Treatment Research News

Alcohol, Drugs and Addiction

May 2005 | *Newsletter of the Treatment Research Interest Group* | Vol 9 No 1

Editorial

Welcome to the first issue of TRN for 2005. Having become one of the many NACers to now bike to work, I have been thoroughly enjoying our "Indian Summer" and the accompanying warm and dry days. A bit of rain for those hydro-lakes would be good now though.

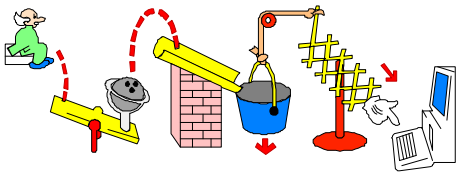
We are continuing to try and bring you fresh and interesting research from the AOD sector in New Zealand. This is a sector that is certainly evolving with new committees, competencies and governing bodies all around. There seems to be a lot of movement in and out the AOD field at the moment with a great number of jobs being advertised on the AandD link.

The evolution of the Alcohol and other Drugs field has now impacted on the TRN. As Simon Adamson mentions in the TRIG chairperson report, TRIG is about to become the Addiction Treatment Research Interest Group. Consequently, this is the last issue of the Treatment Research News per se. From the next issue on we will be known as the more encompassing Addiction Treatment Research News. So keep your eye out for a new look ATRN after Cutting Edge this year.

This first issue of the year contains two interesting and quite different articles. The first is a report on nicotine research from Mark Wallace-Bell of the National Addiction Centre. The second is a meaty discussion of AOD treatment and morality by John Caygill. In addition, we have our usual Gambling spotlight – this issue Sean Sullivan looks at gambling and depression. We also have the regular NAC report as well as the TRIG Chairperson report from Simon Adamson. This year we say goodbye to Fraser Todd as our "I've been reading" columnist. Instead each issue's column will be written by different personalities in the AOD field. First up we will hear what Joel Porter of the Pacific Centre for Motivation & Change has been reading.

Enjoy this first issue of the year. I hope it has a lot to offer you and your service. Please remember we are always more than happy to receive letters to the editor. Happy reading.

Meg Harvey
Editor
May 6, 2005



ATRIG! Bless you!

As the Treatment Research Interest Group (Alcohol, drugs and addiction) is officially changing its name to the Addiction Treatment Research Interest Group, the TRN will be following suit. From the next issue (late September 2005) the Treatment Research News will become the Addiction Treatment Research News. We hope that our name change will provide little confusion for people and are looking forward to our fresh new look.

TRIG Membership

The executive committee of the Treatment Research Interest Group (TRIG) would once again like to take this opportunity to remind current members that membership of TRIG is annual. Currently we have 67 members, only 1 of whom have renewed their membership for 2005.

New members wishing to join TRIG are warmly invited to fill in the membership form on the last page of this newsletter. Current members are also able to use this form to renew their membership.

Membership of TRIG entitles members to an email copy of each edition of the Treatment Research News (TRN) and participation in the TRN discussion group.

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 other drugs field in New Zealand.

The **executive committee** are: Simon Adamson (Chairperson), David Benton, Raine Berry, Alistair Dunn, Meg Harvey (Editor), Janie Sheridan, Lindsay Stringer (Secretary)

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

DEPRESSION AND GAMBLING

Depression is commonly associated with problem gambling – whether you are the person gambling, or you are the family or whanau of someone with a gambling problem. The stress of problem gambling, when occurring with behaviours (secrecy, chasing money to fund gambling), feelings (excitement, stress) and thoughts (dreams and consequences) that surround the gambling, can often trigger depression. With the rapid onset of financial problems that accompany excessive gambling, social problems can intensify as we start to use gambling as a way to temporarily relieve the depression (switch off the negative thoughts and feelings). Instead of relieving the depression, the increased gambling behaviour can cause the depression to deepen, as we gamble more excessively to switch off the unmanaged stress (this is often called developing a 'tolerance'). In other circumstances, some people with depression may find gambling relieves their depression temporarily (self-medicating) with the result that they begin to gamble problematically. There is some evidence that, problem gamblers' depression may initially deepen when attempting to stop gambling, in that the hope of solving often substantial debt through a gambling 'win' is lost, while creditors are seldom influenced by attempts to change behaviour.

Recent indications are that:

- As family or whanau you may be twice as likely as the general population to be experiencing depression, and gamblers with problems may be three times as likely to be depressed.
- Three-quarters of those with gambling problems arising from their own gambling are likely to meet the criteria for Major Depressive Disorder during their lives, with many experiencing recurrent episodes.

Suicidal ideation is common amongst problem gamblers (DSM refers to an estimated 20% of Pathological Gambling Disordered attempting suicide). In many cases, the depression is masked by 'numbing', as the person with gambling problem attempts to dissociate from their emotions.

A substantial proportion of people with gambling problems will also be affected by other problems, the most common being depression, but followed closely by anxiety disorders, alcohol and/or other drug misuse, to a lesser extent personality disorders (particularly Narcissistic PD, Borderline PD and Antisocial PD), sleep disorders, and for many new to New Zealand, Adjustment Disorders. These often interrelate with the gambling to heighten suicidal ideation.

Depression can often be unrecognised by the person experiencing gambling problems. Their developing isolation is often a preferred status to hide the extent of their gambling, but can also result from family break-up resulting from disclosure of the extent of the gambling and lies used to cover it. The reduction of focus to day-by-day and heightened stress, can mask the slowing down resulting from depression by overt agitation.

A screen that can often be used to identify the possibility of depression is the brief, two-question screen based upon the first two questions of Major Depressive Episode. A positive response to either question indicates a higher likelihood that depression currently exists.

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things? (Whooley et al 1997)

Response to a positive screen can help planning some strategies to address the low mood they are experiencing. Emphasise that it will not be a formal diagnosis (that can take some time and cover many more aspects (e.g., medical tests, assessing which mood condition (see above) and look to precipitating causes), but can contribute towards self-monitoring of their mood and, if their behaviour appears to contribute towards the depression, towards motivation to change that behaviour.

The strategies to address depression are based upon whether the depression is arising from a behaviour, such as gambling, or due to another cause. If an exception to the usual course of a development of a mood disorder applies, the focus may be upon the precipitating factor e.g. drug induced depression, bereavement (a normal reaction unless more than two months duration), or medical condition such as dementia.

The strategies below are often used by therapists in addressing a client's problem gambling behaviour, when depression is suspected of being present. Because of the high co-existence between problem gambling and depression, screening for depression is recommended, rather than assume the depression will abate once the gambling reduces or stops. The following are strategies that may be used where the depression is not due to a medical condition, but rather due to behaviours that are affected by accompanying negative thoughts and emotions.

- Identify the depression (e.g., use a screen, give feedback and ask for verification, or otherwise, inform the client of the findings).
- Advise the client that they may obtain an assessment of their mood from a GP; as prescribing antidepressants are a common outcome, identify barriers to taking antidepressants – provide information regarding lack of addictiveness, that there are no overt symptoms of taking an anti-depressant. Also, for gamblers, identify whether they have sufficient money to see a GP. Some mood disorders, such as Bipolar Disorder, may be identified by the GP and best controlled through medicine.
- Discuss with the client where the gambling fits in – relate the gambling to the depression, and that addressing the depression is also a harm-reduction strategy.
- Discuss that depression can be common (normalise), especially when distress occurs.
- Discuss that exercise can be effective in helping to adjust out of the depression - may assist through re-establishing homeostasis in central nervous system (there are reduced levels of serotonin neurotransmitter in depressed people) or may give a sense of achievement and reverse feelings of lethargy and lack of motivation through the exercise strategy. Start with a small task after the client gives support for possible exercise strategies, give positive feedback and support for <u>regular</u> exercise (doesn't have to be strenuous).
- Discuss social activities – socialising can assist with raising their self-esteem.

CONTINUED ON PAGE 3

National Addiction Centre

Two research degrees have recently been completed by students enrolled with the NAC. Cate Kearney, Manager of the Alcohol Drug Association of New Zealand (ADA) has just this month passed her Master of Health Science (Mental Health) with Credit, having completed a Master's thesis titled "Quality Treatment for Women with Problematic Alcohol and Other Drug Use", supervised by Daryle Deering. Earlier this year, Ian Sheerin, Lecturer, Department of Public Health and General Practice, had his doctoral dissertation passed, titled "Consequences of Drug Use and Benefits of Methadone Maintenance Therapy for Maori and non-Maori Injecting Drug Users". Ian was supervised by Assoc Prof Doug Sellman and Dr Terri Green (Lecturer, Dept of Management, University of Canterbury). Congratulations to both Ian and Cate.

Both pieces of research embody the commitment the NAC has to research with a direct clinical application, particularly when relevant to the New Zealand addiction treatment environment. The NAC continues to have a significant number of students enrolled in research degrees, at both Master's and Doctoral level.

Two studies in their early stages worth mentioning are the work of Dr Mark Wallace-Bell (Senior Lecturer) and Dr Ria Schroder (Research Fellow).

Dr Schroder is leading the Youth Treatment Retention Study, which aims to canvas and document factors that improve the length of time young people at serious risk of substance use harm engage with and stay in treatment. One hundred and forty adolescents who have undertaken alcohol and drug treatment in New Zealand from outpatient, daypatient and residential settings, including Maori and Pacific youth, will complete a combination of structured and semi-structured interviews about their alcohol and drug use, mental health and alcohol and drug treatment experiences. Seven youth services from both the North and South Islands are taking part. The study is currently in the early stages of recruiting, and it is anticipated that full recruitment will take about a year.

Dr Wallace-Bell is currently conducting a number of nicotine dependence treatment research projects. This research is targeting smokers who continue to smoke into middle age and beyond who are more likely to suffer from tobacco-related diseases such as COPD and have a higher risk for cardiovascular disease and a range of cancers. Relapse rate among smokers who enter into conventional treatment using nicotine replacement therapy (NRT) is alarmingly high. New strategies are required for the group of chronic relapsing smokers who know they should quit but are reluctant to enter into standard cessation programmes because of past failures and anxiety about abrupt cessation and withdrawal symptoms. The Canterbury Medical Research Foundation funded pilot project that Mark is currently conducting uses NRT for up to six months as a maintenance therapy to assist chronically dependant smokers to reduce their smoking consumption and maintain abstinence. There is limited research to determine the efficacy of Maintenance Nicotine Replacement Therapy (MNRT) and what effects it has on smokers quit rates. This work is a small pilot in preparation for a larger controlled study of the approach.

Mark is also working with researchers at the Clinical Trials Research Unit at the University of Auckland on a number of collaborative projects with funding applications currently under consideration by the HRC. These studies propose to examine the effectiveness of pre-loading smokers with NRT before they quit and a genetically modified reduced nicotine cigarette. These novel approaches have not been tested under controlled conditions and it's hoped that the research will provide useful data for the development of a wider range of treatment options for smokers.

Dr Simon Adamson
Senior Lecturer
National Addiction Centre

Continued from Page 2

- Check regularly where they are with their depression using scale – feedback assists in recognising mood and attributing any downturns to events. *"On a scale of one to ten, where one is very low and ten is feeling very good, how are you feeling now?"* (record the level and use to compare positive changes in the next session).
- When feeling depressed people can fail to acknowledge when things go right. Ask clients to provide themselves with a small reward when things go right in order to raise their awareness of their successes.
- When we are depressed things seem to always go wrong, and we can often incorrectly attribute them to our own 'failings'. Instead, when things don't go their way, ask the client to write down three different reasons that may have been the causes of the poor outcome, then try to objectively choose which one was most likely. Sometimes they will still attribute it to their own faults, but with others they may choose reasons quite independent of themselves. This will encourage clients to use critical appraisal rather than assume personal negative reasons that entrench the depression. Ask them to compare the way they felt after selecting an alternative (compared with their first feelings). This assists to reinforce the client's belief around being able to improve control their own emotions and wellbeing.

Depression is a common experience for clients affected by addictive behaviours: because it becomes normal in the way they interpret events it can become a barrier to behaviour change. A brief intervention to address depression may result in more effective therapy for the presenting condition. Although problem gambling is highly associated with depression, therapy for other addictive behaviours may also benefit by identifying existing depression, and providing information and strategies, may opportunistically elevate what for many is an ongoing negative, unhappy and low expectation for enjoyment of life. In addition, it may address what may be the hidden driver for the harmful behaviour that the client presents to you, their chosen health professional, for help with.

Sean Sullivan PhD, Director
Abacus Counselling & Training Services Ltd

This year heralded the implementation of the Smokefree Amendments Act and the welcome experience of smoke-free bars, hotels and the like. This initiative will have a positive impact on the harm done by second hand smoke, but the extent to which consumption will decrease has yet to be determined. My expectation is that we will see a very small change in the prevalence figures over the long term. Legislation alone is not enough to drive smoking rates down and keep them down. We need effective and evidence-based treatments and more flexibility in how we approach the treatment of nicotine addiction. The standard model is to provide behavioural cognitive interventions with Nicotine Replacement Therapy (NRT). In this kind of treatment NRT is used to relieve withdrawal symptoms. It is not a maintenance therapy. Recently there has been much discussion concerning alternative approaches using nicotine replacement. These include individualising treatment regimes based on differences in nicotine metabolism and modifying cigarette nicotine yield to drive down consumption and reduce harm.

I recently had the pleasure of attending a Science for Tobacco Control workshop in Auckland with Prof Neal Benowitz. Benowitz is Chief of the Division of Clinical Pharmacology and Experimental Therapeutics, University of California. He presented some very interesting data on racial differences in nicotine metabolism involving the liver enzyme CYP2A6. The CYP2A6 enzyme is the primary pathway for nicotine metabolism and research has established that ethnic groups such as Asians and Maori, compared to Caucasians, are fast metabolisers of nicotine. This is a vulnerability to the development of nicotine dependence and may hinder cessation attempts. He discussed the implications of his research for treatment of nicotine addiction. The argument is that doses of NRT need tailoring to specific individuals metabolizing characteristics in order to gain maximum benefit from the treatment. Too little and they will not get the benefit, too much and they will experience unpleasant side effects. Length of treatment is also an important factor. I am currently investigating this issue in a pilot trial of long-term NRT treatment. Clients receive up to six months of NRT at high doses. This treatment targets chronic relapsing smokers. The results will form the basis of a larger Randomised Controlled Trials (RCT).

Other research discussed at the conference focused on the idea of reducing the nicotine yield of cigarettes at a population level. Benowitz has proposed to federal government in the US a long-term nationwide project to reduce the nicotine yield in bought tobacco products over a period of 10 years or more. The proposal is that the yield would drop from its current level to almost zero, thereby eliminating the main addictive element in tobacco and its reinforcing properties. In the early phase of this intervention, there is the possibility of compensatory smoking, smuggling, and homegrown supplies. However, despite these arguments there is overwhelming evidence that this population-wide intervention yields extensive benefits.

Finally studies are underway in New Zealand investigating the efficacy of a reduced nicotine cigarette (QUEST) currently only available in the US to reduce smoking and promote cessation. Smokers would start on a high dose, reduce to the lowest dose and then quit. This is a contentious issue as it involves the use of a genetically modified product and the endorsement of a tobacco industry product. However, the result of a pilot conducted at the NAC in a group of smokers has shown that a GM reduced nicotine cigarette would be a palatable treatment approach. A larger scale RCT is under development to test its clinical effectiveness.

We are now at a most interesting phase of tobacco control development. Public health policy is having its effect, but what we need to support this are more effective and extensive treatments for nicotine addiction. With recent developments in genetic research and clinical trials to test the effectiveness of new approaches we are fast approaching the time when we will be able to offer smokers a wider range of more flexible treatments.

Dr Mark Wallace-Bell
Senior Lecturer
National Addiction Centre

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 Addiction Centre
Dept of Psychological Medicine
Chch School of Medicine & Health Sciences
4 Oxford Terrace
PO Box 4345, Christchurch
Phone 364-0480, Fax 364-1225
www.addiction.org.nz

"Morality": The new pejorative in AOD treatment

In the AOD treatment field, moral considerations are often portrayed as barriers to both understanding and effective interventions, and are likely to be condemned as such. "The scientific study of addiction has strongly opposed value considerations in addiction, regarding these as remnants of an outdated, religious-moral model. Behaviour therapists, experimental psychologists, and sociologists hold this view in common with disease theorists who have championed the idea that a moral perspective oppresses the addict and impedes progress toward a solution for alcoholism and addiction." (Peele, 2000a; p.2).

On our A&D netlink, concerns are often expressed about moral propositions getting mixed up with matters of fact. Putative 'moral' concerns may be unmasked and labelled as though they were subversive contaminants, undermining issues of 'pure' scientific deliberation. This article suggests that moral considerations and dynamics are not easily separable from issues of well-being or processes of treatment.

Defining 'moral considerations'. Moral considerations center around *accountability* in the dual sense of an explanation ('account') of human behaviour that imputes intention and purpose to actions and acts for which the actor can be held responsible, and deserving of praise or condemnation – by themselves according to their conscience, and by others according to societal codes of right and wrong/good and bad, and the finer shades in between. Related notions applied to a person's behaviour over time include the concepts of 'character' and 'willpower' – or their absence. Moral failing, then, may connote either passive weakness or wilful badness of character.

At its most concrete, a moral realm is defined by standards or codes of right and wrong/virtuous or ignoble actions, where the moral valence is inherent in both the act and the imputed character of the actor. Immoral behaviour is a threat to a sense of orderly or virtuous society, and the 'appropriate' response is condemning the sinner and/or facilitating their salvation.

A less prescriptive moral perspective retains the linked concepts of personal choice and individual accountability, but takes a more pragmatic view of the actual consequences to others as well as to the individual concerned.

The place of moral models, and 'culture'. In the AOD field we are used to the idea of various models that provide some sort of explanation for problematic use of intoxicants. Generally, a moralistic approach or 'moral model' is cited as the earliest (Brouwer et. al., 1989, p.149; Lindstrom, 1992, p.147) and in a sense most basic (Edwards, 2000, p.93), superseded over time by medical appraisal – compulsive drinking as a disease – increasingly informed by scientific research in neurochemistry, learning theory, and genetics. Testable objective facts about the human organism replace unfalsifiable subjective imputations around individual conduct and 'character'.

However, biology alone is generally not deemed to provide the answers to the complex issues raised by problem-drinking phenomena - thus the progressive adoption since the 1970s of "a multivariant approach according to which alcohol dependence is maintained by a complex interaction of biological, psychological, and social antecedents and consequences." (Lindstrom, 1992; p.104). Nonetheless, these 'complex' and 'integrative' models retain a deterministic character: notions of individual agency and accountability for intended acts are notable by their absence.

'Culture', as normative patterns of behaviour and belief in defined societal settings, has long been acknowledged as significant - even essential - in understanding problematic substance use (Heath, 1987). However, in the biopsychosocial formulation it is "largely subsumed as part of the social role, with some components being conceded to the psychological" (Heath, 1995; p.331). Elsewhere, 'culture' simply dissolves into sundry 'environmental' factors, as in 'gene-environment' interactional models.

Despite the above, there remains an enclave of resistance to the exclusion of moral considerations from the ruling 'biology plus environment' model of causation. Fingarette (1988) challenges the medicalization of alcoholism, stating that: "The disease concept of alcoholism not only has no basis in current science; it has *never* had a scientific justification" (p.65). He cites family setting, age, ethnic and cultural values as some of the "predominant influences that evoke or shape patterns of drinking" (p.67). For him, agency is crucial: "alcoholics must *want* to change and *choose* to change --- heavy drinkers must take responsibility for their own lives." (p. 69). [emphases in the original].

A related position is held by Stanton Peele (2000b), for whom addictive behaviour "is identified by human experience, which means that individual and cultural outlooks are crucial to its appearance" (p.600). Peele emphasises the values of the individual (derived from socialisation and individual experience) as "the most important of all the unacknowledged factors in addiction, missed by pharmacologists and sociologists and traditionalists and constructivists alike." (p. 607). "That people take drugs at all reflects their values...That people continue to use drugs, use them excessively, ACTUALLY [sic] become addicted to drugs, remain addicted to drugs, and quit being addicted are all in large part value statements" (p. 606). He cites the high valuation of sobriety and achievement in Jewish and Chinese cultures as examples of values orientations that predispose to relatively low levels of alcohol use disorders (2000a), and relates adolescent drug abuse to a "failure--- to develop prosocial values" (p.14).

Both Fingarette and Peele note comparable rates of improvement for 'untreated' compared with 'treated' addicts, and Peele highlights "the relationship of therapeutic and natural remission to personal value resolutions by addicts and to life changes they make that evoke values which compare with addiction" (2000a, p.3).

Outside of this enclave or minority view, the general impression is that moral understandings or issues around addiction have been superceded: in the light of new scientific knowledge they are either trivial, irrelevant, or simply invalid.

CONTINUED ON PAGE 6

CONTINUED FROM PAGE 5

Furthermore, the stigma associated with judgmental perspectives that regard dependence/addiction as shameful and blameworthy is now widely recognised as potentially damaging to individuals, and counter-therapeutic.

The issue of stigma. AOD researchers and treatment workers, along with health professionals in related fields such as psychiatric illness, recognise that stigmatisation is unfairly punitive and harmful. Judgmental views of dependence and psychiatric illness are seen to be commonly based on inaccurate and unscientific understandings, and therefore unwarranted. Stigmatisation adds insult to injury, and complicates individual treatment of substance-use disorders by accentuating disempowering emotions (guilt and shame) and negative self-evaluations, which impedes positive change (e.g. Link and Struening, 1997). Furthermore, at both individual and public health levels, reaction against stigma reinforces denial of the problems, and may deter people from seeking treatment as well as limiting the provision and availability of treatment. Within and across societies, though, such substance-related stigma appears to be widespread and deep-seated.

A recent World Health Organization study (2001) found that key informants in a diverse range of societies consistently rated drug dependence and alcoholism (excessive use, plus inability to control despite problematic effects) as among the most socially disapproved and stigmatised conditions from an extensive list of disabilities and social disadvantages. Substance dependence was widely seen as self-induced, and therefore less deserving of State social assistance than other disabilities (p.252); or social assistance and a sympathetic attitude were conditional on the dependent individual accepting available treatment. "Those who readily expressed their culture's compassion, understanding and willingness to accommodate people with physical health conditions often went on to note the culture's impatience, disdain, or even outright hostility towards alcoholics and mentally ill people. The most often cited basis for this difference was the extent to which the health condition is [perceived as] a result of voluntary actions or morally culpable behaviours." (p. 273).

Substance use, stigma, and sociological considerations. As stigma is shaped and focused by social context, so are substance use patterns themselves: the desired features and the problematic consequences. Even something as physiologically 'basic' as alcohol intoxication is heavily context-dependent in its actual manifestation (MacAndrew and Edgerton, 1970). The other striking sociological feature of alcohol use is its controversiality: "There have been very few, if any, societies whose people knew the use of alcohol yet paid little attention to it. Alcohol may be tabooed; it is not ignored." (Mandelbaum, 1965; p.289). Partly this reflects the actual 'pluses and minuses' of alcohol use. On the one hand it is often highly valued as a source of individual psycho-sensory gratification, as a customary aid to leisure and sociability or celebration and ceremony, imaginative or spiritual facilitation, a source of medicine or food, and a major industrial enterprise. On the other hand, substance use is overtly problematic for many societies, in readily acknowledged and familiar ways. Yet the fact is that the use of alcohol and other intoxicants is problematic beyond straightforward issues of incapacity or harm and their accompanying costs, and that this is widespread across a range of cultural settings and contexts – even allowing that a host of human societies have managed to maintain some sort of equilibrium around the use of intoxicants.

While "most people can learn not to behave too offensively when drunk", intoxication with alcohol "always carries with it some degree of unpredictability" (Edwards, 2000; p.57).

Intoxication and dependence are *inherently* (not just *contingently*) challenging, in many societal, interpersonal, and individual contexts. For a start, there are scarcely resolvable issues for complex societies around both the legal excuse value of intoxication, and less formally the affording of moral licence. Then there are contentions over which intoxicants are allowed, in which social enclaves, and under what conditions – which Edwards attributes to underlying concerns about whether intoxication from other substances – e.g. LSD or amphetamines – can be shaped and contained.

Going a step further, I'm suggesting that there is a deeper and more widespread pre- or proto-moral sub-stratum of concern, valorizing both the benign moral forces that are active in treatment undertakings as well as the impassioned political debate, stereotyping and stigmatising that occurs in diverse social settings.

The infrastructure of morality. Humans are essentially cultural beings, and the phenomenon of intoxication has the inherent potential to disrupt or at least perturb the basic preconditions for the successful operation of culture: intelligibility of action/events, communicability of meaning, predictability of performance, and attribution of intention. From the fundamental interpersonal processes of expectation (with neutral *anticipation* and strategic *obligation*) and accounting (with neutral *explanation* and strategic *attribution of responsibility*), the socio-cultural edifice of social roles and customs/norms/moral codes emerges and is sustained. Further potential perturbation surrounds the phenomenon of dependence, which challenges the stability and therefore the predictability of role performance and interpersonal obligations over time, as well as carrying the asocial implication of an inner-directed drive to obtain psycho-sensory pleasure or relief that takes priority over a more outer-directed and pro-social satisfaction of needs and wants.

In his anthropological account of the preconditions for human society, Wilson (1983) states that: "The establishment of human social relationships and the assurance of their continued existence, no matter what form they take, depends on the exercise and imposition of the promise" [in the general sense of obligation and the onus of reciprocity] (pp100-101). Where the possibility of making and fulfilling 'promises' is compromised, trust is withdrawn and the structure of relationships is undermined (ibid). In different though often related ways, both intoxication and dependence undermine expectations as well as the potential for accountability and the fulfilment of obligations, and are therefore challenging to the basic interpersonal (socio-moral) order. This not only fuels the stigma that treatment overtly opposes – even if it unintentionally reinforces it at the same time – but it may frame the context and permeate the content of the treatment enterprise itself.

CONTINUED ON PAGE 7

CONTINUED FROM PAGE 6

Significantly for this argument, the mind-influencing effects of nicotine are not disruptive of interpersonal processes, incapacity from overdose (acutely) is scarcely an issue, nor is nicotine dependence socially challenging to sustain (given that it is widely, relatively cheaply and legally obtainable). Thus nicotine addiction remains minimally stigmatised, despite the huge burden of eventual individual ill-health and therefore cost to society overall.

Moral factors in treatment. As already noted, the treatment sector as well as the academy disavows moralistic intentions or techniques. Historically, the development in complex societies of professional paramedical treater roles (nurse/therapist/counsellor) and the search for effective clinical interventions has paralleled the move away from overt moral exhortation or paternalistic care for 'fallen' individuals.

On the surface, this is justified – even demanded – by reason, humanitarian considerations, and professional ethics. Stigma is invalid, punitive, and disempowering. Moralising is more likely to fuel resistance than to promote therapeutic change (Miller and Rollnick, 1991). Nor do health professionals have any mandate from society to take a moralistic stance towards their clients: AOD treatment workers are generally not accorded superior moral status, and they generally do not see their clients as morally degraded. Many treatment workers have either themselves experienced the problem of substance dependence or they work alongside colleagues who have been in that position.

At another level, however, this stance is partly disingenuous, and carries the unsupportable implication that the treatment enterprise is carried out in some acultural zone apart or insulated from the underlying moral dynamics of human society.

In reality, the opposite is the case. While people who present to treatment services may have drifted unaware into dependence [who would set out to become addicted?], the generally difficult and often protracted journey out of this condition occurs because the person in large part has decided to overcome the problem. Whatever the person's sense of accountability for his/her actions and the consequences of these actions while they were substance-affected or dependence-driven, the move away from dependence involves conscious choice and generally also some experience of the willed inhibition of desire in order to achieve a goal. The 'treatment' that is offered to help confirm and realise that choice in most cases either openly traverses moral terrain or covertly employs a moral dynamic. Though overt 'moral suasion' is now an historical artefact, one way or another – as guide, mentor or goad – the treater is 'in' the client's 'personal moral space': the arena of choice and commitment, accountability for actions, correction of behaviour through internalised emergent systems of shoulds/oughts, and reappraisal of wants and needs. The very notion of 'salience', embedded as a defining feature of dependence, is in a sense a gateway to a personal moral perspective. AOD counselling, in effect, often encourage clients to take what is an essentially moral view of their lives: to evaluate their behaviour, and to clarify and weigh-up their personal values.

One of the most obvious examples is the 'Twelve Step' approach that originated with the self-help group Alcoholics Anonymous and now features in a variety of treatment settings. This is based on a seemingly paradoxical disease-model absolution for one's own failings while in the grip of addiction, contingent on commitment to a programme of personal moral reconstruction (e.g. making 'a fearless moral inventory', self-monitoring for pride, self-denying service to other alcoholics) and making amends to others for past harms. The move out of addiction and into sustained abstinence is called 'Recovery', often marked by a commitment to a way of living one's life that entails following precepts (e.g. the wisdom of 'the big book'), working to identify and overcome personal deficiencies, suppressing appetitive desires, and being readily available to help others in similar predicaments. While the treater's role in this undertaking is certainly not to pass judgement [clients are encouraged to do that themselves, via Steps 4 and 5] it is nonetheless acceptable to offer suggestions and to 'confront denial' (Project Match 12-Step Facilitation Manual). Often the treater is in a role-relationship to the client of guide or mentor. Clients themselves may view their recovery as a persona-shift from despairing drunk to worthy member of society.

Those treaters who do not accept the disease model or a 12-step treatment approach may still recognise some validity in the term 'recovery', with its connotations of overcoming addiction as a more personally challenging and life-changing undertaking than a simple substitution of habits or modification of lifestyle choices.

At the seemingly opposite pole, there is motivational interviewing/enhancement therapy (Miller and Rollnick, 1991): a set of techniques and a structured treatment approach that appears utterly non-judgemental, non-criticising, minimally confronting or advice-giving, and highly client-centred – yet in fact is highly purposeful and persuasive through the treater's carefully constructed, self-aware yet client-directed responses (p.52). Techniques are employed in an emergent engagement with the client, which is guided on the one hand by the need to convey acceptance, empathy and genuineness, and on the other hand by a determination from the therapist to draw-out of the client their own sense that what they are doing is in some way harmful and undesirable to themselves or others (i.e. 'bad'), and that at least part of them wants to change for the better. Though objectively described with reference to the values-neutral concept of 'cognitive dissonance', it is hard to see how this 'moral judo', with its central technique of selective responding, could operate without an at least implicit reference to personal values orientations on the part of both therapist and client.

The involvement of family and friends in treatment is another purposeful intervention modality with a moral dynamic, structured and steered by the treater so that the 'significant others' use their relationship with the client to bring everyday moral forces to bear. In a sophisticated version that Galanter (1993) has called 'network therapy', the treater is deliberately though covertly manipulative of the situation in order to potentiate and maximise the 'moral suasion'.

In a more detached way than nineteenth century 'moral therapy' (which deliberately aimed "to build up the dormant or decayed powers of self-control through discipline, routine and hard work":

CONTINUED ON PAGE 8

CONTINUED FROM PAGE 7

Levine, 1978, p.164), a 'community reinforcement approach' manipulates 'environmental contingencies' to 'shape' client behaviour in the direction of lifestyle improvements and enhanced social involvement. Though justified by empirical findings that such changes are conducive to diminished or less harmful substance use in cases of otherwise intractable dependence, this approach also instantiates most treaters' beliefs and personal values about desirable social functioning.

Conclusion. Alcohol and other drugs of intoxication and dependence are 'morally-loaded' substances with the potential to challenge and perturb social functioning in different ways and at different levels, as discussed above. Whether 'excusable' or not, it is understandable that negative stereotypes arise, resist correction by fact (e.g. the often large disparities between fantasy and reality pertaining to daily opiate use), and sustain processes of stigmatisation, in a wide range of societal and cultural settings. The experience of contingent unpredictability generates emotionally charged and morally significant stereotypes of essential unreliability - reinforced by culturally-afforded 'excuse value' - or even of dangerousness, further enhanced in some societal settings by limited cultural licence for aggression or other 'acting-out' behaviours. In situations of dependence, limitations on supply may promote criminal offending that provides 'the icing on the cake' - particularly where the development of the addiction itself is seen as 'the addict's fault'.

Recognising the difficulties faced by their clients, it is common for workers in the addictions field to decry stigma and refrain from judgmental expression. The counterpart to this is a tendency to under-rate or disclaim the moral realities that inescapably pervade most treatment undertakings. This tendency is mirrored by the way that science 'brackets-off' subjectivities and various philosophical considerations in order to perform replicable research. However, conclusions that pertain to specific behavioural hypotheses often leave unaddressed the many personal and social (and hence political) difficulties or dilemmas that include a moral element and are so characteristic of problematic substance use. Scientific findings may inform, but often don't resolve moral debates, nor supplant a moral frame of reference.

Miller (1991) quotes Drew (1987) as follows: "No idea, nor system of ideas, is adequate to represent reality. We all need to be comfortable in our use both of a scientific framework and the idea of determinism of human behaviour, and of a moralistic framework and the idea of free will and personal responsibility or autonomy" (p.3).

While Peele's claim - that becoming addicted is an issue more of values than biology – may be contentious among treaters, the corollary that personal values are significant, even crucial to the success or failure of treatment is surely more widely accepted, particularly given the limited success of purely medical treatments to date and the enduring emphasis on self-aware cognitive-behavioural change. There is a crucial difference between attributing responsibility (for either behaviour or for change) as a moral naming act, to apportion blame, versus as a treatment-purposive act, to facilitate a therapeutic shift.

John Caygill
Unit Manager
CADS Dunedin

MESSAGE FROM THE CHAIRPERSON

At the last meeting of the TRIG executive the motion to consider changing the name of TRIG was discussed. This motion had been moved by Doug Sellman at the AGM at Cutting Edge in September last year, but due to lack of time was deferred until the next executive meeting. It was proposed that the name be changed to the Addiction Treatment Research Interest Group (ATRIG), to better convey the focus of the organisation and to align ourselves with the newly created National Committee for Addiction Treatment (NCAT). After some discussion it was agreed unanimously to adopt this new name. As TRIG is an incorporated society there is a legal process to be followed for such a change, and this will be undertaken shortly.

To parallel this change of name, this is therefore the last issue of the Treatment Research News, with the next edition to be produced under the masthead "Addiction Treatment Research News". I'm sure readers will agree that this substantially improves the ability of both names to communicate the purpose of the organisation/publication.

Cutting Edge this year will be held in Dunedin on September 8-10. The closing date for submission of abstracts for Cutting Edge is 27 May. This year's conference will no doubt contain the usual wide range of presentations/workshops, providing the opportunity as it does for our field to come together and not only to network informally, but also to present recent clinical initiatives, share views and promote services. A critical component of Cutting Edge has always been the presentation of clinically-oriented research, with members of TRIG prominent amongst those presenting such work and TRIG formally sponsoring the research component of the conference. TRIG, in partnership with the National Addiction Centre, will once again produce a monograph, bringing together these research presentations in a permanent and accessible written form. I encourage all readers who have undertaken addiction-related research in the past year to consider submitting an abstract to present these findings in either poster or oral form.

Dr Simon Adamson
TRIG Chairperson

I've Been Reading

When I was asked to write about what I have been reading by Simon, I was not sure if I should let him know that what I have been reading *most* is a range of books by Dr Seuss, Winnie the Pooh and *Which Insects Live in New Zealand* to my 4 year-old daughter Abigail. Needless to say I was not sure how this would relate to addiction treatment and theory. So when I am not embarking on another fantastical reading expedition with Abby, I have been reading about two topics that continue to capture my attention and passion, as well as inform my thinking and clinical practice: Motivational interviewing (MI) and Attachment Theory.

As many people know MI is an evidence-based client-centred and directive way of counselling that is widely utilised as an intervention in the treatment of addictive behaviours. Attachment theory is a theory of development that places emphasis on the role of relationships in the early years in the life of a child with emotional communication at its heart. What I have been reading in the area of MI is the soon to be published article titled: A Meta-Analysis of Research on Motivational Interviewing Treatment Effectiveness (MARMITE) by Hettema, Steele and Miller (***2005, Annual Review of Clinical Psychology, in press***) and a 2004 presentation by Miller titled Toward a Theory of Motivational Interviewing. In the area of Attachment theory I have been reading a fascinating piece by Daniel Siegel titled Toward an Interpersonal Neurobiology of the Developing Mind: Attachment Relationships, "Mindsight", and Neural Integration (***2001, Journal of Infant Mental Health, 22 (1-2), 67-94***). Strange bedfellows one may say, but I am starting to see that MI and Attachment theory are actually quite complimentary as they relate to understanding addiction with profound implications for treatment.

From an attachment perspective, attachment is considered "a basic in-born, biologically adaptive *motivational system* that drives the infant to create a few selective attachments in his life". These attachments provide a relationship in which the child will seek proximity to the attachment figure; have a safe base where the attachment figures provide comfort and soothing when she is upset or distressed; develop an "internal working model of a secure base" that allows for external exploration, provides a sense of well being and to soothe himself in times of distress and discomfort in the future (Siegel, 2001, p. 69). Interactions with attachment figures during this time create the "contingent, collaborative communication" essential for healthy emotional and social development. The *attunement* between the adult and the child is the collaborative communication process that the caregiver can modulate the child's positive and negative emotional states.

As you can see attachment experiences are critical to the emotional and social development of a child. Furthermore, the interpersonal experiences that a child has with her attachment figures appear to directly influence brain development.

"Both genetically encoded information and neural activity itself can result in the activation of genes that leads to the creation of the proteins necessary to shape the structure of the brain. Experience involves the activation of neurons. In this manner, experience shapes the function of neural activity in the moment, and can potentially shape the continually changing structure of the brain throughout the lifespan. Recent findings from neuroscience in fact suggest that the brain remains plastic, or open to continuing influences from the environment throughout life. This plasticity may involve not only the creation of new synaptic connections among neurons, but also the growth of new neurons across the lifespan" (Siegel, 2001, p. 70).

To extend this line of thinking further, the relational experiences with attachment figures (e.g., partners, friends and mentors) we experience across the lifespan influence our ongoing development and motivations. With respect to addiction, I have come to see that people develop significant attachments to alcohol, drugs, gambling and other addictive behaviours. For some their relationship with addiction is a real and significant relationship (as opposed to a substance induced behaviour) that has become a well attuned and internalised working model that provides a safe haven for well being, as well as a means for managing discomfort and distress. This, if Siegel is correct, changes the structure of the brain to incorporate the addiction into the person's relational schema. In essence, the experiences of/with addiction then must become somewhat hard wired in the brain and, over time, becomes a central organising agent that governs motivation and choice that leads to behaviour. In other words, at this moment in time the addiction becomes <u>the</u> preferred relationship and takes centre stage in person's life.

So where does MI enter this picture? From what I gather by reading Hettema, Steele and Miller's meta-analysis, the effectiveness of MI are 1) MI provides "robust" and "enduring" effects when added at the beginning of treatment. This is evidenced by increasing treatment retention, increasing treatment adherence and increasing "staff-perceived" motivation; 2) The effects of MI surface relatively quickly; 3) In regards to effectiveness there is a high level of variance across sites and providers. What we know is that MI works and when practised with fidelity to Miller and Rollnick's prescribed model, it works well.

Drawing from over 20 years of research, Miller has articulated two central theses of MI in his theoretical development MI.

1. "MI works by selectively reinforcing change talk"
2. "The resolution of ambivalence is promoted by accurate empathy alone, and it tends to resolve in a positive direction without directive help from the counsellor"

It is thesis two that creates the link between attachment theory and MI for me. In particular, I am intrigued by how the therapeutic relationship based in accurate empathy (as measured by number and quality of reflections) can help to bring about change *without* providing directive help. I think that the practice of MI leads to greater attunement between counsellor and client. And it is this attunement that is experienced by a person with attachment figures (in this case addiction) that people are looking for in their most intimate relationships. MI provides a therapeutic opportunity for people to experience an attuned relationship that does not have the same expectations, negative emotions and consequences as other current and past relationships (e.g., parents, caregivers and addictions). This in itself opens the window for a safe and objective re-evaluation of choices, motivators and behaviours as they relate to their relationship with addiction. In return this "new" experience activates neural activity in the brain, which may just begin to alter brain structure in a way the allows the person to experience the discrepancy between the effects of their lifestyle and relational choices with addiction and the core values and desires related to a life that does not involve the negative consequences of their addiction.

In hindsight, perhaps sitting down reading Dr Seuss in a loving and attuned way with my daughter is connected to addiction treatment.

Joel S. Porter,
Pacific Centre for Motivation & Change. Ltd.

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
- membership in the 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 other drugs related problems in New Zealand.*
- *To disseminate and promote research findings related to effective treatment of people with alcohol and other drugs related problems within New Zealand.*
- *To support the development of improved treatment services for people with alcohol and other drugs related problems in New Zealand.*

Declaration

I support the objectives of TRIG and wish to be a member of TRIG for the 2005 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)