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London Centre for
Applied Psychology

Working with Addiction (in private practice)

Overview

We'll focus more on the causes of addiction and treatment implications. Less on medical withdrawal or residential rehab.

- ✓**Complexity and comorbidity**
- ✓**Definition/s**
- ✓**Causes/ competing theories - esp attachment & CM**
- ✓**Consensus?**
- ✓**Clinical implications**
- ✓**Next steps & further reading**
- ✓**Plus - user-experience!**

I was terrified of other people; I used drugs for emotional protection and social comfort. I suffered no shortage of shame, self-loathing, and guilt…

…. I did not inject cocaine dozens of times a day because I was proud of myself.

(Maia Szalavitz).

Complexity and comorbidity

When we talk about addiction, what do we mean?

Can you help with all addictions - ie are they essentially the same?

Do you feel able to work with any of them? Most therapists refer on… Would you? Why?

If you chose to work with the addiction, what about the (inevitable) comorbid conditions?

Are you skilled to work with those too? Does it depend on which condition?

In what order do you tackle comorbid conditions? Does the SUD always predominate?

Definition(s)…

Not everyone agrees…

NHS

DSM-5

12-Step definition

Mental Health Charity

Trauma literature

NHS definition

https://www.nhs.uk/live-well/healthy-body/addiction-what-is-it/

Addiction is defined as not having control over doing, taking or using something to the point where it could be harmful to you.

Addiction is most commonly associated with gambling, drugs, alcohol and nicotine, but it's possible to be addicted to just about anything, including:

- work – some people are obsessed with their work to the extent that they become physically exhausted; if your relationship, family and social life are affected and you never take holidays, you may be addicted to work
- internet – as computer and mobile phone use has increased, so too have computer and internet addictions; people may spend hours each day and night surfing the internet or gaming while neglecting other aspects of their lives
- solvents – volatile substance abuse is when you inhale substances such as glue, aerosols, petrol or lighter fuel to give you a feeling of intoxication
- shopping – shopping becomes an addiction when you buy things you don't need or want to achieve a buzz; this is quickly followed by feelings of guilt, shame or despair

What causes addictions?
There are lots of reasons why addictions begin. In the case of drugs, alcohol and nicotine, these substances affect the way you feel, both physically and mentally. These feelings can be enjoyable and create a powerful urge to use the substances again. Being addicted to something means that not having it causes withdrawal symptoms, or a "come down". Because this can be unpleasant, it's easier to carry on having or doing what you crave, and so the cycle continues.
Often, an addiction gets out of control because you need more and more to satisfy a craving and achieve the "high".

How addictions can affect you

The strain of managing an addiction can seriously damage your work life and relationships. In the case of substance misuse, an addiction can have serious psychological and physical effects.
Some studies suggest addiction is genetic, but environmental factors, such as being around other people with addictions, are also thought to increase the risk.
An addiction can be a way of blocking out difficult issues. Unemployment and poverty can trigger addiction, along with stress and emotional or professional pressure”.

Getting help for addictions

Addiction is a treatable condition. Whatever the addiction, there are lots of ways you can seek help. You could see your GP for advice or contact an organisation that specialises in helping people with addictions.

NHS definition (highlighted)

https://www.nhs.uk/live-well/healthy-body/addiction-what-is-it/

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- **shopping** – shopping becomes an addiction when you buy things you don't need or want to achieve a buzz; this is quickly followed by feelings of guilt, shame or despair

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DSM-5

Diagnostic and Statistical Manual of Mental Disorders. Published by the American Psychiatric Association

Substance related disorders encompass 10 separate types of drugs: alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants; tobacco, and other (or unknown) substances.

P.481:

All drugs that are taken in excess have a common direct activation of the brain reward system.… They produce such an intense activation of the reward system that normal activities may be neglected. Instead of achieving reward system activation through adaptive behaviours, drugs of abuse directly activate the reward pathways. The pharmacological mechanisms by which each class of drugs produces rewards are different, but the drugs typically … produce feelings of pleasure, often referred to as a “high”. Furthermore, individuals with lower levels of self-control which may reflect impairments of brain inhibitory mechanisms may be particularly predisposed to develop substance use disorders, suggesting that the roots of substance use disorders for some persons can be seen in behaviours long before the onset of actual substance use itself.

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12-Step/ AA definition

Largest peer support programme in world.

Used by most/ all major residential rehabs.

On any given weekday in London there are close to 100 meetings. Many more for NA/ GA/ SAA etc.

Will cover 12-step, and the question of how effective it is, in due course...

https://www.alcoholics-anonymous.org.uk/about-aa/newcomers/about-alcoholism

While there is no formal "AA definition" of alcoholism, the majority of our members agree that, for most of us, it could be described as **a physical compulsion, coupled with a mental obsession.** What we mean is that we had a distinct physical desire to consume alcohol beyond our capacity to control it, **in defiance of all rules of common sense.** We not only had an abnormal craving for alcohol but we frequently yielded to it at the worst possible times. We did not know when (or how) to stop drinking. Often we did not seem to have sense enough to know when not to begin.

Definition(s)…

Bringing the definitions together:

NHS: *Addiction is defined as not having control over doing, taking or using something to the point where it could be harmful to you.*

DSM-5: *All drugs that are taken in excess have a common direct activation of the brain reward system.… such… that normal activities may be neglected.*

12-Step definition: *A physical compulsion, coupled with a mental obsession.*

Mind: *Addiction is often linked to mental health problems. Addiction may have started as a way to cope with feelings you felt unable to deal with in other ways.*

Trauma literature: *Traumatised people hate how they feel. They take drugs in order to stabilise their bodies (van der Kolk)// Addiction originates in a human being's desperate attempt to solve a problem: the problem of emotional pain (Gabor Mate).*

Five-word definition: *Compulsive behaviour, despite negative consequences. (Maia Szalavitz: Unbroken Brain: A Revolutionary New Way of Understanding Addiction) NYT/ N Scientist/ Scientific American*

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Addiction is when you do the thing you really really most don’t want to be doing

(Philip Seymour Hoffman).

Labels/ descriptors

Alcohol dependent/ problem drinkers/ addicts/ users/ drug abusers/ drug dependent/ SUD…

Will swap in this workshop.

Does it matter? In some contexts for some people…

But most people who've been in active addiction, and are serious about recovery, have got bigger things to worry about.

So I stayed in bed and drank…

…. When you drank the world was still out there, but for the moment it didn’t have you by the throat.

(Charles Bukowski).

So I go and get another beer.

…. The supply is already running out. I only had five cans. Where will I be when the darks falls and the dragons come and there is no more beer?

(Thomas Merton).

Definitions - Abstinence vs harm reduction:

Although abstinence continues to be the benchmark for outcomes of treatment for substance abuse, **other outcome variables have come into wider use**, partly **because abstinence is not often an outcome of treatment,** even ‘successful' treatment.

As a consequence, **reduction in consumption and enhancements in the quality of life** have become more widely employed as measures of outcome. They permit a fine-grained reflection of differences in treatment impact than categorical variables such as abstinence or non-abstinence.

12-step recovery aims for abstinence. In reality, if you go along to a meeting, you’ll see and hear how many people have ‘slipped’/ relapsed along the way.

Definitions: Why gambling but not … ~~sex addition/ internet pornography/ gaming~~/ etc?

DSM is always behind the times. Sometimes horribly so (homosexuality, wasn't removed til 1973).

P.481: (DSM)

Gambling disorder reflects evidence that gambling behaviours activate reward system similar to those activated by drugs of abuse and produce similar some behavioural symptoms that appear comparable to those produced by the substance use disorders. Other excessive behavioural patterns such as Internet gaming, have also been described, but the research on these and other behavioural syndrome is less clear. Thus, groups of repetitive behaviours, which some term behavioural addictions, with such subcategories as sex addiction, exercise addiction, or shopping addiction are not included because ***at this time*** there is insufficient peer reviewed evidence to establish the diagnostic criteria.

Still presented as ‘moral failing’

Similar to early views on alcoholism. Likely to change in time.

Paula Hall is reliable source of information - runs a treatment centre/ published in this area/ has a TED talk.

- SA often results in lack of attraction to partner & ED
- NOT the same as high sex drive. Many addicts report a low sex drive or that SA has robbed them of their libido.
- For someone who spends hours online looking at pornography, postponing ejaculation for as long as possible, the real motive is escape from reality - enjoying the aroused brain state rather than genital stimulation or moment of orgasm.

“Hypersexual Disorder and the DSM-5 …” (Reid and Kafka)

Controversies About Hypersexual Disorder and the DSM-5 - Reid and Kafka

https://www.researchgate.net/publication/267215211_Controversies_About_Hypersexual_Disorder_and_the_DSM-5

The current research in the field of hypersexual behavior is in its infancy. No concrete approach currently exists to assess severity in hypersexual populations.

“Concerns were raised about adding new diagnoses to the DSM-5 without sufficient scientific research including anatomical and functional imaging, molecular genetics, epidemiology, and neuropsychological testing”.

Also, ramifications for public policy/ concerns about potential misuse in the legal community - HD as a mitigating factor for criminal defendants, being prosecuted for sex crimes or child sex abuse.

Definitions - final caveat… Can anyone become an addict?

- Important caveat to our definition/s.
- Clip: 1.57-3.24 - Johann Hari TED Talk

Can anyone become an addict? (Continued)

Most people who are exposed to opioids do not become addicted. A third find them unpleasant.

Most estimates suggest 80-90% of people who try heroin do not get addicted. Same with most people who drink or gamble.

(Doesn't mean be casual about the risks…Would you choose to fly a plane that crashed 10-20% of the time?)

Maia Szalavitz - Unbroken Brain

You don't wake up one morning and decide to be a drug addict. It takes at least three months' shooting twice a day to get any habit at all.… I think it no exaggeration to say it takes about a year and several hundred injections to make an addict.

WILLIAM S. BURROUGHS, JUNKY

Overview

✓Complexity and comorbidity

✓Definition/s

✓**Causes/ competing theories**

✓Consensus?

✓Clinical implications

✓Next steps & further reading

✓Plus - user-experience!

Nature Journal

Molecular Psychiatry, Nature 2021

Childhood maltreatment (CM) is considered a risk factor for substance use disorders (SUD), but largely based on retrospective self-reports (subject to recall bias - ie, a study which asked nearly 8000 adults to recall CM at two separate timepoints, 12 years apart, found 39% of respondents gave inconsistent responses). The study is therefore tackling the criticism that contribution of CM to SUD remains unclear.

Here, we evaluated this issue with objectively recorded CM, using medical records and the National pateint register (Sweden) to study 525 young adults (20–37 years) with objectively documented severe CM - alongside 1979 clinical controls (former child and adolescent psychiatry patients, but with no recorded CM history), and 1388 matched healthy controls.

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Nature Journal - 2021

Finding:

More than one third (36%) of those exposed to CM had SUD, compared to only 5.6% in the controls (ie those without prior child psychiatry contact).

The controls who were former child/ adolescent psychiatry patients (but who had no recorded CM) also had higher SUD prevalence (27%) compared to healthy controls, but significantly lower than those exposed to CM.

We find a robust association between CM and SUD. Ie an approximately threefold increase in SUD risk in individuals exposed to CM.

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Nature Journal - 2021 (additional findings)

In addition:

The greater the CM, the higher their rates of substance use (before age 14) and SUD in adulthood.

Of the CM-exposed participants, we also found they were more likely to have parents with SUD.

Notes:

Total sample size, ie included siblings = a population of 28,733 individuals.

Medical records indicate that CM mainly = sexual and physical abuse and severe neglect.

Child maltreatment and the development of substance use disorder

Cicchetti & Handley - Feb 2019

https://www.ncbi.nlm.nih.gov/pmc/articles/

Children who experience maltreatment are at well-documented risk for the development of problematic substance use and disorder in adolescence and beyond, marked by an increased likelihood of failure and disruption in the successful resolution of salient developmental tasks... **Maltreated children are likely to exhibit atypical physiological regulation, difficulty recognising, differentiating and regulating emotion, dysfunctional attachment relationships, problematic peer relationships, and trouble adapting successfully to school.**

The heroin would win me a few blessed hours of blissful calm… I'd heat the spoon to prepare the heroin, which I dissolved in water, adding a dash of coke when it cooled, then injecting the mixture. The first hit would be heavenly… The cocaine would trumpet a burst of exhilaration as I pressed the plunger in; I could taste its icy flavor at the back of my throat. A few moments later, the warmer, soothing harmony of the heroin would take over.

Every atom in my body felt calm, safe, fed, content, and, most of all, loved.

(Maia Szalavitz).

The ‘externalising’ pathway

Dante Cicchettia & Elizabeth D. Handley

Specifically, there is robust support for an ‘externalizing pathway’ in the development of SUDs - also referred to as an antisocial pathway - and marked by behavioral disinhibition, aggression, poor self-regulation, and rule-breaking behavior. All **influenced by maladaptive parenting and family contexts, plus child temperament and peer affiliation**.

The ‘externalising’ pathway

In extreme form, the antisocial pathway leads to ASPD (plus crime/ violence and often imprisonment).

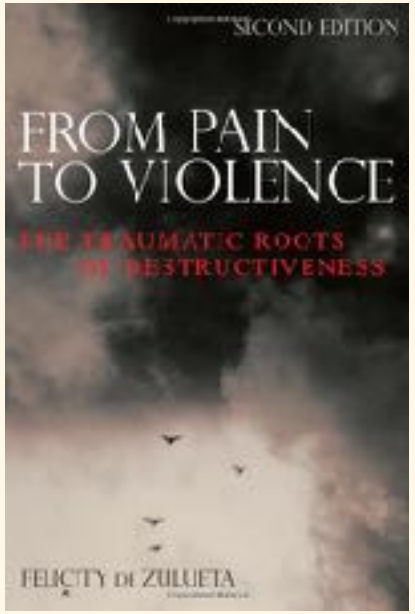
78% of male remand prisoners met the criteria for PD

63% of those were diagnosed with ASPD.

Singleton N, Gatward R (2001) Psychiatric Morbidity among Prisoners: Summary Report. Office for National Statistics London.

Anyone interested in the connection between early pain and later violence in life…

Felicity de Zueleta: From Pain to Violence (Emeritus Consultant Psychiatrist in Psychotherapy (SLaM NHS Trust) and Hon Senior Lecturer (KCL)



But not always! CM does not automatically lead to SUD or other pathology…

A point both **Cicchettia & Handley** (and de Zulueta) make.

However, some maltreated children function in an adaptive resilient fashion, despite their negative and traumatic experiences…. **A particular adverse event should not necessarily be viewed as leading to the same outcome in every individual** and should be considered in the light of individual characteristics, experiences, and social-context and timing.

Attachment theory

Three module course on this:

(https://www.lcap.co.uk/join/attachment)

Essentially the difference is whether there is a secure relationship with an attachment figure in place. Ie can the event/s be understood/ withstood/ or 'buffered' with the help, skill and kindness of another.

Try this article as simple intro (includes links to research and cross references with the ACEs work).

(https://www.lcap.co.uk/articles/the-7-ways-attachment-science-will-transform-your-practice)

Link to ACEs

Originally conducted in the USA, the Adverse Childhood Experiences Study ran between 1995 – 1997. Asked 17,337 adults about their exposure to ACEs:

1. physical abuse 2. sexual abuse. 3. emotional abuse. 4. physical neglect. 5. witnessing violence in the home or the community. 6. having a family member attempt or die by suicide 7. one parent addicted to substance misuse. 8. one parent with mental health problems. 9. parental separation or divorce. 10. one parent in prison

Long-term follow up showed that ACEs are linked to chronic health problems such as: obesity, mental illness, and substance misuse in later life. The higher your ACE score, the worse your health outcomes.

- **ACE score of 4+ meant relative risk of chronic pulmonary disease was two and a half times that of someone with an ACE score of zero.**
- **For hepatitis, it was also two and a half times.**
- **A person with an ACE score of seven or more had triple the lifetime risk of lung cancer and three and a half times the risk of ischemic heart disease (the number one cause of death in the USA).**

https://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract

Link to ACEs (continued)

In 2015, the Welsh ACE Study examined 2000 participants.

47% of adults suffered at least 1 ACE and 14% suffered 4 or more.

Compared to individuals reporting no ACEs, individuals who had experienced four or more ACEs were:

- **4 times more likely to be a high risk drinker**
- **16 times more likely to have used crack cocaine or heroin**

Published by Public Health Wales & Liverpool John Moores Uni - led by Prof Mark Bellis, Director of Policy & Research at Public Health Wales

ACEs… more facts

UCL Institute of Health Equity, 2015 (led by Prof Sir Michael Marmot) was commissioned by DH to report on the social factors that shape health outcomes.

Key messages:

In men, risk of death before 50 yrs is 57% higher among those who experienced two or more ACEs (compared with those who experienced none). In women, the risk is 80% higher.

12% of binge drinking, 14% of poor diet, 23% of smoking, and 59% of heroin/crack cocaine use could be attributed to ACEs.

ACEs… more info available.

Nadine Harris Burke: Surgeon General of California.

TED Talk - 17 million views

Book: ‘Toxic Childhood Stress’

“Kids have faced stress, neglect and violence since God was a boy… Despite rough childhoods, plenty of folks go on to get good grades and build successful lives. Isn’t this just bad behaviour….?”

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Hungry Ghosts

Gabor Mate: In the Realm of the Hungry Ghosts

An idea from Buddhism…

Metaphorical description of the craving of an addict - Mark Epstein, Thoughts Without A Thinker

Hungry Ghosts

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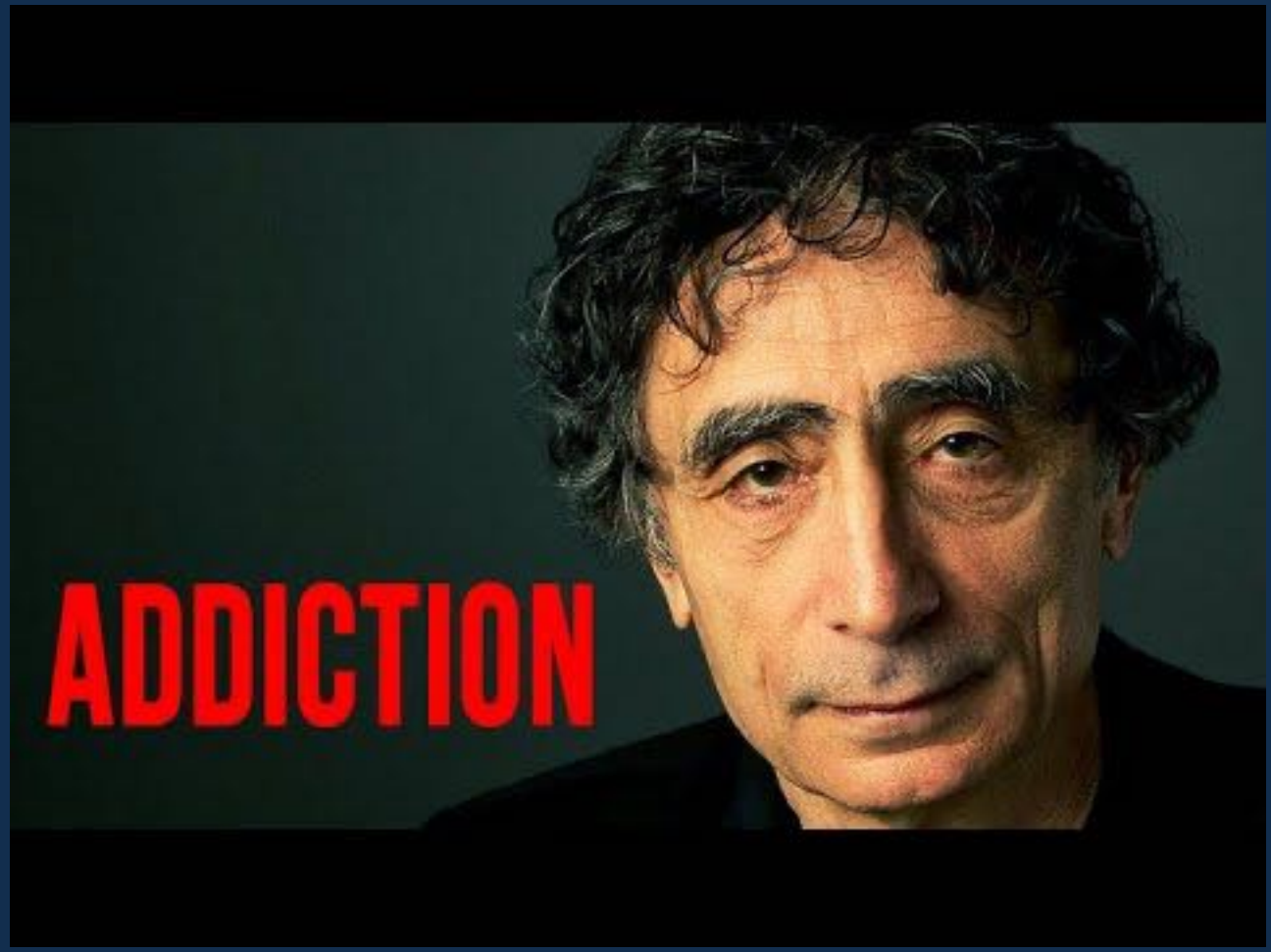

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Downtown Eastside Vancouver:

Over 1000 overdose related deaths every year since 2017.

On July 24 2018 paramedics responded to 130 suspected overdose calls.

I have absolutely no pleasure in the stimulants in which I sometimes so madly indulge. It has not been in the pursuit of pleasure that I have periled life and reputation and reason. It has been the desperate attempt to escape from torturing memories…

…from a sense of loneliness and a dread of some strange impending doom.

(EDGAR ALLAN POE).

Similar to self-medication model (SMH)

- Prof Edward Khantizian = SMH = ‘response to suffering’.
- Diminished capacity to cope with, think about, soothe from pain and difficulty. (Fonagy & Bateman ‘mentalisation’)
- Adaptive in first instance, but worse in due course ie physical tolerance
- Roots of addiction lie in early attachment and trauma.
- “Addicts are best understood not as pleasure-seekers or self-destructive characters, but as individuals who are in pain… seeking comfort”.
- Attachment to a ‘thing’ that won’t let you down. A relationship has in the past, and will again. ‘We feared intimacy more than death’.

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We have faith in poison…

(Arthur Rimbaud).

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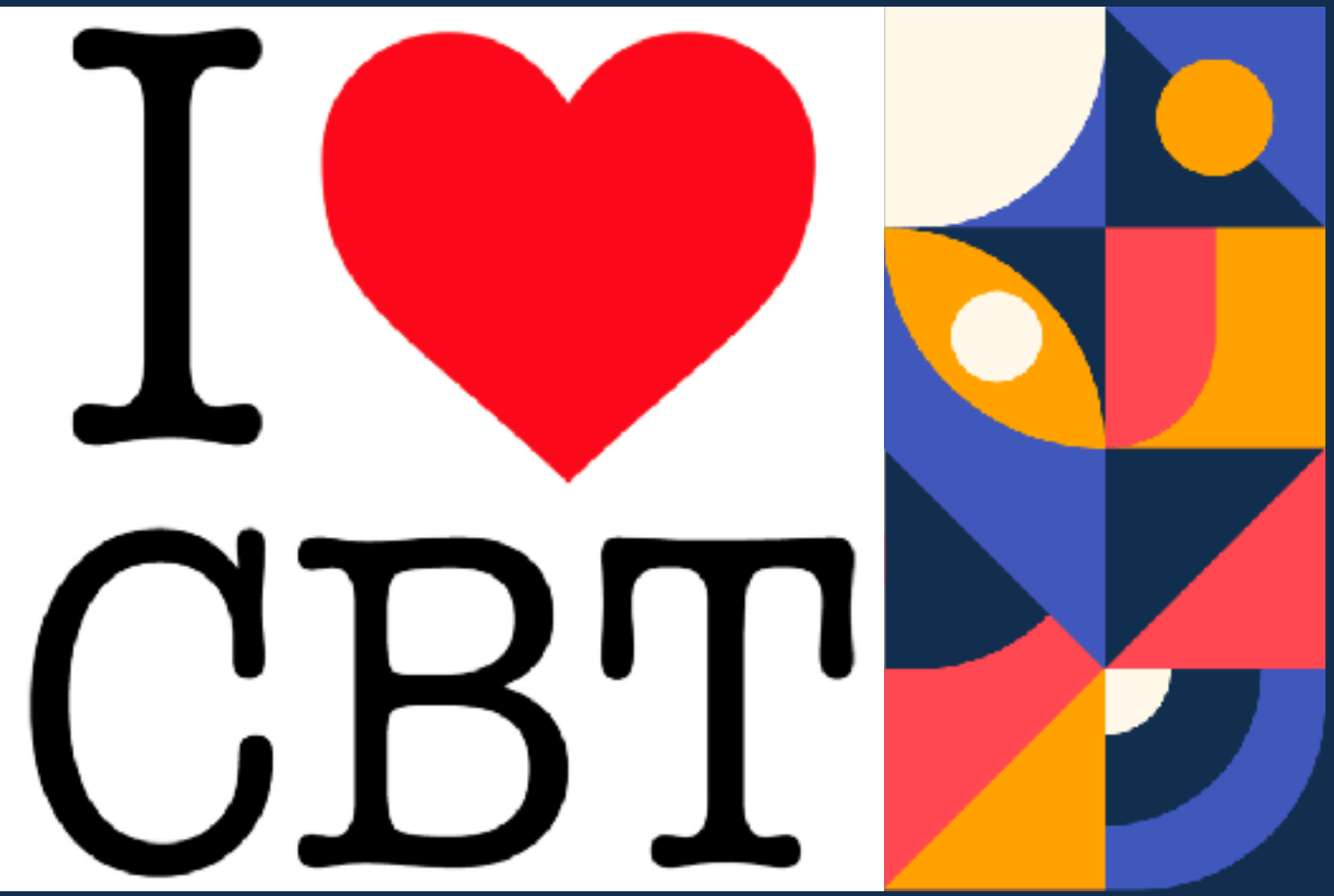
✓Plus - user-experience!



CBT remains the dominant paradigm in the NHS.

Does CBT fit CM/ ACEs/ SMH etc?

NHS website/ Mayo Clinic/ Priory Clinic:

CBT says addictions (inc behavioural addictions) arise via dysfunctional/ deeply-ingrained thought patterns. Negative thoughts undermine your efforts to make healthy choices.

By taking time to gain insight into your beliefs, you can increase your health and wellbeing by changing the way you think and respond to situations.

Once you have identified the set of dysfunctional thought patterns (that have allowed addiction to develop), you can learn to replace them with more accurate/ adaptive ones.

Negative beliefs can stem from childhood coping mechanisms that are no longer functional (but deeply ingrained). By acknowledging these beliefs, you can change your thinking, leave destructive patterns in the past, & take steps towards recovery.

Interrupting negative thought patterns, allows you to alter associated behaviours and feelings, resulting in a greater capacity to cope with stress and make healthy choices. By confronting self-defeating beliefs, you will gain healthier levels of self-awareness and self-esteem that will assist you in building a strong foundation for addiction recovery.

CBT ‘usually has the best results’, according to NHS/ NICE Guidelines

P.71 of NICE Guidelines 2017: 3.7.3.2.

CBT… aims to modify addictive behaviours by changing unhelpful cognitions that serve to maintain behaviour, or by promoting positive cognitions or motivation to change behaviour. **Commonly used variants are CBT-based relapse prevention, motivational enhancement therapy, and CBT focusing on treating depression and anxiety. More recent developments… known as ‘third-wave’ or ‘contextual’ CBT… include ACT and mindfulness-based relapse prevention**… to… encourage psychological flexibility. There is some evidence that mindfulness can reduce cravings and promote abstinence… **the ACT approach has promise as a treatment for substance dependence**.

CBT ‘usually has the best results’, according to NHS/ NICE Guidelines

P.71 of NICE Guidelines 2017: 3.7.3.2.

Motivational enhancement therapy:

Useful summary at National Institute on Drug Abuse in the US - www.drugabsuse.gov

Also a link to a drugabuse.gov download on the principles of treating drug addiction, based on research, more generally

That document says medications are an important element of treatment, for many, esp when combined with counselling/ therapy, BUT, medically assisted detox is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.

ACT:

Useful article comparing ACT to 12-step process - similarities and differences.

In summary… do the various definitions hang together….?

- Abusive/ neglectful experiences impact on the sense of self/ self-esteem & the capacity to develop secure, trusting, comforting r/ships.
- Such experiences result in feeling unworthy of attention, undeserving of care, and undervaluing connection to others
- Poor self-esteem leads to feelings of isolation which may be temporarily relieved by stimulants/ alcohol/ other forms of behaviour - which allows connection to others that would otherwise not feel possible.
- Or, for those passively resigned to withdrawal from connection, that retreat is made easier with obliterating substances/ behaviours designed to numb-out/ get to black/ escape into 'the bubble'.

The function of addiction (summary of the summary):

- Addiction has a psychological purpose, beyond habit - as a coping mechanism; a way of managing life; of relieving negative emotions and/ or creating positive ones; for which friends/ real-life connection increasingly become a poor substitute.

TED Talk

- Rat Park - connection - bonding - attachment - and the causes of addiction…
- Clip: 3.32-6.39

End of Part One

(Part Two: Clinical implications/ further reading/ next steps)

Working with Addiction (in private practice) - Part Two

Part Two:

Treatment implications and options.

- ✓ Complexity and comorbidity
- ✓ Causes and competing theories
- ✓ Consensus?
- ✓ **Clinical implications**
- ✓ **Next steps & further reading**

Part Two (expanded)

Treatment implications and options.

- ✓ Complexity and comorbidity
- ✓ Causes and competing theories
- ✓ Consensus and evidence?
- ✓ **Clinical implications**
  - ✓ **What does the evidence suggest**
  - ✓ **Does 12-step work**
  - ✓ **User-experiences**
- ✓ **Next steps & further reading**

Summary - the function of addiction

- Abusive/ neglectful experiences impact on the sense of self/ self-esteem & the capacity to develop secure, trusting, comforting r/ships.
- Such experiences result in feeling unworthy of attention, undeserving of care, and undervaluing connection to others
- Poor self-esteem leads to feelings of isolation which may be temporarily relieved by stimulants/ alcohol/ other forms of behaviour - which allows connection to others that would otherwise not feel poss.
- Or, for those passively resigned to withdrawal from connection, that retreat is made easier with obliterating substances or behaviours designed to numb-out/ get to black/ escape into 'the bubble'.
- ***Addiction has a psychological purpose, beyond habit - as a coping mechanism; a way of managing life; of relieving negative emotions and/ or creating positive ones; for which friends/ real-life connection increasingly become a poor substitute.***

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Alcohol is the anaesthesia by which we endure the operation of life

(George Bernard Shaw).

Clinical implications

Five priorities:

Five priorities

- Think (read and watch) your way in
- Dont rush to refer on
- Use community resources (inc bio-medical help)
- Strong stance
- Follow the evidence

Read. Watch. Listen.

If you’re not an addict, it’s difficult to think like an addict

That’s good and bad

But you need to know their world…

Read.

NY Times link:

https://www.nytimes.com/2020/02/13/style/addiction-memoirs-are-a-genre-in-recovery.html

- ✓**The Shining - Stephen King**
- ✓**Trainspotting - Irvine Welsh**
- ✓**Junkie - William Burroughs**
- ✓***Open - Andre Agassi***
- ✓**Addicted/ Sober - Tony Adams x2**
- ✓**Infinite Jest - David Foster Wallace**
- ✓***Stories in the back of the AA Big Book***
- ✓***Getting Off - Erica Garza***
- ✓**Me - Elton John**
- ✓**Russell Brand - Recovery**

Watch/ Listen.

Documentaries and podcasts too.

Russell Brand - From Addiction to Recovery
Amy Winehouse documentary - Amy
Heroin(e) - Oscar nominated
Drinkers Like Me - Adrian Chiles
Drinking to Oblivion - Louis Theroux
Bought up on Booze - Callum Best

Documentaries and **podcasts** too.

The Bubble Hour
Busy Living Sober
The Addicted Mind
Seltzer Squad
Hooked BBC Sounds
(All female led/ female voices)

- ✓**Trainspotting**
- ✓**Rocketman**
- ✓**Nurse Jackie**
- ✓**Queen's Gambit**
- ✓**Shame**
- ✓**A Star is Born**
- ✓**When a Man Loves a Woman**
- ✓**Beautiful Boy**
- ✓**Crazy Heart**
- ✓**Walk the Line**
- ✓**Leaving Las Vegas**
- ✓**Drugstore Cowboy**
- ✓**Lost Weekend**
- ✓**Cat on a Hot Tin Roof**
- ✓**Whinail and I**

Refer it on (if need be)

Remember your scope of practice.

No shame in referring on. Develop your network. 'Think like a GP'.

But…

But don’t rush to refer on...

Psycs typically report feeling unprepared to work with SU (Aanavi, Taube, Ja, & Duran, 1999; Harwood, Kowalski, & Ameen; 2004; Madson, Bethea, Daniel, & Necaise, 2008).

Survey of counselling psyc students found only 58% thought they were well trained to address SUDs. Madson et al. (2008)

But, more than half of the respondents (54%) reported that they frequently work with clients who abuse substances.

SUDs often occur alongside other mental health disorders (39%; SAMHSA, 2015).

Most clients seek general outpatient tx, not specialist SU services - so almost certain that you’ll see SUDs in your practice.

Survey of 1,200 psychologists found that more than 90% reported seeing clients with SU problems - Aanavi et al. (1999)

Therapists (of all types) have an informal tradition of referring on to specialist tx.

Two problems follow:

1. Most addiction counsellors are not well trained in co-occurring mental disorders, esp severe disorders.

2. SU treatment typically focuses on addiction alone, not co-occurring mh probs or related family/ interpersonal issues.

The authors below invite us to consider the question: ***does referral place us at risk of not fulfilling our ethical responsibilities?***

Miller, W. R., & Brown, S. A. (1997). Why psychologists should treat alcohol and drug problems. American Psychologist, 52, 1269-1279. doi:10.1037/0003066X.52.12.1269

Community resources

- Friends and family of client - involve them
- GP
- 12-step
- Residential rehabs
- Take it on, but don't go it alone (what does your supervisor know about addiction? Are they willing to join you on the journey?)

Residential rehab

Hazelden Betty Ford cost $1,200 a day (not for profit)

28 days at The Priory in Roehampton costs £22,500 (pictured)

The Kusnacht Practice in Switzerland is $85,000 a week (typical treatment lasts 12 weeks). ‘The most exclusive rehab facility in the world”.

The jury is out…

NICE make the following recommendation for research: “is residential treatment associated with higher rates of abstinence or reduction in drug misuse than community based care? Ie, we don’t currently know.

Another First Lady …Betty Ford

"I liked alcohol," she wrote in her 1987 memoir. "It made me feel warm. And I loved pills. They took away my tension and my pain".

Addiction to pills began when she was prescribed drugs for a trapped nerve in the 1960s. She began recovery in 1978. Following a family intervention.

Spoke out on the issue (was first First Lady to speak candidly to the media):

“They asked me just about everything, except how often I and the President had sex. And if they'd asked me that I would have told them... ‘As often as possible’”.

Subsequently opened what is still one of the most famous residential rehab centres in the world.

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Clinical implications

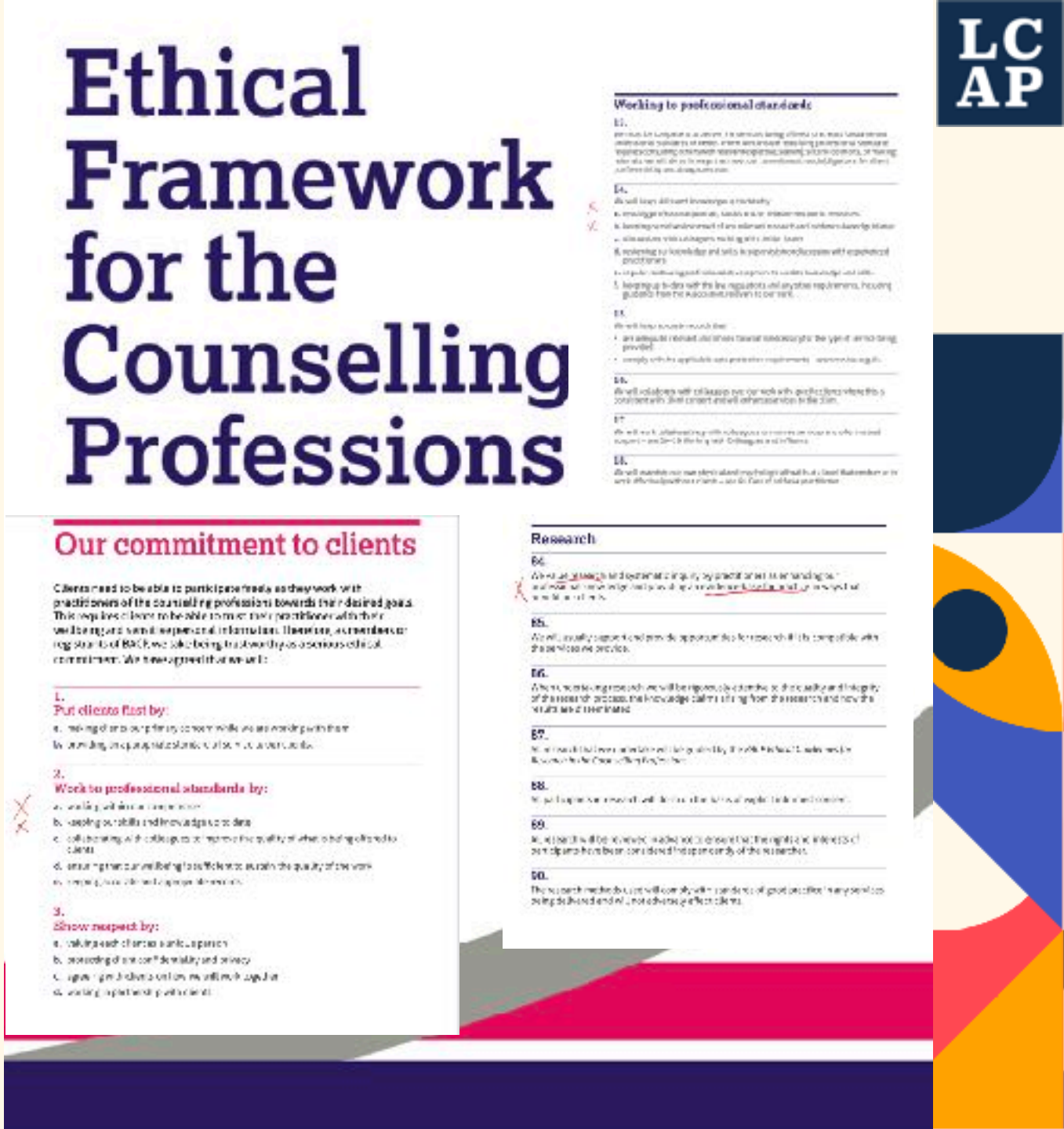
Evidence from the literature:

BACP Ethical Framework:

Work within our competence and keep skills up to date.

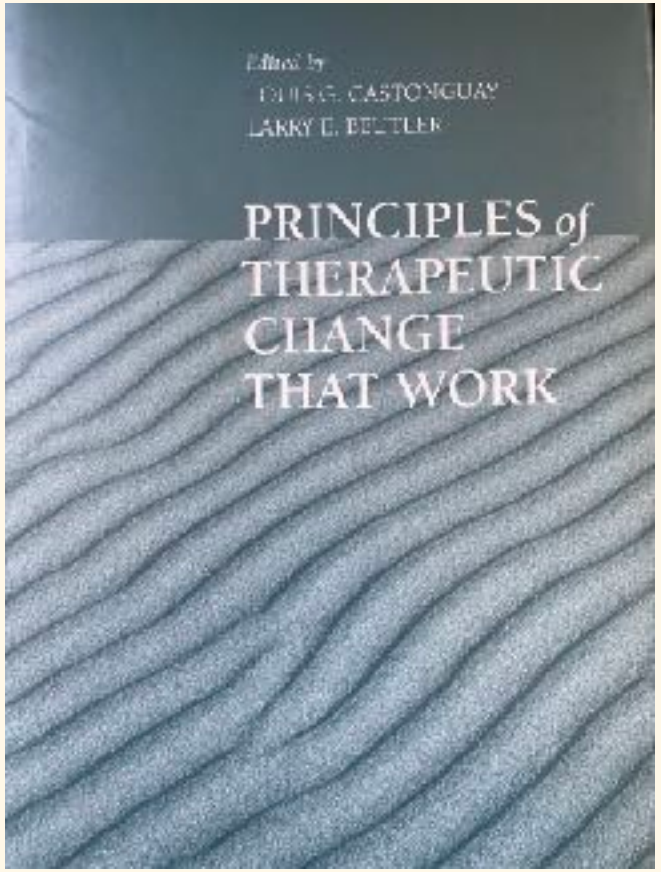
By keeping ourselves informed of relevant reasrach and evidence based guidance.

We value research and systematic inquiry as providing an evidence base for practice **that benefits our clients.**



Two primary sources of evidence x1

- Principles of Therapeutic Change That Work - Castonguay & Beutler
- Identifies empirically supported principles that underpin effective treatment.
- “There is no empirical ‘formula’ to allow the delivery of treatment with complete confidence, but empirically supported *principles,* used flexibly, and tailored to individuals, provide a way forward. This is better than using a rigid treatment protocol, standardised on a somewhat different clinical population, or use of idiosyncratic selected interventions”.

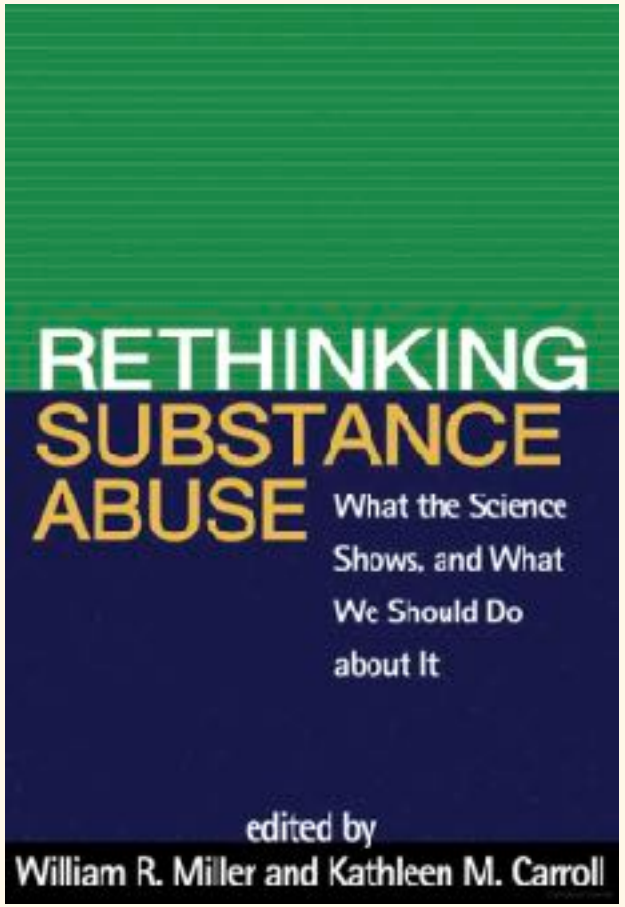


Two primary sources of evidence x2

- Central idea: Substance dependence is a chronic condition. But… unwarranted mystique has over-emphasised the importance of acute tx. As with other chronic health problems, successful resolution of SA depends on long-term behavioural self-management. It is not an isolated endeavour, to be delivered through specialist programs targeting only SA and delivered over an intensive timeframe.

- Purpose of the book: to distil decades of scientific research, funded by billions of taxpayers dollars. To give people/ communities access to that science.

- The challenge to each author was: suppose no brand-name treatments, no addiction specialists - using just the available science, where would you place your bets? Asked to summarise robust *principles* that could inform practice.



Note: Despite title, recognises behavioural addictions; evidence also applies to those.

1. Drug use is ‘chosen’

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
Emphasise self direction, effort and social skills development - ie assume **‘agency’.** **Expect client to take responsibility for their treatment**. Help them develop a greater sense of self-efficacy for change. Help the client become aware of repetitive patterns of thinking and behaviour that perpetuate substance use and learn alternative coping skills to manage these dysfunctional thoughts and behaviours	**Drug use is chosen behaviour. Don’t view drug users as individuals incapable of choice**. Drug use is influenced by the same principles of learning & motivation that shape other human behaviour. Effective interventions ‘only’ facilitate and (perhaps) speed up natural change processes. There is evidence that change frequently involves a ‘click’/ decision/ turnaround - (ie ‘rock bottom’. (Think of disruptive changes in nature - erosion of rock-face vs avalanche).

2. Think long-term/ long-haul

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
Viewing SUDs as chronic/ relapsing conditions suggests the need for a long-term perspective on change and maintenance. Length of treatment and continuity of care are significantly related to positive tx outcomes. The intensity and length of treatment should be determined by the severity of SUD; **those with severe alcohol dependency have better outcomes with more intensive initial treatment and respond most positively to treatment that focuses on 12-step** counselling and involvement with 12-step groups.	**Stick with it and be ready to vary the treatment.** An unsuccessful outcome is a failure of treatment, not the patient - try a different approach.

3. Client motivation is the key

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
In general, client readiness to change is associated with greater treatment success, (also remember, greater severity of the SUD, the poorer the response to treatment). Focus on motivation is crucial to outcome. Help clients develop awareness of repetitive patterns of thinking & behaving that perpetuate use. **Clients with positive expectations have better outcomes - therapist should work to enhance them**.	**Motivation is central** People who stop drug use often refer to a choice/ decision point/ life events as instigating change. So aim to enhance motivation and commitment to change. Brief motivational interventions can and do often triggers change, effectively tipping the balance. (Don't wait for 'rock bottom'). Better outcomes follow from attending more sessions/ staying longer in treatment/ going to more 12-step meetings. ('It works if you work it', appears to be true).

4. Therapist skill matters - build the alliance, via ‘accurate empathy’

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
Work calls for finely honed therapeutic skills - these predict tx outcomes. (But, therapists in recovery do no better than those not). **Addiction specialists have better outcomes than primary care providers.** **Alliance is crucial – accurate empathy & respect for client’s experience - provide goal-directed, semi-structured tx, which titrates challenge and works with ambivalence.**	**Therapist/ client relationship matters.** When randomly assigned, clients of counsellors who are higher in warmth and accurate empathy show greater improvement in tx outcomes (even in manualised tx). **Strong stance useful, but confrontation that puts clients on the defensive is not.** **Make services easily accessible and welcoming** (people do what is rewarding/ attractive to them). Make services **available at convenient times** (eves/ weekend). Avoid waiting lists & several layers of screening/ assessment.

5. Drug problems don’t occur in isolation - treat the whole problem

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
Substance-use disorders exist in complex web of social forces. **Tx may not be effective unless attention is paid to reshaping the social environment - ie involvement of significant others who support change, such as family and peers (esp in adolescence).** Individuals able to establish and maintain relatively positive social contexts are more likely to recover. **Clinicians should address other social services/ medical care needs.**	**Drug problems occur within a family context. In general, the later a child starts using substances, the lower the risk of progression. Parental disapproval of drug use is protective**. Family involvement in religion/ other conventional activities is a strong protective factor - particularly in counterbalancing peer-influence in adolescence. **In adulthood, having a meaningful role in society is a protective factor**. Unemployment, divorce, and social isolation all increase the risk of drug use.

6. Coping skills & social skill are essential to recovery

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
Effective tx is clear and well organised & provides a supportive and emotionally expressive environment, emphasises self-direction and social skill development. A social network supportive of abstinence should be promoted. Plus skills to generate and maintain that (and skills to deal with <u>those in social network who *support* continued use).</u> Involve stable, non-using partner.	Most **salient 'dynamic' protective factor is having close, positive relationships with people who are not using drugs**. To achieve this, **social and other coping skills need to be encouraged/ taught.** Effective prevention and tx approaches address coping skills & promote '+' relationships. Having a meaningful role in society is a protective factor. Unemployment, divorce, and social isolation increase the risk of drug use. Clients may need help with skills to regain role in society.

7. Take comorbidity seriously

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
Modifying treatment for clients with different presenting characteristics may improve outcomes - 50% of those with SUD have another comorbid disorder. Research on **differential treatments for women versus men, for eg, is quite limited**.	**Drug problems** do not **occur** in isolation, but **as part of behaviour clusters.** **Drug use usually represents one of a larger clusters of life problems associated with psychological difficulties - and is usually accompanied by one or more other diagnosable mental health conditions**. Drug use occurs in the context of life problems, and **abstinence is often well down the client's list of priorities**. Tx that targets broad range of life functioning is most successful.

8. Drug use emerges slowly, then becomes self-perpetuating... kick-start recovery via abstinence

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
"90 in 90" advice/ expectation in 12-step recovery buttresses this intent – involvement in an alcohol and drug free social environment is key. **Be directive and problem/ solution-focused in therapy**.	Dependence emerges over time. In general it's easier to back out of drug use earlier, at less severe stages. **A well-established pattern can be interrupted via initial period of abstinence.** Once drug dependence is established, it often becomes self-perpetuating. A period of abstinence destabilises this and can jump-start change. **The longer absence continues, the more stable it becomes. Invite client to consider chosen specific period of time to try out abstinence.**

9. Find compensatory pleasures

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
Rearranging consequences of use to maximise contingent reinforcement. **Even more simple: New friends in AA.** Involve significant others. Help restructure social environments to include support and connection. Attend to the affective experiences of the client, esp in relationship to the substance. **What was the drug doing for them? It was fun at first!**	**Stopping use eliminates a source of positive reinforcement. Long-term change involves finding compensatory satisfactions/ alternative sources of reward.** Don't just focus on taking away drugs = more miserable. **Organise treatment around developing meaningful/ rewarding life - establish social connection (12-step = readily available source of social support).** (Meds can reduce the 'pleasure/ reward' of drug use - principal problem is compliance. But also think of MI (what are the consequences of continued use/ what's the value of stopping).

10. Use MI for inevitable lapses in motivation/ relapses

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
Use MI/ MET to explore and promote motivation. **Motivation isn't static. Relaspsing is a fact. Work *<u>with</u>* it!** % of patients completely abstinent - the traditional gold standard for alcohol tx - was less than 50% at each follow-up (**in Project MATCH**), suggesting that although patients drunk much less and much less often after post-tx, the **majority never achieved or maintained abstinence.**	MI is a person-centred, goal-oriented approach to facilitating change which explores & tries to resolve ambivalence. **Clinical trials support use of MI.** Typically 1-4 sessions. **Evoke clients own statements of desire and commitment to change**. Use as prelude and an adjunct. **Confrontation doesn't work. Purposeful stance does. When clients are in denial: "You don't see a problem, but what do you think your children would say or like to be different, (or partner/ co-workers). Asking clients to reflect on others view allows them to acknowledge other views and difficulties with their stance, without immediately owning them/ & defending against them.**

11. 12-Step ‘works’

Principles of Therapeutic Change: Eds Castonguay & Beutler	Rethinking Substance Abuse: Eds Miller & Carroll
Educational films, family interventions, and general alcohol counselling largely ineffective. Project MATCH found 12-step approaches comparable to MET (Motivationally Enhanced Therapies) and CBT. **12-step more effective at maintaining continuous abstinence during follow up.** (Trial was 1/ wk as outpatient. There is no RCT on inpatient-intensive). ‘Disease with no cure’, needs continuous treatment.	**Project MATCH, the largest RCT of alcohol treatment ever conducted** (1726 patients), examined the efficacy of 12-step tx compared to CBT and MET. **Patients in 12-step tx were significantly more likely to remain continuously abstinent** than patients in the other treatments – by difference of 11 percentage points. This **effect persisted three years after tx.**

NICE Guidelines 2020: National Institute for Health and Care Excellence

Evidence-based independent up to date guidance for people providing, commissioning, and using public health and social care services.
https://www.nice.org.uk/guidance/cg51/resources/drug-misuse-in-over-16s-psychosocial-interventions-pdf-975502451653

- **Pharmacological approaches are the primary treatment for opioid misuse, with psychosocial interventions providing an important element of treatment. Pharmacological treatments for cannabis and stimulant misuse are not well developed - psychosocial interventions are the mainstay of effective treatment.**
- People who misuse drugs should be **given info about self-help groups. These groups should normally be based on 12-step principles** (staff should consider facilitating the persons initial contact and/ or arranging transport or accompanying them to the first session)
- Staff should explain options for abstinence oriented, maintenance oriented and harm reduction interventions. Do so by considering the service users previous treatment, **goals in relation to drug use, and treatment preferences**.
- Establish and sustain a **respectful and supportive relationship**
- Help the service user identify situations and states when vulnerable to drug misuse and explore **alternative coping strategies**
- Staff should **discuss whether to involve families/ carers** in their treatment – ensuring the service users right to confidentiality
- Interventions should **offer incentives** – ie **vouchers for goods/ services**, contingent on drug negative test (**'Contingency Management'**).
- Incentives need to be meaningful to the client, target should be agreed, relationship between goal and incentive should be understood, and incentive should be aimed at changing/ reinforcing a specific behaviour (not a reward for general good behaviour).
- Contingency management involves offering incentives for abstinence (usually on presentation of negative urine test) or reduction in illicit drug use, or participation in health promoting interventions (ie attending a hep C test),
- The aim is to reinforce positive behaviour, consistent with current knowledge about the underlying neuropsychology of many people who misuse drugs - that is more likely to be affective than penalising negative behaviour.
- **Behavioural couples therapy should be considered for people who have a non-drug misusing partner. Therapy should focus on drug misuse**.
- Psychosocial interventions can improve concordance with naltrexone tx (an opioid antagonist which eliminates '+' experience of opioid use).
- **Evidence-based psychological treatments** – in particular CBT, should be considered for the treatment of comorbid depression or/ and anxiety - for people who misuse cannabis or stimulants and for those who have achieved abstinence, or are stabilised on opioid maintenance treatment.

(Emphasis in bold, added throughout)

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12-step evokes strong feelings…

The world's biggest support group

Advocates claim millions get clean

Group on every corner/ every hour of the day

Cheap

Used in almost every residential rehab in the world - even those that cost $$$

But…

Feels like a cult

God/ Higher Power puts many off

Insistence on abstinence (not harm reduction)

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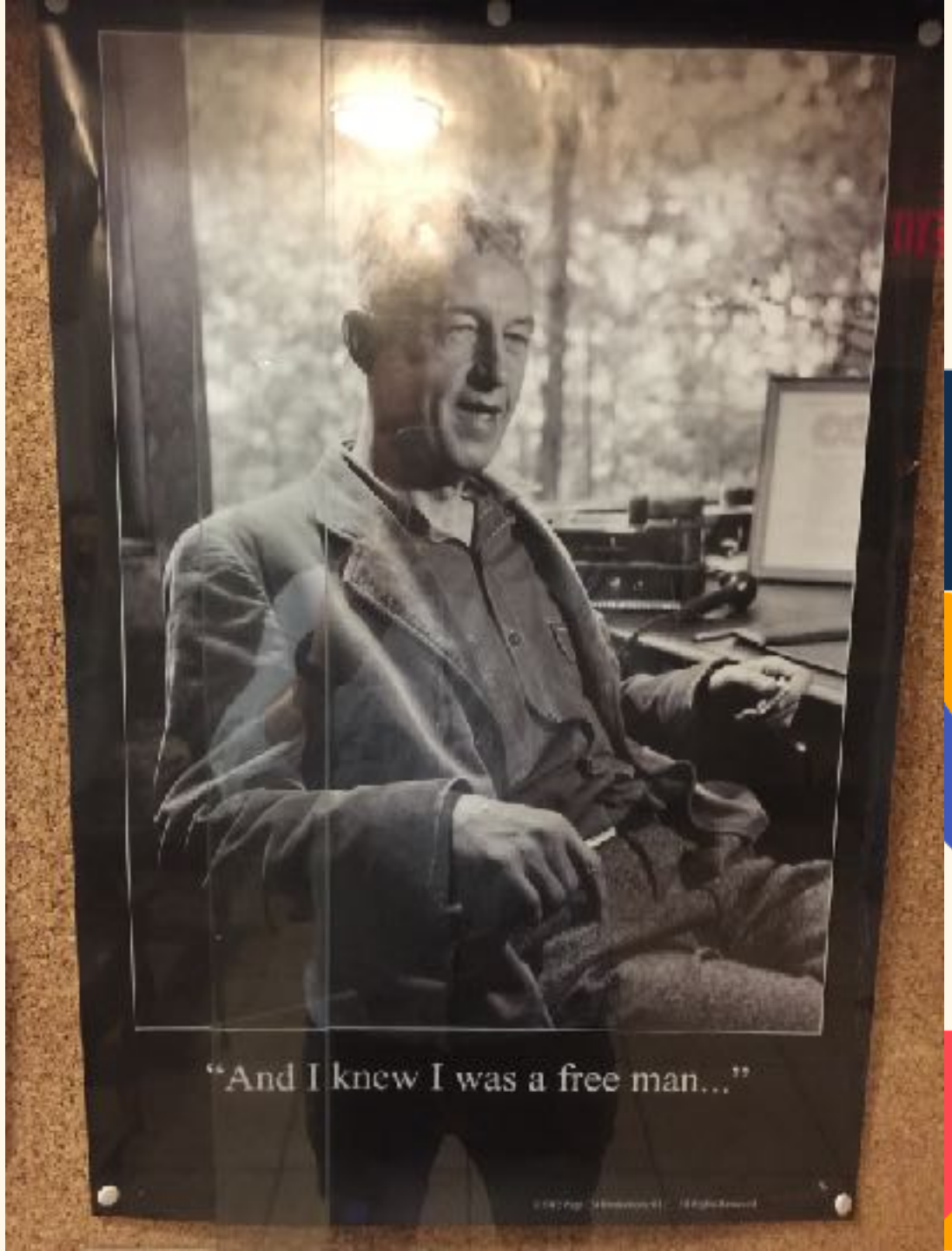
This unhip, cliched AA thing. So unlikely and so unpromising. This goofy slapdash anarchic system of low rent gatherings and corny slogans and hideous coffee is so lame you just know there's no way it could ever work except for out and out morons.

(David Foster Wallace).

Bill W

- Founder of AA (with Dr Bob).
- Would agree with DFW!
- Story of his recovery is worth reading - first story in AA Big Book
- Bill W describes himself having a spiritual awakening - finding a power greater than himself.
- For many, thats quite ordinary: God = Group of Drunks, the fellowship, connection, nature, or the bus or uber that took them to the mtg.
- For many, it's the opposite of a selfish life. A life of service to others.
- Miami Beach - died of pneumonia and emphysema
- ~~Honorary degree from Yale/ cover of Time magazine~~
- Hero of the C20th: Rosa Parks, Anne Frank, Emmeline Pankhurst, Mother Teresa.



12-step

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Recovery is about what you're going to do, as much as what you're no longer going to do. What you 'take up' vs what you 'give up'

"Alcohol" etc isn't the problem. Sober-living is the prob. If you just stop drinking/ using it makes things worse.

Dr Steven Hyman (Prof of Neurobiology/ previous Director of NIMH): we have to come up with things that will deliver compensatory pleasure - a requirement that it's tough to get the medical world to accept. A.A. understood this. Drugs approved for decreasing craving in alcoholism often don't work because they block and suppresses, but don't give something back. Altruistic activity affects the brain like drugs do. AA understands this.

Kurtz: The Higher Power of AA is the life of service, to others. Something beyond yourself. You are not the most important person in the universe. You are 'not God'. You are connected to others. The truth of a good life is interconnection. You didn't teach yourself to breath. You didn't grow the food you eat. You are here be connected, dependent on others and attached. You are here to contribute, to play your part. (Not God: A History of Alcoholics Anonymous).

The path to recovery is service to others. Learn how to ask for help and support from a community; learn how to give your help to others. It's not a sacrifice or obligation; it's a joy.

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12-step or not?

- AA and other 12-step programs provide a predictable and consistent holding environment.
- Through their identification with others in the same position, addicts come to accept themselves - they are not uniquely bad, as they once supposed.
- We've also seen the evidence, via Project MATCH

But…

Feels like a cult

'God/ HP' puts many off

Insistence on abstinence (not harm reduction)

There are alternatives, such as SMART - which some see as more 'science-based'.

Summary and take away

From all that information, what's our top three…?

✓ **Pause and review the table of information…**

Summary and take away

From all that information, what's our top three…?

- ✓ **Don't *immediately* refer - it's like other psyc problems (& often comorbid with them). Think/ read/ feel your way in - aim for accurate empathy.**
- ✓ **Emphasise connection & use session time to consider practical ways to increase/ create it. 12 step = readily available community of like-minded. *Which meeting and when?***
- ✓ **Take an active stance. Teach social skills. Promote period of abstinence. Use MI to explore (inevitable) ambivalence. Relapsing is a fact. Work with it.**

Addiction as a microcosm of classic human dilemma/ psychological problem…

... ie why do we persist in patterns of behaviour that lead to harmful consequences?

The use of substances is just one manifestation of the timeless trade-off of immediate gratification vs our long term welfare.

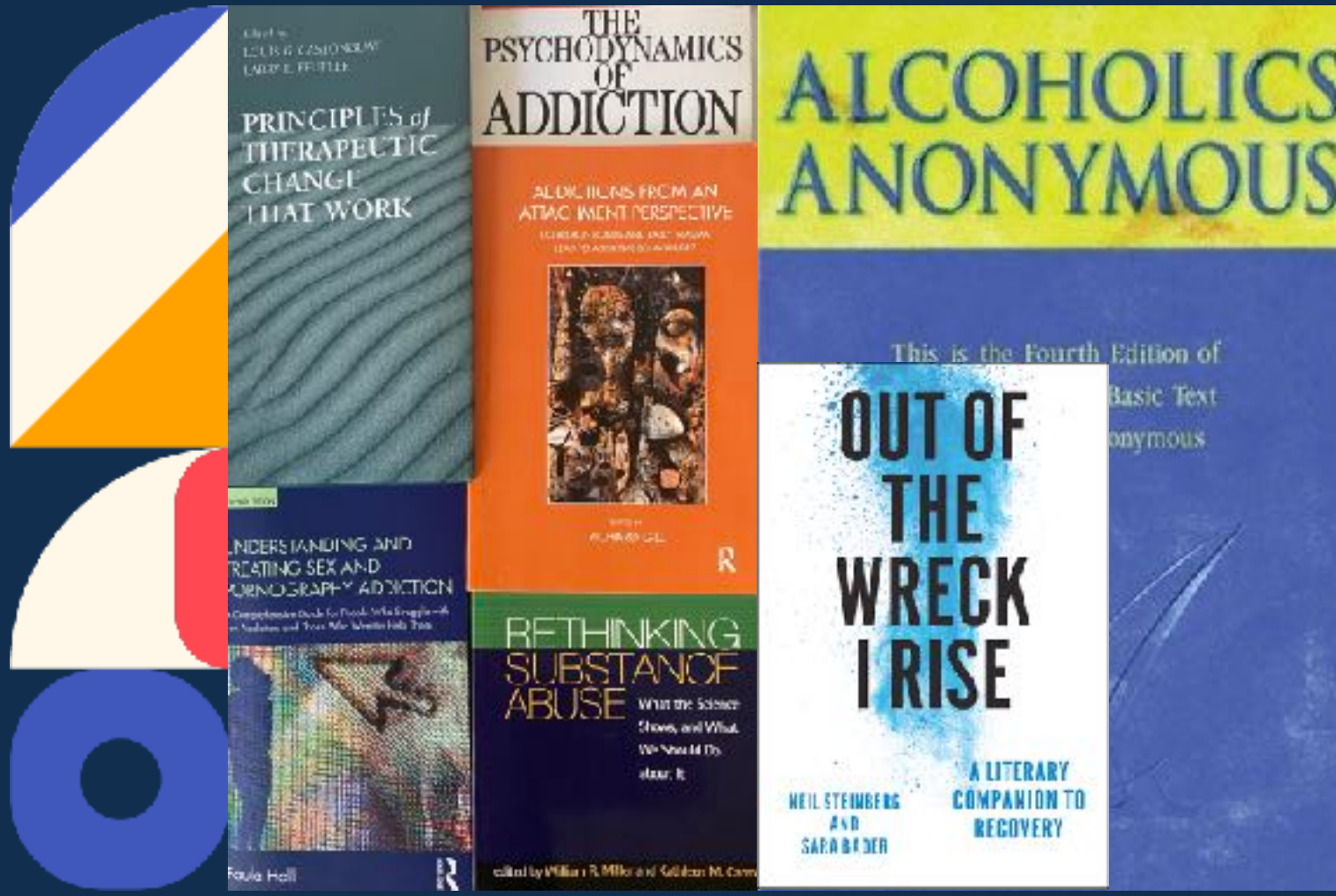
Similar underlying vulnerabilities could emerge as SUD in one person, as depression and isolation in another, anger and aggression (or even criminal behaviour) in another.

The principles and frameworks for intervention we've looked at are not specific to problems associated with substance use - they apply to a broader range of human problems.

Further reading/ next steps:

Rethinking Substance Abuse - Miller and Carroll
Principles of Therapeutic Change That Work - Castonguay and Beutler
Motivational Interviewing - Miller and Rollnick
Addictions from an Attachment Perspective - Gill
The Psychodynamics of Addiction - Weegmann and Cohen
Mindfullness & Acceptance for Addictive Behaviours: Applying Contextual CBT to Substance Abuse and Behavioural Addictions - Hayes & Levin
Understanding & Treating Sex and Pornography Addiction - Hall
Out of the Wreck I Rise - Steinberg & Bader
AA Big Book

<u>Next steps:</u>
Read/ watch/ think - earlier slide
Visit/ help out



Last word goes to…

My identity shifted when I got into recovery. That's who I am now and it gives me greater pleasure to have that identity than to be a musician.

It gives me a spiritual anchor. Don't ask me to explain. (Eric Clapton).

I had not thought of myself as a person who could choose…

…. Freedom was a terrible prospect, exhilarating and terrible. (Claire Messud).

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Thank you for your time!

More workshops at…

lcap.co.uk

Attachment

Challenge in Therapy

Neuroscience

And more…