Treatment Research News

Alcohol, Drugs and Addiction

November 2002 *Newsletter of the Treatment Research Interest Group* Vol 6 No 3

EDITORIAL

Saved by the bell! Or popular demand at the very least. It was decided at the Treatment Research Interest Group AGM at Cutting Edge 2002 that TRIG will continue in its current role and that the TRN will continue to be published. Further details about these decisions can be found in the Message from the Chairperson, TRN goes electronic and the new membership form. The upshot is that the latest in A&D treatment research news both internationally as well as from the field here in New Zealand will be available for a while longer.

The year is rapidly winding up with less than 32 working days until Christmas (now you hate me!) and only three weekends of rugby left in 2002 (sob). Lindsay and Lisa have already sussed out the location for next year's Cutting Edge conference and the first issue of TRN for 2003 is beginning to fill up. Thank you very much to all those who sent in articles for this issue of TRN by the deadline I optimistically set. Your response was so great that we could not fit everyone in. I apologise to those who wrote so quickly, but won't be read until next year.

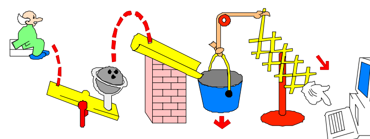
Cutting Edge 2002 in August was a roaring success – there was a real collegial feel to the conference and so much information to gather and digest. We are lucky to have such a warm and friendly opportunity each year to meet others working in our field and spend time connecting with like minded workers. A report from the conference can be found on page 7.

Also connected to Cutting Edge is Doug Sellman's news from the NCTD, which reports on the survey put to the field at the conference regarding the future of the NCTD. Another NCTD member, Simon Adamson, appears in Names & Faces. We have two attention-grabbing articles to round off TRN 2002 – Joel Porter writes about attachment and addiction, and Sean Sullivan reports on gambling and smoking. Also in this issue is a Letter to the Editor from John Caygill and the ever informative "I've been Reading" from Fraser Todd.

Those who know me well will know that I tend to be a little…obsessive at times. So recently I went through all the past issues of the TRN and made a database of what contributions had been written and by whom. At the end of the last issue of TRN we had reached the proud milestone of having 100 contributors. It was also very evident that particular members of the A&D field (past and present) have made significant offerings to TRN over the years. I feel these individuals should be noted and thanked for their efforts. They are Peter Adams, Simon Adamson, Raine Berry, Daryle Deering, Stuart MacKinnon, Grant Paton-Simpson, Doug Sellman and Fraser Todd.

I hope that you are all able to have a good break over the festive season and that the summer is drier than last year! I am looking forward to bringing you TRN electronically from next year and providing plenty more happy reading.

Meg Harvey
Editor, 8 November 2002



LETTER TO THE EDITOR

With his concise observations on treatment evaluation research in the last TRN, Ian MacEwan raises some challenging issues and rightly concludes that: "The complexity of the alcohol and drug treatment task needs recognition…" Complexity is guaranteed in those A&D services that are part of a wider treatment realm (e.g. Mental Health services), and have tended to develop around the broad mandate of providing some sort of therapeutic response to a wide range of help-seekers and referrers, rather than around the delivery of a neatly bounded programme. This means that an initial chunk of the work is process-oriented and the immediate outcome is simply in terms of tasks achieved (such as one-off assessment and feedback, referral-on to another programme, initiation of detoxification, etc.). While the rest of the work may be based around specifiable goals negotiated between client and counsellor, these are often subject to 'slippage' or change mid-stream, and the interventions themselves tend not to correspond to standardized packages expertly delivered to a 'treatment-matched' client group. Under these conditions, as Ian indicates, valid comparison of results within and between programmes and services is limited, if achievable at all.

It follows that considerable effort by managers and forbearance by staff and clients is required in setting-up and refining even a limited ongoing evaluation process (as distinct from a one-off research project). In my experience the effort and forbearance are likely to be wasted if the process is not embedded in a site-specific and genuine quality improvement framework – as opposed to being an exercise in impression management, intended to appease external audit dictates.

John Caygill

TRIG NAMES & FACES

Simon Adamson is a Lecturer at the NCTD as well as a Clinical Psychologist at CADS in Christchurch and a member of the TRIG Executive Committee.

NCTD: NATIONAL CENTRE OR NOT?

INTRODUCTION

The National Centre for Treatment Development (Alcohol, Drugs & Addiction) (NCTD) has been in existence since core funding was obtained from the Alcohol Advisory Council of New Zealand (ALAC) in 1996. The NCTD is venued in the Department of Psychological Medicine, Christchurch School of Medicine & Health Sciences, University of Otago and its aim has been to make a significant contribution to improving treatment for people with alcohol, drug and addictive disorders in New Zealand through the following activities:

1. Providing postgraduate training in the alcohol, drugs and addiction area;
2. Undertaking treatment related research with an emphasis on Masters and PhD projects;
3. Linking, supporting and advocating for the alcohol and drug treatment field in New Zealand.

Over the first four years, a Board consisting of representatives of the treatment field and the University met three times a year. Since 2000, the National Treatment Forum has taken over as the key reference group for the NCTD.

At the end of 2003, the ALAC core funding will be coming to an end. Without alternatives to this funding, the NCTD will be severely compromised in its function as a National Centre in terms of responsiveness and connection to the treatment field. In preparation for this transition and the challenges ahead, the NCTD decided to survey the field about the importance, or otherwise, of having a National Centre and the NCTD's future in this regard. An assumption was made that those who attend the Cutting Edge conference, an annual treatment conference on alcohol, drugs and addictive disorders, were likely to be amongst the more active and committed members of the treatment field, and therefore who's opinions are of highest priority to tap. A questionnaire was therefore developed for the purpose of surveying delegates at the Cutting Edge Conference in Nelson 2002 and included three main questions along with demographics. The three main questions were about the importance to the field of having a National Centre, the usefulness of the NCTD to the field, and what the NCTD should do in the future in the light of losing its core ALAC grant.

METHODOLOGY

The questionnaire was inserted in all Cutting Edge delegates' satchels. Two announcements were made during conference "housekeeping". Finally, those delegates attending the final morning's plenary were given a second copy of the questionnaire if they had not already deposited their first, as they entered the session.

The questionnaire was an anonymous one and participants were asked to either deposit their completed form at the Conference Registration Desk, where a box was situated for the deposit of both this questionnaire and a conference feedback questionnaire, or fax it to the NCTD. Seventy-seven questionnaires were deposited in the box and one was faxed to the NCTD following the conference. There were 302 delegates at the conference making a response rate of 25.8%.

RESULTS

The 78 respondents were 48.6% men and 51.4% women. Ten-year age bands revealed that 3.9% were 20-29, 15.8% were 30-39, 51.3% were 40-49, 27.6% were 50-59 and 1.3% were 60+ years of age. In terms of ethnicity, 14.7% said they were Mäori, 72.0% Pakeha, 4.0% Pacific and 9.3% Other. The mean number of years worked in the treatment field in any capacity (n=64) was 9.1 (sd=6.8, range 0-24). The number who had been working in the field for no more than the time the NCTD had been in existence (i.e. 6 years) was 46.9% and 53.1% for longer. The current working roles of the respondents (n=57) were as follows: clinician/A&D worker – 59.6%, manager – 19.3%, student/trainee – 8.8%, teacher/educator – 7.0%, and other – 5.3% (e.g. health planner, on study leave etc).

The first question asked "how important is it to have a National Centre in New Zealand, focused on improving treatment for people with addiction, through education, research and active linking with the treatment field?" This was rated as "very important" by 84.6% and a further 10.3% thought it was "fairly important" making a positive opinion rating of 94.9%. There were no significant differences in those who had a positive opinion compared with those who didn't in terms of any of the demographic variables.

The second question tapped opinions about the usefulness of the NCTD in asking "how useful has the NCTD been to the treatment field as a National Centre (as defined in the first question) over the past six years?" It was considered "very useful" by 60.3% and a further 29.5% thought "fairly useful", making a positive opinion rating of 89.8%. Again, there were no significant differences in those who had a positive opinion compared with those who didn't in terms of any of the demographic variables.

The third, and most critical question, asked "what do you think the NCTD should do in the event of losing the ALAC core funding?" Of the sample 61.5% thought it should "remain as a National Centre, in name at least, while it lobbies for ongoing funding, knowing it is unable to be a National Centre in terms of active connection or accountability to the field". A further 19.2% thought it should "revert to being teaching and research group within the Christchurch School of Medicine and Health Sciences with no expectations of it being a National Centre". Finally 19.2% either didn't know or spelt out an alternative to the two main options given. A theme of these alternatives was increased collaboration of the NCTD with other units. This question was further analysed in two ways by collapsing the answers into two alternatives; first whether respondents said the NCTD should remain a National Centre or not and secondly whether respondents said it should revert to being a local research and training centre or not. Men (75%) were more likely to say the NCTD should remain a National Centre than women (50%) (Chi square=4.91, df=1, p=0.03). No other demographic differences were found for this analysis or for whether the NCTD should revert to being a local unit or not.

DISCUSSION

This was not a highly representative sample of the alcohol and drug treatment field in New Zealand. Not only was it neither a random sample of the field directly nor a random sample of the delegates of the Cutting Edge, it also represented only a little over a quarter of Cutting Edge delegates. There were less than 15% Mäori and only three Pacific respondents and nearly 80% of the sample were in their 40s or 50s.

The findings represent the collective opinion of 78 Conference delegates who took the trouble of filling in a questionnaire and depositing it at the Registration desk on a topic that was not directly associated with conference proceedings. It therefore represents the opinion of people who are likely to have an active opinion of the issues at hand. The fact that the sample had balanced numbers of men and women, with full spread across the age bands and included at least some Mäori and Pacific input, gave further confidence to it being a set of findings that require listening to regarding the future of the NCTD and the issue of a National Centre.

Continued on Page 7

Unlocking the Future: Exploring the Psychobiological Connection between Addictive Behaviours and Trauma

"What does being sexually abused when I was a kid have to do with my drinking?" asked a 37 year-old male client. "I don't see how my crazy childhood has anything to do with my alcoholism...that was so long ago...I have been sober for a year now", stated a 47 year-old client as we completed her family genogram. I have also wondered how traumatic events so far back in the past continue to haunt them in the here and now. The timeless quality of trauma has always made intuitive sense to me. However, it was not until writing my doctoral dissertation that I came to understand the psychological and biological sequela of trauma. Through the work of Judith Herman (1993) and Bessel van der Kolk (1989), the process of trauma and its implications became clear. One aspect of trauma, however, remained troubling: Why is it that people with traumatic histories have such difficulty engaging in, and maintaining, therapeutic change with their addictive behaviours?

Theory and research findings from the area of attachment theory are providing some keys to help unlock the answer to this question. Through comprehensive and integrative research on the psychobiology of attachment, American psychologist Allan Schore (2001), has began to quantify the work of John Bowlby (1969). This theory of attachment trauma, originating in infancy and childhood provides convincing evidence for a psychobiological pathway, which leads to the development of traumatic stress syndromes such as PTSD. It is my hypothesis that a similar attachment-based psychobiological pathway also exists between early attachment trauma and addictive behaviours.

Given what we know about the inextricable connection between the body and mind, it makes sense that addictive behaviours are a by-product of the synergistic relationship between genetic-constitutional factors *and* environmental factors. Thus, given the amount of physical and neuronal growth that occurs from conception through childhood, we must begin to focus on how early life experiences relate to addictive behaviours acquired later in life. Attachment theory offers a sound explanation to account for this conceptualisation of addictive behaviours (Cassidy & Shaver, 1999). Bowlby (1969) hypothesised that early attachment experiences between infants and mothers (or primary caregivers) influence neurophysiological development. This is, in turn, directly linked to whether an individual follows a path toward emotional well-being or veers toward psychopathology. The advances in technology and research methodologies since Bowlby's time have made it possible to quantify the profound effect that early traumatic experiences have on neurophysiological and psychological development. This research offers us help in solving the mystery of why some people are more prone to struggle with addictive behaviours than others.

Clinical experience complimented by research (Medrano, Hatch & Zule, 2002) informs us that traumatised clients are at risk to develop problems with addictive behaviours. Similarly, people with past traumas tend to have marked difficulty attempting to change addictive behaviours. These clients appear to perpetually cycle through the "Stages of Change" (Prochaska, Norcross, & Diclemente, 1994). In reality what these clients are facing is a psychobiologically-based cycle that most likely began with early attachment experiences. From an attachment theory perspective, infants and children who experience stress due to relational misattunement are at risk to develop an insecure or preoccupied attachment style (Schore, 2001b). This misattunement may take the form of inconsistency, emotional dysregulation, abuse, shame-based interactions and/or chaotic parental relationships - all hallmarks of substance-using families. These individuals commonly struggle with interpersonal relationships, intense fears of abandonment and difficulty regulating their emotions.

So how does this happen? Schore (2001a) reports that early exposures to relational trauma, as well as the defences against such trauma, become embedded in the core structure of the personality and influences brain development and functioning. Traumatic stress, intrusive memories and emotional disturbance fundamentally reflect impairment of the right brain and frontal lobes (van der Kolk, 1996). In the developing infant brain these states of anxiety, fear and helplessness become traits (Perry, Pollard, Blakely, Baker & Vigilante, 1995). These negative psychobiological traits become the foundation of the insecure attachment style developed to negotiate both the interpersonal and phenomenological world. Underneath the insecure attachment style are neurohormones and neuromodulators that underpin the attachment style and fuel the ongoing dynamic. In exploring this connection between trauma and behaviour we begin to understand how an addiction process completes the picture.

In essence, the cycling and recycling through this trauma induces an addictive process that begins in childhood and continues through adulthood. This ongoing and chronic pattern ignites a kindling effect (Robertson & Cottrell, 1985; Gaito, 1976). In short, kindling is an enduring change of brain sensitivity to a stimulus. Consequently, this change in the brain alters neurotransmission which, in turn, influences neurophysiological and psychological development. The neurological and behavioural pathways for addictive behaviours are forged during infancy and childhood through repeated exposure to relational trauma. Once the individual discovers that substance use and related behaviours can expedite and mimic the chemical process that leads to immediate relief from psychic pain, the process shifts to a set of maladaptive addictive behaviours. The kindling effect created by early attachment trauma is fuelled by addictive behaviours. Addictive behaviours share the same reward pathways in the brain with trauma based behaviours. Based on this kindling process and our current knowledge of the physiological and psychological aspects of addiction behaviours (i.e., craving, tolerance and withdrawal) and trauma, it is reasonable to hypothesise that a psychobiological relationship exists between trauma and addictive behaviours.

Continued on Page 4

MESSAGE FROM THE TRIG CHAIRPERSON

TRIG SURVIVES

You may recall (from the August TRN) that a proposal was to be put to the AGM of TRIG at Cutting Edge, Nelson for TRIG to be wound up, given its dire financial position. However, even before the AGM was held I became aware of a strong feeling among members that further efforts need to be made before “admitting defeat”. This sentiment was reiterated at the AGM where constructive brainstorming was held and a variety of offers of help extended. The new executive was charged with the job of deciding specifics. A new path ahead was developed at the first meeting of the new executive yesterday (7/11/02).

The new Executive of TRIG voted at the recent AGM are:
Peter Adams (Auckland)
Simon Adamson (Christchurch)
Alistair Dunn (Whangarei)
Meg Harvey (Christchurch – Editor, TRN)
Helen Moriarty (Wellington)
Lee Nixon (Nelson)
Doug Sellman (Christchurch)
Linsday Stringer (Christchurch – Secretary/Treasurer)
Eileen Varley (Nelson).

TRIG membership will now cost $20 per year (see new Membership Form in this edition). This will entitle members to regular copies of TRN personally distributed via email (see p. 5 for details), continuing discounted Cutting Edge registration fee, and the opportunity to take part in a TRIG email discussion group (if sufficient support for this idea exists). As you will see on the new Membership Form, we have included a question asking whether you would like to take part in a TRIG email discussion group. Our feeling as an Executive is that this could provide a forum for excellent discussion related to the contents of each TRN, after it is published as well as any other treatment research-related issue that members would like to put up for discussion.

Further news - the second Research Monograph from the Cutting Edge Conference has now been assembled and is in the final throes of publication before distribution within the next month or so. Remember, this is a collaborative project between TRIG and the NCTD, funded by ALAC as continuing principal sponsor of Cutting Edge.

So it is full steam ahead for another year (and beyond) for TRIG and I thank members generally, but particularly the new Executive for their enthusiasm in helping keep TRIG alive and moving on positively in the new era.

Doug Sellman
8 November 2002

CUTTING EDGE 2002

Cutting Edge 2002 (the annual Alcohol and Drug Treatment Workers Conference) was the best Cutting Edge so far by all accounts. The conference, held in the Rutherford Hotel in Nelson, had a wonderful warm and friendly feeling to it. It was held from Thursday, August 29th till Saturday, August 31st. Over 300 delegates attended and there were nearly 70 presentations or workshops to choose from.

Once again the topics covered were very diverse. Particularly obvious this year were the number of presentations on or about women, dual diagnosis, or gambling. Culture continued to have a considerable and appreciated presence with Mäori and Pacific Nation topics and workshops. Other presentation areas included benzodiazepines, nicotine (making an appreciated reappearance), shopping, opioid substitution through narrative therapy, music therapy and stigma.

This year Carina Walters and Grant Paton-Simpson won the John Dobson Memorial prize for the best presentation on an opioid topic for their paper on “Amphetamine use in a Methadone Maintenance client population” presented at the conference by Amanda Wheeler. The John O’Hagan prize for the best presentation by someone under the age of 35-years was won by Klare Bray for her fascinating paper “High tea” about opium tea abuse in a Wellington client group.

The NCTD are putting out the official Cutting Edge Proceedings from the conference and the NCTD and TRIG (with Doug Sellman as Editor) are again putting together a Monograph from the research stream.

Meg Harvey

NCTD: NATIONAL CENTRE OR NOT? – CONTINUED FROM PAGE 3

The vast majority thought that a National Centre was an important thing to have (94.9%) and that the NCTD had been useful to the treatment field over the last six years (89.8%). In terms of losing the core ALAC grant and therefore the potential ability of the NCTD to be responsive to the field in a truly national sense, over 60% still thought the NCTD should remain as a National Centre, in contrast to only about 20% who thought it should revert to being a unit with only local standing.

These findings are interpreted as general support for the NCTD in concept, its performance to date and its future as the National Centre. These findings strengthen the resolve of the NCTD to survive the upcoming loss of the ALAC core grant and remain a National Centre for the treatment field in New Zealand. The finding that women were split 50:50 in their supportive of the NCTD remaining as a National Centre compared with the majority of men supporting it (the only differentiating demographic factor across the three main questions) raises questions about the perceived value of the NCTD to women in the field. This issue will need further consideration as will the view (albeit a minority one) that the NCTD should become more collaborative with other units.

Doug Sellman
Director, NCTD
24 September 2002

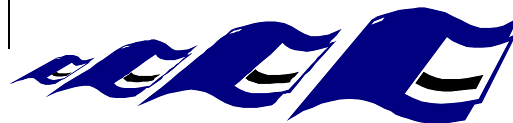
TRN Goes Electronic!

The decision at this year's AGM to try and keep TRIG and the TRN alive was unanimous. Everything in life, however, comes at a price. As Doug Sellman mentions in the Message from the Chairperson, after this issue TRN is going electronic and membership becoming paid in a bid to save money and keep TRIG alive.

So what does this mean for you the reader? From the first issue of TRN in 2003 the newsletter will only be available on the internet or via email. It will be posted on the NCTD website (through the Consultation and Liaison page) in all its usual glory in pdf format (requiring Acrobat Reader), free for anyone to download and distribute to staff. It will also be available in text only via email for all paid members of TRIG. We will no longer being sending out paper copies of TRN to members or attaching it to the ADA Connection or alcohol.org.nz

A message alerting people to when the latest issue of TRN is on the NCTD website will be posted on the A and D Link.

Meg Harvey
Editor



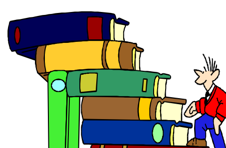
I've Been Reading Continued from Page 8

The use of naltrexone for the treatment of opioid dependence appears widespread internationally, and it was this use that was one of the main arguments put forward for its registration and funding in Australia several years ago. This has always confused me. While naltrexone is undoubtedly helpful in the treatment of people with alcohol dependence, my impression was that there was very little evidence of its effectiveness in the treatment of other drug dependencies including opioids. Kirchmayer and colleagues (***Addiction 2002;97:1241 – 1250)*** have published a review of the evidence-base for naltrexone's effectiveness for opioid dependence in which they conclude that there is no significant evidence supporting it. Negative research findings are often as important as positive ones but are far less likely to be published. It is good to see such reviews receiving a prominent place in influential journals.

Along similar lines, there is little published evidence that SSRI antidepressants aid smoking cessation. However, several other classes of antidepressants do appear to be helpful; some of the tricyclic antidepressants and bupropion for example. SSRI's appear helpful in cannabis cessation in depressed alcoholics and have traditionally been thought of as having similar if not more effectiveness compared to other types of antidepressants for most people with depression. The assumption might be that they are worth a try. However, a randomised study on the effectiveness of the SSRI sertraline in smoking cessation for people with a history of major depression by Covey and colleagues (***American Journal of Psychiatry 2002;159:1731-1737***) not only reports an important finding; that sertraline added nothing significant to counselling at six-months, but also raises an important issue regarding the nature of publication bias in research. A number of "reliable sources" suggest that there have been several good studies submitted which failed to show significant benefits of SSRI's in smoking cessation, but that these studies were turned down for publication by journals. In this area, probably one of many, publication bias appears to impede our ability to make informed evidence-based decisions about which treatments we offer.

So how do we ensure that the research literature that is produced is made available, understood and integrated in appropriate ways into clinical practice? This is an issue that bodies such as NIDA are spending significant resources tackling in the United States at the moment. Rawson and colleagues (***Addictive Behaviours 2002;27:941-949***) summarise the key issues and approaches being undertaken to "close the gap", such as research collaborations between research and treatment agencies, and the production of treatment guidelines and protocols based on the latest research findings. What the US appears to be ignoring is something that we seem rather strong on in the addiction field in New Zealand; researchers who are also clinicians and teachers and who are not only aware of current research findings, but who integrate this into clinical practice and disseminate it by teaching in our various postgraduate addiction papers. There are at least three alcohol and drug orientated postgraduate programmes in New Zealand, and many clinicians working in the alcohol and drug and related fields have undertaken postgraduate study. Okay, so I must admit some bias on this. But I don't think that diminishes the point.

Fraser Todd
Senior Lecturer
NCTD



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

TRIG was established in 1997 to promote research in the alcohol and drug field in NZ.

The **executive committee** are: Doug Sellman (Chair), Lindsay Stringer (Secretary), Peter Adams, Meg Harvey, Alistair Dunn, Eileen Varley, Simon Adamson, Lee Nixon, Helen Moriarty.

Please direct **enquiries to Lindsay Stringer**, PO Box 2924, Christchurch, Phone (03) 364 0480, email: lindsay.stringer@chmeds.ac.nz

Stop Press

The National Centre for Treatment Development (Alcohol, Drugs & Addiction) (NCTD) whew!! is undergoing a name change, to be actioned at the beginning of 2003. The new (simplified) name will be the National Addiction Centre.

Smoking and Problem Gambling: Implications for these Co-existing Conditions

Although about one in four New Zealanders smoke tobacco, a brief tour of gambling establishments would suggest that smoking was more common amongst those who participated in gambling. As a prospective study to ascertain the level of smoking amongst those with serious gambling problems, and whether the rate of smoking changed during gambling, clients (n=79) attending a day clinic for problem gambling treatment for their own gambling behaviour were surveyed over a consecutive period of time; no declinatures occurred. Almost 90% of participants attributed their problems either solely on gambling machines or gambling machines and another gambling mode. Some two-thirds were current tobacco smokers compared with one in four of the general population, while only 2.5% (n=2) had given up smoking. Over 90% already smoked tobacco when their gambling became problematic. The rate of smoking was perceived by problem gambling smokers on two measures to increase significantly on gambling days over non-gambling days ($p<0.0001$) with those smoking more than one packet of cigarettes per day increasing from less than one in twelve smokers on a non-gambling day to more than one in three smokers. Over 80% responded through either of two measures that their smoking increased on a gambling day. Notwithstanding, over 40% of problem gambling smokers considered that their use of tobacco had no relationship to their gambling.

The rate of tobacco use by problem gambling smokers compares with just one in fifty smokers in the general population that smokes at this rate (ACNielsen (NZ), 2000), although for statistical reasons these are not strictly comparable. Over half of the smokers responded that their perception was that tobacco smoking relaxed them, while just under a quarter of smokers indicated that smoking either stressed them or that being unable to smoke made them stressed; a further quarter indicated that smoking both relaxed and stressed them, suggesting that a substantial proportion of problem gambling smokers were experiencing withdrawal symptoms in their use of tobacco.

Currently there is a strong debate in New Zealand and overseas over whether gambling venues should be smoke-free. Some researchers have suggested that up to 40% of revenue comes from continuous forms of gambling (i.e. where winnings can be immediately reinvested, such as gambling machines; Productivity Commission 1999) and, if so, the high rate of smoking behaviour of problem gamblers, if established, may impact strongly upon the gambling industry. The high level of tobacco consumption suggests psychological and physical dependence with the addictions possibly 'competing' for their behaviour if only one were able to be satisfied. In effect this was not tested as smokers could interrupt their gambling to smoke outside in a smoke-free gambling environment or could attend an environment that may be exempt (e.g. some casinos overseas have smoking/gambling areas). However, in the current study, problem gambling smokers were asked whether they would attend a gambling venue, even if it were their favourite, if it became smoke-free. Just over half would continue to frequent the smoke-free gambling venue, with the remainder stating they would not. Most heavier tobacco consumers (up to two packets or more per day) would not frequent smoke-free gambling venues while most lower tobacco consumers (up to one packet a day or less) would frequent them, however the statistical significance was marginal ($p=0.07$)

Findings suggested that gambling environments were hazardous areas for both problem gamblers and non-problem gamblers due to high levels of tobacco smoke. Problem gamblers commonly attend gambling sessions for extended periods, with many gambling machine venues being largely enclosed and separated from other entertainment areas. Some 4,500 New Zealanders' deaths each year are attributed to their smoking while almost 400 are attributed to passive smoking (MOH). The intensity of smoking behaviour by problem gamblers suggests the need for more extensive research in this field as well as consideration of smoking cessation in problem gambling therapy from associative (classical conditioning) and biochemical perspectives.

Sean Sullivan PhD
Abacus Counselling & Training Services Ltd
www.acts.co.nz

Unlocking the Future: Exploring the Psychobiological Connection between Addictive Behaviours and Trauma - Continued from Page 2

The implications for conceptualising addictive behaviours and trauma disorders as a consequence of early attachment experiences are tremendous. The realisation of the importance of the parent/child dyadic relationship, both antenatal and postnatal, brings into question a wide range of controversial issues from the aetiology of addictive behaviours to how we care for children and parents. Based on the scientific evidence available to us on infant development, brain functioning and plasticity, it is an overly simplistic, if not myopic, choice to view addictive behaviours as solely a learned behaviour, lifestyle choice or an inherited disease. In the field of mental health we encounter many individuals imprisoned by trauma from the past and struggling with current maladaptive addictive behaviours. As health care practitioners, it is essential that we allow new sound information to challenge our paradigms of understanding and helping people change addictive behaviours. It is equally as important that we understand and appreciate the time it takes clients to learn new skills, perspectives and ways of being in order to heal the attachment wounds from the past. The key to helping people change is for us to realise that corrective emotional experiences through therapeutic relationships coupled with learning new ways to cope with stress and emotional pain creates new psychobiological realities. This is what opens the locked doors and leads to lasting change in addictive behaviours.

Joel S. Porter, Psy.D
Consultant Psychologist
CADS Waikato DHB
porterj@waikatodhb.govt.nz

For a copy of the references quoted above please email meg.harvey@chmeds.ac.nz

Treatment Research Interest Group (TRIG)

Alcohol, Drugs and Addiction

MEMBERSHIP RENEWAL FORM

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

Membership in TRIG entitles you to the following
- three issues of the Treatment Research News via email
- a reduction in registration fee at the 2003 Annual Treatment Conference
- membership in a potential TRN email discussion group

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

Surname ______________________ First Names ______________________

Postal Address ____

____

Daytime Phone Number ______________________ Fax Number ______________________

E-Mail Address ____

(NB - You Must Provide An Email Address If You Wish To Receive A Copy Of TRN)

The objectives of TRIG are:-
- *To foster interest in scientific research on treatment of people with alcohol and drug related problems in New Zealand.*
- *To disseminate and promote research findings related to effective treatment of people with alcohol and drug related problems within New Zealand.*
- *To support the development of improved treatment services for people with alcohol and drug related problems in New Zealand.*

Declaration

I support the objectives of TRIG and wish to be a member of TRIG for the 2003 calendar year. I understand membership fee is $20

Signed ______________________ Date ______________________

Please make cheques payable to: TRIG

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

Thank you for completing this form and sending it back to:

Lindsay Stringer, PO Box 2924, Christchurch (Phone 03 364-0480, Fax 03 364-1225)

One of the roles of good research is to provide more objective (and note the use of a relative term "more", rather than an absolute!) ways of understanding the world, tempering the biases and prejudices in our own beliefs, which may be useful and valid in our own lives but which may not always be applicable to the lives of others. To this end, good research requires the rigorous application of some safe-guarding principles in its design and it is the role of peer reviewed journals to ensure that the research that is published is of good quality. To varying degrees this is usually the case especially in those journals with a reputation for good quality. In our field, good quality seems to be judged on the basis of the rigorousness of the studies and their applicability to the people we are involved with in our professional roles. But to have meaning for the people the research is designed to help, those people in the population with alcohol and drug related problems, we also need to know how to make sense of the research, and it is here that problems often arise. The interpretation of a body of knowledge is open to personal bias and prejudice. Again, some rigour in translating research into our professional practice is needed, but it seems to me that outside academic environments such as universities, this skill is seldom taught and equally seldom appreciated. The result is that research findings are often interpreted to support peoples personal biases, undoing much of the value of the objectivity of the research in the first place.

A common error in the interpretation is the assumption that an association between variables indicates causality. The current vogue of publishing studies that find associations between things such as alcohol use and various medical problems or unwanted behaviours in certain age groups troubles me. While these studies do provide some interesting information, often readers of these articles draw unjustified conclusions from these findings and proceed to put them into clinical practice. For example, the data showing associations between levels of cannabis use and legal sanctions against it – whether positive or negative – are often used to assume causality and therefore used as arguments for or against decriminalization. Korf (***Addictive Behaviors 2002;27:851-866***) reviews data on the relationship between the legal status of cannabis and rates of use, focusing on the Dutch experience but also drawing on data from other countries. He presents a persuasive argument that while cannabis use rates have increased in many countries at the same time as laws around cannabis use have changed (though in different directions in different countries), and that taken in isolation this data could suggest a causal relationship, the most likely explanation is that rates of cannabis use in a population fluctuate in wave-like fashion depending on fashions in youth culture quite independent of its legal status. Another example, in a similar vein is the effect of cannabis use on younger people. Cannabis use in younger people appears to be associated with a range of problems including conduct problems, family disadvantage, mental health problems and suicide rates. The assumption from this is often that cannabis use is therefore unwise for these reasons. In other words, cannabis causes these problems and the problems would go away if people stopped using cannabis. However, the degree to which cannabis causes these problems versus problems arising as a result of common predisposing or confounding factors remains controversial. Fergusson and colleagues ***(Addiction 2002;97:1123-1136)*** tackle this issue in an interesting way in their paper reporting more findings from their Christchurch Health and Development Study. Adapting statistical modelling techniques more commonly used in areas such as economics, they explore the relationship between cannabis use and various psychosocial outcomes taking into consideration not just those known and observable confounding factors, but also non-observed confounding factors; factors that were not necessarily known and taken into account in previous similar studies but may have still played a part in the association. They conclude that in the people studied who ranged from 15-21 years of age, cannabis use, especially regular use, is:

1. Associated with a significantly increased risk of other forms of illicit drug use.
2. Associated with a small but detectable increase in crime, depression and suicidal behaviour.
3. More harmful for younger users and that harms decline with increasing age.

The authors acknowledge that their model may still have omitted to consider some confounding variables and therefore may overestimate these associations, but their analysis provides us with a more comprehensive picture than previous approaches.

Eisen and colleagues ***(Addiction 2002;97:1137-1144)*** investigated the effects of heavy marijuana use on an older population (38-51 years) of monozygotic twin pairs, one of whom was a past heavy marijuana user, the other not. Able to control in this way for confounding genetic influences, they found that heavy use two decades previously was not associated with significant adverse psychosocial events.

In their editorial, Solowij and Grenyer (***Addiction 2002;97:1083-1086)*** introduce the Fergusson and Eisen articles and provide a good overview of the associated research, proposing that these two papers do not contradict each other. Rather, they suggest that heavy cannabis use may be particularly harmful for people in their early adolescent years, but much less so later; the effects of heavy marijuana use may be age dependent. They propose that this provides a potential target for prevention and early intervention initiatives. Now if we only knew how to do that effectively…

Continued on Page 5

Contact Person for Treatment Research News:
Meg Harvey
Phone 364-0480
Email:
meg.harvey@chmeds.ac.nz

Treatment Research Interest Group (TRIG)
PO Box 2924
Christchurch

TRIG is sponsored by the National Centre for Treatment Development (NCTD)
Dept of Psychological Medicine
Chch School of Medicine & Health Sciences
4 Oxford Terrace
PO Box 4345, Christchurch
Phone 364-0480, Fax 364-1225
www.nctd.org.nz