



# **FORGING A NEW TEMPLATE**

**Proposing a more effective  
way of working with drug users**

**Kilbarrack Coast Community Programme**



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**The inside covers show a photograph supplied by St. Benedicts  
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# *Forging a New Template*

**Proposing a more effective way of working with  
drug users.**

Report written by Declan Byrne  
On behalf of the Kilbarrack Coast Community Programme Ltd.

**Kilbarrack Coast Community Programme (KCCP) Ltd.**

**Kilbarrack Coast Community Programme Ltd. (KCCP) is a drugs rehabilitation and aftercare project based in northeast Dublin. It was established in 1997 in response to the increasing use of drugs in the Kilbarrack area and its emphasis is on a quality, user-led services for drug users in recovery. KCCP runs a three-year support and aftercare programme for recovering drug misusers; a Parents Support Group; and a youth service for 10 to 18 year olds in the area**

**KCCP has funded this report. The views expressed in this report are the author's own and do not necessarily reflect the views and opinions of KCCP. However, KCCP. are delighted to assist in its publication in the hope that it can start a debate that may lead to improved services.**

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# About The Author

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## Declan Byrne



Declan Byrne began working for Kilbarrack Coast Community Programme in December 2000 as a Community Employment Supervisor. In 2005 Declan was awarded a Masters Degree in Addiction Studies from Dublin Business School. Declan believes that the services currently being provided to problematic drug users are totally inadequate. Declan is firmly in the “beyond maintenance” camp.

“Beyond Maintenance” was a book published, which detailed the proceedings of a conference held in June 2000 organised by the Catholic Bishops’ Conference in conjunction with the Irish Times to look at the challenge facing those who wished to provide a service to problematic drug misusers. Dr. Jane Wilson from the Scottish Drugs Training Project was the keynote speaker.

In her address she dealt with the complex issues and the challenges involved for service providers. She sets out a framework for programmes hoping to meet individual client needs. Her paper ‘Substance Misuse in the New Millennium’ had the power to question existing services and the courage to make practical suggestions for future models.

In 2004 the National Advisory Committee on Drugs commissioned MacGabhann et al from Dublin City University to bring out a groundbreaking report entitled “Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland”. (Dual diagnosis is defined as “the co-existence of both mental health and substance misuse problems for an individual”). The report highlights ‘the inadequacy of services for dual diagnosis’ the ‘exclusion’ from the services for people with dual diagnosis and the current ‘gaps’ that exist. The report concludes ‘Clinically effective service models and treatment approaches need to be developed that fit the context of people in Ireland with dual diagnosis at (both) regional and local level.’

In April 2006 official statistics show that there are 8,039 problematic drug users in ‘treatment’ throughout Ireland but Declan’s experience over six years has led him to question the nature of this treatment.

# The Author

# Table of Contents

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<b>About the Author</b>	<b>2</b>
<b>Foreword</b>	<b>4</b>
<b>Acknowledgements</b>	<b>8</b>
<b>Executive Summary</b>	<b>9</b>
<b>Chapter 1:</b>	
<b>INTRODUCTION</b>	<b>10</b>
<b>Chapter 2:</b>	
<b>METHODOLOGY</b>	<b>11</b>
<b>Chapter 3:</b>	
<b>THE PROGRAMME</b>	<b>12</b>
<b>Chapter 4:</b>	
<b>THE PARTICIPANTS</b>	<b>15</b>
<b>Chapter 5:</b>	
<b>THE UNDER-UTILISED TOOL OF TRANSFERENCE</b>	<b>18</b>
<b>Chapter 6:</b>	
<b>CONCLUSION</b>	<b>24</b>
<b>The Final Word</b>	<b>25</b>
<b>References</b>	<b>26</b>

Contents

# Foreword

Dr. Rik Loose

Addiction is characterised by a sense of urgency or immediacy and it concerns a need to feel good, to be without pain or even to acquire an ideal state of feeling. But are these needs not something that most people can identify with? Indeed, addiction is a very human phenomenon. However, what sets addicts apart from others is that they do not just want to feel a certain way, they also demand these feelings and, moreover, they have found something in the effect of alcohol and drugs that will give them these feelings (at least for a while). These chemical substances will provide addicts with the sought-after feeling because that is the effect they have on them. It is important not to forget the simple fact that drugs and alcohol do not affect everyone in the same way: for instance, addicts do not get the same effect from drugs as non-addicts do.

Drugs and alcohol are chemical ways that (more or less) immediately influence body and mind via the toxic route of the organism. Taking drugs or alcohol addictively is an activity that is closely related to an avoidance of the social bond with others. Active addiction is largely a matter of sidestepping the realm of language and speech. Indeed why not call it *a-diction*? The sidestepping of this realm is the very reason why it is extremely important to get addicts to speak at all cost.

What happens in addiction treatment is the following: addicts are asked to abstain from - or at least put a limit to - that which provides them with a good feeling. If they have to abstain or limit themselves in terms of access to pleasure or

lack of pain (which comes down to the same thing as experiencing pleasure) they will often come to depend on a substitute mechanism, namely, the dynamic between them and the counsellors (or institution). In other words, the pathology is drawn into the relationship between addict and counsellor. That means that in this situation addicts demand something of the counsellors (or institution) that drugs or alcohol had given them in the past. What they found in drugs or alcohol is an enjoyment that is situated beyond the mediation of speech or language. In treatment this “more-of-enjoyment” has to be given up.

What addicts repeat in the transference relationship is indeed something that is related to the lost immediacy or the lost satisfaction (enjoyment) that was part of taking drugs. Now they want to regain some of this via the transference relationship. The crucial thing is that this relationship (the relationship between counsellor and addict) does not lend itself very well for regaining this lost enjoyment or satisfaction.

Addicted clients will demand something of the counsellor that cannot - and indeed should not - be given to them. The pathology of the clients is forced into a realm in which it is uncomfortable. The reason for this is that the social bond of the transference relationship is the realm of language and speech and this realm is structurally lacking in terms of being able to provide the possibilities of immediacy and full-satisfaction. Again, addicts will demand something that cannot be given to them within an institutional

framework. This will lead to frustration, aggression, “us-and-them” situations, a toxic atmosphere, and so on.

In addiction treatment relationships are always ambivalent. What we encounter here ranges from a demand for recognition, trying to please, being good, wanting to be loved, to, accusation, irritation, aggression, transgression, behaving badly, “acting-out”, and so on. However, it is important to understand that all these emotional expressions are signs of the pathology of addicts that manifest themselves in the relationship between addicts and staff.

These emotions, thoughts and behaviours are forced by the institutional setting to express themselves within the transference relationship. In other words, they are not interfering by-products; they are the very essence of addiction treatment. These are the phenomena that addicts have to experience such that they can work through them. These phenomena are therefore the very way into - and indeed very way out of - a treatment. Institutions and their staff have to allow these phenomena to occur. But that is of course not always easy.

The only way to manage this process is by maintaining a function as object of transference for addicted clients. To maintain this function is at times extremely difficult because the pathology of addicts will try and move beyond the social bond of the transference. It is in the very nature of addiction to undermine the (symbolically structured) pact that exists between people. This is what staff or counsellors have to be able to withstand and when this becomes problematic it can lead to what is called counter-transference.

The demands of addicted clients on staff can be huge and often impossible. The question we should ask ourselves is: why do addicts provoke so much negativity or counter-transference in others who try to help them?

To some degree most people identify with the ideals that addicts implicitly pursue with their addictive behaviour. Indeed it may very well be that *some* aspects of addiction “act-out” what non-addicts dream or fantasise about (I deliberately emphasise *some* because most aspects of addiction ultimately end up in tragedy). We cannot afford to ignore those aspects of addiction that we may perhaps unconsciously identify with. In that sense addiction is able to expose an unconscious fascination in others. Curiously, if this is the case we may well ask ourselves the following question: why are we not all addicts? The answer is that some of us have other symptomatic ways of coping, but more importantly perhaps, most people can indeed accept that life is not a matter of unlimited pleasure or a total avoidance of suffering; most of us can accept that total satisfaction is not attainable and that immediacy does not exist (except via the chemi-



cal substance). For most people total and immediate satisfaction only exist in fantasy. However, it can have a disturbing effect when these fantasies meet their real counter-parts in addicts one works with. When this happens it can lead to counter-transference and that often implies that anxiety is provoked, which frequently leads to a reaction rather than a carefully considered response. This reaction is often aggressive in nature.

Briefly summarised, for a lot of addicts drugs and alcohol represent something in relation to an ideal and this ideal is transmitted onto the relationship with the counsellor (or institution) when the addict enters treatment. The relationship with the counsellor can become an addictive one but it should be acknowledged that this situation is part and parcel of addiction treatment and that it is a necessary phase in a treatment. That means that the addicted client has to be given an opportunity to work-through this addictive relationship. In other words, dependency on drugs or alcohol is transformed into a dependency on staff and/or treatment centre and it is on the basis of a working-through of this relationship that the addict can recover. What often happens is that staff are idealised by addicts. The problem related to this is the following: it can happen that at an unconscious level staff members identify with this idealisation by clients. In other words there is a need in them to be admired and revered by their clients. In fact, it is even difficult sometimes to escape this process in an addiction treatment centre because the transference of addicts and their demands can be very subtle and at the same time forceful. Moreover, as just suggested, there are staff members whose desire is to be susceptible to being positioned in this way by their clients. If that desire of the counsellor feeds into

the pathology of the addicted clients the treatment can become destructive. This will create a therapeutic deadlock and the treatment will stagnate because it will not lead to a desire in addicts to take responsibility. It means that addicts are forced to remain within a relationship of dependency on their counsellors and institution. In this situation transference and counter-transference will become destructive forces; it will lead to toxicity on both the level of the therapeutic relationship and the therapeutic community. To some extent treatment centres and institutions dealing with addiction have to go through phases like this, but it has to be properly recognised, managed and therapeutically dealt with, at both an individual level as well as a group level.

Treatment centres and staff always function as substitutes for drugs and alcohol. This new substitute position forms the beginning of a treatment for addicts. The chemical route does not allow for a therapeutic way out; only the social bond of speech and symbolisation does. The only way out for addicts is via verbalisation within a relationship where very difficult and anxiety provoking experiences can be articulated and worked-through.

It is indeed of crucial importance that space is created in the policy of addiction treatment for addicts in such a way that their experiences can be openly articulated within a social bond with others. On that basis, what is problematic for addicts in terms of the social bond can be re-experienced within a therapeutic context. The creation and maintenance of a space of transference within society is absolutely essential, not just because addiction is not on the wane, but especially also because we are increasingly confronted with a culture in



which the immediacy of enjoyment is forced on us. A dire consequence of this is that there is increasingly less space for dissatisfaction, desire and the social bond. In other words, more and more we are being dominated by an enjoyment-and-consumption culture in which we should be feeling satisfied (after all haven't all conditions for satisfaction been satisfied?) but in which the "not-feeling-so-good" becomes increasingly unbearable. This is the kind of culture that becomes less demanding of its subjects in terms of making them responsible for finding solutions to suffering in ways that are radically singular. These are the kinds of solutions that need to be discovered by people themselves through being confronted - and coming to terms - with the problems of life. In reality rather the opposite is the case: culture increasingly forces external solutions onto people. One of the consequences is that people become more and more dependent on these external solutions and this could possibly herald what can be called the *addictification* of our society.

The creation of space for the singularity of addicts is more necessary than ever because the particularity of the human being tends to disappear under the uniformity of external solutions for the problems of life. The uniformity of external solutions often leads to a relatively simple and straight forward image that people have of addiction. However, it is of crucial importance that we are not fooled by the illusion that this image might indeed represent the truth. This document written by Declan Byrne is an eloquent defence of the argument that it is crucial that a transference space is created for young addicts and, moreover, it demonstrates clearly that it is wrong to consider that all (young) addicts are the same.

Once you open yourself up to the possibilities of the transference relationship you realise that people's life-stories are different and only recognition of that difference will lead to a treatment that is ethically grounded.

**Dr. Rik Loose is the director of several post-graduate programmes (including an MA in Addiction Studies) in Dublin Business School of Arts and is also Head of the Unit of Psychoanalysis. Dr. Loose is a psychoanalyst and clinical psychologist with ten years experience of working with addicts in a residential setting. He also lectures on the Masters in Psychotherapy programme run by University College Dublin in association with St. Vincent's Hospital. He regularly holds seminars on his research in psychoanalysis and addiction in England and on the Continent where he was involved in a research project on addiction treatment. In addition to numerous book chapters, journal articles and reviews he published his book *The Subject of Addiction: Psychoanalysis and the Administration of Enjoyment* in 2002.**



# Acknowledgements

I would like to thank the lecturing staff at the Dublin Business School. In particular Rik Loose who inspired me, Siobhan O' Donnell who encouraged me to stay focused, Barry O'Brien who was always available to give me advice and Andrew Honeyman who shared the wealth of his practical experience and knowledge. I would like to acknowledge Louis Farragher (Health Research Board) for all the help that she provided. I wish to thank Sean McDermott (HSE counsellor-Kilbarrack) for repeatedly coming to my rescue. Also Anna Quigley (CityWide), Fergus McCabe (formerly of the National Drug Strategy Team) and Conor Rowley (Crosscare) who were all there when I needed someone to bounce half-baked ideas off. FAS support KCCP financially but I am particularly grateful for the hands-on support I have received from Dermot Reynolds. I would also like to thank everyone in the Health Services Executive and in the voluntary and community organisations that have engaged with me in an open and honest manner. I would like to recognise the work of Noel Ahern (Minister of State with responsibility for tackling the drugs problem) and his predecessors Eoin Ryan, Chris Flood and Pat Rabbitte who have attempted to keep the drugs issue high on the political agenda.

A debt of gratitude is owed to the founders of KCCP, people like Brenda O'Connell, Marian Clarke, Kevin Arnold and Stephen Reid who had the courage to confront the problem in the 1990s. Likewise people who have served through thick and thin on the management committee, giving up their free time to deal with the on-going problems, people like Michael Finn, Fr. Cathal Price, Brian Stewart, Martin Timmons and Paul O'Brien. Currently community drugs programmes enjoy a level of cross community support however in the early days they met with fierce resistance from certain sectors of the community. In Kilbarrack one politician supported the project when it was far from popular - Dr. Michael Woods. Without all their contributions KCCP would not be in existence. Credit is also due to the staff because they are prepared to critically evaluate their work and have shown a refreshing desire for change. I

would also like to thank the Co-ordinator, Marian Clarke for her constant support.

I would like to thank Carol, Adam and Denise (not their real names) – three participants who have allowed me to tell their stories. In over five years of work with KCCP I have been privileged to work with thirty-five participants. I really appreciate their honesty and integrity. Some have discussed their drug addiction with me at great length and all have contributed to my knowledge of the subject. From early on I realised that addiction is a highly complex area not amenable to any quick fix solutions. Through my studies I have come to realise that the prognosis for drug addiction is not good but this should not deter us from trying to improve the way we work with problematic drug misuses

I would like to dedicate the report to my wife Margaret and to my children Jenny and Lorcan who keep me sane (well half sane).



**Management Committee & Senior Staff L-R :**

Back Row: Paul O'Brien, Brian Stewart(Treasurer), Garda Martin Timmons, Declan Byrne.

Front Row: Fr. Cathal Price (Vice Chairperson), Michael Finn (Chairperson), Marian Clarke (Co-ordinator)

# Executive Summary

This report set out to investigate how KCCP relates to its clients. Does the transference/counter-transference problems dominate the life of the programme and does the management of the transference present the greatest opportunity for transforming the project? This was no utopian exercise but an effort to increase the effectiveness of a community drugs programme, which is working under serious constrictions.

The report suggests a better way of working with problematic drug users and this has policy implications not only for other voluntary/community organisation but also for the Health Services Executive (HSE), who has a statutory obligation in this area.

The design of this report draws on all the tools of qualitative research including the examination of all material documentation and the use of key informants in order to place KCCP in its social and historical context. Then it used participant observation, interviews, life histories (treatment histories) and questionnaires to capture the current situation, the failures, problems and challenges. The report looked at the theory and practice of transference and arrives at the conclusion that as well as it being the biggest problem it also presents the greatest opportunity to forge a new template.

It concludes by making practical suggestions for improving the programme.

- **KCCP** must make the management of the transference / counter-transference central to its programme.
- **Through** experiential learning the staff should be trained to use the transference/ counter-transference relationship as a tool of recovery.
- **Staff** supervision must be seen as essential.
- **KCCP** should build up a core of experienced full-time staff.



- **KCCP** should be used as a pilot to look at the effectiveness of employing psychotherapists particularly with those with dual diagnosis and trauma histories.
- **The** treatment should be designed around each individual client rather than every client being expected to fit into a system. The relationship is everything.



# Chapter 1: Introduction

## The Purpose

The purpose of this report is to focus on the phenomenon of transference. The report argues that transference can be seen in all forms of therapy but can be witnessed in its starkest form in programmes that attempt to deal with addiction. It sets out to prove this point by drawing on the evidence from one programme - Kilbarrack Coast Community Programme (KCCP). The author feels that there is an onus on all those working in the statutory, voluntary and community drugs programmes to recognise that this problem exists and to accept that if we do not learn to address the problem that our programmes will continue to have limited success. Transference in drug programmes presents a major problem yet the proper management of the transference and counter-transference presents the greatest opportunity for these programmes to increase their effectiveness.

## The Context

KCCP was set up eight years ago with an abstinence model in mind. The practical experience gained from dealing with the hard cases has led to a shift in emphasis. KCCP is now looking at helping people move from chaos to a more stable lifestyle. KCCP attempts to empower their clients, to give them more independence, to develop their abilities and to help them re-establish relationships. Success is no longer measured in the numbers that become 'drug free' or the numbers who enter full-time employment.

## The Therapeutic Context

In the clinic of addiction you find ambivalence, contradictions, non-linear change, chaos and uncertainty. The report sets out to look at transference, examining both the challenge and the potential that the proper management of the transference/counter-transference presents. It will attempt to devise a more appropriate framework that will allow KCCP to improve the way that it works with its clients.

The theory of transference is well documented and accepted in orthodox psychotherapy and psychoanalysis. The possible reason that it is not recognised nor addressed in drug programmes in Ireland is that the treatment of drug addicts has in the main been relegated to the realm of the non-professionals (or untrained). This results in certain cases in the staff becoming part of the problem or worse still the project itself becomes a major obstacle. The problem persists because staff members are unaware of the problem. They need training not only to recognise it but also to work with it. Transference can and needs to become a tool of effective treatment. Rawson (1995) said that 'psychotherapy as a singular treatment method with actively addicted or detoxifying opiate addicts has produced very little success'. Rawson argues that elements from psychotherapy can be combined with broader treatment approaches to produce more effective results. He maintains that psychotherapeutic techniques have been and can be adapted to suit the needs of drug treatment programmes. This report is an effort to see if a psychoanalytic technique - the management of the transference can be borrowed and used to make a community drugs programme more effective and by extension all drugs programmes.

This report rejects models that try to fit all problematic drug users into a rigid system or models that take an authoritarian approach. These models tend to use rules in an attempt to eradicate the pathology of addiction. Programme efforts should not be directed at control and uniformity. This new model or template starts from the basis that no two problematic drug users are the same and therefore that all treatment to be effective must take account of the individual. In particular recognition must be given to those with dual diagnosis and particular trauma histories. This report locates addiction in the psyche of the individual and it advocates that it is at this level that it must be tackled.

# Chapter 2: Methodology

## Method and Sample

The research was conducted in 2005 when there were sixteen participants on the programme. The report is partly based on participant observation (the author has worked on the programme since 2000). Three participants were selected for more detailed examination, all three gave consent altering their names to protect their identity. A structured interview was held with Carol, a life history with Adam and a treatment history was undertaken with Denise.

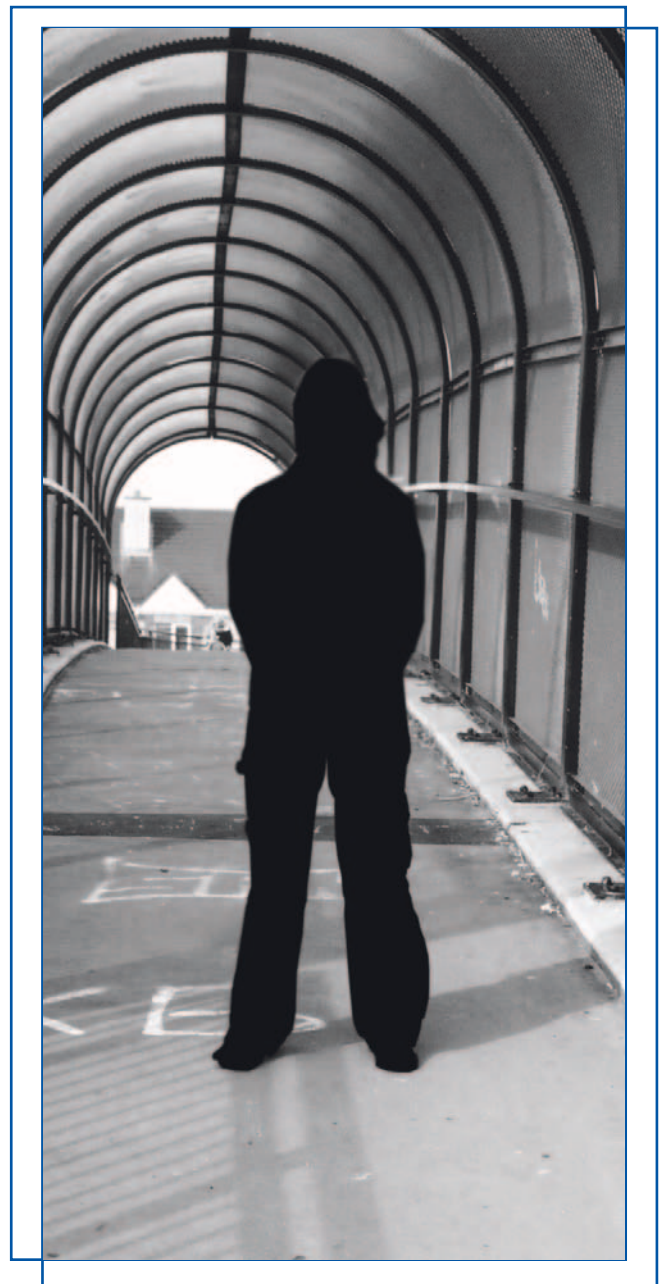
## Taking the Context Seriously

The author gained unrestricted access to all documentation held by the programme. The report uses 'key insider informants' firstly by drawing on the insights of the current Co-ordinator Marian Clarke (Marian was one of the original founders). Then between 2004 and 2005 two meetings were held with the entire group, participants and staff. In March 2005 the sixteen participants filled out a general questionnaire. Three participants were chosen for more detailed examination. In November 2004, an in-depth interview was conducted with Carol. In December 2004, Adam's life history was recorded and in July 2005, a detailed treatment history for Denise was drawn up.

## Research as a Tool for Action

This report follows in the footsteps of Samson et al who in their article *Qualitative Research as a Means of Intervention Development* (2001) set out in an Indian context to "focus on an example of how qualitative research can be useful for informing the design of drug treatment interventions in a locality where drug use is a rapidly growing phenomenon and where resources for intervention developments are extremely scarce." In their experience "this is best achieved by developing and evaluating interventions on the basis of qualitative research, including via ethnographies, unstructured and structured interviews, focus groups and observations."

Their research was driven by "the aim of empowering members of the community to effect and sustain improvement in the quality of their lives."



# Chapter 3: The Programme



Entrance to KCCP

## Introduction

This chapter introduces you to the area of Kilbarrack. It places KCCP in its historical context. It explains how FAS has adapted Community Employment (CE) Programmes to help communities support problematic drug users. Then it identifies some of the major problems facing KCCP. These include, unsuitable premises, lack of qualified staff and the absence of professional supervision. Finally it focuses on the transference/counter-transference problems that exist within the programme.

## Kilbarrack the Area

Kilbarrack is located in Dublin North East. As Farrington (2004) points out, “The area consists of a mix of local authority-built and private housing estates...using the Index of Relative Deprivation (2002), the area shows low to moderate levels of socio-economic deprivation. The local authority built estates show the highest levels of deprivation and it is in these areas that the heroin problem took root in the 1990s.

## History of Kilbarrack Coast Community Programme (KCCP)

KCCP was set up as part of a process of community action. In the early 1990s a group of community activists came together to form Kilbarrack Community Families Against Drugs. This group came together to organise against the sale of heroin in the area. Then they began to negotiate with the Health Board to open a drugs clinic in the area and they also began the process of setting up a community based aftercare project.

The Health Board opened a drugs clinic in May 1996. In December 1998 the Kilbarrack Aftercare Community Programme was set up. The group received funding from FAS and the Health Board. In January 2001 at the request of its clients the group changed its name to the Kilbarrack Coast Community Programme (KCCP).

## Core Programme

Since opening in 1998 KCCPs’ function was to provide rehabilitation, care and training to recovering drug mis-users. From December 1998 until 2005 the client group has risen from twelve to twenty-one. Since KCCP started it has had forty-one clients linked in on a nineteen and a half hours per week basis. During this time KCCP has also linked in with another thirty-five drug users. These people would have received support around such issues as their health, drug use, childcare, employment, police and courts. From December 1998 until February 2001 KCCP operated an afternoon drop-in service. Due to the decision by KCCP to expand its youth programme (in 2001 KCCP set up a youth initiative called Youth Matters) this service has been discontinued. At the start the client group was predominantly female but this has changed over time (65% female in 1999 to 35% in 2004).



Main Room in KCCP

### What are ‘Special Status’ Community Employment Programmes?

Community Employment (CE) Programmes are labour market training projects designed to help the long-term unemployed. In the late 1980s community leaders pleaded with the government to allocate resources to the areas most affected by problematic drug use. FAS (the National Training Authority) were authorised to run a number of pilots using CE for problematic drug users. Following the pilots these programmes were rolled out and by December 2003, fifty-four community/voluntary groups had been set up and were running what was now described as ‘special status’ CE (catering for 1,119 participants). In the past ten years most of these programmes have secured a second source of funding.

### The Problems Facing the Programme.

This section of the report looks at inadequate facilities, the lack of professional staff, the absence of supervision and the mismanagement of the transference.

### The Building

KCCP operates from premises, which is totally inadequate with no dedicated training or counselling rooms. The programme primarily runs all its activities from a large room (46.68 sq. m.).

### Lack of Professional Staff

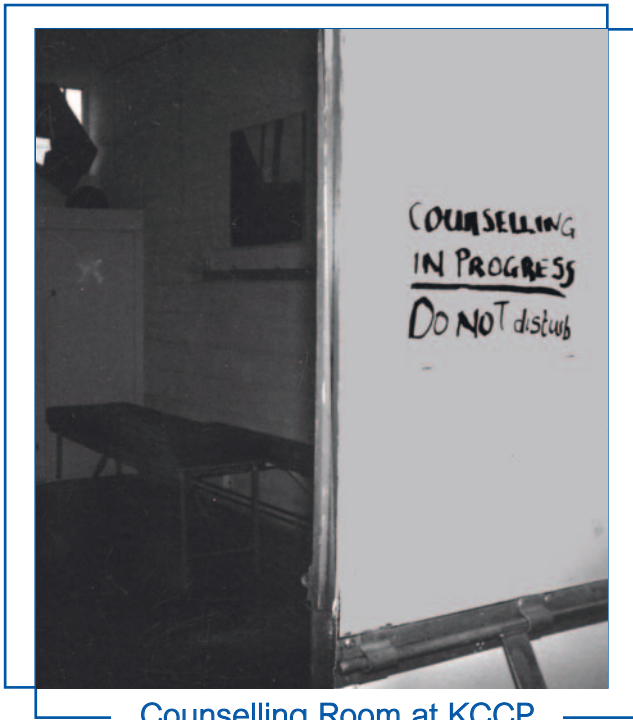
KCCP has never employed anyone who was professionally trained in addiction (the majority of those working in CE drugs programmes on the frontline of addiction do so with no prior training). The most vital workers are the support staff. These employees work the same hours and receive the same pay as the participants (their rate of payment ranges from €160 to €230 per week). The participants and staff on CE are allowed to remain for three years.

### Absence of Supervision

Missen and May (2005) Hawkins and Shohet (2000) and Page and Wosket (1998) have developed models that “emphasise that successful outcomes in therapy are often achieved through the effective use of supervision”. Garland (2005) discusses the sheer necessity of supervision to deal with how people can become “stuck in their clients dilemmas”. It is therefore regrettable that for the mental well being of the staff and the increased therapeutic potential that KCCP never had the resources to provide supervision.

### Mismanagement of the Transference

In CE drugs programmes transference/counter-transference presents a problem. In KCCP it is a problem because of the way the group deals with the transference and how it fails to manage the counter-transference. Some CE programmes have tried to address this problem by introducing an “authoritarian model”. They attempt to regulate all



Counselling Room at KCCP

behavioural problems out of the programme. Rule upon rule are introduced and enforced with strict discipline. Serious questions must be raised about the use of this model with problematic drug users. Drug addicts ‘act out’; this is part of the pathology. An administration requires certain rules but these rules should not be so stifling to suppress the emergence of the pathology. KCCP in the beginning attempted the ‘rules and regulations’ way of doing things. In more recent years it has retained some basic rules but it has attempted to be more flexible in its dealings with clients. Here are two examples of how KCCP has failed to deal with transference/counter-transference issues. On joining some participants made steady progress. They addressed health and criminal issues. They became less suspicious and more communicative. They could be described as being on the verge of personal change. Then without any apparent trigger they would begin to ‘act out’, starting a process that would inevitably lead to their dismissal from the programme. When they were eventually dismissed they were at pains to point out that they would not hold it against the programme. These cases would indicate that KCCP did not have the ability to manage the transference.

Managing the counter-transference is a major headache for KCCP. An instance occurred where a participant was cheeky to one of the support workers and a support worker who was not involved interjected “You are not going to let him get away with that?” I have recognised counter-transference issues in myself and I can see them each time a worker acts in a defensive way.

## Conclusion

The programme operates on very modest resources (it cannot afford to employ professionally trained staff or provide supervision) in grossly inadequate premises. This chapter also looked at the problem, which may represent the greatest stumbling block for KCCP increasing its effectiveness that is dealing with the transference and managing the counter-transference.

Despite all this, the numbers using the programme has doubled. A safe haven has been developed, where the participants are treated with dignity. KCCP has attempted to build up the group so that the group dynamic would act as an influence to reduce or stop drug taking. This has not happened. However through a policy of self-empowerment each year individuals do have the ability to reduce their drug taking and in the exceptional cases some people have shown the ability to give up drugs altogether. This chapter raises the issue, which will be dealt with in subsequent chapters. Could the proper management of the transference/counter-transference transform KCCP as a drugs programme?





# Chapter 4: The Participants

## Introduction

In this chapter four methods are used to give the reader a glimpse into the lives of the participants of KCCP. They are, general questionnaire, semi-structured interview, and life history and treatment history. This hopefully will provide the insider perspective that will power this report.

## Meet the Participants

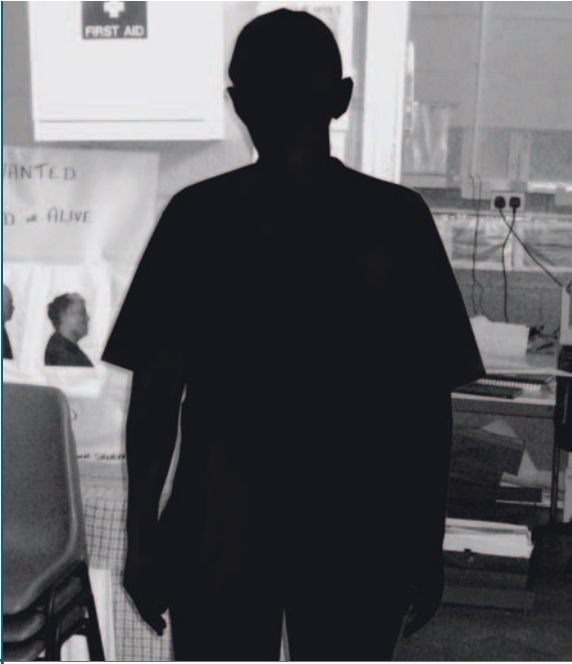
In March 2005 a general information questionnaire was administered to the then sixteen participants on the programme. Some of the information gleaned from this exercise included the fact that the age profile of the group ranged from twenty-three to thirty-eight years.

The earliest two to leave school were both thirteen, while the oldest two to leave school were both seventeen. None of the sixteen had stayed in school to do their Leaving Certificate examination. All sixteen had held full time jobs at some time in their lives. Fourteen had reduced the amount of methadone that they were using since joining the programme (two in dramatic fashion). Two had remained on the same amount. Five had never attempted a drugs detox. This would mean that eleven had detoxed but had failed to remain drug free. All participants were asked to list the six main activities of the programme, only seven included counselling. The group were also asked to name the one most successful activity and only one from the seven picked counselling.

Loose (2002) made the point that “behind the manifest uniformity of addiction one encounters the complexities of the subject and addressing those should be the ultimate aim in treatment.” The next sections hope to zoom in on the subject.

## Carol – Not Getting What She Needs From The Clinic or KCCP.

On the 22<sup>nd</sup> November 2004 a semi-structured interview was conducted with Carol. Carol is a twenty-seven year old mother of two. To the outside world her petite frame presents a quite spoken nature. When you get to know her you discover that she possesses a steely determination especially concerning her children and she possesses a nature that bristles whenever she encounters injustice. Carol took her first illegal drug when she was about ten or eleven, when her brother gave her cannabis. She went from cannabis to LSD and then when she started going to discos with her friends she started drinking. It was during this period that she began taking E and speed and soon afterwards cocaine and then to come down off these drugs she began using heroin. She was fifteen when she began using heroin. She linked in with the Health Board drugs clinic in 1997 and as she says herself “it was meant to be for a detox and I’m on it ever since.” She still uses heroin on a weekly basis (sometimes more regularly) and avails of the clinic to get weekly ‘take-aways’ of methadone. On her years attending the clinic she has reduced her methadone dosage from 50mls to 25mls. It is apparent from her interview that she gets on well with the Health Board counsellor but is inclined only to link in with him when she is trying to stay clean “And when I’m not then, I don’t really want to go into him because I don’t want to face the truth.” From various comments she makes she would like the clinic and KCCP to be stricter, to impose sanctions when she is caught using heroin. “I would like to be on a programme, which tells you to stop using.” It could be argued that Carol is trying to establish a transference relationship that is she is looking for an authoritarian father figure, who will tell her what to do (or rather what not to do).



### **The Life and Times of Adam**

Pelto & Pelto (1993) point out “the richness and personalized nature of life histories afford a vividness and integration of cultural information that are of great value for understanding particular life ways.” Therefore the objective of conducting a life history with Adam was to secure an in-depth personalised account. It was explained to him beforehand that the life history covers all aspects of his life but he took the opportunity to concentrate on those parts of his life that were linked with his drug use. He seemed driven to explain how he had begun to take drugs. He described his early experiences of sniffing petrol. He then went on to describe how at the age of sixteen/seventeen he became a heavy solitary drinker (averaging fourteen cans of beer, seven nights a week). He spoke of how up to the age of twelve his parents had been protective and he was not allowed to play with other children. Asked if this might have played a part in his pattern of solitary drinking? He replied, “Never even thought of it. Sort of used to being alone” but he then went on to form a link between his heroin taking and his ‘aloneness’. Though he clarified in detail how drinking had not started out as a solitary pursuit and explained in detail how this habit came about. Asked if at that stage if he was drinking to get out of his head? To which he replied that he was. He explained how he began to smoke heroin when he was twenty-

one/twenty-two. He explained how he had stopped drinking when he started injecting heroin (he put this down to the fact that he needed a lot more money for the amount of heroin he needed to inject). He explained in detail the circumstances in which he went from smoking heroin to injecting. He describes how good taking heroin was, “I really have to say that I don’t ever remember feeling as good as that before or since to be honest with you. Yeah I can’t even think of anything that could come close to it, some people say sex...but no way.” Asked if ever thought of coming off heroin? He explained in some detail the two times when he tried to quit. The first time took place after he discovered a friend of his, dead from an overdose. He stayed off heroin for six or seven months but explained that he was then drinking between one and two bottles of spirits a day. He joined the local drugs programme – KCCP in order to stay ‘clean’, only to discover that no one on the programme was ‘clean’ and within a few weeks of listening to ‘drugs talk’ he was back using.

The second time happened in January 2000, when he got a great opportunity to do a television production course in Tralee. From the time he stepped onto the train he stopped using heroin. He (unlike the other trainees) remained in Tralee at the weekends. He said he “didn’t feel strong enough to stay away from heroin” so he stayed in his flat in Tralee. He explained that Monday to Friday he did not drink but that he “just drank Saturday and Sunday away.” He explained how he came to Dublin to do a job interview but never made it out of Heuston Station. He met some one who offered him a “turn-on” and “being well gargled” he took up their offer.

Once back on heroin he ended by saying, “Nothing’s changed since, still here! Adam is thirty-three, highly intelligent and highly gifted. He shares a number of characteristics with the larger group (such as the fact that he left school early). This life history shows that everyone’s experience is unique and that this should lead to the understanding that any efforts to improve drugs programmes will require taking all the clients individual needs into consideration.

## Is Denise Being Treated Properly?

The typical profile for those with dual disorders makes them system misfits. The range of inter-connecting problems they possess extend outside the specific remit of any of the services they are involved with. (Wilson 2000: 29)

In my opinion it is now impossible to say if Denise's bouts of depression pre date her drug use or are a direct result of her drug use. Denise has been taking drugs now for thirteen years. The amount and range of drugs that she has taken is truly staggering. Her initial drug of choice was heroin. Since 1996 she has been combining this with methadone. At various times she receives prescribed drugs from her family doctor, the HSE prescribing doctor and for the past two years from the local psychiatric services. In recent years she has tried 'crack' cocaine but in the past two years her stable diet of drugs is made up of cocaine, methadone and a range of prescribed 'sleepers' and anti-depressants. She has been a participant on KCCP on three occasions. The first time she was put off the programme for six months for being 'too chaotic'. The second time she completed her three year term and the third and current time FAS made an exception because of her grave medical condition and allowed her back in the hope that she could complete a 'stabilisation'. Denise is a client of the HSE Drug Treatment Services. She has undergone regular assessments and has completed several detoxs and stabilisations. She is a client of the counsellor attached to the HSE drugs clinic and a regular client of the health nurse. On the three occasions that she gave birth she became a client of the HSE social work service. For over the past two years she has been a client of the HSE local psychiatric services. Since beginning her problematic drug use she has linked in with her family doctor and has been a regular patient, both on an inpatient and outpatient basis with the general medical services for a range of issues related to her drug use. Each time she links in with a service it appears as if they deal with a bit of Denise. There has never been an attempt in Denise's treatment history to take a multi-disciplinary or multi-agency approach. In all her years of being linked in no attempt has

been made to come up with an individualised treatment plan. She has a long history of being linked in and at times of severe crisis the system does respond but for the rest of the time she just falls through the cracks. Some of the services involved try to blame Denise ("she failed to turn up for her appointment") but though nominally linked into treatment she has never experienced a consistent joined up treatment service. The reason Denise's treatment history is used is to underline the issue that those who engage in problematic drug use usually have severe behavioural problems not amenable to quick fix solutions.

## Conclusion

In this chapter you were introduced briefly to sixteen participants. Greater detail was given on Carol, Adam and Denise. Hopefully you have come to see that drug users are not a homogeneous grouping. Their uniqueness and the 'complexities of the subject' are there to see. No matter how similar they appear to be they all have their different histories, stories and reasons for taking drugs. Corrigan (2000) made the point "I have always had great difficulty with the concept of treatment 'slots', which conveys to me the idea of slotting individuals into a conveyor-belt treatment process, when the treatment programme should ideally be built round the individual. The art should be to find which treatment is most appropriate for a given individual at a given point in their drug-using career."



# Chapter 5: Transference



## Introduction

Loose (2002) “argues that aspects of the ethics, method of treatment, and experience of psychoanalysis should be seriously considered and, where possible incorporated into the treatment of addicts, irrespective of whether this treatment takes place on an individual, group, community or institutional basis”. Part of his theoretical framework incorporates working with the transference. This chapter traces the origins of the concept, looks at how professionals in the treatment of addiction have used it as a tool and examines the authors’ experiences in this area. An important factor in this discussion should be the treatment urgency. Since KCCP was set up seven years ago two former clients have died from drug related causes (both in the past six months) and one additional person from the Kilbarrack area (who did not link in with KCCP) has died in similar circumstances. KCCP has dealt with two serious cases of self-harm, one of which culminated in a suicide attempt. One current client has been readmitted onto the programme in the hope that she will reduce her drug intake following a life threatening attack of cellulites brought on by her drug taking. As Loose (2002) points out “the urgency of their need for treatment is in direct proportion to the time they have left.”

## Beginning with Freud and the Classic Cases

Freud was an ardent student of the relationships that developed between his professional colleagues and their patients. It was through this route that Freud discovered transference. He discovered it with Bertha and Breuer, he found it with Otto Gross and Jung and he came across it in his own work in the first instance with Dora. This section refers to a number of classic cases, which throw light on the phenomena of transference. Kahn (1997) dealt with how Freud discovered transference in the case of his mentor Josef Breuer and his patient Bertha. It was clear to Freud that Breuer was fascinated by Bertha and that the fascination was by no means one-way. Freud came to the conclusion that Bertha related to all male authority figures in the same way and that this was a consequence of her relationship with her father.

Loose (2002) dealt with the case of Gross and his relationship with Jung and Freud. From correspondence between Freud and Jung, Loose maintains, “One can glean... that the relationship between Gross and Jung was not very good. Freud suggested that there was a negative transference on Gross’s part and that this was a symptomatic repetition of the relationship with his father. As Loose points out this ‘gross episode’ is interesting in that it highlights how both Jung and Freud viewed Gross as the “waste product of the psychoanalytic establishment.” “Gross had been ‘too much’ for Jung and Freud; Freud did not want to analyse him and Jung’s treatment of him was at times unbelievably farcical.” In this example we have not only encountered transference but counter-transference as well.

Lacan (1966) studied the relationship between Freud and Dora. It is important because it was “the first case in which Freud recognised that the analyst played his part.” Freud believed that at the early stage in her treatment, Dora begins to relate to him as if he were her father, then after the first dream it is from Herr K that she makes her transference. Freud places the failure for the treatment on his own inability to recognise this latter trans-

ference before her abrupt departure. It is interesting that Lacan sees the mistake in the realm of the counter-transference. “As regards Dora, Freud admits his personal involvement in the interest which she inspires in him.” Lacan maintained that it is not the failure to recognise the transference early enough but the failure to give proper consideration to the counter-transference that caused the problems in this case.

### **The Theory of Templates and the Repetition Compulsion**

Kahn (1997) explains “According to Freud, when people enter therapy, the way they see and respond to the therapist and the reactions they set out to provoke are influenced by two tendencies: they will see the relationship in the light of their earliest ones, and they will try to engender replays of their earliest ones. To these perceptions, responses, and provocations Freud gave the name transference, meaning that the client transfers onto the therapist the old patterns and repetitions. Kahn makes the point that he comes across this phenomenon constantly in his work with clients. Explaining “Since the repetition compulsion operates everywhere, it is no surprise that it turns up in the clients’ relationship with the therapist.”

### **The Roundabout Road to the Unconscious**

Kahn feels that Freud first became interested in the transference because he felt that the transference was a tool of the resistance and as such interfered with the ‘real work’ of analysis. His position altered radically when he discovered that the transference could be used as a means of penetrating the unconscious. Freud described his treatment as surgery (the knife that cuts) as compared to other treatments that were cosmetic. Freud argued that dealing with the symptom alone was inadequate (this would still leave “all the processes that have led to the formation of the symptoms unaltered” (1916-17: 504). “Analytic treatment (working through the transference) makes its impact further back towards the roots, where the conflicts are which gave rise to the symptoms” (1916-17: 504). Freud stated that “In order to resolve the symptoms, we must go back as far as their origin, we must renew the conflict from which they arose, and, with the help of motive

forces, which were not at the patient’s disposal in the past, we must guide it to a different outcome” (1916-17: 507). Freud’s goal was for a “permanent cure of the neurosis” (1912: 108) “a permanent improvement in his (the patient’s) psychological situation” (1912: 106). By managing the transference properly the ‘suppressed impulses’ (1916-17: 497) “can be traced back to its unconscious origins” (1915:166) and through the analytic treatment can be brought “back into consciousness and therefore under her control” (1915: 166). Freud emphasises that “The decisive part of the work is achieved by creating in the patients relation to the doctor in the ‘transference’ – new editions of the old conflicts, in these the patient would like to behave in the same way as he did in the past, while we, by summoning up every available mental force (in the patient), compel him to come to a fresh decision. Thus the transference becomes the battlefield on which all the mutually struggling forces should meet one another.” (1916-17:507).

### **Learning from the Professionals**

In order to gain insights into the phenomena of transference/counter-transference and to learn how its proper management can produce benefits for problematic drug mis-users the report turns to those who have worked in the field of addiction. These include Brown (1950), Fine (1972), Gustafson (1976), Selzer (1967), Davidson (1977), Imhof et al (1983) and Imhof (1995)

Brown (1950) examined the transference phenomenon in alcoholics. Brown maintained that the “familiar tool of therapy, the transference is not being utilized for all its worth” in the treatment of alcoholics. He made the observation that “it appears that the relationship with the therapist is of major importance and that the nature of the therapy itself is of much less significance.” Brown illustrated this point by providing a case history. Brown also touched on counter-transference issues when he wrote, “It is possible that a prevalent and unfortunate attitude of those undertaking the care of alcoholic patients may be a major obstacle to favourable results.”

Fine (1972) decided to contribute to the literature on the psychoanalytic treatment of drug addicts by describing a case from his practice.



From this case we can see the positive transference occurring from the very beginning of treatment. We learn that soon after this “every aspect of the transference, though specifically positive, sooner or later became a source of resistance” and then after about two months “came the first significant break in his pattern, an intensification of the transference drama.” Fine realized that with this client insights would have minimal value but that it was by working with the transference that changes in behaviour could be achieved, which is what happened over time.

Gustafson (1976) uses a client’s case report to demonstrate the “successful application of the ideas of Kohut and Balint to the psychotherapy of a very self-destructive alcoholic patient whose core disturbance proved to be that of a narcissistic personality disorder.” The article underlines Gustafson’s recognition of counter-transference issues in his provision of treatment. Like similar patients he displayed “an intensity of rage”, which resulted in Gustafson’s “subtle withdrawal”. Gustafson hid this from himself with the idea that he was being “consistently and strategically empathic concerning his situation.” Whereas in fact he was “being empathic from a considerable and cool distance.” The treatment benefited from the “transference interpretation”(in this case dealing with Gustafson’s reaction to his client). This allowed him to overcome the “counter-transference reaction” and this subsequently allowed the patient to “re-experience in the transference” some of his childhood traumas.

Selzer (1967) put the spotlight on “the feelings that the alcoholic engenders in those attempting to treat him with psychotherapy.” In a previous paper Selzer examined the psychotherapist’s hostility toward his patient, these feelings arose from “(a) unconscious envy of the hedonistic aspects of the alcoholic’s behaviour, and (b) a tendency to regard the patient’s relapses as the therapist’s personal failures.” He then focused on four aspects of the alcoholic, his/her dependency, egocentricity, depression and hostility. He concluded by saying that “psychotherapy alone does not constitute effective treatment for most alcoholics, it nevertheless remains an invaluable treatment modality when used in conjunction with other therapies.”

Davidson (1977) stated “there is now widespread acknowledgement...that attempts to treat heroin addiction by chemical means alone have failed.” She referred to what she considers to be the dominant trend in the treatment of addicted patients – “the wish to locate the cure for addictive illness *outside* the patient’s psyche.” Her article describes “certain recurring patterns of behaviour” that she observed while working in a methadone maintenance clinic over a thirty-four month period. She is particularly interested in describing the transference phenomena in a clinical setting. She defined transference as “a term that the patients’ behaviour at a given moment in treatment is determined more by his early experience with significant others than by the reality stimulus of the present setting” and “counter-transference...will refer to the totality of the therapists’ response to the patient.” In the out patient clinic where she worked she observed patients exhibiting extreme rage and hatred. She then noted that the staffs’ most common response was “to retaliate”-“most commonly expressed through the dosage of methadone.” In conclusion she said, “Much of the ‘difficult’ behaviour is often seen as part of a constellation of undesirable social characteristics attributed to addicted patients. Staff may try to eradicate this behaviour (usually through elaboration and enforcement of clinic rules) with the associated hope that the patient will become more compliant, and then amenable to therapy. This is somewhat akin to stating that if the patient did not have psychological problems he/she would be easier to treat.”

Imhof et al (1983) set out to address the situation where “scant attention is given to one factor that may affect the positive or negative outcome of any treatment provided: the counter-transferential and attitudinal posture of the treatment provider. “ They wish to focus on the role of the therapist. The purpose of their paper was to “explore the concept of counter-transference specifically in relation to its presence, utilization, and impact in the evaluation, diagnosis, and therapeutic management of the drug-involved patient. The article showed how some therapists view this client group as both “untreatable and unmanageable.” They show that part of the challenge lies with “the initial transference reactions of the patient (which) may be of such an intense nature that the therapist is overwhelmed by the ensuing assault.” The article went on to study certain “therapeutic misalliances.” You have the example of the therapist who assumes the role of “good parent rescuing the bad impulsive child.” You have the patient who “deftly manoeuvred two staff psychiatrists into providing neuroleptic medication... twice resulting in life-threatening overdoses.” You also have the therapist “identifying with the ‘victimised’ patient and joining forces in a ‘you and me against the world’ scenario.” In their conclusion they found that “in the majority of all treatment outcome studies reviewed, the cause of treatment failure is viewed as a failure within the patient, resulting from his own psychopathology, rather than from any negative derivatives of the patient - therapist interaction.”

Imhof (1995) starts with Wurmser’s (1972) observation that “drug abuse is the nemesis to haunt psychiatry itself...sheer mass of ‘emotional problems’ substance abusers bring to treatment ‘dwarfs our skills’.” This article makes two core points (1) that the negative attitudes of the treatment providers continues to impede progress in treatment, and (2) that there is a need to stress patients individuality – “Gallant (1990) has argued persuasively for recognition that “each...patient and family has unique and distinct backgrounds and characteristics which deserve different therapeutic approaches”.

### Loose on Managing the Transference

Loose (2002) examines three aspects of transference in the context of addiction. (1) The difficulty with the management of the transference, (2) The imperative for treatment centres to work with the transference, and (3) The need to keep the levels of toxicity within workable limits.

(1) Loose (2002) highlighted “The fact that the management of the transference is very difficult in the treatment of addiction. Often addicts do not seek help because they have a ‘perfect’ solution at hand.” He also focused on the other side of the coin “It is not difficult to see how addiction can easily lead to counter-transference, especially where we take note of the fact that addiction as a fundamental human problem, highlights the impasses of human existence and the shortcomings of the subject, including those of the therapist.”

(2) Loose stresses the need of working with the transference. “To maintain the transference and to allow it to develop is, however, an ethical imperative and it is the only way out of a lethal impasse for the addicts.” Similarly he wrote “A treatment centre or therapeutic community is set up in order to bring the pathology of addiction within its realm...The pathology of addiction will manifest itself in the transference and it is crucial that the transference is allowed to take place.” He goes so far as to state that “the dynamic of transference has to be allowed to develop or else therapy is not possible.”





(3) Loose refers to levels of toxicity – “In therapeutic communities this structure can lead to, what Snoy (1993, p.48) calls, a ‘toxic space’. A toxic space can take many different forms in this context. There can be a bad atmosphere, an euphoric one, an aggressive one, a secretive one or what is called an ‘us-and-them’ situation. Snoy argued that when the toxicity rises above a certain level the therapeutic work becomes impossible, even in an orientation of therapy in which these behaviours are considered to be symptomatic of transference. The ‘toxic space’ in the therapeutic community is a manifestation of negative transference. Too much toxicity stops the work of transference. The level of toxicity has to be kept within certain workable limits, “

#### **Personal Experience of Transference/ Counter-transference.**

In just over five years I have gone through the full range of transference and counter-transference phenomena. I have experienced them myself or have witnessed them on the programme. Like Freud I have to admit to experiencing fascination with some of the participants. I have come to realise “the interest which (they) inspire in me.” Imhof et al (1983) refer to the “good parent rescuing the bad impulsive child”. In the first few weeks and months, I was like a mother hen trying to solve all the participants’ problems. On the other end of the scale Gustafson (1976) talked of “subtle with

drawal”, while I have been guilty of the not-so-subtle withdrawal with participants who are constantly negative, egocentric and complaining. Despite my best efforts I mirror Kohut’s (1971) description, I suffered from “boredom...and the precarious maintenance of attention.”

Davidson (1977) talked about denial – the denial of entire segments of reality especially involving behaviour concerning drug usage.” These remind me of a time when I felt total frustration dealing with a participant. He/she was a problematic drug user (using on a daily basis) telling me how great he/she was because he/she was off drugs for so many months.

Brown (1950) described the case where the clients “frequently manufacture situations” in which they “suffer retaliations.” This has happened in KCCP, where a participant for no apparent reason begins to act out with the inevitable consequence that they are asked to leave the programme. I have also witnessed a similar case to the one described by Imhof et al (1983). A participant in KCCP invoked a similar response in everyone he met. He was ‘poor’ ..... (everyone felt sorry for him). In the example from Imhof et al (1983) two staff psychiatrists were prescribing for the same client, resulting in a near fatal overdose. This led to an investigation where one psychiatrist admitted, “I had to give her something, I felt sorry for her.” I maintain that our ‘poor’ participant elicited the same reaction, which resulted in the same disastrous consequences. I have experienced what Kohut has described as the “idealized parent imago”. Here a participant was looking for an external control, a father figure. Selzer (1967) describes it thus, “wanting some authority figure, parental figure or surrogate to take over the responsibility of guiding him, directing him, and making decisions for him.”

I have experienced or witnessed a range of counter-transference feelings. I have witnessed anger and resentment. I have witnessed people becoming moralistic and judgemental. I have seen all the staff; myself included becoming drained with the level of negativity within the group. In its first year in existence KCCP closed down the programme for one week to try and reduce the pressure that had built up on the programme. There has only been



one incident of a physical assault between participants. There have been so many altercations between participants and between participants and staff, that at certain times it can become a regular occurrence. In the context of KCCP the situation can go from zero to a hundred in a matter of seconds? A serious incident can be sparked off by what appears to be a throwaway remark. I have also seen the bushfire affect. One person displays aggression and instead of having to deal with one particular incident, fires breakout throughout the group involving totally different individuals. I have seen the same happen with depression. It creeps into the group and spreads. The depression then becomes so strong that you could feel and touch it.

Another source of increased pressure is if the group perceive that the staff members are showing favouritism (this sometimes manifests itself in 'pairings', where a staff member pairs with a particular participant). KCCP has experienced the pressure cooker exploding but more commonly it is the pressure cooker ready to blow that would best describe the situation.

**Conclusion**

The atmosphere, the underlying currents and the acting out represent a problem for community drugs programmes. These programmes are set up to deal with the pathology of addiction so it is nonsen-

sical to ban manifestations of the pathology. The pathology cannot be dealt with in abstentia.

This chapter has set out to explain the concept of transference, it has tried to learn from those who have worked with alcoholics and problem drug users and tried to bring the authors experiences to bear on the subject. This chapter set out to ground the subject both practically and theoretically. This report argues that in the clinic of addiction no efforts should be made to suppress the transference – it should not be interpreted as bad behaviour (within limits of personal safety). Treatment institutions that use punitive structures to deal with addiction stand little chance of success.

In the case of KCCP a safe space was created but when people sought help through the transference their pleas were ignored because of a lack of understanding. Loose in his book refers to the 'toxic space' and in his lectures referred to the clinic as a 'pressure cooker' (to cook the food pressure needs to be applied, too much pressure and the cooker explodes). In its current context KCCP could be described as a pressure cooker where the lid is ready to blow.



# Chapter 6: Conclusion

## Introduction

I have used a community drugs programme KCCP as a case study to demonstrate the need for change in the way we work with problematic drug users. By looking in some detail at three participants I hope that I have been able to convince you that "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 prerequisite in addiction treatment." (Loose 2002).

## Training and Supervision

KCCP held a half-day training course on the 13th June 2005 to examine the issue of transference/counter-transference (in five years this would be only the second time that all the staff had been brought together for a training session). Has it solved counter-transference problems within the programme? Certainly not, it has proved to be a first step in increasing awareness, further steps now need to be taken to build on this foundation. KCCP in the short to medium term will not be in a position to employ trained psychotherapists or psychoanalysts. It can however through experiential forms of training ensure that its' staff are psychoanalytically informed. A structured training programme over time could result in the staff being able to manage the transference/counter-transference in order to help the individual clients. The training would have to be accompanied by the clinical supervision of all the staff.

## The New Template

I believe that the report has demonstrated the need for KCCP to take a number of steps in order to increase its effectiveness.

(1) KCCP must recognise the central role that transference and counter-transference plays in the proper treatment of addiction. KCCP should place

at the centre of its programme the management of the transference.

(2) Staff training needs to be prioritised. Funding should be provided so that training in transference and counter-transference should be provided to all staff working with problematic drug mis-users.

(3) KCCP and the HSE must recognise the value of supervision. I believe that no matter how stretched the resources are within KCCP that external supervision should be an imperative.

(4) The current financial position of KCCP does not allow it to employ a qualified psychotherapist. Additional funding should be sought to employ a psychotherapist on an hourly basis to work with clients who have severe problems (particularly those with dual diagnosis and trauma histories).

## Conclusion

I intend no criticism of community drugs programmes, for without them problematic drug users would be in a more isolated and more stigmatised position. I do not want any part of the report to be used to criticise FAS. In my opinion FAS came to the assistance of deprived communities in their hour of need and have been left holding the baby ever since. The Health Services Executive (HSE) has financially supported KCCP and a range of other community programmes but to date they have limited their input into these programmes. The HSE must take more responsibility for the running of these programmes. By taking a more hands-on approach, they could ensure that all staff are professionally trained and that clinical supervision is provided.

I hope I have made a good case for working with the transference in the clinic of addiction, and I hope that I have demonstrated that by so doing KCCP could increase its effectiveness in its work with its clients.

**Declan Byrne (086-8138618)**

# The Final Word

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## Mary O'Shea



This report gives a very comprehensive description of the work of the Kilbarrack Coast Community Programme which was established in 1998 in response to the increasing use of drugs in the area. It is obvious that the project is successful in attracting clients with a wide range of social and addiction problems. The case studies described give detailed accounts of this.

The author makes a strong argument for addiction being located in 'the psyche of the individual client' and that the issue of transference and counter transference should be recognized and become an integral part of the training for all staff.

There are a number of glaring gaps in the service provision, which I think warrant attention. It seems imperative that trained staff are recruited or that existing staff are seconded to addiction training. An agreed model of supervision needs to be implemented with all staff. There are blurred boundaries if staff and clients are on similar FAS programmes.

Many of the clients presenting to the programme are active drug users in addition to those on methadone programmes. Many have immediate needs regarding treatment and access to detoxification and rehabilitation. Dealing with addiction issues I would

argue needs a multi-faceted approach of which awareness of transference and counter transference is a component rather than a one-dimensional approach. A variety of staff should be considered ie. project workers, addiction counsellors, outreach staff etc. It is also possible that KCCP is being too ambitious in trying to meet too many needs. While the appointment of a psychotherapist or any other professional would enhance the service delivery to the clients. I think, as a first step an overall evaluation needs to look at current client needs in addition to a training needs assessment for all staff.

**Mary O'Shea is Assistant Director of Merchant Quay Ireland since 1999. She previously worked as Head Social Worker with the Drug Treatment Centre Board and prior to that worked for a number of years with the Probation and Welfare Service in court and prison settings.**

# The Final Word

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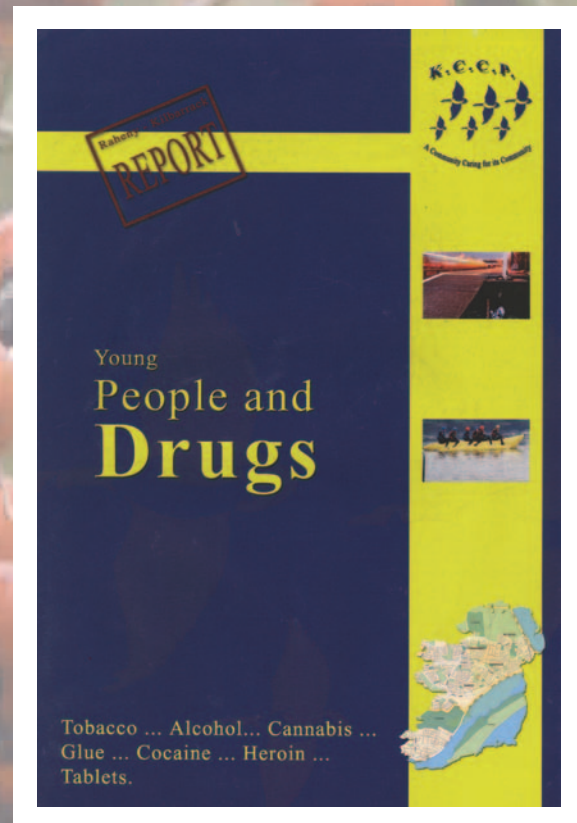
**Other Publications by Kilbarrack Coast Community Programme (KCCP) Ltd.**

In 2004 the National Advisory Committee on Drugs (NACD) published ‘ A prevalence study of drug use by young people in a mixed suburban area’. This was a report based on research conducted by KCCP under the community/voluntary sector research grant scheme. This study established the patterns and trends of alcohol and drug misuse in the Kilbarrack area by young people aged 10-17 and examined their attitudes to alcohol and drug use, and the risk factors accompanying their use. The study also assessed the alcohol and drug use among a sample of early school leavers and examined the views of community members on the alcohol and drug situation in the area.



‘The Raheny/Kilbarrack Report -Young People and Drugs’ was a synopsis of the NACD report, which was distributed to over 2,000 homes in the Kilbarrack area.

Both reports are available on request from KCCP - (ph. 01-8324516).



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Rather than mis-diagnosing the problem and mis-prescribing the cure, Byrne centralises the concept of addiction, (as opposed to drugs), critiques current orthodoxies, and highlights the inadequacies of a system which fails to account for the tool of transference in the treatment of addiction/therapeutic alliance. ”

Conor Rowley- Drugs Education Co-ordinator-Crosscare

“This report focuses on an important aspect of working within therapeutic relationships, where interpersonal challenges are the norm rather than the exception. It is presented in a user friendly narrative style and there is a message here also for services beyond the context of KCCP.”

Liam MacGabhann-Dublin City University (Co-author of ‘Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland’ (NACD) 2004).

“This excellent piece of research by Declan Byrne is timely and very welcome.

Ten years ago I chaired the Cabinet Sub-Committee on Drugs Mis-use that led to the setting up of National Drugs Strategy and the Local Drugs Task Forces. There is now a need to revamp the National Drugs Strategy to take account of changed conditions and altered patterns of drug abuse.

In doing that, new research like this is vital in order that we can best understand the phenomenon of drug dependency and its treatment and respond as effectively as possible.”

Pat Rabbitte T.D.-Labour Party Leader

“I would like to warmly congratulate you on the completion of this report. It provides a valuable account of what has been achieved by KCCP and the Kilbarrack and District Community Association and also of the very real difficulties under which it had to operate over these past several years.

I note particularly your own insights into what is needed to improve the effectiveness of KCCP and I very much hope that it will be possible to put these ideas into effect, for the benefit of all connected with the programme.”

Michael Woods T.D.-Fianna Fail- Dublin North East

“ In doing a Masters in Addiction Studies, Declan has applied his learning to his place of work and engaged the interest of colleagues to change and improve the way they work with drug users. This report clearly shows the value of professional development and lifelong learning. “

Mairéad Lyons- Director-National Advisory Committee on Drugs

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# Kilbarrack Coast Community Programme