Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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ATRIG CHAIRPERSON REPORT

I was sitting in a meeting recently … well specifically it was a meeting targeting researchers and clinicians interested in the promotion of research. We were discussing the importance of the dissemination of research, the challenges of research informing practice and policy, the responsibilities of 'knowledge transfer' and 'science implementation', when lo and behold someone referred to the flip side of the dapaanz newsletter, which if you are reading this, obviously refers to the Addiction Treatment Research News (ATRN). Without even knowing that both the Chair of ATRIG and the Editor of ATRN where sitting just rows away, they reported on it being 'a really exciting publication', 'what a great place to find snippets of information', 'how useful it was to get an idea of recent research ideas, without having to subscribe to a peer reviewed journey'. Yay - music to our ears. Not only is ATRN being read and its value recognised, but we also got some ideas of what to include for the future editions. So please, don't be shy, let us know what and how you want us to support the promotion and dissemination of your research, or the research initiatives you want to hear about.

So...what else is happening in the world of research promotion and dissemination?

The 4th Addiction Research Symposium was recently held in Auckland. What a great event for providing a forum for New Zealand addiction researchers to meet and share their work; providing an opportunity for research students to present and be supported by more experienced colleagues, and to allow for focused discussions on issues of common interest to addiction researchers, including potential collaborations. The quality of the speakers was fantastic, the support of the students phenomenal, and the application to clinical practice was encouraging.

A couple of weeks prior to this event was the Collaborative Research Hui in Christchruch supported by the Canterbury Youth Workers. This year they extended the hui to two days with, I understand, not only great keynote presentations and interactive discussion, but also the amazing application of positive youth development (PYD) principles utilising the skills of the Aranui High School Theatre Academy to role-play PYD in action.

Another interesting activity recently held was 'Supporting the Promotion of Activated Research and Knowledge' (SPARK) training run by Te Pou and modelled on the work of the Canadian Mental Health Commission. The goal of this two-day training was to improve people's capacity for implementing effective 'Knowledge Exchange' (KE) practices in the field of mental health and addictions. This was a great practical example of how research knowledge can be put in to practice – a necessary requirement as the frustrations between knowledge/research and practice/policy are expressed by an action that works to 'close the gap between what we know and what we do.'

And, of course, the Cutting Edge Conference 2013 "Crossing the Border (into community care)" to be held on 12th – 14th September at the Rotorua Convention Centre. The call for abstracts closed on May 3rd, but watch out for the awards again this year: Dapaanz makes an annual award of $250 for the best poster contribution to clinical practice and The Addiction Treatment Interest Group (ATRIG) will present an award ($300) for the best research presentation (poster or oral) by a 'young or emerging' researcher.

Klare Braye
ATRIG Chair

EFFECTIVE INTIMACY: A TREATMENT FOR OUT OF CONTROL SEXUAL BEHAVIOUR PRELIMINARY FINDINGS FROM A DOCTORAL THESIS

Introduction

'Out of control sexual behaviour' (OCSB) has been a popular topic since the 1980s when Patrick Carnes introduced it to the clinical literature as 'sexual addiction', and definitional debates continue to characterise the field. Most researchers agree that those with OCSB, estimated to be around 3-6% of the population, experience difficulties with sexual thoughts, feelings, and behaviours that result in distress or negative consequences (Reid & Woolley, 2006), such as financial, occupational, health, and relationship impairment (Muench et al., 2007). With the advent of the internet, smart phones, and social networking, there are increasing opportunities to find anonymous, affordable sex on demand (Weiss & Samenow, 2010).

Contributing factors towards OCSB include genetics and neurobiological vulnerabilities; experiences such as abuse, neglect, and trauma; and affect regulation difficulties (Bancroft & Vukadinovic, 2004; Reid, Carpenter, Spackman, & Willes, 2008). An emerging theory is that insecure attachment contributes to OCSB, as sexual behaviour becomes a way of meeting emotion regulation and intimacy needs (Collins & Sroufe, 1999; Hudson-Allez, 2009; Salisbury, 2008). Preliminary evidence suggests that OCSB may be associated with insecure attachment (Faisandier, Taylor, & Salisbury, 2012; Zapf, Greiner, & Carroll, 2008).

However, the effectiveness of an intimacy- or attachment-focused approach for OCSB has not been evaluated. The current exploratory study aimed to evaluate the effectiveness of a treatment approach for OCSB that focused on increasing intimacy skills. This paper describes the study and presents the results for a single case.

Method

Single-case research design (SCRD) with multiple baselines was used to examine treatment outcomes for 12 New Zealand men with OCSB who completed up to 12 sessions of treatment with three clinical psychologists from specialist service Sex Therapy New Zealand (STNZ). Sexual behaviours were tracked over a weekly baseline phase; a therapy phase of varying intervals depending on individual needs, and monthly follow-up over three months.

Participants were recruited via a national press release that invited men over the age of 18 who thought they had OCSB to email the researcher. The first 12 to meet eligibility criteria, including no acute mental health problems or sex offending, were accepted into the study.

Self-report data were collected weekly via email and comprised 11 items pertaining to sexual activities, such as frequency of masturbation and duration of pornography viewing, as well as subjective units of distress about OCSB

(0 = least distressed to 10 = most distressed), and incidence of satisfying sex with a partner. Pre- and post-therapy questionnaires also measured OCSB (Compulsive Sexual Behaviour Inventory, CSBI; Coleman, Miner, Ohlerking, & Raymond, 2001), consequences of OCSB (Compulsive Sexual Behaviour Consequences Scale, CSBCS; Muench et al., 2007), adult attachment style (Relationship Scale Questionnaire, RSQ; Griffin & Bartholomew, 1994), and intimacy (Fear of Intimacy Scale, FIS; Descuter & Thelen, 1991).

The treatment approach was tailored to contain and reduce OCSB while assessing and treating relevant deficits in attachment and intimacy skills (Salisbury, 2008). Treatment was provided in each therapist's own clinical rooms in Auckland and Palmerston North and sessions were usually 50 minutes in length.

The study was approved by the Central Regional Health and Disability Ethics Committee in November 2011 (CEN/11/09/050).

Results

Participants ranged in age from 27 to 57 and the majority were heterosexual with three identifying as bisexual and one homosexual. Nine were in relationships that included being married, de facto, or dating and the remaining were single. Most had completed university study and all were employed and earning between $40-60,000 and $500,000.

At the time of writing, data analysis was ongoing and so the present paper includes preliminary findings for one participant, P5. Figure 1 shows that P5's baseline distress trended downwards over therapy and remained relatively stable over follow-up. His frequency of masturbation was consistent over all phases while partner sex increased over the follow-up phase. Hours spent watching pornography and using the internet for sexual purposes reduced sharply at the end of the baseline phase and this remained stable over therapy and follow-up.

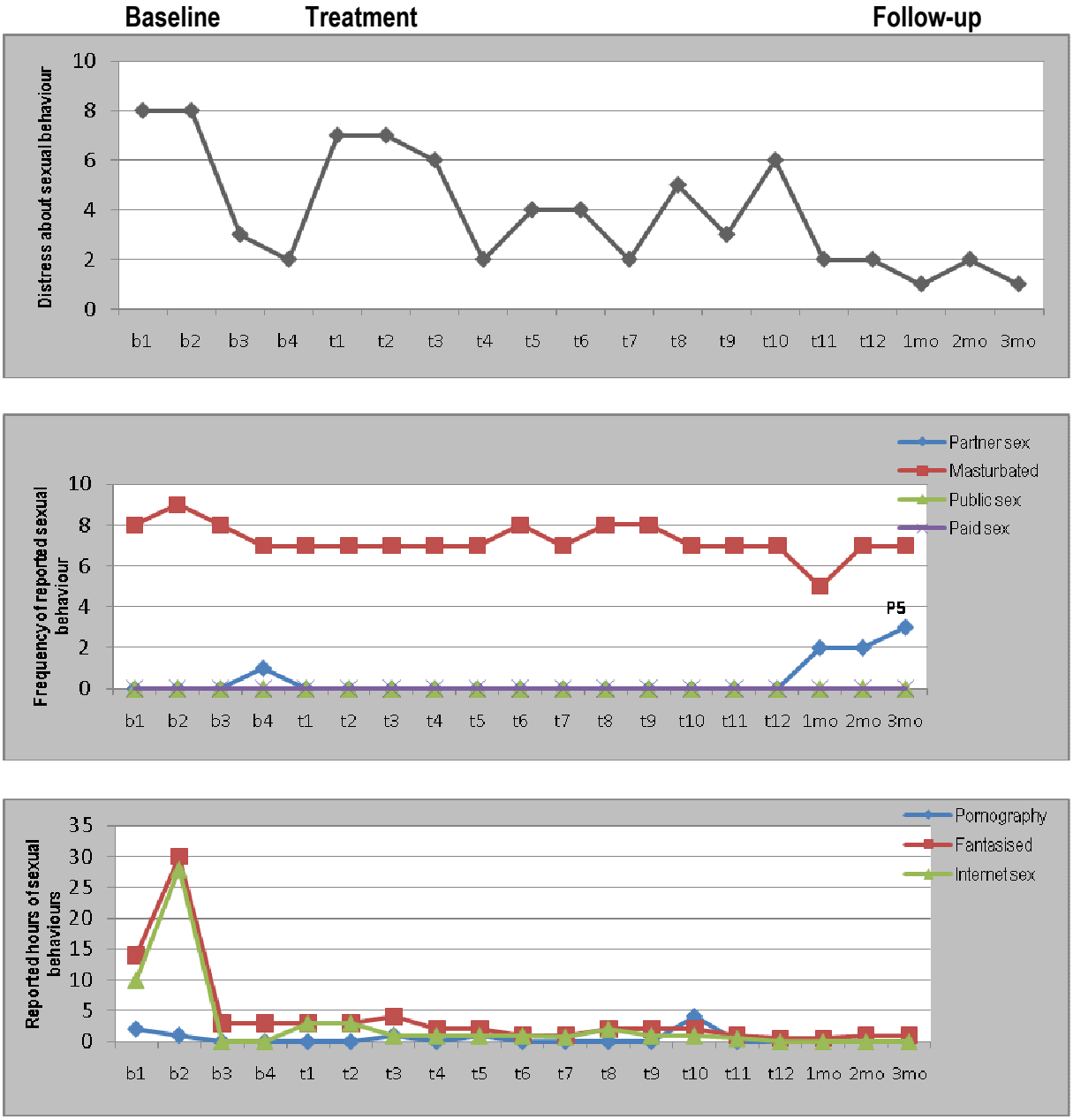
As displayed in Table1, P5's CSBI scores increased over treatment and follow-up while CSBCS scores reduced, both suggesting that OCSB and OCSB impairment reduced substantially. Scores on the FIS also reduced over treatment and follow-up, suggesting the capacity for intimacy increased, albeit to a lesser extent. P5's RSQ scores reduced on fearful and preoccupied attachment, and, unexpectedly, for secure attachment which had been hypothesised to increase. This was maintained at follow-up. The exception was dismissing attachment which increased before returning to its original level at the final follow-up.

Table 1: Pre-, post-treatment, and follow-up questionnaire scores for P5

	Pre	Post	1 mth	2 mths	3 mths
CSBI[a]	33	56	54	53	52
CSBCS[b]	46	8	12	10	11
FIS[b]	121	105	110	91	97
RSQ:					
Secure[b]	3.60	2.80	2.60	2.60	2.60
Fearful[b]	3.50	3.00	2.25	2.50	2.50
Dismissing[b]	3.20	3.60	2.80	2.80	3.20
Preoccupied[b]	3.00	2.75	2.25	2.50	1.75

Note. CSBI = Compulsive Sexual Behaviour Inventory (range 13-65), CSBCS = Compulsive Sexual Behaviour Consequences Scale (range 0-84), FIS = Fear of Intimacy Scale (range 35-175), RSQ = Relationship Scale Questionnaire (subscales range 0-5).
[a]Lower scores indicate a higher experience of that construct.
[b]Lower scores indicate a lower experience of that construct.

Figure 1: Sexual behaviour and related distress over baseline, treatment, and three-month follow up for P5



Discussion

For P5, the therapy approach reduced key markers of OCSB identified in the literature, including distress and impairment. Frequency of some sexual behaviours did not change, such as masturbation incidence remaining constant, but sexual fantasy and internet sex markedly reduced, while partner sex increased at treatment completion and follow-up.

Intimacy was a key focus of the treatment approach and study findings for P5 provide evidence that intimacy increased over treatment and was largely maintained at follow-up; however, the rate at which this increased was lower. As the construct of intimacy is based on entrenched attachment deficits, it is possible that the reason that this reduced at lesser rates is because this aspect of treatment requires longer-term intervention. Future research should explore whether longer treatment would effect a greater degree of change.

Insecure attachment scores also reduced over treatment for P5, except dismissing attachment and, unexpectedly, secure attachment also reduced. One explanation for this might be that as P5 became engaged in the process of

therapy, he became more aware of attachment deficits and was able to report these more accurately which would have affected secure attachment scores. Future research should explore these attachment changes over therapy to understand the nature of this finding.

Preliminary findings from this study indicate that the treatment approach reduced OCSB and improved intimacy for this participant. Completion of data analysis for remaining participants is required before any conclusions may be drawn regarding the overall effectiveness of the treatment. Full results will be available in early 2014.

Karen Faisandier - Clinical Psychology Doctoral Student
Massey University, Manawatu Campus
Supervisors: Dr Joanne Taylor, Robyn Salisbury, Dr Shane Harvey

My gratitude goes to the participants of this study, Sex Therapy New Zealand, Massey University's Post-Graduate Research Funding, The Oakley Mental Health Foundation, and Te Rau Matatini.

A full reference list can be obtained by contacting the editor ria.schroder@otago.ac.nz

UNIVERSITY OF AUCKLAND: ADDICTION TREATMENT RESEARCH UPDATE

It's been a busy start to the year for researchers across the Faculty of Medical and Health Sciences. In this update, we are pleased to be able to provide the ATRIG with a brief overview of the 4th National Addiction Research Symposium held in April, as well details of addiction treatment research currently being undertaken by four PhD candidates at the University of Auckland:

Internet addiction (IA) – exploring the relationship between IA and certain psychopathologies; Delia Cotoros, School of Population Health

As our culture becomes progressively dependent on the Internet, it is not surprising that there has been an increase in the number of people who display addictive-like behaviour to the Internet. The aim of this PhD is to develop a new screening measure for Internet Addiction (IA) and to explore the relationship between IA and certain psychopathologies (social anxiety, depression and substance abuse). Although there have been previous attempts at developing measures for IA, many of those studies were methodologically weak, and were developed based on the researchers' observations of people's pathological use of the Internet. In comparison, the current study will adopt a participatory approach by involving study participants in the development of the measure itself.

Cytisine – what happens to it in the human body? Soo Hee Jeong, School of Pharmacy/Department of Pharmacology & Clinical Pharmacology/School of Population Health

Cytisine, an extract from the Golden Rain tree (*Cytisus laburnum*), has been used in Eastern Europe for 50 years as a smoking cessation aid. However, no human data have been published on the pharmacokinetics or dose response characteristics of cytisine. The aim of this PhD is to obtain pharmacokinetic data for cytisine in humans (under single and multiple dosing conditions) and to measure dose response in human smokers with outcome measures including craving, mood, withdrawal, smoking satisfaction and smoking cessation.

Data on pharmacokinetics could then be used to develop an improved dosing regimen and to inform the design of future trials using evidence-based dosing regimens.

Preliminary results show that cytisine is detectable in the blood at 24 hours following a 3mg single dose. Cytisine had no adverse effect on the physiological measures. No severe adverse reactions have been reported. The most common side effects reported were change in appetite, cigarettes tasting less pleasant, dry mouth/thirst, vivid dreams and irritability.

SPILLIT – Safe drinking reminders by personal SMS; Karen Renner, School of Population Health

Two RCT feasibility studies have been undertaken to deliver harm reduction text messages during alcohol consumption. The messages and message delivery were created by each participant. Messages related to reducing alcohol consumption or drinking safety. Participants aged 18–34 years (study 1) and 18–67 years (study 2) accessed the intervention via a web site (and iPhone or Windows Phone 7 apps).

Five IDENTITIES have emerged from the participant generated messages: The Student, The Winner, The Responsible One, The Family Member, The Anti-Hero. Four message approaches were identified: practical advice, motivational directives, minimal consumption, consequences. Analysis of data is ongoing.

Problematic mobile phone use in the New Zealand adolescent population; Michael Vacaru, School of Population Health

Michael's doctoral thesis is concerned with the relationship between young people and mobile phone technology, with a particular focus on problematic usage. The research aims to evaluate the existence of problematic mobile phone use (PMPU) in the New Zealand adolescent population, to develop a youth-informed measure of PMPU, and to assess the prevalence of this behaviour amongst New Zealand youth. Three sequential studies have been developed in order to achieve these aims, and a critical realist, mixed-methods perspective has been adopted. The research is underpinned by attachment theory, and the methodology based on a youth-participatory approach.

4th National Addiction Research Symposium

We were delighted to have the opportunity to host the fourth National Addiction Research Symposium in late April. The Symposium (a collaboration between the Universities of Auckland, Otago and Victoria, with support from Matua Raki) was well attended from across the sector and provided an insight into the breadth of research currently being undertaken in New Zealand in the addiction field.

The very full agenda included:

- an overview by Associate Professor Chris Bullen (Auckland) on work being undertaken at the National Institute for Health Innovation assessing the effectiveness of e-cigarettes to help people quit smoking;
- an investigation into the impact of law enforcement on the availability, price and purity of ecstasy in Auckland by Dr Chris Wilkins (Massey);
- an introduction to his research on client welfare as a by-product of professionalisation by Tony Carton (Weltec);
- Sue Paton and Kristen Maynard from the Health Promotion Agency (HPA) outlined the HPA's new strategic direction and also invited input from participants to help feed into the HPA's forthcoming addiction strategy;
- an overview and presentation of preliminary results of the use of ASSIST in a community-based treatment centre by LaNae Fisk at Recovery Solutions' Phoenix Centre and Dr David Newcomb (Auckland);
- a survey examining the recreational use of Salvia Divinorum in Wellington by Dr Bronwyn Kivell (Victoria);
- thoughts on the use of Zopiclone in New Zealand by Merlin Curreen (Northland DHB);
- an introduction to gambling in Hawaii by Dr Robin-Marie Shepherd (Auckland).

Importantly, the Symposium also provided an opportunity for postgraduate students to present their research: Soo Hee Jeong and Karen Renner presented their research as detailed above, and Annabel Prescott, a PhD candidate in the School of Population Health, also presented an update on her research into drug policy in schools. Michele Yeoman, a Professional Teaching Fellow in the School of Nursing, presented progress on her masters' research looking at mental health nurses' personal and professional stories of alcohol.

We hope to make abstracts and selected presentations available to participants and others on our website before the end of May – visit www.fmhs.auckland.ac.nz/faculty/cfar.

Associate Professor Janie Sheridan

ABACUS REPORT: SMOKING - ITS ROLE IN ADDICTION THERAPY

"Every problem comes with a baggage of solutions."
Santosh Kalwar

Tobacco smoking is a recognised cause of a growing number of diseases and mortality risk with an estimated one out of every two tobacco smokers dying prematurely of a smoking-related disease. Further, the recent New Zealand Health Survey (MOH, 2012) noted that of those who were daily smokers, 63% smoked between 6-20 cigarettes per day. This quantity and regular daily use suggests that two-thirds of smokers may be demonstrating aspects of psychological or physical dependence (although research suggests just over half of problem gamblers (PG) who smoke may be addicted to nicotine) (Maccallum & Blaszczynski, 2002). Smoking remains disproportionately high among a number of at-risk groups, with Māori smoking prevalence at 41%, Pacific peoples at 26%, and those living in most deprived areas (2.5 times that of least deprived areas) (MOH, 2012). Research indicates that over 60% of problem gamblers in treatment will be smokers (Sullivan & Beer, 2003), while those with alcohol problems are also often smokers. Yet, smoking may gradually be becoming less of a long-term problem. Daily smoking of tobacco has reduced from 18% (2006/7) to 17% (2011/12) (MOH, 2012), with the goal that it will reduce to 5% or less by 2025 (MOH website).

How relevant is addressing smoking?

From a problem gambling (PG) and alcohol and other addiction (AOD) treatment perspective, the relevance that tobacco smoking has on the client's presenting addiction problem is an important issue that may seldom be addressed. Smoking appears to be highly addictive, yet is it perceived as a parallel problem to PG or AOD, with high personal health risk but perhaps without the high social costs (theft, violence, family breakdown) of PG and AOD? The risks of smoking appear almost 'contained' to the individual when compared with PG and AOD, other than health effects on others of passive smoking, with effective public health strategies in place that even foresee almost an end to the behaviour in just over a decade. These issues may reduce the importance of addressing smoking within an AOD or PG treatment plan in the eyes of addiction therapists, or even result in avoiding the subject for fear that response to enquiries about this common client behaviour will be counter-productive in the development of a therapeutic alliance.

With the roll out of integrated treatment for addictions and other coexisting mental health problems, we may ask the very pertinent question, how does smoking impact upon PG and AOD? The answer to this question is likely to be poorly understood, despite addiction clients being far more likely to smoke when compared with the general population. Is this high correlation between smoking and other addictions also indicative of causative factors that may increase risk for developing, maintaining or relapse for addictions, and if so, by addressing smoking within a treatment plan, will this improve outcomes for the other addiction/s? Research suggests that smoking usually precedes PG or AOD (Ladd & Petry, 2003), but this may be confounded by easier and earlier accessibility in the past to smoking, rather than proof of causation. Evidence of severity suggests heavier smoking correlates with more severe PG, further raising concerns (Ladd & Petry, 2003).

How does smoking impact upon other conditions?

Here, evidence is somewhat sparse. PG who were smokers were likely to have more severe family problems, psychiatric problems (particularly anxiety) and greater PG severity than non-smokers, craved gambling more and had lower perceived control over their gambling (Ladd & Petry, 2003).The high correlation of smoking with addictions does raise the possibility of smoking having some causative or even moderating effect on addictions. If the latter is correct, then addressing smoking may become an important factor to include in any addiction treatment plan.

Do we ask about smoking?

Many assessment instruments used by addiction treatment providers will include a question around tobacco use; the CHAT screen, sometimes included in assessments, is a composite one-page tool validated for NZ that includes alcohol, other drug, gambling, mental health questions, and starts with two smoking questions. Although this screen was developed for GPs' patients, it is now widely used in primary care services and by some addiction services, as the CEP approach requires further enquiry. However, asking is just the first, albeit important, step in an intervention.

Do we intervene in smoking?

Many addictions specialists have completed a smoking cessation module (ABC-Smoking Cessation in Practice) either on-line or have attended a course provided by a trainer, and may be qualified to provide clients with an intervention and provide support by enabling them to obtain nicotine replacement medicine (NRT) from a chemist at

a heavily subsidised price. An interesting exercise that may provide useful evidence of the degree of smoking intervention provided in our practices is to identify what percentage of our clients have received such an NRT script.

Does a smoking cessation focus fit with other harm minimisation addiction approaches?

Cessation is on the harm minimisation continuum, albeit at one end. The ABC smoking cessation approach is to elicit a quit date commitment ('regardless of their desire or motivation to quit') and provide support, following asking if they smoke, and providing advice (MOH, 2007). This model does differ from models commonly used in NZ for alcohol, other drugs and gambling, in that a well-being perspective offered in addressing addictions and co-existing problems (CEP) (Todd, 2010) has a harm minimisation focus that if applied to smoking cessation would be client focused and could accept a client goal of continued smoking (presumably usually with less cigarettes). Balanced against this, is the high mortality from smoking and that even small levels of smoking may retain this high risk. If there is a risk that addiction counsellors may perceive a clash between these models, this may result in either a reluctance to intervene using this model, or to refer clients who smoke to specialist services who use the model. An important consideration of the CEP approach is to monitor that when clients are referred out to other specialists, integrated care requires 'use of compatible models, where possible' (Todd, 2010, p129).

To determine to what degree, if any, these different approaches might act as a barrier to interventions in smoking by AOD and PG counsellors may require a survey; however, the previous suggestion of examining levels of NRT scripts issued may provide some indication as to whether NRT interventions appear to be lower than expected.

Conclusion

Addictions are mental health conditions, and smoking has often reached the addictive stage in its use. The CEP approach of addressing addictions and other mental health issues (and other social issues) in an integrated treatment plan would support identifying and including issues or problems that impact upon the presenting condition. The question remains, how important do we see including smoking in an AOD or PG treatment plan?

Sean Sullivan, ABACUS

A full reference list can be obtained by contacting the editor ria.schroder@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 members** are:
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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:

- Four issues of the Addiction Treatment Research News via email

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

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Declaration

I support the objectives of ATRIG and wish to be a member of ATRIG for the 2013 calendar year. I understand membership fee is $20.

Signed _____ Date _____

- Please make cheques payable to ATRIG and return with membership / renewal form to address below
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