Practitioner Perspective

Is there a role for counselling in the treatment of addiction?

Mick Devine

Introduction

This article seeks to articulate the place for counselling in the treatment of addiction. With harmful and hazardous alcohol and drug misuse, education and prevention measures are preferred with some brief solution focused interventions (Department of Health; 2012). For opiate addiction, medical interventions to stabilize and reduce harm are rightly to the fore (Health Service Executive Social Inclusion Unit, 2010). I am Clinical Director of Tabor Group, a Cork-based treatment agency guided in treating addiction by the Minnesota Model of care. This approach is based on a 'disease concept' of addiction and favours the long term goal a 'drug free lifestyle' for clients. I am often asked "what is your success rate?" and in my experience, many who opt for 'drug free lifestyle' treatment options, relapse is common and is therefore seen as failure. To assist service users in achieving ia drug-free lifestyle counselling is essential. In this article I present the case for counselling in the management of addiction at Tabor Group and this article uses the American Society of Addiction Medicine's (2011) definition of addiction to answer the question posed in the title. This definition will structure the article as I present addiction as (i) a 'chronic disease', (ii) a 'chronic brain disease' that (iii) diminishes the person's recognition of the problem. I will quote directly from this definition and also use it to reflect on my professional experience of the value of counselling in the treatment of addiction. This will prepare the way for presenting the role of counselling in treating addiction.

Multi-agency Treatment of Addiction

On one hand there is growing acceptance of harmful and hazardous misuse of alcohol and drugs which requires education and prevention services and where treatment services are necessary they may be brief and solution focused (HSE 2012). On the other hand there is a growing awareness of the complexity of needs that often accompanies addiction (MacGabhann et al., 2004; Najavits, 2002).

From this awareness results an emphasis on the need for multiple agencies to be involved in the rehabilitation of people affected by addiction (Department of Community Rural and Gaeltacht Affairs, 2009).

General Practitioners, Pharmacists, Detoxification Services, Community Drugs Workers, Homeless Services, Social Workers, Key Workers, Case Managers, Community Enterprise Schemes, Adult Learning and Training agencies, Probation Services, Treatment Agencies of various types, 12 Step Fellowships, Family Support Services, and Parenting Programmes all have valuable roles to play in rehabilitation. From my experience of engagement in delivering treatment for 20 years in the Health Service Executive Southern Region, all of these agencies have a caring dimension and staff is equipped with

some level of listening skills and capability for empathic response.

Part of the response to the overwhelming complexity of need in many of our addicted population is to see that a realistic goal for individual care plans is to reduce the harm caused by the addiction rather than a goal of full rehabilitation including a drug-free lifestyle. With such an approach the emphasis is on maintaining a stabilisation in the individual's situation. This includes assisting the person to refrain from illicit drug use, from criminality in order to obtain illicit drugs and keep the person safe from risky behaviour by introducing them to a stable dose of prescribed methadone. As a result the key agencies of General Practitioner and Pharmacist come to the fore in the delivery of care. Allied services have an important support role.

Counselling can also be part of this important support role allowing the person explore healthy options and the motivation to pursue them. It is my experience however, that counselling really comes into its own when the service user responds to the challenge of establishing a drug-free lifestyle as central to managing addiction. This can be an extremely difficult task but not impossible. The following will hopefully portray the nature of the difficulty and also demonstrate how success is possible when counselling is fully utilised.

Disease Concept of Addiction

In her preface to National Institute of Drug Abuse 2010 publication, *Drugs Brains and Behaviour,* Nora Volkov MD, Director of National Institute of Drug Abuse recalls that when science began to study addictive behaviour in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower. We now know addiction is a disease that affects the brain (National Institute of Drug Abuse, 2010). While the '*disease* concept' of addiction seems to confirm that the lead agents in its treatment should be medical, it is this disease concept which appears to most securely establish the role of counselling in its treatment.

When science began to study addictive behaviour in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower.

To elaborate the point it is useful to present a definition of addiction issued by The American Society of Addiction Medicine (short version) (ASAM,Web 2011):

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/ or relief by substance use and other behaviours (Home Page).

Addiction is characterised by inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of significant problems with one's behaviours and interpersonal relationships and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death (Home Page).

There are many elements of this rich definition which provide food for thought when considering the question of the role of counselling in the treatment of addiction. However I will highlight three elements; (i) that addiction is a 'chronic disease', (ii) that addiction is a 'chronic brain disease' and (iii) that addiction is characterised by a diminished recognition of significant problems of one's behaviour and interpersonal relationships and dysfunctional emotional response.

Addiction is a chronic disease

To establish the nature of a *chronic* health condition it is useful to contrast it with an *acute* health condition. White (2003) outlines that acute health conditions are of sudden onset and short duration; symptoms appear suddenly and the pain is insistent. Additionally he argues that immediate care is required and is usually clearly defined, administered by an expert using surgery or medication and brings about a cure. Examples are infection, appendicitis and a broken bone. Acute health conditions, he says, are seen to be something that happens to a person.

White (2003) contrasts this with a chronic health condition which he says is persistent and long lasting, usually more than three months. He says that the onset is gradual and the condition may be characterised by periods of remission and relapse. Furthermore, the condition may not insist on attention until well progressed. He contends that the condition is managed rather than cured and the participation of the 'patient' is central to the successful management. Insight, for White, is a crucial component of the recruitment of the patient in the management of the condition. Examples of chronic health conditions are diabetes, hypertension and heart condition. Chronic health conditions,

he concludes, are seen to be physiological defects in the person.

Considering addiction as a chronic condition and that the individual must be actively involved in the management of their addiction creates an opening for the inclusion of counselling in this process. The management of a chronic health condition such as diabetes also requires the active involvement of the person but counselling is not usually required to secure the person's engagement as the organ affected is the pancreas. Once the person has the insight that their pancreas is dysfunctional in the production of insulin and the patient needs to assist its functioning, they are generally recruited to the enterprise of managing the diabetes. In the case of addiction however it is the brain that is affected. The person's identity is centrally bound up with the brain because, while the pancreas produces insulin, the brain produces our thoughts, feelings, instinctual motivations, decision making apparatus and other functions central to all that establishes us as an individual. (Hanson & Mendius, 2009).

Addiction is a brain disease.

ASAM (2011) states that in addiction vital brain functions are impaired; (a) reward circuits, (b) motivation and memory circuits and (c) the executive function of decision making. The reader is referred to the full text of this rich definition for the following observations.

Firstly, if drugs enhance reward function then drug using is preferred to other healthy behaviours (Koob & Moai, 2001). The person is therefore more motivated for drug use than for other activities which the brain also rewards. Such activities include those which ensure safety and security, maintenance of interpersonal relationships, stable accommodation, successful occupation or student career. As far as the brain knows the drug use satisfies these needs. Over time such altered priorities for drug use lead to a lifestyle that is unsuccessful, frustrating and characterised by agitation and negativity (Keane, 2014).

Secondly, the repeated engagement in drug use leads to neuroadaptation in the motivational circuitry which leads to further addictive drug use hence the individual is motivated towards further drug use. In other words, the positive reinforcement of the euphoria obtained from drug using and the negative reinforcement of the relief from negative emotional states conspire to reinforce the motivation for continued drug use. Additionally, memory circuits play a role in addiction as memories of previous drug use trigger cravings to resume use in their current situation (Koob & Moai, 2001).

Finally, the frontal cortex of the brain is charged with executive functioning. Therefore, it is the centre with the power to think, solve problems and make decisions and when it becomes affected by addiction the person's decision making capacity is impaired. Examples of such impairment include powers of perception, learning and judgement being compromised as well as the ability to defer gratification as impulsivity is strong. Furthermore, the person can make many mistakes when it comes to deciding if it is a good decision to use drugs. The ability to choose to avoid using is compromised by the strength of the craving to continue using, the strength of the reward obtained from using, and the positive memory of previous use. Therefore the situation is out of the person's control and it is not realistic to expect choices to be made according to conventional value hierarchies. Despite the negative consequences that inevitably come with impairment of executive functioning the person shows a low readiness to change (Koob & Moai, 2001).

Addiction is characterised by a diminished recognition of significant problems with one's behaviour and interpersonal relationships and a dysfunctional emotional response.

As part of the treatment programme at Tabor Lodge clients are encouraged to learn about addiction and apply the learning to their own real-life situations. The ASAM definition in its long and short versions is used. The Diagnostic and Statistical Manual of the American Psychiatric Association Edition V is also used. From many clients undergoing the treatment programme the following reflections are possible.

The addicted person cannot see the reality of their situation. The shame, guilt, failure and suicidal tendencies associated with addiction are defended against by the person. They do not recognise significant problems as such. The dysfunctional emotional response causes them to minimise the extent of their difficulties and disadvantage. They may become detached from their difficulties by being overly intellectualising. It causes them also to disregard, diminish or explain away the problems in inter-personal relationships. Alternatively, the dysfunctional emotional response may cause them to exaggerate their difficulties resulting in their anger

and aggression, blaming, resenting, or self-pitying and hopelessness.

They adapt to accommodate themselves to their diminished circumstances and to avoid being confronted by the difficulties addiction is causing. Accommodation may take the form of developing a false self which has an insistence that 'all is well'. Addicted people may become avoidant and distant and lose real contact with meaningful others.

Clients often acknowledge that changes occur both in cognitive and affective functioning. For example, the person is preoccupied with drug use, has a distorted view of the benefits of using and can attribute unwanted consequences to other causes than the drug using. Emotionally there is increase in anxiety and sensitivity to stressors. Furthermore, the client comes to see that there can also be emotional overreaction and under reaction. This may include emotional responses which are inappropriate for the situation such as an aggressive reaction to a child making a mistake and spilling milk or at another time showing no reaction to an inability to pay an important household bill.

The client can become crisis prone. Failures and set backs are inevitable. Over time the addicted person burns their bridges and their social and personal support network is weakened. It is harder for them to bounce back. If the person is the parent in a family unit the impact on all the family is devastating, particularly on children. As the situation spirals out of control the person's ability to cope with stressors is overwhelmed. The resulting sense of panic increases cravings to continue using. Drug using is the main coping strategy and so the person has nowhere to turn. Stressful situations mount and escalate. In response the person becomes more defensive. The person is unable or unwilling to take corrective action. The person's self-deception is significant.

The Role of Counselling

My experience in the field has led me to believe that it is very difficult to separate the impact caused by the addiction from that caused by the contribution of the person themselves; it is as if there is no difference between the two. The person is an addicted person. I mentioned above how the person's reward center is affected by substance use, the person's motivation and incentive system is affected by the substance use, as is their executive functioning. It is my opinion that these functions of our brain are instinctive and unconscious; they are part and parcel of who we take ourselves to be. Hence our identity is intricately wrapped around these brain functions. Therefore, to reflect on the thinking, feeling, attitudes, beliefs, perceptual apparatus, judgement and choices that have all become affected by substance abuse is very challenging as it is almost impossible for the person to separate all that out from who they are in the first place. The education is difficult for the person because the syllabus is themselves and what their life and the lives of their loved ones has become as a result of not addressing their addiction. Additionally, the insight is illusive because the instrument of obtaining insight is the most affected. It's like the eye seeing itself.

I would argue therefore that counselling is crucial to the person in order to succeed in managing the condition. It is within a trusting therapeutic relationship that the person can undertake the necessary reflection so they can see the reality of their situation as opposed to the distorted perspective noted above. Counselling is needed because it is uncommon for the person to be capable of such insight without assistance. The person must firmly but gently confront him/herself about situations that are beyond their ability to see for themselves. Hence, the counsellor is particularly well positioned to assist the person with this task and to provide the necessary emotional support for such confrontations. My experience has highlighted how the honesty required to allow the full picture to emerge is often not easy to come by yet the detached but trusted counsellor can provide the 'holding' to allow this to happen. I have witnessed how the greater the accuracy in developing an awareness of the extent of the impact of addiction, the more motivated the person becomes to manage the condition successfully. The counsellor skilled in the art of listening and empathic response, who has understanding of the defense mechanisms of a person feeling trapped and overwhelmed, and who has the ability to maintain the person in positive regard is crucial to the success of this enterprise. (Mate, 2012)

The insight needed for the management of a chronic condition can be gradual. The contribution of the counsellor can be an indispensable part of the treatment process. Through the expertise in the caring support of an interpersonal relationship the addicted person can achieve enough distance from the catastrophe to see it clearly and to see that that is not all there is to them. The counsellor models in their interactions that there is no stigma, no judgement, no loss of essential value and goodness. The addicted person can begin to believe that recovery is possible.

Conclusion

In this article I have tried to

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articulate the centrality of the role for counselling in the treatment of addiction. I have used the short and long version of the definition of addiction of the American Society of Addiction Medicine. In my experience, concealed within this medical definition of addiction is the securing of the place for counselling in the management of this chronic health condition. I have demonstrated that if we don't see the chronicity of the disease we overlook the role of the addicted person in the management of the condition. The organ chiefly affected is the brain. Our brain is the organ where our drives, attitudes and beliefs are seated as well as our executive capacities such as thinking, motivations, deferring immediate gratification and decision making. As such its functioning is central to our identity.

I hope it is now clear that, in my experience, the addicted person is challenged with an intractable dilemma. Those seeking to successfully manage the condition need help. For the addicted person to succeed they need to get some distance from this identity to see its operations. When they can do so insight and objectivity are possible. Counselling is central to the addicted person achieving this distance.

This is a delicate matter particularly when there is so much shame attached to being addicted and there is so much societal stigma surrounding it. That the person can address painful issues associated with being addicted is central to good quality outcomes. To address the matter takes skill. Supportive, challenging interventions delivered with care and empathy can play a significant role. From this support the addicted person sees the disease in action and the part they play in its dynamics. They can also see their part in neutralizing these dynamics so as to achieve full rehabilitation (TZU, 2014; Dupuy, 2013).

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