Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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EDITORIAL

Welcome to the new look edition of the Addiction Treatment Research Newsletter. Now that this is largely an online publication, we have changed the format to make it easier for online reading. I hope you find this format more satisfactory and, of course, welcome any comments or suggestions you may have about this or any other aspect of the ATRN.

Although the format of ATRN has changed the regular content has been maintained to keep you up to date with addiction treatment research and some of the associated events happening in Aotearoa New Zealand.

This issue as always begins with a report from ABACUS' Sean Sullivan. In this issue Sean provides a great review of the pros and cons of treating multiple addictions simultaneously. With this evidence base in mind practitioners are urged to review their own current practice.

Simon Adamson, deputy director of research at the National Addiction Centre, provides an update of research activities at the centre, while highlighting the importance of careful planning and patience when designing research studies. As Simon points out, such forethought can lead to great things for the researchers who designed the original study as well as for other researchers and those in the wider sector for many years to come.

Dr Robin Shepherd, lecturer at the University of Auckland, writes about some of the research she has been doing in relation to getting undergraduate students to engage in reflective practice while completing their course assignments. This research not only revealed how useful reflective practice is as an educational tool for individual students, it also highlighted how it can be a useful process to alert teachers to gaps in knowledge/understanding that they need to work on. Although only a brief version of this article is presented in the ATRN, readers should be alerted to the fact that Robin will be presenting this research in more detail at this year's Cutting Edge conference.

Speaking of Cutting Edge, Klare Braye in her report as the Chair of the Addiction Treatment Research Interest Group (ATRIG) encourages all ATRIG members to attend this year's Cutting Edge conference and, even more importantly, to attend the ATRIG AGM which will be held at the conference. The conference and the AGM provide a great opportunity to meet others interested in research (you don't have to be doing research to be involved). So come along and bring any others you know who are interested in addiction treatment research.

The annual updates from the Dunedin and Wellington schools of medicine indicate a high level of addiction treatment research activity at both schools. Helen Moriarty reports how Wellington, in particular, is working hard to establish strong networks of interested researchers and is successfully gathering these parties together by arranging a number of meetings with top class speakers. Dunedin's most recent focus has been on "informal coercion" with Gavin Cape providing an overview of an extremely interesting study that he and his colleagues have recently received funding for from the Health Research Council. This mixed method study promises to produce some interesting findings and we look forward to bringing you more information as it progresses.

Finally, as spring appears and to end this edition of the ATRN, we turn our thoughts to the topic of 'love'. This is a topic that Joel Porter has recently been thinking and reading a lot about. Love might seem like an unusual topic to be discussing in the ATRN, but as Joel so eloquently points out, although it is not commonly written about in relation to addiction treatment, love is certainly something that deserves much more attention both in our practice and in our writings.

My many thanks to all the writers who have contributed to this edition of the ATRN, without people willing to write about their work, this newsletter would not be possible. I would also like to thank Lisa Andrews who tirelessly does such a wonderful job in formatting the ATRN. I hope you appreciate her efforts with this new look version as much as I do.

Happy reading.

Ria Schroder
Editor, August 2009

AOD, Tobacco Use and Problem Gambling: Any Connection?

"The present is a point just passed"
(*David Russell)*

In a busy practice those working with clients presenting with a specific addiction may have some reluctance to head off into enquiries about other addictions for a range of possible reasons. These could include:

- Insufficient time to address all possible issues, especially non-core, less important ones.
- Providing information about referral following completion of treatment may be sufficient.
- It may be confusing for the client to address two or more addictions contemporaneously, especially if at a different service.
- Addressing the presenting reason is sufficient as they have prioritised it and it is a client-centred approach, while identifying other problems may be demoralising for the client.

In the absence of information that supports the importance of addressing co-existing addictions, it would be easy to support one or more of these reasons for leaving other addictions out of the screening, assessment or treatment plan. Clients with addictions often present with a myriad of issues affecting their lives, including high levels of other, serious, mental health conditions, and it can be difficult to know where to draw the line, especially in assessment. Assessment processes may be relatively comprehensive, but remain a compromise, based upon evidence of conditions known to coexist with our particular addiction treatment focus, funding specifics that seek to avoid duplication of service provision, practitioner skills, and even attitudes of 'what our role is'. Perhaps the most important of these should be what evidence supports reasons for inclusion of other addictions in our assessment and treatment.

Alcohol & Tobacco

Tobacco use is common in those affected by alcohol, with 80%-90% of alcohol dependent people being smokers, and 70% of these being heavy smokers (NIAAA). Statistics indicate that more alcohol dependent people die of tobacco-related illness than alcohol-related problems (Hurt 1996). Evidence suggests that alcohol and tobacco use combined, substantially increases risk of certain cancers (Pelucci 2007). Studies indicate that tobacco and alcohol together are synergistic, augmenting the pleasure experienced by either drug alone (Barrett et al 2006; Rose et al 2004). Both drugs act on the mesolimbic dopamine system, the part of the brain involved in reward, emotion, and cognitions, with their interaction thought to occur in the nicotinic receptors, such that when these are blocked, people consume less of both nicotine and alcohol (Corrigal et al 1994; Soderpalm et al 2000). In addition, cross tolerance can occur between nicotine and alcohol, with tolerance in one resulting in tolerance to the other (Funk et al 2007). From a treatment perspective, research suggests that quitting smoking may decrease the likelihood of treated alcoholic dependent people relapsing (Hughes et al 2003). Whether to treat both alcohol problems and smoking simultaneously has mixed research findings, however, the National Institute on Alcohol Abuse and Alcoholism have stated that these findings may be an artefact of what is considered 'concurrent', and simultaneously delivered treatment for concurrent addictions is the most effective approach (NIAAA 2007).

Alcohol & Gambling

The co-occurrence of pathological gambling with people affected by substance use disorders has ranged from 9% to 30%, and substance abuse in pathological gamblers from 25%-63% (SAMSA 2005). In NZ, one in five clients attending AOD services has been found to be experiencing a gambling problem, with the majority severely affected by both AOD

and gambling (Sullivan et al 2006). High levels (17.3%) of gambling problems and alcohol misuse have been found in NZ in those admitted to hospital following a suicide attempt (Penfold et al 2006). In a recent study, Kessler et al (2008) identified from a large sample (n=9,282) that two thirds of those with substance use disorders with coexisting gambling problems were affected by the substance use disorder prior to the gambling. This may indicate a higher risk for those with AOD issues for gambling problems, a factor also to be possibly addressed in AOD treatment plans.

Gambling & Tobacco

Tobacco use with problem gamblers has been found to be elevated with severe problem gamblers (Smart & Ferris 1996: 41.6%; Petry et al 2005: 60% nicotine dependence), and even higher in NZ, with rates of smoking increasing during gambling (Sullivan & Beer 2003: 67%). Legislation may have reduced the ability to smoke and gamble contemporaneously, but the process indicates that some inter-effect is occurring.

Alcohol, Gambling & Tobacco

The British Gambling Prevalence Survey (2007) of 9003 adults over 16 years of age, identified that cigarette smokers were more likely to have recently gambled than non-smokers, were over three times more likely to be a problem gambler, that alcohol use (particularly heavy drinking) was significantly associated with recent gambling, and that those with poor health were over three times more likely to be having gambling problems. The interaction between AOD, alcohol and gambling is gradually being unwound, but currently is incompletely understood. A large recent study has identified that nicotine influences the associations between gambling and multiple psychiatric disorders, but that further research is required to apply this to best practice treatment (Grant et al 2009). Petry (2005) has stated that problem gambling has both genetic and environmental risk factors, and that 'the consistent association of pathological gambling with substance use disorders may suggest that the two disorders share some genetic linkage' p120. Other shared biological possibilities may be the orbitofrontal cortex (OFC), which is the part of the prefrontal cortex that is not only involved in decision-making processes, but also in emotional functions (reward, punishment), as found in the limbic system. Injury to the OFC is associated with disinhibited behaviour, including AOD and problem gambling (Hardin et al 2009; Snowden et al 2001).

However, biological connections between these addictions may not explain the relationship, or may only explain part. Addictions can interact through psychological reinforcement and learning. For example, gamblers who smoke may find that, while gambling, smoking allows them to concentrate more and exclude intrusive negative cognitions, while also reducing the negative aspects of arousal. Following a substantial loss, a problem gambler may find that heavy alcohol use is a relatively low cost way to reduce anxiety and cognitive withdrawal effects, or alternatively, alcohol use may stimulate the desire to gamble (Griffiths et al 2002). A further possible pathway for multiple addictions is through substitution. Substituting another addiction for one discontinued may provide the comfort needed to address the negative effects of stopping the first addiction, perhaps after treatment. Research has shown that problem gamblers who had received prior treatment for substance abuse were more likely to have greater problem gambling severity and psychosocial problems, when compared with problem gamblers who had not received substance abuse treatment (Stinchfield et al 2005). This may indicate that successful AOD treatment places clients at greater risk for gambling, perhaps through substitution. Certainly, the current environment in NZ contributes through the policy of often selling alcohol and gambling at the same venues, thereby assisting in opportunities to adopt one for the other, unless this possibility is addressed during treatment.

An integrated model of treatment for multiple addictions

Although further research may be beneficial, there is support for an integrated treatment approach:

> *'The ideal treatment of clients with multiple addictions, just as of clients with dual diagnosis, is integrated. The treatment centre or agency has the expertise to treat all the various addictive and psychiatric disorders, and tailors an integrated program with combined, sequential, and concurrent elements that is individualised for each client' (Schneider 2005).*

Work is currently underway to align the competencies of AOD, tobacco cessation, and problem gambling practitioners. The current evidence supports practitioners in each of these fields having at least some core knowledge and skills of the other two addictions, as well as other common conditions, such as depression and anxiety. What comprises this level of knowledge/skills has yet to be determined and is part of the competency process, but in addition, the buy-in or attitude of practitioners for competencies is an important factor. The

information above may well provide some evidence that answers some of the four concerns or beliefs raised at the beginning of this article. Effective outcomes may require composite skills to identify and intervene in these often coexisting addictions, and for us to focus only upon our own addiction field, may short-change our clients, and consign us to output focus, with the inevitable 'revolving door' treatment. This new direction appears to be evidence-based, and for many practitioners, formalisation of practice elements they already provide to their clients, and will provide vindication for their approach.

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NATIONAL ADDICTION CENTRE REPORT

Since the last ATRN we at the NAC have continued with all of the things outlined in the last report. Progress has been steady on the various projects with which we are involved. Patients continue to be recruited, grant applications are being revised, we continue to wait for the Ministry of Health to release our report on barriers to opioid treatment in New Zealand and the various research staff at the NAC continue to work on papers for peer reviewed publication, a number of which are currently under review.

Research is a long-term activity. While opportunities occasionally arise which can be undertaken from start to finish within a year more commonly research projects take much longer, potentially many years, from generation of the initial idea, refinement of the research questions and planning the research methodology, to seeking and gaining both funding and ethical approval, data collection, write up, publication and dissemination.

This long time frame can present considerable challenges for managing workload. However it is also hugely satisfying to be involved in a project, particularly as part of a team, which spans such a long period.

The longest running research activity undertaken by the NAC was/is the Brief Treatment Programme for Alcohol Dependence (BTP) a randomised controlled clinical trial which compared motivational enhancement therapy (MET) with two control conditions. Funding for this study was secured in 1996, while recruitment, treatment and data collection up to the six-month post-treatment follow-up occurred between 1997 and 2000, with the primary outcome paper published the following year in the Journal of Studies on Alcohol. Since that time a further seven papers have been published, including one reporting on five-year outcome data. A ninth paper was recently submitted by Samadhi Campbell summarising findings from her completed Masters degree examining the relationship between client language during MET sessions and treatment outcome. A tenth paper will soon be submitted by PhD student Deirdre Richardson examining therapeutic alliance and treatment outcome. Furthermore, we have recently been in communication with researchers in the USA who are interested in potentially collaborating on some secondary analysis of our data for a further paper. So the BTP's lifespan is 13 years and counting, and this does not include the two years or so that was spent discussing the ideas behind the study before funding was secured.

The ongoing publication of data from the BTP is an example of the benefits of putting a lot of energy in to conducting a large well-run study and the many opportunities that the resultant data set present for future researchers. Not only does such a study provide the opportunity to examine a number of secondary research questions planned prior to data collection it also provides the opportunity to answer questions not considered by the investigators during the initial planning stage. Such post-hoc "data mining" can lead to publications of value within academia and the clinical world and require considerably less time and money compared to undertaking a research project from scratch. To date the BTP has provided data for two completed masters theses and two PhDs, one completed (my own) and one ongoing (Deirdre Richardson). There's no doubt that the BTP and other studies completed by the NAC and other research units around the country contain answers to many as yet unasked research questions.

Dr Simon Adamson
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REFLECTIVE PRACTICE AMONGST STUDENTS LEARNING ABOUT ADDICTIONS IN HIGHER EDUCATION

As a lecturer in the 'communities and addictions' paper within the health science sector at the University of Auckland, I felt that it was important to employ reflective practice amongst undergraduates studying addictions. This was especially important given that these students will be working in the health sector encountering people struggling with addictions.

This course introduced five addiction models (e.g. disease model) followed by related public health approaches (e.g. minimizing gambling harm). The paper provided a balance of speakers (e.g. Alcoholic Anonymous members, academics, and treatment providers) offering their expertise.

The students were instructed to write two essays followed by a 500 word reflective piece on what they learned while writing this essay. According to Boud's model, reflective practice is a combination of cognitive and emotional experiences occurring in or outside the classroom while assimilating one's past knowledge and experiences [(1)].

The first assignment required students to, 'critically evaluate the disease model' and the second to 'critically evaluate a public health approach to gambling, substance use, eating disorders, or smoking'.

The students were given a presentation on writing reflectively to prepare them for writing this piece. The data were collected by detaching the reflective pieces from the main essay when the grades were final. Students' identification details were omitted from the reflective pieces to ensure anonymity.

The aim of the study was to examine the reflective pieces for emerging themes. Due to the space limitation in this article, only the themes that emerged from the public health approach essays will be featured. Details of the full article can be found in an upcoming issue of the International Journal of Mental Health and Addictions.

The following quotes from the students' reflective pieces supported the emerging themes. These were: Personal, Responsibility, Cultural, and Academia.

Public health- Reflective Practice Themes

Personal theme: This illustrated how the students vocalized their own personal thoughts regarding public health approaches.

> *Regarding drink driving advertising, I have identified aspects of 'tolerance,' knowing the road and luck as reinforcing factors in both my friends and my actions towards drink driving. Firstly, tolerance, by developing a tolerance towards large amounts of alcohol (beer 500ml, 5%), my orientation of movement, thought processes and actions were at a level which I could control. This means that my state of wellbeing after 16-18 bottles of beer was the equivalent of 2-3 beers. Therefore, internally I don't have a problem with drinking and driving as I can mentally and physically perform similar to a level of a sober state.*

This quote clearly demonstrated how important reflective practice can alert the lecturer as to how the students are digesting information. This allowed the lecturer the opportunity to clarify this misinterpretation regarding alcohol tolerance. The lecturer provided this clarification in the next lecture as others may have interpreted the information in the same way, too. It also raised the issue that we cannot safely assume that education alone will minimize harm.

Responsibility Theme: This illustrated who should be responsible for potentially addictive problems in the communities within the context of public health.

> *Public health also emphasized the importance of citizen participation in decision making for better policies by policy makers. This gives citizens democracy and such channels for being proactive which builds self-*

efficacy and empowers citizens to advocate for relevant policies. This is unlike policy makers who take a top down view which poses a bias on policy making as they fail to comprehend the needs of communities.

Long term approaches can be done in community settings involving the whole community to form a 'maintenance programme' of having to constantly distribute information, share, and help one another.

This quote along with the other students' reflective pieces illustrated that many of the students became aware that public health is a collective effort within communities.

Cultural Theme: This illustrated how one's cultural background influences one's perspective on public health approaches.

Nevertheless, the public health comprehensive approach is feasible as New Zealand has a wide range of ethnicities and to fully address every ethnic groups' problems, public health approaches need to be culturally sensitive and flexible.' 'For the Chinese community, for example, information can be distributed and posted on the Chinese community websites. Information to create awareness is important especially for the Chinese community as shame is a crucial barrier to seeking for help. Information also forms them that gambling can be a problem even though it is part of the culture, and they should help their members rather than shutting them away.

Many students pointed out that cultural needs should be addressed if public health approaches are to be successful.

Academic Theme: This illustrated how the students' reflective practice was an incentive to deeper learning.

Initially I considered myself to be vastly familiar with the numerous public health approaches that currently exist in New Zealand today, due to my knowledge gained during the course of my health science degree. I thought I fully understood the 'ins and outs' of what public health exactly is and its role in society. However, it was during the research phase of this experience that I truly was able to assess how deeply I understood what public health is and in doing so, I was able to crucially evaluate a public health approach of my interest.

This quote also described how the students were required to focus on research articles and its methodology to refute or support their points. This approach is considered a powerful practice for reflective practice [2].

Conclusion

These findings highlighted two important points. First, reflective practice has allowed the students to learn on a deeper level both academically and personally. Consequently, this finding supported Boud and colleagues (1996) [1] model that reflective practice is the assimilation of affective and cognitive components. Such assimilation of these two components is vital for those who expect to work in the health field particularly addictions.

Second, the quote from the student on drinking and driving highlighted a concern that education is not an intervention on its own right. Reflective practice is one option to include in education intervention schemes to assess whether or not the information being put forth is taken within its correct context.

References

1. Boud, D., Keogh, R. & Walker, D. (1996). Promoting Reflective Learning model. In *Boundaries of Adult Learning* (Eds.) R. Edwards, A. Hanson, Raggatt, P. New York: Routledge.
2. Williams, D. & Coles, L. (2007). Educational Research. Teachers' approaches to finding and using research evidence: an information literacy perspective. *Educational Research*, 49 (2), 185-206.

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MESSAGE FROM THE CHAIRPERSON

With the Cutting Edge conference looming fast this is an exciting time of year for the addictions field. If you haven't already registered or talked with your manager/colleagues, the date to mark is Thursday 9th through to Saturday 12th September. This will be the 14th Cutting Edge and the first time that DAPAANZ (Drug and Alcohol Practitioners Association) is hosting the event, this year being held at Te Papa, Wellington. With the theme 'Our Place, Our Future', we wish them well. I understand that there has been much hard work and dedication to the cause in the organisation and development of the programme. There are meetings arranged for Wednesday the 9th, the 'gathering' dinner being held on the Thursday night, speakers, abstracts, presenters and posters selected for the Thursday and Friday, and the final day, Saturday rounds off the proceedings with workshops. With the sponsorship and support of ALAC, the Ministry of Health, Mental Health Commission and The Drug Foundation this is bound to be a great event for all in the addiction field, be it alcohol and drugs, nicotine cessation, gambling, mental health workers or public health.

Cutting Edge is also the time of the Addiction Treatment Research Interest Group's Annual General Meeting, This will be held on Thursday 10 September at 1.05pm in Rangimarie 3, Telstra Clear Centre, Level 3, Te Papa, Wellington. Whilst the meeting itself has a number of formalities that must be attended to there will be several of us available if you are interested in chatting about the role and function of ATRIG. We are basically a bunch of individuals who are interested, or even it might be said, passionate, about research. We are by no means all working in the research field, nor necessarily had work published (or even completed!). We can probably at best be described as an eclectic bunch of clinicians, researchers, students and tutors who are interested in research in addiction treatment. We work to produce this newsletter disseminating ideas of New Zealand research. We would love to get some fresh input and contributions from the field out there. I know that more abstracts were submitted than there are presenters for this year's Cutting Edge conference and I understand there is a great line up of posters, the information of which could further be circulated through this forum.

I look forward to seeing you there. Please, come and introduce yourself and enjoy the opportunity to share with your colleagues from around the country. In the mean time, work hard, enjoy life and look after yourselves.

Klare Braye
ATRIG Chairperson

MEDICAL SCHOOL UPDATE: WELLINGTON SCHOOL OF MEDICINE

Wellington addiction researchers have formed an informal collaborative network across multiple organisations in order to give addiction research greater visibility and uncover potential areas of mutual research interest. This collaboration already includes many players: the University of Otago, Wellington, Victoria University Wellington, the Medical Research Institute of New Zealand, ESR, Wellington Health and Biomedical Research Society, the NZ Drug Foundation, and Capital Coast DHB. Representatives of these organisations meet several times a year to discuss addiction research projects and progress. The next meeting is being widely promoted as a seminar with an addiction focus to draw out other interested researchers and potential researchers. Speakers for the upcoming meeting will include Simon Adamson from the National Addiction Centre and Maria Belringer from Auckland. University of Otago, Wellington is also looking forward to the visit of Prof Barry Jackson, Graduate Professor of Counselling and Director of the Drug, Alcohol and Wellness Network (DAWN), Bloomsburg University of Pennsylvania. Barry will be in NZ for a six month sabbatical from July 2009 during which time he will be available to share some of his research expertise with interested groups across the country. Barry will also be in attendance at the Cutting Edge conference which is to be held in Wellington in September.

Helen Moriarty
University of Otago, Wellington

Informal Coercion: What Is It, Is It Important - Read This Or Else…

Coercion within the mental health services is almost ubiquitous. Within the addiction treatment field in New Zealand there is the antiquated Alcoholism and Drug Addiction Act (1966) which would constitute a formal (legal) process for an individual to undergo treatment of an addictive disorder. Despite its problems the use of this act is relatively transparent in that there is a procedure to be undertaken which involves a judicial process and explicit acceptance by the sanctioned provider to provide treatment. However, coercion may be utilised in informal ways in order to elicit behaviour, satisfy a condition or modify an outcome. This informal coercion (sometimes called 'leverage') may be subtle e.g. clinician pressure to enhance treatment adherence or more overt e.g. cease taking benzodiazepines or your methadone treatment will be discontinued. Indeed one of the recognised addiction therapy paradigms utilises a form of informal coercion explicitly, albeit with noble intentions — Osher and Koefed's [1] 'engagement and persuasion' model of therapy. This is despite the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Regulation (1996) which states that a service provider has an obligation to the consumer to preserve "the right to freedom from discrimination, *coercion*, harassment, and exploitation". With the rise of drug courts one could postulate that there are legitimate reasons to use coercion as it is stated that "the crux of coercion is to motivate the patient to comply with addiction treatment by enforcing alternative consequences" [2]. Formal coercion is usually easy to identify although informal coercion is less recognised and more difficult to define [3]. It is thought that all forms of coercion albeit in the service of good "clinical goals is often perceived negatively because it clashes with important values such as autonomy, informed consent, and least restrictive alternatives" [4].

I am an investigator in collaboration with Dr Collings, Dr Mullen, Dr Stanley, Prof Burns and Prof Dawson in a recently proposed project entitled — *The Nature and Extent of Informal Coercion in Community Mental Health in New Zealand*. This has been awarded a substantial grant from the Health Research Council. This research will investigate the experience of informal coercion (IC) in NZ mental health services (including a sample of methadone treatment consumers and clinicians) and from other sources such as the Housing, Work and Income and Criminal Justice sectors. For the purposes of this research IC is defined as the use (outside a legal framework) of various strategies to influence a consumer's behaviour or adherence to treatment. The main aims of this research are to determine:

- What is the extent and variety of informal coercion (IC) experienced by three diagnostic groups of mental health consumers (people with schizophrenia, opioid addiction or personality disorder) over three District Health Boards?
- What are the socio-demographic, ethnic, clinical (including adherence), clinical relationship, service use and medico-legal correlates of receipt of IC?
- What strategies to foster treatment adherence are reported by key-workers? What are their attitudes to IC?
- How do rates of the various kinds of IC compare with results from the parallel USA and Oxford, UK studies?
- What are consumers' beliefs and attitudes towards IC, and how do they experience it in relation to the clinical relationship and their daily lives?
- What are key workers' beliefs and attitudes towards IC, and how do they experience it in the clinical relationship and in their routine practice?
- What are informal carers' beliefs and attitudes towards IC, and how do they experience it in their relationship with clinicians and in their daily lives supporting mental health consumers?

There are two arms to this project with the first being quantitative (e.g. the extent of IC). The second will use a qualitative framework to explore and report consumers', carers' and key-workers' perspectives on IC by engaging participants in in-depth loosely guided interviews using grounded theory principles. We hope to recruit over 400 participants for the first arm (of which 136 will be from opioid substitution treatment clinics) and 60 for the second arm divided between Wellington, Christchurch and Dunedin. The research is intended to take two years. We have been fortunate to have collaboration with a parallel research programme in Oxford, UK so that meaningful comparisons may be made between New Zealand and the United Kingdom.

There is a paucity of research on IC. One study [5] completed in the US found that approximately half of their psychiatric outpatient consumers studied perceived some kind of leverage as a means to accept or adhere to a

treatment. Perceived coercion can often lead to conflict, a not uncommon situation in opioid substitution treatment (OST) programmes with consumers sometimes referring to the provision of service as 'liquid handcuffs'.

Dr Adam Simms from Wellington (personal communication) recently addressed the National Association of Opioid Treatment Providers with a presentation entitled 'Persuasion, Inducement, Coercion or Threat? in the Methadone Treatment Service'. He included research by Monahan (1995) [6] that indicates that 'procedural justice' influences the perceptions of coercion.

> *"The amount of coercion a patient experiences in the admission process is strongly associated with the degree to which that process is seen to be characterized by "procedural justice." That is, patients who believe they have been allowed "voice" and treated by family and clinical staff with respect, concern, and good faith in the process of hospital admission report experiencing significantly less coercion than patients not so treated. This holds true even for legally "involuntary" patients and for patients who report being pressured to be hospitalized."*

Coercion is closely linked to a sense of self-autonomy or control over a situation. Patients that have some control over aspects of their illness (symptoms, course or treatment) adjust better than patients who believe they are helpless [6].

The significance of this research is to firstly define the extent of IC, develop a greater understanding of this phenomenon and finally refine clinical practice leading to greater mutual participation in health discourses, increased treatment adherence and reduce suffering and disability.

References

1. Osher F C, and Kofoed L L. (1989) Treatment of Patients With Psychiatric and Psychoactive Substance Abuse Disorders. Hosp Community Psychiatry, 40, 1025-1030.
2. Miller N S, Flaherty J A. (2000) Effectiveness of coerced addiction treatment (alternative consequences): A review of the clinical research. Journal of Substance Abuse Treatment.; 18: 9-16.
3. Hoge S K, Lidz C W, Eisenberg M, Garner W, Monahan J, Mulvey E, et al. (1997) Perceptions of coercion in the admission of voluntary and involuntary psychiatric patients. International Journal of Law and Psychiatry, 20(2), 167-181.
4. Nace E P, Birkmayer F, Sullivan M A, Galanter M, Fromson J A, Frances R J, Levin F R, Lewis Collins, Suchinsky R T, Tamerin J S, Westermeyer J. (2007) Socially Sanctioned Coercion Mechanisms for Addiction Treatment. American Journal on Addiction, 16(1), 15-23.
5. Monahan J, Redlich A D, Swanson J, Robbins P C, Appelbaum P S, Steadman H J, Swartz M, Angell B, McNiel D E. (2005) Use of Leverage to Improve Adherence to Psychiatric Treatment in the Community. Psychiatr Serv, 56(1), 37-44.
6. Monahan J, Hoge S K., Lidz C, Roth L H., Bennett N, Gardner W, and Mulvey E. (1995) Coercion and commitment : Understanding involuntary mental hospital admission. International Journal of Law and Psychiatry. 18(3), 249-263.

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I'VE BEEN READING …

> *"So far as love or affection is concerned, psychologists have failed in this mission. The little we know about love does not transcend simple observation, and the little we write about it has been written better by poets and novelists. But of greater concern is the fact that psychologists tend to give progressively less attention to a motive which pervades our entire lives. Psychologists, at least psychologists who write textbooks, not only show no interest in the origin and development of love or affection, but they seem to be unaware of its very existence"* (Harlow, H.F., 1958, p.673) [1]

I have been thinking and reading about love lately.

Perhaps better stated, I have been thinking about the absence of love in the literature and discussions around the prevention, treatment and research on addiction. As professionals we speak freely and openly about the importance of building a good rapport and a strong therapeutic alliance. The addiction counselling field seems to have *re-discovered* the key role of empathy in the process of change. Imagine that how we engage and interact with people probably has as much of a role, if not more, than what we do with them in a session [2]. In order to take a deeper look into love, I have needed to look outside the mainstream addiction literature and wander into history and into the area of psychotherapy.

Two of the early pioneers who explored the place of affection and love in psychology were Harry Harlow and John Bowlby. Harlow and Bowlby were radicals. Perhaps more radical than any one else of their time, or ours. Going against the grain of mainstream psychology and medicine, they dared to be the first to talk openly about love and the importance of relationships and were professionally ostracised for it. Harlow's life and works has been pulled together in a wonderful book entitled: *Love at Goon Park: Harry Harlow and the Science of Affection* [3]. For a solid understanding of Bowlby's theory of attachment, I suggest *Becoming Attached: First Relationships and how they Shape Our Capacity to Love* by Robert Karen (1994) [4]. For the more curious and dedicated reader, I highly recommend Bowlby's trilogy: *Attachment: Attachment and Loss* (1999) [5], *Separation: Anxiety and Anger* (1973) [6] and *Loss: Sadness and Depression* (1980) [7]. Harlow and Bowlby's nonconformist approach to understanding and changing the way we relate to each other (young or old) holds great salience for the work we do in the field of addiction today. The bottom line in regards to understanding the phenomenon of addiction and treatment is that the quality of our relationships with each other (people seeking help and our colleagues) really do matter. In my mind, people form intimate loving relationships with their addiction(s) as a surrogate for intimate and attuned relationships with people. As a helping professional the best thing I can offer a person seeking help is the opportunity for a safe relationship that is free from blame, shame, judgment and confrontation. This kind of relationship is grounded in love.

I set out on my search keen to learn what my colleagues had to say about love and addiction. In my mind I was hoping to discover stimulating theories and corelational coefficients that would support my hypothesis that love matters in addiction treatment. Perhaps there would even be a Cochrane Review on love! An hour into my literature search I began to loose faith. I conducted a search on PSYCHINFO for "love" and got over 11,000 hits, but none of them related to addiction counselling, addiction treatment (including substance abuse, alcoholism, drug addiction and problem or pathological gambling) psychotherapy or even research. The treasure chest of research I was hoping to find was supplanted by interesting topics such as, pathological love, narcissism, love-and hate-addiction, stalking, drug use among female sex workers in Hanoi and the concept of *autogynephilla*. I was not sure what autogynephilla [8] was, so I looked up the article and learned it is the tendency of some men to be erotically aroused by the idea or image of themselves as women. It was all interesting but not relevant to the idea of how love may be involved in the talking cure of addiction. As far as psychology and love goes, it seems that what Harry Harlow said back in 1958 [1] is as true today as it was then. After all these years we have yet to find a place for love in the field. We are still under the grand umbrella of the behaviourists, diagnosticians and empiricists in many ways, including, even, how we define addiction, it is mostly in terms of behaviours and how long/severe they persist isn't it?

I did find one peer-reviewed publication that related to love and addiction: *Rediscovering Fire: Small Interventions, Big Effects* by William Miller (2000) [9]. In *Rediscovering Fire*, Miller confirms Harlow's assumption about love and psychology:

> *The strangely transforming power of love has been widely lauded for millennia, yet it is a concept often curiously absent in traditional psychology textbooks and clinical training* (Miller, W.R., 2000, p.11) [9].

In particular, Miller focused on the place *agape* love may have in the role of change. Some of the characteristics of agape love in the counselling world are hope, positive regard, acceptance, humility, selflessness and patience. Through providing an honest relationship with the people that rests on foundation of agape we provide people an opportunity to experience change. Miller (2000) [9] highlighted a fundamental paradox in Rogerian theory: that being

unaccepted (unacceptable) inhibits change; it is the experience of being genuinely accepted as a person truly that is the starting point for change to begin.

Sometimes I wonder if our rigorous and quantified scientific search for the biggest effect size has obscured us from looking at what has been there all along. The one thing, that cement that holds us together as people - Love.

References

1. Harlow, H.F. (1958). The nature of love. *American Psychologist*, 13, 673-685.
2. Beutler, L.E. & Harwood, T. M. (2002). What is and can be attributed to the therapeutic relationship? *Journal of Contemporary Psychotherapy, 32*, 25-33.
3. Bloom, D. (2002). Love at Goon Park: Harry Harlow and the Science of Affection. Perseus Publishing: Cambirdge, MA
4. Karen, R. (1994). Becoming Attached: First Relationships and how they Shape Our Capacity to Love. Oxford University Press: New York.
5. Bowlby, J. (1999). Attachment. Attachment and Loss (vol. 1) (2nd ed.). Basic Books: New York.
6. Bowlby, J. (1973). Separation: Anxiety & Anger. Attachment and Loss (vol. 2). Hogarth Press: London.
7. Bowlby, J. (1980). Loss: Sadness & Depression. Attachment and Loss (vol. 3). Hogarth Press, London.
8. Blanchard, R. (2005). Early history of the concept of autogynephilla. *Archives of Sexual Behavior, 34*(4), 439-446.
9. Miller, W.R. (2000). Rediscovering fire; Small interventions, large effects. *Psychology of Addictive Behaviours,* (14)1, 6-18.

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ATRIG AGM

The Addiction Treatment Research Interest Group (ATRIG) will have its Annual General Meeting at the Cutting Edge conference in Wellington 10-11 September 2009. The meeting will start sharply at 1.05pm on Thursday 10 September in Rangimarie 3, Telstra Clear Centre, Level 3, Te Papa. Elections will be held for all Officers and members of the Executive. All past, present and future members are warmly invited to attend this meeting, regardless of whether or not you are a delegate at the conference. If you have any further queries about this meeting please contact the ATRIG secretary, Lindsay Atkins, on (03) 364 0480 or lindsay.atkins@otago.ac.nz.

Addiction Treatment Research News is the official newsletter of the **Addiction Treatment Research Interest Group (ATRIG).**

ATRIG was established in 1997 to promote research in the addiction treatment field in New Zealand.

ATRIG's objectives are:

- To foster interest in scientific research on treatment of people with addiction related problems within Aotearoa NZ.
- To disseminate and promote research findings related to effective treatment of people with addiction related problems in Aotearoa NZ.
- To support the development of improved treatment services for people with addiction related problems within Aotearoa NZ.

The **executive committee** are:
Klare Braye (Chairperson), Simon Adamson, Alistair Dunn, Ria Schroder (ATRN Editor), Robin Shepherd, Janie Sheridan, Lindsay Atkins (Secretary)

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Addiction Treatment Research Interest Group (ATRIG)

MEMBERSHIP/RENEWAL FORM

Please note all individuals wishing to be a member of ATRIG must join by completing this form regardless of current membership status.

Membership in ATRIG entitles you to the following:

- three issues of the Addiction Treatment Research News via email
- membership in the ATRN email discussion group

PLEASE ENROL ME AS A MEMBER OF ATRIG (ADDICTION TREATMENT RESEARCH INTEREST GROUP). I HAVE READ AND SIGNED THE DECLARATION BELOW.

Surname _____ First Names _____

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(NB - You must provide an email address if you wish to receive a copy of ATRN)

The objectives of ATRIG are:

- *To foster interest in scientific research on treatment of people with addiction related problems in Aotearoa New Zealand.*
- *To disseminate and promote research findings related to effective treatment of people with addiction related problems in Aotearoa New Zealand.*
- *To support the development of improved treatment services for people with addiction related problems in Aotearoa New Zealand.*

Declaration

I support the objectives of ATRIG and wish to be a member of ATRIG for the 2009 calendar year. I understand membership fee is $20.

Signed _____ Date _____

Please make cheques payable to: ATRIG

I am interested in participating in an email discussion group around ATRN ☐

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