

February 2007



IRISH ASSOCIATION OF ALCOHOL AND ADDICTION COUNSELLORS

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Editorial

Dear Members, Associate members and all Readers,

Our last addition prior to the Annual General meeting and Conference, we would like to say how much we enjoyed working on the Newsletter for the past three years. Thanks to every single person who contributed, please continue to be as prolific with your writing to the newly elected committee after the AGM. We are looking forward in seeing you all at the Tullamore Court Hotel, Tullamore Co. Offaly for the Conference and AGM on the 2nd and 3rd March 2007, many thanks to Mary O' Neill, Sharon in the office and other members of the Executive Committee who are working hard organising this event.

We would like to remind you too about the Half-Day Conference to mark the 25th Anniversary of 'The Ana Liffey Drug Project' co-hosted by Ana Liffey Drug Project and Trinity College Dublin on the 15th March 2007. More details about this event and other exciting initiatives in this issue.

So it is up to you now to take some time to read our interesting articles in this issue of our Magazine/Newsletter. Our renewed thanks to all who shared their news with us in this edition, enjoy reading it. We would like to express our gracious thanks to the Executive Committee, Sharon McCluskey in the office and Mark Beveridge our printer for their support, help and fun over the past three years.

Mairin and Hugh
Editorial Committee



Congratulations Recently Accredited Members.

David Kinsella ... Dublin 22
Tom O'Connor... Dublin 8
Rosaleen Dodson ...Dublin 24
Paul McCarthy ... Cork
Robert Field ... Cork
Ann Daly ... Dublin 8
Kathy Watts ... Dublin 24
Patricia Byrne ... Carlow
Gerry McWilliams ... Wicklow
Bernadette Murphy ... Dublin 8
Dennis O'Sullivan .. Dublin 22



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AGM AND CONFERENCE

BY MARA DE LACY

The next AGM of the IMAC is fast approaching and now seems like a good time to put a few short words on paper about what is involved in being part of the executive committee of my professional organization.

My first AGM was now about four **years** ago, when children had grown and family and friends encouraged me to "go see what happens". Because I had many doubts about what was involved, I left it to the last minute to make my booking for Mullingar. I found myself another hotel away from the AGM venue, because there was no room left in Bloomfield House, the long established venue for the AGM. This, I think, is my only regret about that first conference and AGM. I arrived alone and was warmly welcomed by Sharon McCluskey, the IAMC Administrator, and rapidly found myself among old friends. People I had not seen for **years** but had previously had a close working relationship with were there and it was really enjoyable reminiscing about old times and catching up on the news. I had forgotten how easily we as a group can unite around issue and ideas. I met people who were now working in the "big" jobs, **in** Dublin and all around the country. It was stimulating and **exciting** hearing about developments in other agencies. I felt that I was re-connecting with old and trusted friends. The conference itself was stimulating, the Gala Dinner sponsored by Merck, **delicious** and I decided to hang around and participate in the AGM. The activity around the election of members of the committee was electric and I observed people I knew and trusted being voted into positions of chairperson, company secretary and treasurer. I also discovered that these were not just names but were people I knew like Tony Geoghegan from MQI. We had spent time in a drafty port-a-cabin many years ago while waiting for access to Arbour Hill Prison and Mary O'Neill, who had been one of the first outreach workers on the streets of Dublin and very involved in the initial days of harm reduction. I also learned that the burden of work associated with the committee was not arduous, just one meeting per month and then the sub-committee meetings about matters **like** training for members, the newsletter and accreditation. The committee members all seemed relaxed and enthusiastic, not burdened and full of news, ideas and plans **both** for the future of the Association and their own **agencies**. It felt empowering to be among them.

The following year, again **in Mullingar** at the AGM, I took the risk and was elected on to the committee. The group of people was supportive and friendly. I took on the role of training officer and enjoyed the new contacts I made with various other **agencies** by being cheeky enough to ring them and ask for training days. I re-established connections with **agencies** connected with drug work after 15 years of being

focused on alcohol-related work and Dual Diagnosis. I met others who attended training days and realized that we have a Northern Ireland Membership, who travelled south for some of our expertise. The trainings were fun and I owe a big thank you to individuals like Stephen Rowan (The Rutland Centre), Peter Kelly (MQI), Ceny Cooney, Eoin Stephens and several others for filling the training days and in some cases **travelling** to ensure other areas of the country have training too. Indeed there have been consistent trainings in Cork, my thanks to the very able individual who arranges them.

Last year, the AGM was held in the Hudson Bay in Athlone and again **it** was a very enjoyable event. Arlene Vertere spoke about the use of family therapy with Addictions and there was a workshop on the Associations way forward. The executive committee had a brief meeting at the end of the AGM and dates for subsequent meeting were set. This year sees a lot of the existing committee retiring, last year the Chairperson and our company secretary retired. This year sees five people retiring having served their maximum length on the committee. It is also a time of great change with the Government's moves to standardise qualifications and practice between all the various therapeutic associations. The IAMC has been well represented by our current acting-chairperson (Brendan Moore) at the various meetings and he will do a presentation on the developments to date at the AGM which is due to be held on March 2nd and 3rd 2007. There will also be another speaker who will highlight the implications for the future. On the business side, all inputs at this critical stage are desired and most welcome, and all nominations for the future executive committee will be greeted and supported by those current committee members who are resigning. The Association received a substantial sum of money last year to employ a development officer, this **is** currently **in** train and it **is** hoped that the development officer will join us for the AGM and that next year will see that person making further moves in developing and **enhancing** the Association's profile.

This year the AGM **is in** the Tullamore Court, Tullamore, Co. Offaly. A good meal will be, as usual, sponsored on the night by Merck, developers of Campril, the anti-craving drug. There **will** be great chat, mighty craic and general good fun. The **out-**going committee members **will** answer any questions from anyone who wants to go forward onto the executive. The whole event will be informative and lively, the roles and rules of the committee are a light burden and working on the committee supplies an individual with a helpful toolkit of resources in terms of other committee members and associates. Looking forward to seeing you there!

Born in Dublin and after finishing my studies went to Great Britain where I worked in the community with drug users (mostly those on methadone maintenance and those using amphetamines). Came back to Ireland at the end of the 70's and worked in Sean McDermott Street. Out of my time and experiences there I started The Ana Liffey Project with Frank Brady S.I. Subsequently, I worked on the Chemical Dependence Programme in St. Patrick's Hospital and then on the Dual Diagnosis Programme until I left and am now working as the senior addiction counsellor in Stanhope Alcohol Treatment Agency. Married for longer than either of us care to remember, with two wonderful daughters, I love cooking and am currently finishing a degree in sociology. I am a trained therapist with an interest in families and addictions.

"It was twenty years ago today"

(With profound apologies to Paul McCartney and all The Beatles).

Sadly, I have to admit it was more than twenty years ago, more like twenty-seven years since I walked myself into setting up a voluntary agency with my colleague and now close friend, Fr. Frank Brady S.I. The issue of drugs was a new one here and as a returned immigrant who had worked in the community in England and Scotland, my commenting on the prevalence of drug users I thought I saw in the inner city area where I worked, was labelled paranoia. Eventually, I asked the people who worked with me if there was a lot of "smack" about. They were more than happy to tell me that it was readily available and very cheap. This information confirmed this

"Paranoid's" suspicions and everywhere I asked questions I came up with the same answer, there are no choices here, only Jervis Street Hospital and Coolemine Therapeutic Community for rehabilitation. This was strange and fascinating because I had experienced a significant choice and range of services for drug users while in Britain.

When I was finally told to stop talking about it and either do something or shut up I set about pulling all those around me into action with the persistence which previously led to other strange courses of action (such as setting up a vegetarian restaurant in Scotland).

1980 saw a deliberate attempt on both Frank and my part to research the situation and to put forward some plan by the end of the year. Frank did his work by participating in some outstanding placements in Coolemine Therapeutic Community and the Centre Medical Marmotan in Paris, and I spent my time reading and dealt with the arrival of my first child. While I coped with colic,

he learned the inner workings of alternative detoxifications and the French system of rehabilitation. He got his beard shaved off to gain admittance to Coolemine Lodge (I'm not sure which of us had the best experiences) and then suddenly, it was either "quit or go ahead".

September 1982 and we were occupying a very small counselling room in the **Pro-Cathedral**, wondering how to get funding, annoying all and sundry with requests for advice, information and support. Meetings were set up and requests made, some with very funny outcomes, but the burning question remained, "How do you start an agency with no money?" Applications were made to the Ireland Fund and other such groups that had a social interest in the country, a small amount of money trickled in and we moved into a Jesuit House in Sherrard Street. The project was gaining momentum. Now there were young people volunteering their services and the occasional drug user called by. The sense of development was exciting. Then our world ended, the Jesuits wanted the premises back and we were homeless again. Then the ecumenical movement in Dublin got involved with Salter Stirling in Trinity College, David Kingston in Irish Life and the Salvation Army adopted us. We were offered the basement of their building in **Lower Abbey Street**. Joy was unconfined!

By the end of November, we were in! There was a staff of young people who were employed on Temporary Youth Employment Schemes, a training course being run by Philip Kearney of the Clanwilliam Institute and great discussions about the project's philosophy. The vision was one of accompaniment, the openness to travel the road with the drug user regardless of their choices to continue using or to stop. The idea was to give information and support about issues that the drug user faced on daily basis from a non-judgemental point of view. The hope was to create more choice for the client and more support.

The centre was up and running. There were workshops and individual chats and lots of tea and coffee. The best attended workshop was a percussion workshop which meant that any real work on phones or otherwise was not feasible. But boy did the building rock when all the clients and staff got together once a week! There was still no money and our team leader sadly got ill and left. Things were going well but more needed to happen especially on the financial front. Our contacts spread and we started to work in Mountjoy Prison. There was also a little band of staff that went out on the streets each day as outreach workers. Frank was well known to a lot of drug users as he had done some work as a chaplain in a number of the prisons. It seemed we had something to offer and the building began to get busier and busier.

Some of the people on these Temporary Youth Employment Schemes went on to work in addiction, and we all got involved with the HIV crisis. Working in the prisons became totally focused on the very shocked newly diagnosed group who were segregated in the Old Separation Unit and a Wednesday morning prison group began in conjunction with Pat Jennings of the Probation and Welfare Service. The story for the clients in the centre also became focused on HIV and the whole needle exchange and maintenance issue was a constant debate.

There was still no money and the building was bursting at the seams, Frank was looking for money in the private sector and individuals were very generous. £10,000 came from the Ulster Investment Bank on the occasion of their 10th birthday in Dublin, and so there was money for the rent and the other bills. But there was no state funding available, then just before Christmas in 1985, a cheque for £2,000

came from the Dept. of Justice. At last, a bit of state acknowledgement, despite wishes to preserve it or at least photocopy it as a memento, it was lodged in the bank by close of business that day.

From there things improved, the situation with drug and HIV progressed, suddenly there was an interest in providing services for drug users and negotiations with the Dept. of Health guaranteed the project an annual income. It took a real crisis for those drug users we were attempting to support, for the project to get funding but it ensured the continued existence of the agency to date. There were many funny moments on the way to this point and many good friends who supported our efforts but in the private sector and in the permanent government. Many are still there and continuing their care for the drug user today, people like Dr. Des Corrigan of the National Advisory Council on Drugs, various outreach workers like David Wyse, and then those unfortunate individuals like David Went and David Kennedy (the private sector) who encouraged and endorsed our efforts, especially in the ecumenical community. I suppose the list is endless, and the gratitude owed monumental, from us who worked in the project for realizing our vision and from the drug users for helping create the choice that exists today.

Finally, would we do it again? Yes, yes, yes, of course! Did we learn anything? Well of course we did but like everything attempting it to day would be a totally new experience but if you want to try well, there's always people who will help!

Accredited members sought to join a co-operative venture establishing a centre for excellence in Dublin for the out-patient treatment of alcohol problems.

Part-Time - one to two days per week.
Contact Dr. Ian Me Cabe Ph.D., Psy.D.
-ianmccabe@juno.com or Tel. 01 -496-5998

Ana Liffey Drug Project & Addiction Research Centre TCD

By Tony Duffin

A Half-Day Conference to Mark the 25th Anniversary of the Founding of Ireland's first Harm Reduction Agency - The Ana Liffey Drug Project.

The Ana Liffey Drug Project

During the early-1980s, drug policy and service provision in Dublin struggled to adapt to what became known as the 'opiate epidemic', the first wave of injecting heroin use in a city previously accustomed to much less risky drug use. This adaptation was not helped by the lack of formal drug policy-making structures or by the assumption that the only legitimate health and social service interventions were those which had abstinence as their goal. It was against this background that Frank Brady and Mara de Lacy set up the Ana Liffey Drug Project in 1982, a project which introduced the concepts of 'user friendliness', 'low threshold', 'outreach' and 'peer education' to a somewhat bemused policy community. The Ana Liffey Drug Project developed close

links with the Addiction Studies programme which began at the School of Social Work & Social Policy at Trinity College Dublin in 1983, and the aim of this half-day conference at TCD is to reflect on the subsequent evolution of Ana Liffey, as harm reduction policy and strategies gradually gained acceptance in this country.

It would obviously be foolish to assume that all of the contentious issues have been resolved either in Ireland or anywhere else, and there are ongoing tensions for the Ana Liffey Drug Project and for other harm reduction services which are based in city-centre locations. To provide a broader context for this debate our keynote speaker, Dr Tim Rhodes, will draw from his own empirical research on injecting drug use to argue for policy and service provision which does not focus solely on individual behaviour change, but which also accepts the need for 'safer injecting environment interventions'.

Harm Reduction for Problem Drug Users:

15th March 2007

Venue:

Edmund Burke Theatre, Arts Building TCD

Programme

Chair: Dr Paula Mayock, Children's Research Centre TCD

2.30pm: Risk, Injecting Settings and Environmental Approaches to Harm Reduction

Keynote Speaker: Dr Tim Rhodes, Centre for Research on Drugs & Health Behaviour, London School of Hygiene and Tropical Medicine

3.30pm: Coffee Break

3.45pm: The Founding of the Ana Liffey Drug Project
Frank Brady, S.J. First Director of the Ana Liffey Drug Project

4.10pm: The Ana Liffey Drug Project: Carving out a Niche in the Middle Years
Marguerite Woods, Addiction Research Centre TCD

4.35pm: The Ana Liffey Drug Project Today
Tony Duffin, Director of the Ana Liffey Drug Project

5.00pm - 5.30pm: Plenary Discussion and Conclusion

Dr Paula Mayock is Senior Research Fellow at the Children's Research Centre, TCD, and is author of Choosers or Losers? Influences on Young People's Choices about Drugs in Inner-City Dublin (2000).

Dr Tim Rhodes is Reader in Public Health Sociology and Director of the Centre for Research on Drugs and Health Behaviour at London School of Hygiene and Tropical Medicine. He leads a programme of research focused on the social aspects of risk and HIV/HCV prevention associated with injecting drug use. His academic background is in qualitative methods and public health sociology. He is editor of the International Journal of Drug Policy.

Frank Brady is a Jesuit priest who was co-founder and the first Director of the Ana Liffey Drug Project.

Marguerite Woods is Course Director for the Diploma in Addiction Studies at TCD and a former Director of the Ana Liffey Drug Project.

Tony Duffin is the current Director of the Ana Liffey Drug Project and a former Director of Services with the Depaul Trust Ireland.

There is no charge for attendance at this half-day conference but, so as to assist its organisers, people intending to attend are asked to confirm this by emailing:

Gloria Kearns the Administrator at the Ana Liffey Drug Project - gloria.kearns@aldp.ie

It should be noted that there is no car-parking available on the TCD campus..



YOUNG PERSONS' PROGRAMME

BY KEVIN DUCRAY

Kevin Ducrey is the Senior Clinical Psychologist at the Drug Treatment Centre Board. He completed his Undergraduate Degree, BA Honours in Psychology and Masters Degree in Clinical Psychology (with Distinction) from the University of Natal, South Africa. His MA thesis was in the area of Clinical Neuropsychology and investigated higher cortical function deficits in male alcoholics. Positions held in South Africa included the post of Clinical Psychologist/ Lecturer in the Sub Department of Medically Applied Psychology at the University of Natal and Principal Psychologist in the South African Police Behavioural Science Unit. Kevin has also worked as a Senior Clinical Psychologist in the area of adult mental health in Ireland. Kevin also holds a Higher Diploma in Education and a qualification in Human Resource Assessment.

Kevin is currently working with Or Trish Byrne and Or Clare Burke on research investigating the Needs and Quality of Life of cocaine users on a Methadone Maintenance Programme.

The Young Persons' Programme (YPP) based at the Drug Treatment Centre Board (OTCB) in Pearse Street, Dublin, was established to provide treatment to young people under age of 18 who have a serious drug misuse problem. The YPP therapeutic team comprises a Project Manager, two Consultant Psychiatrists, a Psychiatric Registrar, a part-time Counsellor, a part-time Senior Social Worker, a Senior Clinical Psychologist, a part-time Systemic Family Therapist, Project Workers, a Nurse, Art therapists and a part-time Reiki practitioner. The YPP team aim to assist young drug misusers by developing a holistic and systemic understanding of the unique needs of their clients, establishing collaborative treatment partnership and using evidence-based interventions to address as many of the biological, psychological and social needs of the drug misusing young person as possible.

Whilst the majority of clients attending the YPP will have a primary diagnosis of heroin dependence, there is recognition of the negative impact of other drugs such as stimulants, alcohol and benzodiazepines. There is thus a great awareness of the need to also develop appropriate, relevant and evidence based interventions to assist those young people who require assistance with serious dependence to drugs other than opiates.

As harm reduction is an important concept in drug treatment, many care plan and treatment goals are initially negotiated within the context of this philosophical approach. The harm reduction approach recognises that for some clients abstinence may still be an unattainable goal and that a valid aim of treatment is to reduce the relative risks associated with drug misuse. Other clients may have abstinence as a final goal and their care plan may thus concentrate initially on harm-reduction, followed by goals of abstinence either for illegal drugs or for all substances. A hierarchy of treatment goals ranging

from a reduction in biological, psychological, social and other problems related to drug use, to attaining controlled, non-dependent or non-problematic drug use, to abstinence from all drugs may thus be initially negotiated.

The young client's treatment process commences with the conducting of a multidisciplinary team assessment followed by the collaborative development of a holistic treatment plan in which the client plays a very active role. Regular structured treatment plan reviews are held with the client and their family members (if so agreed) to monitor progress and to adapt interventions as needed. There is also a close partnership with other allied agencies that can offer appropriate supports and services to the client.

Internal research conducted by Drs Smyth and Fagan into the profile of our clients found that they were extremely young by international standards. Their personal backgrounds were characterised by a high incidence of homelessness, a history of placement in care, opiate abuse by Siblings, parental alcohol abuse, poly-drug abuse including injecting, previous convictions and commonly many years of contact with child psychiatry before commencing their drug use.

Barriers to treatment frequently include a chaotic lifestyle dominated by the procurement, use and recovery from episodes of drug use; a history of withdrawal from pro-social activities as well as living with unmet basic needs such as food, security, safety and shelter. Many clients may be initially unmotivated for treatment, exhibit poor frustration tolerance and behavioural impulsivity as well as being emotionally fragile and vulnerable. For some clients their only experience of feeling loved may be in the context of a relationship with (an older) heroin using partner.

Thus an early and key phase of treatment is a focus on actively facilitating engagement in treatment and the establishment of a therapeutic relationship.

The referral process to the YPP generally commences with the client, or **their** representative, making contact with a Project Worker who will make an appointment for an initial assessment or **assisting** with an alternative referral if this is felt to be more appropriate. During the **initial** assessment phase the client **will** give three consecutive urine samples over a number of days to determine their drug use profile. During this period they will also be assessed by the Project Worker, Registrar, Clinical Psychologist and also the Consultant Psychiatrist if necessary. In addition to the clients current drug use patterns, the assessment process will also attempt to lead an understanding of those developmental, family and community factors relevant to the genesis and maintenance of the clients drug use and to identify those problems which co-exist with the clients drug problems. Topics covered during the initial assessment will include their current and past drug-use patterns, alcohol use, physical or medical problems, psychological difficulties, legal difficulties and any relevant social issues. The appropriate involvement of family *members* significant others during this process **is** encouraged.

As it **is** recognised that structured care planning and regular reviews is central to good clinical care, an individualised treatment plan arising from the assessment process is generated during meetings held between team members and the client. To reinforce client investment and participation in their treatment, the treatment plan **is** negotiated with and fully endorsed by the client. The treatment plan covers a number of broad domains and sets down the goals of treatment and the objectives to be achieved. It designates the interventions planned and the professional responsible for these activities. It makes clear reference to the management of risk and describes the agreed information sharing process between internal and external treatment agencies. The treatment plan is an adaptable and organic document which contains regular review dates with agreed time frames for a review of recommended interventions.

There **is** a cohesive, multidisciplinary team ethos within the YPP and the various team members often play supportive and overlapping roles in the overall treatment process. These roles and functions **will** now be briefly discussed.

The client's Project Worker is very much a frontline figure who facilitates the client's engagement with members of all internal disciplines and with external agencies that exist to support them in their recovery. They will assist with **their** orientation and with informal and formal introductions, explain the menu of treatment options and the Token Economy programme. They will stress importance of

psycho-social treatments and discuss the treatment plan with each **client**. With the client's consent they will **invite** parents or guardian to consult and collaborate in the care plan and oversee the signing of the treatment plan and related documentation. They will ensure that both the young person and their guardian have copies of this document. The Project worker will also report back as to the client's progress at weekly team meetings, hold regular meetings with the client to review progress and liaise with other relevant agencies to implement the care plan. The Project Worker will also prepare the treatment plan review documentation with the client and the YPP team, notify and **invite** relevant people to the Review Meeting that is held at least once every three months.

The Psychiatric Registrar will monitor, review and discuss psychopharmacological treatment options with the client as well as assist with symptomatic relief of withdrawal symptoms. The Clinical Psychologist **will** primarily employ Cognitive Behavioural-based approaches to assist the client in considering working towards and to maintain abstinence. Issues such as decision-making, problem solving, assertiveness, stress management, sexuality, career and existential issues **which** may arise during or after this process may also be addressed. likewise psychological therapies may be employed to assist in addressing underlying problems such as depression or anxiety, post traumatic stress syndromes, or issues pertaining to emerging personality traits which often emerge once the presenting problem of substance misuse starts to be addressed. Clients frequently also require support and assistance in the effective management of situational difficulties which include relationship break-ups, arrests, assaults (esp. by family members), unplanned pregnancies, exposure to traumatic incidents as well as deaths of friends and family members. The counsellor aims to provide the client with a safe environment in which to explore difficult personal issues and to focus on possible connections between their emotional life and subsequent behaviours. The counsellor **will** also assist the client developing a sense of balance between **their** current difficulties and past experiences and help them develop a greater sense of trust and more appropriate personal boundaries. They may also provide relationship, parenting and sexuality education as well as encourage personal creativity through safe group activities and discussions. As adolescent substance misuse generally affects to a greater or lesser degree all family members and may often affect or be affected by the community in which the family **lives**, the Systemic Family Therapist intervenes at this systemic level. Family therapy maintains and respects the family as being central to the young person's treatment.

The Social Worker's major focus will be on Child Welfare/ Child Protection issues (both for the client and the client's own offspring) and may include such problems as the meeting of basic needs, homelessness, financial support, eligibility for benefits, and liaison with Statutory Agencies. Internal and external advocacy regarding a range of psycho-social issues, Court Work (Reports and Expert witness/ testimony) liaison with Maternity Hospitals and assistance with practical welfare administrative matters is also performed.

The YPP Nurse will offer the young client assistance with health promotion by addressing such issues as promoting a healthy diet, dental care, sleep hygiene, exercise, weight monitoring and wound care for broad spectrum of conditions ranging from abscesses to abrasions to stab wounds. The nurse will also assist in the dispensing of opiate substitutes and psychotropic medications as well as monitoring the client's viral screenings. Counselling and education on safe injecting, hepatitis and HIV is also provided. The nurse will also assist with blood testing, vaccinations, liaise with the Hepatologist, provide advice on sexual health and contraception.

Given its reported calming effect, Reiki is a popular complimentary intervention amongst many of the clients who take up the offer of this alternative approach. Reiki is based upon the notion laying of hands in order to channel universal healing energy through the practitioner to the recipient in order to stimulate the life energy inside the recipient.

The YPP recognises the importance of developing sound collegial and professional relationships with other related agencies in the interest of holistically assisting young clients. There is considerable liaison and inter-agency work with other organisations such as FAS, Youthreach, Local Community Addiction Teams (CAT's), the Youth Justice and Probation services, Care Units (e.g. Hostels, Residential Units), Health Board Social Workers, and various advocacy groups.

Given the ever varying patterns in drug use patterns as well as cultural and societal changes, the YPP strives to ensure that its practices reflect international best practices. To this end staff participate in regular training including in-house personal development in contemporary approaches such as Motivational Interviewing and attend local and international conferences. The YPP team also hosted a well attended international conference on the topic of adolescent addiction during the latter period of 2006. Arising from client feedback and clinical experience, future areas to be covered in order to more fully develop our service have been identified as including the focussed treatment of cocaine and stimulant abuse, the provision of 'stand alone' counselling and family therapy services, working with new immigrants to Ireland and the use of interpreters in treatment.

Students, professions, groups and organisations wishing to visit the YPP would be most welcome to do so and are invited to contact the acting programme manager, Dave Cahill to schedule a convenient time to be hosted.



Response to Report: "Forging a New Template"

BY MICHAEL FOX

Michael Fox works as a psychotherapist, in private practice and as an external supervisor to counsellors in the HSE addiction service.

He has worked as group therapist in the Drug Treatment Centre, Trinity Court and before that as a psychiatric nurse in England and Ireland.

E-mail: michaelfox72@eircom.net

The launch of this report (subtitled "*Proposing a more effective way of working with drug users*"), on 25th January 2007, by *Kilbarrack Coast Community Programme (K.C.C.P.)*, presents a challenge to all those who work directly with drug users in Ireland, but I believe most particularly to counsellors (including their supervisors and line managers).

The author of the report, community employment supervisor Declan Byrne, uses a community drug programme, (K.C.C.P.), as a case study to demonstrate the need for change in the way we work with problematic drug users. He highlights the needs of clients attending the K.C.C.P. for a more individualised approach. It is focused on how working with relationship, -including the issues of transference and countertransference, is a necessary part of the proper treatment of addiction. The report particularly illustrates the issues of three clients and asks serious and searching question about the effectiveness of responses which "try to fit all problematic drug users into a rigid system". In his conclusion he puts forward the case for a training of existing personnel in the understanding of transference and countertransference, for outside supervision and for the appointment of a psychotherapist.

Interestingly, the launch was attended by 130 people from a wide variety of backgrounds: community drug programmes, counsellors, politicians, lecturers from colleges running courses in addiction, gardai, community partnerships, Dublin city council, the voluntary drugs sector and many more. This, coupled with the warm welcome for the report from those present suggests that the "need for change" and some "more effective way" (terms used in the report) are exercising the minds of many people.

What I believe this report succeeds in doing, is to provide a clear rationale for a return to the centrality of relationship, as the main tool in the process of addressing addiction. This is a challenge to counselling most of all, where relationship is the key to the work.

I believe the time has come for counsellors working in the area of drug dependency to reclaim the ethics and values of the counselling *relationship*. It can begin with affirming what the profession already

knows: Firstly, as human beings, we are relationship oriented. We know that for lasting and deeper change to take place a counselling relationship is invaluable. (this applies to counselling expressed in a one to one situation, but can include couple/family/systemic/group therapy). Anything which impedes the formation and development of this rapport needs to be thought about and addressed seriously, -such is the potential value of skilled addiction counselling in terms of benefit to the clients.

So it is time, I think, to remind ourselves what happens in the practice of addiction counselling which tells us that the counselling relationship is effecting lasting change:

1. We see that the emergence of the counselling relationship as a way to gradually replace the drug experience. The progression happens when the client is held in a consistent, reliable, sometimes firm, but always professional and caring therapeutic rapport, within the structures of counselling. This rapport compliments and interfaces favourable with other measures in support of recovery and change.
2. It is within the quality, calibre and holding capacity of the relationship that changes in drug using behaviour (and later on many other changes) come about.
3. For the client to be in a position to respond to this highly skilled work (which often functions in the subtlest of ways), he /she must be able to resonate with the interactive "events" which occur continuously in sessions between counsellor and client. This can best be achieved if the client stops taking mood altering drugs (or limits them as an incremental step). This needs to happen at the earliest possible time in the process. Certainly, the client needs not to be so dulled or in any way affected by any drugs (illicit or prescribed), that self awareness of deeper as well as subtler feelings is impeded. It is for this reason that learning through counselling is greatly accelerated during and after the drug withdrawal/detoxification stage as the person progresses towards recovery.

4. Once personal awareness and personal growth begin to happen, the client senses this, and feels less inclined to use drugs. The person values being "in touch" with him/herself. This becomes a benchmark experience which the person wishes to reconnect with, even if a relapse happens.

5. The client begins to learn to understand, tolerate and accept feelings and through this begins to make better sense of the circumstances which led to a life dominated by a wish to escape from reality through drug use.

6. The client, as a result, begins to see him/herself in a more positive, compassionate and understanding light.

7. Eventually the person may be able to take responsibility for the personal issues which need to be worked on in counselling. These issues may include dealing with self esteem and/or family of origin issues (for example parental addiction, their own lack of individuation, quite often experiences of sexual, emotional, physical abuse and neglect.).

8. This offers space for the client to mature, grow into adulthood and also become more socially integrated. The person also has a chance to realise their potential in outside relationships.

So what are we seeing in the way drugs services are organised and delivered in clinics, treatment centres and local drugs programmes that is blocking these worthwhile possibilities?

1. Usually, the client is opiate (and often other drug) dependant, and is prescribed Methadone early in treatment and before ever getting to counselling. The client thus feels held by a prescribed drug which prevents withdrawal symptoms. As a result of the chemically held experience, the person avoids the interpersonal holding of a therapeutic relationship. So for the counsellor, the client is quite out of reach from the outset.

2. When counselling does take place subsequently is usually mediated by a concerned doctor or nurse rather than sought out by the client. It is often crisis-driven, sporadic, poorly boundaried, availed of around the timetable for Methadone and therefore severely compromised in terms of a deepening and meaningful involvement in a change process. The client often spills out the problems, in an uninhibited way, rather than works through them gradually and incrementally alongside the slow building of a therapeutic relationship.

3. Even if the client is only taking the Methadone only- as the doctor prescribed, he/she is usually unable to follow the necessary procedures inherent in effective counselling for addiction. The level of resonance needed in the client, for lasting benefit to occur, is impaired. For example: in the session when the client says or hears something quite poignant to his life on drugs, (perhaps about having lost out on years of growth and fulfillment,) he is unable to feel it deeply enough at the time, or remember and use it as a reference point in future sessions. So although

such grief is real, it is not sufficiently embodied to become a focal point for the work.

4. There is little self exploration or movement on the part of the client towards becoming drug free.

5. Counselling cannot work on developing resilience, an important component of recovery from opiate addiction, as the client continues to feel drug dependant.

6. The client cannot develop ways to understand his own inner, emotional self or deal with inner turmoil. Developing emotional literacy and self awareness, which is a necessary part of addiction counselling is extremely difficult in this context.

7. The person does not come with a request for help from knowing that life is out of control from using drugs. Yet drug addiction is a cry for help and should always be interpreted as such.

8. The persons social self remains underdeveloped-ail too often the drug user during treatment becomes even more embedded in a drug sub-culture of people attending treatment centres, or becomes socially reclusive, going from treatment centre to home and staying indoors. In cases where the drug user has dependant children, often their parenting capacity fails to develop, which serves to continue the tragedy of transgenerational traumatic effects of addiction on children.

We need to remember of course all this is in the context of a fraught situation:-a serious, life threatening problem for the presenting client, one of considerable agony for the family and one which impacts on the community as a whole.

So in commenting, I wish to be respectful of the intentions of treatment providers to respond in a compassionate and effective way, from their own frame of reference and professional standpoint.

In the K.C.C.P Report, the author, Declan Byrne, advocates for the use of a psychoanalytically based understanding of the (often strained) relationships which can develop between staff and clients in the programme, drawing on the position of Rik Loose: "the cause of addiction is not a general cause, but a cause that is specific to the subject, and this cause can only be approached through speech in a transference relationship. That is why treatment that is based on the transference is an absolute pre-requisite in addiction treatment" (Loose 2002).

Whilst it seems to me that the suggestions made in the report may lead to more meaningful relationships between staff and clients in a community drug programme, I am doubtful that, in the present climate, the essential learning through therapeutic encounter can be internalised and used by the client.

I believe it is time to dispel a myth that has existed that somehow being on Methadone for an extended period somehow renders the client more amenable to counselling and rehabilitation. In fact the opposite prevails. However, it was never the intention of Methadone prescribing to inadvertently preclude the possibilities of the progress that could stem from counselling.

Counsellors are seeing that what is happening in Dublin is that clients generally remain on Methadone based treatment for many years, avoiding any prospect of a detoxification and recovery based programme while developing an even more dangerous and intractable poly drug habit. It is especially difficult to reach these clients with counselling at this stage because even if they stop using unprescribed drugs they are still heavily dependant on Methadone.

For counsellors, statistics showing indicators of improvement of clients in treatment (moving away from criminality, getting a job, giving "clean urines"), is not akin to real and lasting recovery. These limited parameters frequently mask the clients' stagnation and serious and lasting susceptibility to further addicted behaviour.

I believe that the real value of counselling has not informed the development of programmes for drug users in Ireland, and the signs of this are in the fact that programmes are over-reliant on Methadone at the expense of interpersonal intervention. The strength of counselling is that ultimately people are relationship oriented. So drug programmes, although responding to a demand, are not geared towards facilitating recovery and growth at the earliest possible stage in the clients' contact with services.

Counselling looks at a big picture-that which is possible through human growth and realisation of potential. It is for counsellors to convey the value of counselling in addiction -this cannot be done adequately by others.

This, I believe is where the discussion needs to come in and within addiction counselling to begin with. Counsellors already have a grounding from their training and experience on many aspects of the development of therapeutic relationship and can provide a flexible, integrated approach -not just in terms of transference and countertransference. Most counsellors are already recognised as essential members of multi disciplinary teams and have supervision arrangements in place, in order to help them work therapeutically and support their work.

I believe counselling needs to stand on its own platform, developing a convergence of views within its own profession through more open dialogue. It needs to face the challenge of not turning its back on existing clients while helping to design programmes that could prevent a new cohort of people becoming chronically addicted.

In my work as a supervisor I have heard and seen many counsellors becoming de-skilled and disillusioned because they are not getting to do the work they came into the profession to do, -which is to make a very real difference in the area of addiction. Some are distressed with the knowledge that their clients (with few exceptions) are not getting better. Over time this stress can lead to ill health and burn out amongst counsellors, much more so, I believe, than from the rigours of addiction work per se. So the cost of "non achievement of potential" is considerable, for staff and clients alike.

Counselling, in many ways already has a template- any "new" template needs to be developed primarily around interpersonal work, as happens in counselling based programmes here in Ireland and internationally. It would need to offer a viable, robust alternative to clients -one which could stand up to evaluation.

As a priority programmes need to help develop genuine and healthy growth in the self esteem of clients. (Any programme aimed at "treating" the actual addiction of the person through counselling and similar interpersonal work, which ignores the need for work on self esteem is bound to fail ultimately).

Counsellors could seek the development of separate counselling centres, away from Methadone treatment centres, for at least some clients entering the services, as well as for clients who have managed to become drug free. They should seek a similar level of appropriate ancillary supports, in the service of developing counselling, as those provided to medically based services.

(Such counselling centres may still need to have access to medical drug treatments but these would be kept at a minimum and aimed at supporting counselling).

Counselling based programmes need to be designed to retain the client in counselling which is seen to be benefiting, for as long as possible, to prevent drop-out caused by having to move from counsellor to counsellor.

The timing of this more proactive approach by counsellors has some urgency and needs to be before more public funds are wasted by replicating the worst aspects of Dublin's response to drug dependency across the country.

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Helping Women Recover: Creating Gender-Responsive Treatment

Editor's Note:

The following is our summary of Dr. Stephanie Covington's contribution to "The Handbook of Addiction Treatment for Women: Theory and Practice" (Eds.) S.L.A. Straussner and S. Brown, Jossey-Bass (2002). The reader is encouraged to read the source material for a more thorough and detailed discussion of this important issue or log on to www.stephaniecovington.com for the full text and other information.

Addiction and Women

Recent research indicates that addiction treatment which specifically addresses women's issues is more effective for women compared to traditional approaches originally designed for men. Despite this, many services are not designed for women or are inconsistent in their theoretical bases.

Dr. Covington believes that effective treatment for women must include a **clinical** perspective of the experience and impact of **living** as a woman in a male-based society. In other words, treatment needs to be gender-responsive: an environment where the location, staff selection, program development, content, and material reflect an understanding of women's lives and is responsive to the issues of the clients.

Recent research provides important information about the woman **addict** and the issues that must be considered in treatment design and process. Addiction is rarely a single dimension issue for women. Effective treatment must be based on a multidimensional perspective, in which the context of women's lives are taken into account.

Two elements that many women in treatment share in addition to their chemical dependency are a lack of healthy relationships and the personal experience of trauma. Together, these elements create multiple and interrelated issues to be considered in assisting a woman into recovery.

Dr. Covington acknowledges the debate over the disease model of addiction and believes the holistic health model of disease offers the most helpful approach. It is comprehensive (addressing **phYsical**, emotional, psychological, spiritual, and **environmental** dimensions) and therefore, meets the requirements for a multidimensional framework for effective treatment.

The holistic health model allows clinicians to address addiction as a primary condition, while concurrently addressing the complex issues women bring to treatment: often a combination of genetic factors, health issues, shame, isolation, **and** abuse

issues.

Male vs. Female in Research

Generically, addiction can be defined as a chronic neglect of the self in favor of something or someone else. This neglect includes patterns of repetition and compulsion that reinforce self-destructive behavior, thinking and affect.

Male addicts are often described as self-focused with grandiose false selves. Confrontation was a common approach used in traditional treatment to break through the grandiosity. **Addicted** women, in contrast, generally experience a diminished sense of self. Their true selves have been neglected - and neglected in favor of others and their drug of choice. They may appear self-obsessed because of the constricting nature of their drug addiction. This obsession, however, hides their true selves.

Critical Areas of Focus for Women's Treatment: The (enter for Substance Abuse Treatment (1994)

1. The causes of **addiction, especially** gender-specific issues
 2. Low self-esteem
 3. Race, ethnicity, and cultural issues
 4. Gender discrimination and harassment
 5. Disability-related issues
 6. Relationships with family and significant others
 7. Attachments to unhealthy interpersonal relationships
 8. Interpersonal violence
 9. Eating disorders
 10. Sexuality
 11. Parenting
 12. Grief related to loss of children, family members, partners, and alcohol and other drugs
 13. Work
 14. Appearance and overall health and hygiene
 15. Isolation related to a lack of support systems and other resources
 16. Development of **life-plans**
 17. Child care and child custody
-

Though research on male addicts has established a clear father-son genetic link for **alcoholism**, similar studies involving women are rare. However, environmental and psycho-social factors in women's addiction have been studied more thoroughly. The main psycho-social issues differentiating male and female addicts are the severe social disapproval women experience. Clearly, excessive drinking among men is seen and described quite differently than it is for women, and women internalize this stigma. Guilt, shame, despair, and fear of severe consequences (such as losing their children) often cause women (and their families) to minimize their substance abuse problem.

Although society may stigmatize a male addict as a bum, attacks on his sexuality or competence as a parent are rare. A woman who carries a heavy burden of shame needs to be offered hope that she can heal. As the addiction retreats, the woman's world will expand away from her drug to **include** healthy relationships, and an expanded self-concept and a richer sexual and spiritual life.

Theory of Women's Psychological Development

So how does a woman move from chronic neglect of self to healthy self-care, from the constriction of addiction to expansion and growth? How do women grow and recover? Understanding how women grow and develop, Or. Covington says, is vitally important for clinicians working with women with addiction.

Unlike traditional theories that describe human development as a progression from dependence to mature independence through a process of separation and individuation, connection, not separation, is the guiding principle of growth for women according to the relational model. In this model, the primary motivation for women throughout life is to establish a strong sense of connection. Actions that arise from and lead back to connections with others support a sense of self and self-worth. Mutual and empathetic relationships empower women, not with **power** over others, but with power that is used with others.

Psychological problems in women can be traced to disconnection or violations of relationship with family, friends, or society. The disempowerment, confusion, and diminished self-worth are fertile ground for addiction. From this perspective a therapeutic environment where women can change, heal and grow is one where they can experience empathetic, healthy relationships with counselors and with each other.

According to the relational model, women often use drugs to make or keep connections. Researchers have identified five ways in which relationships with male partners, for example, can contribute to women's substance abuse and undermine their recovery:

- Male partners often introduce women to alcohol or drugs
- The male partner or other men are often their suppliers once addicted
- Men in their lives often disappoint, fail to support their children, or are incarcerated -
- Women often report physical abuse and use drugs to cope with the pain
- Women receive less support on entering treatment from partners than do men

Sexually dysfunctional women may use alcohol to function sexually. Abusive relationships can lead to a downward spiral of confusion, diminished self-worth, and the abandonment of relationships. Women may turn to alcohol or drugs to provide the energy or sense of power missing from their relationships. Finally, many addicted women speak of their addiction as a relationship. One thinks of the book "Drinking: A Love Story" by Caroline Knapp.

Theory of Trauma

A history of abuse significantly increases the likelihood that a woman will abuse alcohol and/or drugs. In a comparison study (Covington & Kohen, 1984) of addicted and non-addicted women, respondents reported:

| | Sexual Abuse | Physical Abuse | Emotional Abused |
|--------------------|--------------|----------------|------------------|
| Addicted Women | 74% | 52% | 72% |
| Non-Addicted women | 50% | 34% | 44% |

While both male and female children are at risk for abuse, women continue to be at risk in adolescence and adulthood. Consequently, treatment for addicted women must take into account the likelihood that most clients will have suffered abuse. Even beyond suffering violence directly, witnessing violence as well as the stigmatization of gender, race, poverty, incarceration, and sexual orientation produce trauma.

Many **so-called** "treatment failures" are now recognized as trauma survivors who returned to substances to medicate the pain of trauma. An increased understanding of trauma opens new possibilities for substance abuse treatment by integrating trauma treatment with addiction treatment. Unfortunately, even though abuse issues are primary triggers for relapse, traditional treatment does not often deal with trauma issues early in recovery.

Clinicians do not need to be experts in trauma recovery but do need a basic understanding of trauma theory and a conceptual framework for clinical practice. Dr. Covington presents such a framework developed by Judith Herman in

"Trauma and Recovery" New York: HarperCollins, 1992. This is part of the theoretical foundation of her curriculum entitled *Beyond Trauma: A Healing Journey for Women*. Herman considers trauma a disease of disconnection and presents a three-stage model for trauma recovery:

Stage 1, safety, is focused on caring for oneself in the present. This primary need for safety can be addressed by ensuring that addicted women entering treatment feel safe. The treatment environment should be free of physical and sexual harassment. The subjective feeling of safety can be enhanced by teaching self-soothing techniques rather than drugs to alleviate depression and anxiety. In addition, women working on safety issues need to be in a homogenous group as they are often unwilling to discuss issues of sexual or physical abuse in groups that include men.

Stage 2, remembrance and mourning, is focused on past trauma. In a survivors group, participants tell their stories of trauma and mourn the loss of themselves. Women who are stabilized in their addiction treatment are typically ready to begin Stage 3 work.

Stage 3, reconnection, focuses on developing a new sense of self and creating a new future. This phase corresponds with the recovery phase of addiction treatment and can occur in heterogeneous groups. For some, this work can only occur after several years of recovery.

The three perspectives considered thus far: addiction, women's psychological development, and theory of trauma are often addressed by help from three different sources. Addicted women are expected to integrate their addiction treatment, treatment for psychological disorders, and trauma work on their own. A comprehensive, gender-responsive model that integrates these three theoretical approaches would remove that burden and increase the potential for recovery.

Guiding Principles of Women's Treatment

In addition to the theoretical framework, Dr. Covington has identified six key principles to consider in implementing an effective therapeutic process and milieu for women's treatment:

1. *Develop and use women's groups.* Research indicates that group dynamics differ between all-female and mixed groups. In the early stages of treatment, women-only groups, lead by a female facilitator, are the modality of choice.

2. *Recognize the multiple issues involved, and establish a comprehensive, integrated and collaborative system of care.*

CSAT (The Center for Substance Abuse Treatment) has identified seventeen critical areas of focus for women's treatment (see inset on page 14). These issues of focus can be grouped into four major areas: self, relationship, sexuality, and spirituality, and highlight the need for a collaborative approach.

3. Create an environment that fosters safety, respect, and dignity. Both the relational theory and trauma theory presented earlier emphasize the profound effect of the treatment setting on a woman's recovery. The elements of safety, mutuality (exchanges between counselor and client are mutual rather than authoritarian) and empowerment characterize an environment that facilitates healing.

4. Develop and use a variety of therapeutic approaches. In order to fully address the needs of addicted women, therapy needs to work at multiple levels using behavioral, cognitive, affective, dynamic, and systems perspectives. Cognitive behavioral therapy, a popular evidence-based practice, has not been shown to be the best treatment approach as the sole basis of treatment for women.

5. Focus on women's competence and strength. A strength based treatment approach can help identify the multiple issues a woman must contend with and the strategies she has adopted to cope. The focus is on support rather than confrontation. For example, relationship difficulties are portrayed as efforts to connect rather than failures to separate or disconnect.

6. Individualize treatment plans, and match treatment to identified strengths and issues. Despite the common threads of gender, it is important to be sensitive to both the similarities and differences between women. Race, sexual orientation, and age are just some of the factors that produce differences.

Mutual-Help Groups for Women

Mutual help groups like AA, AI-Anon, and NA mirror the traditional ways in which women teach and support themselves and each other. The twelve-step model is now employed by more than 126 "anonymous" groups where people cope with a wide spectrum of substances, behaviors, and processes. The success of these groups is an indication of the many problems to which complete solutions have not been offered by established helping professionals.

Advantages of mutual-help groups for women is that they are usually readily accessible (in many places) throughout the day, and they are free. Unlike conventional problem-solving services no appointment is needed and there are regular, frequent meetings.

Although feminists have been concerned about the emphasis of the twelve-step model on powerlessness, Dr. Covington points out the confusion between surrender and submission. "When we submit, we give in to a force that's trying to control us. When we surrender, we let go of our need to control."

The nonhierarchical, spiritual, and non-commercial aspect of twelve-step programs can provide a growth-fostering relational context for recovery. Finally, despite the sexist language in which the twelve steps are couched, some women are able to interpret the steps in ways that are distinctly personal, meaningful, and useful. Dr. Covington has also created a gender-responsive 12 Step book and workbook, "A Woman's Way through the 12 Steps."

A Mode! Treatment Program for Women

Helping Women Recover (Covington, 1999) is a program curriculum for creating gender-responsive treatment based on the theories and principles described in Dr. Covington's contribution to *The Handbook of Addiction Treatment for Women*. The program is organized into four modules: self, relationships, sexuality, and spirituality. These reflect the four areas that women say are triggers for relapse and areas of greatest change in recovery. The program curriculum includes a Facilitator's Guide for counselors and a Woman's Journal, the participant's workbook.

Log on to www.stephaniecovington.com for more information.

Dr. Stephanie Covington is a clinician, author, organizational consultant, and lecturer. Recognized for her pioneering work in the area of women's issues, Dr. Covington specializes in the development and implementation of gender-responsive services. She has conducted seminars worldwide on addiction, sexuality, families, and relationships for health professionals, business and community organizations, and recovery groups. The seminars, both practical and sensitive in approach, provide professionals with a valuable opportunity to learn new skills for dealing with personal, institutional, and societal changes as we move into the 21st century.

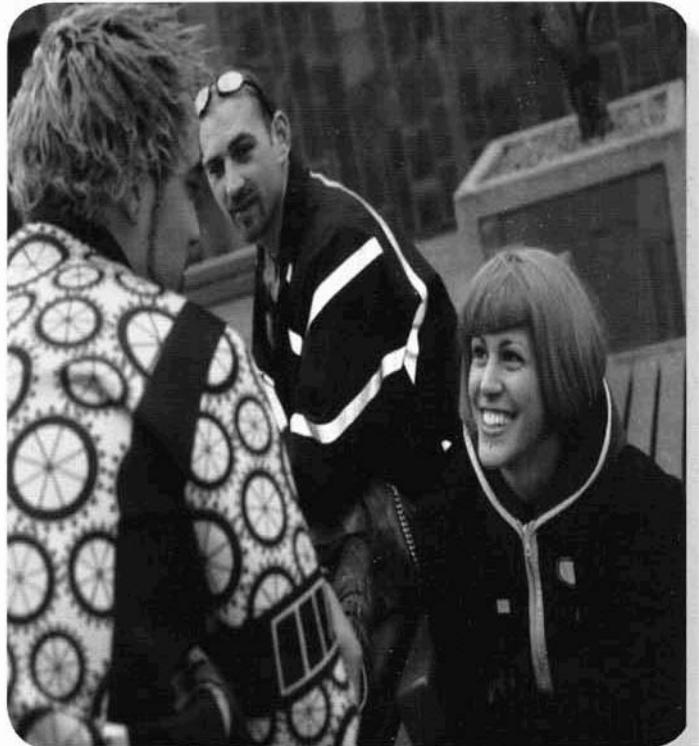
Dr. Covington's organisational work in both the public and private sectors focuses on systems change and the development of caring, compaSSionate, and empowering environments. Her work as a consultant to the Betty Ford Treatment Center included the creation of a progressive and innovative program for women. She also consulted with the Hanley Center in West Palm Beach on the development of the Center for Women's Recovery. Dr. Covington recently completed a multiyear contract with the Pennsylvania Department of Corrections to provide comprehensive, system-wide consulting services to address the issues of female offenders. She also helped the PA DoC create an addiction treatment philosophy and design a treatment framework to serve both women and men.

Dr. Covington has also served as a consultant to the United Nations Office on Drugs and Crime (UNODC) in Vienna and the Center for Substance Abuse Treatment (CSAT) in Washington, D.e. She was a workshop chair for both the Women's Treatment Improvement Protocol (TIP) and the Trauma TIP (published by CSAT). She also co-authored the National Institute of Corrections three year research project "Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders."

Educated at Columbia University and the Union Institute, Dr. Covington has served on the faculties of the University of Southern California, San Diego State University, and the California School of Professional Psychology, and she is a former chair of the Women's Committee of the International Council on Alcoholism and Addiction. Dr. Covington is a board-certified Diplomate of the National Association of Social Workers, the American Board of Sexology, and the American Board of Medical Psychotherapists, and she is a member of the American Association of Marriage and Family Therapy.

Among the many articles and books written by Or. Covington are:

- A Woman's Way through the Twelve Steps and its companion workbook*
- Awakening Your Sexuality: A Guide for Recovering Women*
- Leaving the Enchanted Forest: The Path from Relationship Addiction to Intimacy*



Substance Abuse / Addictive Behaviour, & The Counsellors/ Psychotherapists Role

By Martin Rafferty

Martin Rafferty works as a Counsellor in the Drug Treatment Centre Board. He is the Editor of 'Spiritual Well Being' a book which is designed to assist any twelve step programme & co author & editor of 'Journey of Life' a booklet of Prayers and Poems. Martin is also the Founder & Director of Chara Counselling a service dedicated to working with people in the area of Addiction.

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Rising Tide

Over the years we have watched with batting breaths how substance misuse and addictive behaviour have become a universal phenomenon, so much so, they are regarded as a major health problem. The health and social problems associated with consumption have long been causes of concern in international public health care circles (Butler 2002).

With the widespread availability of psychoactive substances such as tobacco, alcohol, illicit and prescribed drugs have had bio psycho social implications for the individual, family and our communities. (Rassool' 93).

Ireland is no exception; Substance abuse has become a critical problem in Ireland across all segments of the population. It has no class, makes no distinctions, and extends its way across socio-economic, cultural, religious and ethnic boundaries. Its impact is felt in some way by all members of our society.

One only has to look at the illicit drug market and the impact it is having on Irish life and society. Whether it be within the world of rival gangs killing each other or from the individual injecting a syringe, creating a fear that one day our own children will fall prey to the same faith.

This explosion of drug use over the last two decades among people of all ages is all too familiar to us. And for those of us working as counsellors/psychotherapists it can seem like trying to empty the ocean with a bucket. As service providers in every setting we have an important part to play in dealing with substance abuse and addictive behaviours.

The term addiction comes from the Latin "ad dicere" which means to give "oneself up". Addictive behaviour and Substance abuse is characterized by preoccupation with the substance or the experience. As defined in Diagnostic & Statistical Manual IV (DSM-IV).

In this scribe's **opinion** addiction occurs when a "person surrenders to a substance or activity, which can control and ultimately destroy their lives". Compulsion, dependence, regularity of usage and associated destructiveness are all essential addictive elements. Clearly, the potential for profound negative impact on the user and others is to the fore.

Substances abuse includes alcohol, sedatives, amphetamines, cannabis, cocaine, hallucinogens, inhalants, opiates, caffeine, nicotine, and prescription drugs. Similar addiction processes to those of substance abuse include experiences such as eating, gambling, sex, and work addiction.



Causation/models

While many models of causation of substance abuse/addictive behaviour have been proposed, no clear etiology has been identified. Models emphasise morality or individual conscious choice, biological or disease vulnerability, behavioral learning patterns, Cultural-environmental concerns, or bio psycho social impact.

The bio psycho social model views substance abuse/addictive behaviour as a complex interaction of all of the other models and endorses multiple strategies for counselling from these models as appropriate. Counsellors/psychotherapists need to review these models to develop a conceptual position regarding causation upon which he/she can make consistent therapeutic assumptions and decisions to guide counselling practice. (Inaba, D. S; 1997).

Counsellors/Psychotherapists Role

Whatever the cause, as counsellors/psychotherapists no matter what our specialty or setting we will encounter clients (directly or indirectly) with presenting or related problems of substance abuse/addictive behaviour. An individual with a substance abuse problem is unique in his/her history, pattern of use and abuse, and counselling and related treatment needs. Within this relationship, we must provide focus for the process by addressing the client's presenting problems directly and identifying client need for change. Counsellors/psychotherapists of clients with substance abuse problems often find this process difficult because of the chronic nature of interrelated destructive attitudes and coexisting disorders these clients often bring to counselling. In order to have a successful outcome it requires, a sound knowledge base and assured belief that what we are offering is both valuable and valued.

"Successful relationships are facilitated by skilled counsellors who help the client become more invested in the process and who utilizes therapeutic techniques appropriate to the client". T & Mc Bride, 2002,

We must be able to establish the same open, collaborative, therapeutic relationship in counselling individuals with substance abuse problems as we do with other client populations. This ability is viewed as a prerequisite to successful outcome in any counselling setting. As counsellors/psychotherapists we act as change agents within the context of therapeutic relationships with individuals. Once problem identification and client need for change are identified, we must be able to articulate and

implement counselling intervention strategies perceived by both the counsellor and the client as appropriate to the client's need to change.

To be effective we must first have the ability to develop an open, collaborative relationship with our clients, and be able to meet them where they are at, and not where we would like them to be, so to speak. Carl Rogers identifies, and research supports, this ability as related to the counsellor's skill in conveying, in interaction with clients, unconditional positive regard and empathic understanding (Austin, 1999).

And finally all counsellors/psychotherapists should be thoroughly familiar with the facilities and services in his/her community to ensure proper referral for clients with substance abuse/addictive behaviour problems, (e.g., Alcoholics Anonymous (M), Narcotic Anonymous (NA), Al Anon, education programmes, halfway houses and therapeutic communities and group therapy, etc).

Conclusion

The nature and profile of addiction is ever changing in the context of substances used, the demeanor of those taking the drug and the environments in which they are most often taken. It is the most prevalent mind disorder, encompassing some 40 percent of the diagnoses in the DSM-IV (American Psychiatric Association IAPAL, 1994). The need for continuing education and insight into substance abuse and addictive behaviour, is a priority for all counsellors/psychotherapists no matter what our setting.

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ADDICTION - A GENDER ILLUMINATING ISSUE?

BY Teresa Daly

Teresa Daly attended Trinity College Dublin where she gained an honours degree in psychology and a M.5e. in Counselling Psychology in 1997. She also works as an addiction counsellor and supervisor.

Teresa works in a variety of settings, with a diverse clientele. This would include community-based settings such as DROp, an addiction programme and a community development project, both based in the Dun Laoghaire area. She also maintains a private psychotherapy practice.

It could be stated that the area of addiction has begun to emerge increasingly as a specialist area. One of the ways in which such a development can be noted is via an increased emphasis on the importance of evidence-based research. For example, Kaufmann (1994) refers to how up to the 1980's, few distinctions were made between different types of substance abusers e.g. drug users and alcoholics; teenagers; older substance abusers; those who choose stimulants versus sedatives, and other variables including class, culture, ethnicity and gender. The focus in this piece pertains to gender and is characterised by the objective of exploring gender-related issues in addiction. Moreover, in what ways do the psychodynamics of the etiology of addiction operate as well as the ways in which psychopathology is gendered.

Gender is an area of relevance in substance abuse treatment services. Kandall (1996) refers to the fact that early substance abuse treatment studies Le. Drug Abuse Reporting Program (DARP), Simpson et. al. (1990), and the Treatment Outcome Prospective Study (TOPS), Kandall (1996), did not fully analyze male-female differences in the treatment data. Brady & Ashley (2005) have noted how the proportion of females among substance abuse treatment clients has increased over the past **decade** - currently **constituting** about one third of the treatment population. Female substance abusers can experience greater obstacles to accessing and availing of treatment Le. running a single household; lack of supports and child care responsibilities. Kaufman (1994) states that males have traditionally used more **alcohol**, marijuana, heroin and cocaine, whilst females used more legal drugs - predominantly prescribed by **doctors**. The National Client Data System (1992) found that for women in treatment, alcohol was the **primary** drug of choice, (followed by cocaine, heroin, cannabis and sedatives), and that they tended to present more often in mental health facilities with issues not overtly related to substance abuse i.e. depression, anxiety.

It is useful to examine more closely the literature on the personality characteristics, psychodynamics and presentation of psychopathology of both sexes.

Male Substance Use

Kaufman (1994) states that no specific personality typology exists among male substance abusers but nevertheless notes a number of characteristics that promote an understanding of their behaviour. They are as follows:

(A) Male Alcoholics

Bepko & Krestan (1985) refer to how drinking enhances identification, companionship, communication and closeness with other males. Drinking can permit men to violate the male code of self-sufficiency and independence by expressing feelings and exhibiting dependent and 'emotional' behaviours. Kaufman (1994) states that most alcoholic men have a pervading sense of low self-esteem and poor self-image and drinking is triggered by stresses affecting those areas where they feel most inadequate. Thus, letting go of such a precious object without a replacement is inconceivable. Craig (1982) states that male alcoholics exhibit more depressive symptomatology, guilt and anxiety than male drug users.

(B) Male Drug Users

In relation to male drug users, Kaufman (1994) again notes the importance of certain personality structures. This would entail a high incidence of anti-social personality traits. Such a view or finding can perhaps be understood in terms of the behavioural skills that is necessary in the procurement of illicit substances. Khantzian (1980) refers to what he describes as the "lifelong preoccupation of heroin addicts with aggression". He also believes that heroin is used specifically as an antidepressant, which **seeks** to **blunt** the emotional impingement of painful inner and outer reality.

(C) Psychopathology

In relation to initial reasons for use of heroin and sedatives, Kaufman (1994) refers to their use in relation to the lessening of anxiety about sexual performance, assertive performance, and communication skills. The masculinity, exhilaration, autonomy and potential self-destructiveness involved in risk behaviours - be it sports, business, compulsive gambling can temporarily substitute for drug use but the aforementioned behaviours are "powerfully paired conditioning stimuli" for drug and alcohol use which produce a euphoria similar to drug effects.

Levant (1998) states that biologically oriented psychiatrists have strongly referred to the linkage between substance abuse disorders - especially alcoholism - and depressive symptomology. Pollack (1998) has put forward a theoretical framework of Major Depressive Disorder Male Type which includes such behavioural and psychological factors as 'discontent with self'; 'interpersonal antagonism' (blaming), 'impulsivity' and 'unconventionality', which are in turn exhibited as disorders of conduct, dangerous risk behaviours to self and others, and types of lifestyles that create stress-induced, hostility-based physiological disorders.

The above literature serves to challenge the traditional differential prevalence of rates of depressive symptoms between the genders, and may further suggest that depression has been 'feminized'. In a review of a national study of 23,000 males and 500 practitioners by PoUs et. al. (1991), the treating physician's diagnosis was compared with random administrations of an objective diagnostic instrument, the Diagnostic Interview Schedule (DIS). They found that 65% of men's verified depressions went undetected and undiagnosed. The incidence of completed male suicide begins to come into sharper focus.

Female Substance Use

Research has indicated that psychosocial antecedents are more likely to be associated with substance use by females than with males such as the following:

(A) Marital and relational issues

Females often are referred to substance abuse treatment through social Services - re: childcare issues. Clark (2001). Amaro & Hardy (1995) finds that of those women who have sought treatment for alcohol and drug use, they tend to be in relationships with partners who also abuse substances more frequently than the partners of non-substance abusing women. Findings also demonstrated higher

separation and divorce rates, more abortions, miscarriages, childbirths, rape, domestic violence and encounters with law enforcement agencies. Tucker (1980) found that female SAs are more socially isolated than male SAs and that sources of support for women SAs primarily derive from either family members or women friends. In addition, women SAs are more likely than male SAs to form co-dependent relationships that are characterized by control and domination.

(8) Trauma specific issues

Gentilello et. al.'s (2000) study indicated that women SAs tend to use alcohol and drugs to self-medicate as a primary means of coping with traumatic events. An increasing challenge within the addiction field concerns the increasing awareness of child sexual abuse - including incest. Therefore women, (this also pertains to men), may present with inter alia, post-traumatic stress disorder (PTSD), self-harming behaviours, and suicidal ideation. Copeland (1997) has criticized the confrontational treatment approach model on the grounds that it increases the likelihood of re-enacting traumatic experiences which further elicit feelings of distress and powerlessness.

(C) Social stigma

Grella & Joshi (1999) notes that substance use among women is more highly stigmatized than among males. They point out that stigma and the resulting guilt may seek to foster further denial by women which may act as a barrier to seeking treatment.

(D) Psychopathology

In attempting to decipher the rates and level of psychopathology, it is challenging to consider where pre-existing pathology ends and the social consequences of substance abuse begin for both genders. Kaufman (1994) refers to the high incidence of depression among female alcoholics. Helzer & Pryzbeck (1988) found that of those who presented with both depression and alcoholism - alcoholism was primary and depression secondary for 78% of males; whereas depression was primary and alcoholism secondary for 66% of females - a striking reversal. However, Burt et al. (1979) in their review of 15 studies, found scant support for the hypothesis that females exhibit greater psychopathology than males - though eating disorders are more prevalent in females. Of the 15 studies, 5 found that females functioned more poorly than males; 4 studies made no comparison and 6 did not report male-female differences of significance.

DISCUSSION

Thus, the above suggests that one of the most interesting areas in the area of addiction is the differential etiological factors between males and females. In what way are the initial reasons for use and routes towards substance abuse gendered? It could be stated that this is an area that remains poorly understood, particularly in light of the plethora of theoretical approaches - entailing the genetic, biological, environmental and sociocultural models. Therefore, it may be useful to consider emerging gender-role paradigms and how these can contribute further to our understanding.

A New Psychology of Men?

The Gender Role Strain Paradigm by Pleck (1995) has been described as a robust representative of the social constructionist perspective on gender. It does not assume that masculinity and femininity is the same thing, rather it views definitions of gender as historically relative and socially constructed for the most part. The Gender Role Strain Paradigm proposes that, to the extent that parents, teachers, peers and society subscribe to a particular gender role ideology, children will be socialized accordingly. This can be understood, to take an example, in the emotion socialization process through which a boy's natural expressivity is suppressed and channelled. Haviland & Malatesta (1981) reviewing data from 12 studies, concluded that male infants are more emotionally reactive and expressive than female infants - that they startle more easily, are more excitable more quickly, have a lower tolerance for tension and frustration and cry sooner and more often. Levant (1996) suggests that the socialization process suppresses this initial advantage in emotional expressivity and its effects become evident in terms of verbal expression by 2 years of age and facial expression by 6 years of age. Essentially, boys are required to prematurely dis-identify with their maternal caregiver in order to 'move psychically' closer to the father and be accepted into masculinity. Pollack (1995) contests such a view and considers such demands as a "traumatic disruption of boy's early holding environment". In adult life, this can serve to create a "highly shame phobic stereotypic male character with a propensity to funnel most hurt and pain into one anti-dependent undifferentiated affect of anger/rage" Pollack (1995) further views the above in terms of a 'normative epidemic' involving men's numbed inner experience, characterized by a form of affective dysregulation or abandonment depression.

The above does not seek to pathologise maleness but seeks to put forward a theoretical template that can

inform our work in this most challenging of specialist areas. Pollack (1998) states that treatment which is informed by such a (psycho) dynamic awareness "must pay close attention to the requirement for creating a symbolic recreation of the early holding environment in the treatment of narcissistic issues" It involves an understanding of the need for facilitating and maintaining an experience-near, non-judgemental stabilizing self-object transference arrangement that is of a mirroring or idealizing type.

What Do Women Want?

Brady & Ashley (2005) state that there is no universally accepted definition of substance abuse treatment programming for women. They do, of course, acknowledge that there are needs that are specific for women in terms of improved delivery of services i.e. access to quality child care facilities, prenatal, well-baby care and healthcare services. Kaufman (1994) states that since female substance abuse is very often precipitated by loss, professionals should be aware and sensitive to these issues and an empathic understanding of these issues should be a focus of therapeutic treatment.

Collier (1982) states that when women do not develop a sense of the right to their own bodies, it inevitably renders them vulnerable. She concludes that "body power has social, economic and legal ramifications great enough that any change in women's attitudes to their bodies is highly significant". Therefore, it is pertinent to examine the kind of issues that women may present in their treatment. Its relevance can be appreciated in terms of the need of an increased awareness that can be incorporated in the treatment cultures of existing substance abuse programmes.

Common issues would include the following:

Powerlessness - The loss of the power in relation to the ability to do, act or to effect.

Limited behavioural and emotional options.

Socialization limits the number of options in feeling and behaviour which both sexes exercise automatically. People censor their own behaviours and emotions in order to think of themselves as female or male. For example, to facilitate the identification of feelings of anger, the aim needs to be concerned with helping the female client to deal with anger through crucial skill-building areas including verbal and nonverbal communication styles, confrontation, negotiation, alliances, compromise and resoluteness.

Failure to nurture self

A culture which expects that women centre around others while men must centre on themselves has caused suffering in different way for both sexes. Women need to understand the importance of developing the ability to combine self-nurturance with nurturing other. To wait for others to do so is a manifestation of powerlessness.

A diffused sense of self

A sense of self means that one can define the boundaries between oneself and others or the **world** at large. Collier (1982) suggests that women as a group tend to manifest a diffused and weaker sense of self. They tend to be 'autocentric' in style e.g. order of events is only relevant in terms of the degree that it relates to themselves. This creates exhaustion in women. Men tend to be 'allocentric' in style e.g. order of events as having a direction and logic of its own. For women, in particular, be it relationships or work-related, a clear sense of a self with boundaries is invaluable.

Balancing independence with interdependence

The challenge here is to find a healthy balance between autonomy and interdependence. Both are deemed necessary in that it seeks to facilitate a recognition of needs both in oneself and the other.

Substance abuse disorders also promote a state of alexithymia (disruption in both affective and cognitive processes that results in an inability to translate feeling states into language). Levant (1998) suggests that a more emphatic incorporation of alexithymia treatment may well be indicated as a corrective measure - especially for men in terms of double jeopardy. This would entail a psychoeducational approach which focuses on the development of a vocabulary for emotions and learning to read the emotions of others.

CONCLUSION

In an Irish-based study, Cahill & Bunting (2005) examined whether individuals can be grouped into distinct profiles based on their drug-use behaviours. Findings demonstrated that membership of a specific class was found to change dramatically as a function of age. This is interesting in terms of Haseltine's (2000) finding that females are more likely to need help for emotional problems at a younger age. And what of males? Brook et. al (1992) did not find a differential gender effect in the developmental path to delinquency but did however, demonstrate earlier delinquency and drug use in males. Cahill & Bunting (2005) concluded that there was a notably poor match between an individual's drug misuse/abuse category and treatment which raises issues about

best practice. This is a challenge not only to related disciplines but also to the field of psychology, which needs to begin to embrace this area more fully with its attendant complexities.

Denning (2004) promotes the view that exclusive focus on drug behaviours can be at the expense of human psychology. She further states that overall, most clients will present with emotional problems even if they are also experiencing drug use issues. For example, she states the statistic that cocaine use is rampant and yet major depression, (17% prevalence), is more common; or that generalized anxiety disorders, (5.1%) are more common than cannabis use. This serves to give rise to a consideration of how the overall medically based emphasis on drug problems is at the expense of emotional/psychological issues in people's lives.

The important question of how treatment will be approached remains contingent upon a multitude of factors and variables. Le. treatment setting, level of substance use, types of substance, stage of readiness, **motivation** and recovery, as well as what forms of therapeutic interventions are **utilized**, resources as well as the contemporary socio-political climate. Nevertheless, the tentative contribution of the above paradigms is essentially, in its challenge to society and professionals, to, so to speak, look outside the box, to examine our own beliefs and prejudices and how they consciously and unconsciously inform our work - a way of seeing and understanding more so than a set of structured interventions.

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The Matrix of Life

People don't talk anymore, all they do is text,

Mobile **phones** are taking over technology Is all about what's out next,
You could be **standing** at a bus stop everyone with their head down,
Their thumb is the only muscle they use, just standing still with a frown,
People are becoming like the machines they use, with no personality or
ch to loose,

We are becoming a computerized race, **everybody** with the same
emotionless face,

It's only a matter of time, till we **catch** up with the sci-fi themes,
Were everyone will **take** a pill, and live there life In there dreams,

Martin Murray

REPORT ON THE CURRENT POSITION RE 'THE WAY FORWARD' PROPOSAL.

Mr Nicholas Fenlon was invited to facilitate a session at the 2005 AGM on an IAME proposal for 'The Way Forward.' This was a very interesting session and the group participation was excellent. A variety of views on the proposal emerged. In its briefest format the proposal, which has been first raised by Mr. Tony Geoghegan at a previous AGM, was to expand the existing IAME in order to incorporate and therefore recognise other allied professionals working in the field of addiction. These other professionals included education officers, outreach worker, project workers and support service workers. While there was enthusiasm expressed at the AGM there were also some reservations and fears.

By way of recognising and addressing these concerns it was decided to hold regional meetings where more members would have the opportunity to have their say. These regional meetings were held in Dublin, Cork and Athlone during 2005. The attendance at these meetings was generally small and varied but it did give the opportunity for expression of both fears and innovative ways of moving forward. While there was an acceptance of the necessity for change in order to stay relevant and professional, the greatest fear was the dilution of counselling within the organisation. A report outlining the emerging issues was presented to the executive for their consideration.

Mr. Fenlon was invited back to the 2006 AGM to facilitate a session on 'How the Change would look. Le. how it would affect the IAAAC should they choose to embrace it, and likewise how the IAAAC would be affected if it doesn't move to change. Many novel ideas emerged on how the organisation could incorporate other sectors who work in the area of addiction.

Here the situation lies and awaits the arrival of the new Development Officer. We look forward with enthusiasm to his/her input with IAAAC of the 'Way Forward'



..DRUGS: ISSUES AND EXPERIENCES 2007"

Community Awareness of Drugs

Patron:
President Mary Mc Aleese

Registered Charity Number:
CHY 67 42



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Drug education and training opportunities for
community and new-to-post workers for the coming
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Each year CAD hosts several drug education events
which aim to reduce the demand for drugs. The next
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Saturday, March 3rd 2007

Registration from 9.15am to 9.30am with close of event
at 5.15pm. Our **principal** speakers are:

Dr Des Corrigan

Senior Lecturer at the School of Pharmacy, Trinity
College Dublin, and Chair of the National Advisory
Committee on Drugs (NACD)

Brian Foley

An experienced **trainer** and addiction counsellor with the
Irish Association of Alcohol and Addiction Counsellors
(IAAAC)

Young People in recovery associated with
Coolmine Therapeutic Community along
with members of a Family Association will share
their personal experiences.

(CAD Education Days for 100: June 16th and Oct. 20th 100)

Registration form: To reserve a **place** please return this form with the full **€60 non-refundable fee** to CAD
office as soon as possible. Bursaries are available in exceptional circumstances. Many thanks.

Cost: **Education Day** €60
(includes refreshments and lunch)
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