the treatment.

When we started working from a psychoanalytic angle, we were mainly inspired by ego psychological and object relational thinking concerning borderline pathology. This was also the case for the way in which group psychotherapy was conducted. We focused more on confronting maladaptive patterns of interpersonal relations between group members (Stone & Gustafson, 1982; Marziali & Munroe-Blum, 1994; Roth, Stone & Kibel, 1990). We tended to be more restrictive and limit setting in our approach that was framed within a one person psychology.

Important authors within a *deficit model* of addiction are Jerome Levin (1991) and Edward Khantzian (1994). They offer an explanation for the origins of addiction using the concepts of Kohut (1977a; 1977b) on the development of the child and of two self-structures that try to recover the lost perfection, namely the grandiose self (omnipotence and perfection are attributed to the self of the child) and to the idealized parent image (omnipotence and perfection can be attributed to an idealized other).

To develop a strong or cohesive self and therefore healthy narcissism the child needs an environment that on the one hand mirrors his grandiose self by offering approval and realistic admiration, and on the other hand, meets his need to feel one with the idealized parent. For the very young child, phase appropriate mirroring and idealizing parents perform functions that it cannot yet perform for itself, such as regulation of tension, of affect and self-esteem and the ability to comfort itself.

Under normal circumstances, the child arrives at internalizing these parental functions and thus creates an inner psychic structure that leads to the development of realistic ambitions and ideals, a balanced self-esteem and the ability to create relationships with others as independent objects.
Self psychological theorists conceptualize addiction as a narcissistic personality disorder with the addictive substance fulfilling the role of mirroring selfobject and idealized selfobject for the addict.

However, recently Ulman & Paul (2006) have developed an extended and more sophisticated model of the narcissistic problems of addicts. Whereas Kohut posits three narcissistic fantasies or scenarios (mirroring, idealizing and twin ship scenario), they describe a fourth one within the addictive pathology namely the narcissistic megalomaniac scenario.

This stands for a vision of oneself as a demigod who has control over things or activities in a way that one is magically capable to alter the laws of human nature.

According to Ulman & Paul addiction cannot be reduced to a kind of narcissistic personality disorder characterized by disturbances in the relation between the subject and its selfobjects. Such a disorder is situated at the level of thinking, feeling and relating. The authors argue on the contrary that addiction has to be understood as a narcissistic behaviour disorder which involves impairment in the use of other people, things and activities as self-objects. The disorder goes beyond thinking and feeling; it extends to the domain of action and behaviour.

From the moment we started studying the self psychological contributions to the understanding of addictive pathology we also made a shift towards a two person psychology. The group therapist is less an objective observer and interpreter of group interactions, but more a subjective participant in these interactions (Eagle, 2011). The focus now lies less on the patient achieving self knowledge but more on developing a mentalizing capacity and the self management of maladaptive representations.

Clinical vignette

In a session of our inpatient group psychotherapy of some time ago, Phillip announced that he would change groups the next day in accordance with the unit staff. The separation theme was raised by this announcement and immediately an intense discussion developed between two others group members Walter and Alex who was about to end his treatment the following week. Walter had already had years of sobriety in the past but due to his relapse and unavoidable readmission to our unit, had lost his self confidence. He couldn’t find any explanation for his relapse.

Walter had great difficulties in taking steps outside of the unit. He was convinced that Alex took his treatment to lightly and also pointed out to the other group members that they too would relapse sooner or later. Alex blamed Walter for having to negative an attitude and a lack of perseveration. Emotions quickly ran high up to the point when Alex started talking about his brother, also an alcoholic, whom he couldn’t prevent from committing suicide. This memory was too painful for Alex who left the therapy room. The group at first had little reaction and the session terminated soon afterwards.
After a tense silence at the beginning of the next session, the therapist asked the group what they thought happened the previous session, but still the group remained silent. At that moment the therapist told the group how he looked back at what happened between Walter and Alex. He pointed to the fear that Walter and Alex probably had felt when listening to each other. What the other said, confronted them with a part of their own situation which they found extremely frightening but could not avoid feeling. On the one hand their fear was the awareness that the possibility of a relapse can never be excluded and that they would remain vulnerable. On the other hand they were afraid to leave the unit and the safety it provided them but they also feared becoming dependent on the unit and never being able to leave it.

After this intervention the group became more interactive and relapse formed the theme for the rest of the session. Several group members talked about their experiences in this area. Relapse was no longer attributed to bad friends or bad luck. The group considered more their difficulties in tolerating strong feelings of fear, anger, loneliness and uncertainty. Alex no longer minimized the extent of his alcohol abuse and spoke more openly of his fear for relapse in the weeks to come. Walter started talking about the great shame he was feeling because he was unable to stop drinking himself. The group then explored factors that could minimize the risk of relapse and attributed great importance to the support of peers.

**The work of Michèle Monjauze**

Another important source of inspiration in working with alcoholic patients was found in the work of the French psychoanalyst Michèle Monjauze. Inspired by Anzieu, Monjauze (1991; 1999; 2011) outlines the alcoholic problem in a very specific way. She argues that in treating alcoholics one should always consider two parts of their psyche, an alcoholic part versus a healthy, adaptive part. According to Monjauze it is a trap to try to understand alcoholics within the vicissitudes of borderline and narcissistic pathology, which is often the case in contemporary literature. Doing this the alcoholic specificity is covered up rather than anything being revealed of the true nature of this pathology.

The pathogenic core of alcoholism arises from a split in an alcoholic and an adaptive part of the self. This alcoholic part of the self has important autistic and psychotic features. Especially when the person is still drinking, his self is dominated by the alcoholic part and we see in the alcoholic someone who is unwilling or even incapable of seeing differences between himself and others, who doesn’t recognize any relation between his drinking and his problems, who can’t stand being alone and tolerate solitude, with little psychological continuity, and great difficulties with transitions. The alcoholic patient remains in a perpetual repetition. He is stuck in the undifferentiated somatic, and has little conscience. Once the alcoholic has been sober for a while, the adaptive part can become stronger and more in control so that autistic.
traits fade away into the background. However, they never really disappear. The self of alcoholics always carries with it an autistic enclave that is different for each patient. Its autistic nature makes this part inaccessible. It remains split off from the adaptive part. Initially, it acts as a saviour of the alcoholic part of the person as it seems able to make the nameless and uncontrollable fears disappear.

The result is a covenant where the healthy part of the alcoholic person's self protects the alcoholic part and helps it to develop. The crisis between the two parts only arises when the environment demands that the alcoholic patient should be admitted for treatment. The healthy part then is confronted with a dilemma between the need to further self-medicate with alcohol versus the awareness that it is the alcoholic part it has to recover from. We repeatedly recognize this dilemma in the alcoholic patient as a fluctuation between engaging in a therapeutic alliance and thwarting the help that is provided. The successive periods of sobriety and relapse reflect the split between the alcoholic and the healthy part.

Treatment of alcoholism requires a modification of the therapeutic technique. According to Monjauze, the alcoholic symptom will not disappear but can only be transformed. In treatment we try to resolve excessive drinking by turning it into its opposite, i.e. drinking no alcohol at all. Both ways are different modalities of the same symptom. An alcoholic in treatment lives with the conflict between the need to abstain from alcohol and the urge to drink. Such a crisis cannot be resolved with brief interventions, the imposition of abstinence or providing genetic interpretations.

Initially the alcoholic cannot imagine any benefits of abstinence. Sometimes a relapse is necessary and even beneficial if confronted in a non-judgmental way. Abstinence can only be achieved if the alcoholic rejects alcohol with the same rigidity with which he drank it. Instead of compulsive drinking, we try to bring him into staying sober compulsively. The treatment should therefore not only be directed to alcoholic mechanisms but also, and above all, to the adaptive capabilities. In the initial phase of treatment, we focus on forging a therapeutic alliance. Negative evaluations are made briefly and only with the intention of remobilizing the adaptive part of the self. What the patient cannot yet understand, should not be said. Monjauze expresses her view in the adage, "soigner, c'est créer des liens": This concerns not only forging a therapeutic alliance. It is also about ensuring continuity in treatment, establishing links between sessions, between inside and outside, between body and emotion, between cause and effect, between past and present. The first bond that has to be forged is probably the one between staff members.

The goal of psychoanalytically oriented psychotherapy is to enable the alcoholic to gradually understand and deal with his own pathology. To this end we provide a supportive environment. Analysis of transference and countertransference is equally indispensable to the alcoholic but it is only interpreted if necessary to unblock a stalled therapeutic alliance. In the psychoanalytic treatment of the alcoholic, we counter his traumatic repetitions with a repetition of care. The alcoholic and adaptive part of the self make up a couple that reminds of the famous Siamese twins Chang and Eng Bunker, with the first one being an excessive drinker and the second a
Living together was difficult, living separately was impossible. An awareness of the inner split should not be forced, as this could lead to suicide as the only way to discard the alcoholic part, like in the famous novel by R.L. Stevenson (suicide was the only way for Dr. Jeckyll to free himself from his Mr. Hyde). Initially the healthy part of the self tries to understand the sequences of relapse and sobriety by ascribing the causes to external circumstances. This projection of the alcoholic must first be respected as a defence against the inability to bring coherence to his personality. Therefore, in the treatment of alcoholics we focus foremost on their narcissistic recovery. Monjauze puts it in a nice French pun by describing psychoanalytic treatment of alcoholics as a work of panser (nursing) of the narcissistic injury and penser (thinking) the nameless fear and shame in the alcoholic. In the treatment of alcoholics mediating forms of therapy such as occupational therapy, psychomotor therapy, and music therapy get an important place. These can help to build a bridge between the adaptive part of the self and the alcoholic part, without access to verbalization. By making the alcoholic talk too much, and too much about alcohol, we only achieve that the split between the adaptive and the alcoholic part becomes confirmed and strengthened. Both parts then remain in parallel existence, with one still more verbal, and the other developing even more towards abuse of alcohol. Only when both parts are addressed and can be expressed in treatment, this split can decrease.

**Working with the addicted patient in group psychotherapy**

For several years our work with these groups was mainly inspired by the self psychological approach and by the work of Monjauze. But in recent years we have been thinking about specific dynamics that can be seen at a group level. The works of Claudio Neri (1998) and René Kaës (2007) now serve as another important guideline for us. Concepts as the <<field>> and the <<group psychic apparatus>> gradually offer us new ways to look at a group and at the collective dynamics that go on inside it. Our interest was especially aroused by Kaës’ concept of the <<phoric function>>. According to Kaës (2007) a group is essentially the experience of the meeting, combining and adjusting of three different mental spaces: the intrapsychic space of the private and individual, the inter-psychological space of the common and shared by the group, and the trans-psychic space of the group.

On each of these levels psychological contents have their own form and effect. With the concept of phoric function Kaës refers to intermediate formations, a kind of hatches he situates on the various junctions between the three different psychic spaces of a group. These are the places in a group where an exchange of psychic contents occurs. More specifically this concerns members of the group who as a go-between perform certain functions for themselves and for the group. Kaës emphasizes that a group member fulfilling a phoric function chooses to do so through his own desire but that he is chosen for that function by the group too. In a way he has been called to this function by the other group members who have a common interest in
creating this function. One of these phoric functions Kaës calls the <<speech bearer>>. This group member verbalizes connections between certain experiences and their meaning. He doesn’t speak for himself only, but sometimes he also speaks on behalf of another group member or of the group as a whole, and this without immediately realizing it. Kaës also describes other phoric functions such as the <<symptom bearer>> or the <<dream bearer>>. All these phoric functions are only expressed in a group context and are inherently connected with it.

Our attention was particularly drawn to the role of the <<voice carrier>>.

Kaës describes how some phoric functions can be reversed into their opposites. As an example he points to a speech bearer who can change into a word-twister, a word-reverser or the bearer of persecuting words. Thinking about psychic contents is then prevented or made very difficult. This is a phenomenon that we've recently come to understand better in our groups.

Since 1995 an outpatient group therapy for alcoholics was started as part of their aftercare. In the outpatient group, there are several members with years of abstinence. In this group it always feels as if at any given time one of the members of the group is in need of extra care and attention. In most cases this is a group member with rather poor attendance to the sessions, and who sometimes remains absent without prior notification. Or it can be someone who unexpectedly starts to talk a lot about alcohol or alcohol-related situations. Sometimes such a person tries to change the group norm about substance use or expresses even more openly his doubts about the usefulness of abstinence. Or it can be someone who is at risk of relapsing or who has relapsed several times with the vicious cycle of relapse and withdrawal that is hard to stop. Several other members then begin to respond very hard and polemically, and demand that the group norm of complete abstinence be reaffirmed. They can sometimes even threaten to leave the group if there isn’t something done about this problem. They demand that this member should be temporarily readmitted to our treatment unit.

Only when one or more of these measures are taken, calm returns to the group.

Our hypothesis is that in group therapy with a group of alcoholics we face a specific phoric function. We see it as inextricably linked to the alcoholic group. The concept of a homogeneous group of alcoholics by definition means that there is always someone fulfilling the phoric function of speech bearer but then in its reversed form. This group member is the carrier of the autistic part of the alcoholic group. Drinking then takes the place of talking. This member has chosen this function within the group from his own inner split and he does so at a time when his intrapsychic space is again largely dominated by his own alcoholic part. But at the same time he has unconsciously been chosen for that function by the other group members who project their own alcoholic part in order to control it. Just as it is an illusion that an alcoholic could ever get rid of his alcoholic part, it is impossible for a group of alcoholics to function without an alcoholic part. One group member will always have to take up this function. If the group therapist focuses too much on trying to eliminate the alcohol part of the group, the split will just become bigger within the group, which threatens to perish over time.
Michael, one of the participants in the outpatient group told how a former group had helped him to stay sober for several years but had gradually disintegrated. For members who relapsed, no place was kept in the group. Only those who could stay sober met. But over time only three members were left, each with many years of sobriety. Each had little to tell, felt strong, and the group decided to stop and each to go their own way. Not long after that, Michael began drinking heavily again, and what followed was another long ordeal to renewed abstinence. We suppose that his former group was no longer a place where Michael could find someone who would fulfil the function of the bearer of the alcoholic part of both the individual members and of the group as a whole.

Some clinical issues
In residential settings we are more and more confronted with government pressure to keep treatment as short as possible. And there is the additional pressure of waiting lists that are always too long and have to be shortened as fast as possible. The ideal course of treatment as we have learned during our own training through manuals of group psychotherapy is hardly ever achievable. We always get less time to work within the framework of consecutive phases in group psychotherapy (Khantzian, Halliday & McAuliffe, 1990). Much too often in our residential setting we can get no further than help the alcoholic patient to become and remain sober. Working through underlying dynamics must be passed on to the aftercare institution too often.

Working with alcoholic groups is characterized by a constant movement in the group which can be compared with a glass that is constantly being emptied and refilled. The glass is never empty nor full. Group members are often absent, or they relapse into drinking. New group members appear or drop out again. The group psychotherapist may then be prey to a variety of counter transference feelings that in a way can be understood as an externalization of an inner conflict within the alcoholic patient between his great dependence needs and an equally great fear of attachment and dependency. Sessions in which a group was able to be more open, to show some of their vulnerabilities are almost always followed by session that are tiresome, boring, or even in which any intervention on my part is either not understood or simply pushed aside by the group.

Counter transference feelings can change a lot over time. Just as alcoholics tend to think and speak about feelings in extreme terms, so the group psychotherapist too can experience extreme feelings. Regular intervisio and supervision are therefore essential. When the therapist feels abandoned because once again patients are blatantly absent, we think he should try to refrain from reprimanding them next time but instead think about their instability in relationships. When the therapist feels cheated when it becomes clear that a group member has secretly turned to drinking, we advise he should try not to take a moralizing stance but start to think about that member’s great ambivalence with regard to abstinence and about his use of splitting as a defence mechanism. When the therapist feels hopeless about a patient who...
invariably continues to deny having an alcohol problem despite severe liver damage, he’d better try to make contact with the depressive feelings that the patient cannot feel for himself. When feeling like reprimanding group members, the group therapist shouldn’t do so but instead try to focus on their lack of inner psychic structure. Whenever feeling charmed or even somewhat euphoric in his work, the group therapist should try not to defend himself in a manic way, but try to understand this as an expression of an idealizing transference and a desire of the group members to merge with an omnipotent figure that will solve any problems they might have. When feeling bored in a group session or finding himself falling half asleep, the group therapist first has to wonder whether he has had enough sleep the previous night. If this is the case he should start thinking about the grandiose arrangement with a group member who seems to know everything better, who is anxious to show that he doesn’t need anybody but who, by behaving that way, reveals something of the fragile and vulnerable self he is so desperately trying to ward off.

**Conclusion**

The core of the psychoanalytic group psychotherapy for alcoholics is to provide a supportive and nurturing relationship as an antidote to the traumatic repetition by the alcoholic. Research shows that most alcohol-dependent patients need three to four treatments over an average of eight years before they reach a stable abstinence (Emmelkamp & Vedel, 2007). Patients who are less loyal to the group sessions, and do not engage in after care treatment are more likely to relapse. In contrast, maintaining a therapeutic contact with the alcoholic patient over long periods of time provides better long term outcomes than when that contact is broken off. In the psychoanalytic group psychotherapy for alcoholic patients we ensure to steer away from any tendency to amputate the alcoholic part but persist in trying to integrate it. However difficult it may seem, we have to continue trying to speak with the drinking part of these difficult patients.

**References**


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