Clinical Psychology Forum

Clinical Psychology Forum is circulated monthly to all members of the Division. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial team welcomes brief articles, reports of events, correspondence, book reviews and announcements.

Clinical Psychology Forum is published monthly and mailed on the penultimate Thursday of the month before the month of publication.

Editor
Stephen Weatherhead

Editorial Team
Nicola Cogan, Richard Cosway, Ruth Erskine, Jennifer Foley, Alan Grieve, Garfield Harmon, Stephanie Hutton, Jill Jones, Joe Judge, Deborah McQuaid, Sarah Morgan, Helen Miles, Penny Priest, Angela Simcox, Jane Vinnicombe, Tony Wainwright

Columnists
Steven Coles, Abi Methley, Tony Wainwright

Guidelines for Contributors

Copy
Please send all copy and correspondence to the coordinating editor, Stephen Weatherhead, c/o Sue Maskrey, CPF Administrator, Clinical Psychology Unit, University of Sheffield, Western Bank, Sheffield S10 2TN; tel: 0114 2226635; e-mail: s.j.maskrey@sheffield.ac.uk

If you are thinking of writing a paper for Clinical Psychology Forum then please read our FAQs and Guidelines for Contributors: www.bps.org.uk/dcpcf.

DCP Notifications editor
Please send all copy to: Sue Maskrey (see above).

Book reviews editors
Tony Wainwright (University of Exeter).
Please contact Sue Maskrey (see above) in the first instance if you are interested in reviewing a book for CPF.

Advertisements

Advertisements not connected with DCP sponsored events are charged as follows:

- Full page (20cm x 14cm): £140
- Half page (10cm x 14cm): £85

All these rates are inclusive of VAT and are subject to a 10 per cent discount for publishers and agencies, and a further 10 per cent discount if the advertisement is placed in four or more issues. DCP events are advertised free of charge.

The Society’s Terms and Conditions for the acceptance of advertising apply. Copy should be sent to:
Mark Wellington, The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR; tel: 0116 252 9589 (direct line); mark.wellington@bps.org.uk.

Publication of advertisements is not an endorsement of the advertiser or the products and services advertised.

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.
Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

For all other enquiries please contact the Society on:
Tel: 0116 254 9568; E-mail: mail@bps.org.uk.
ADDICTION is a major concern around the world. It is estimated that 205 million people worldwide use illicit (non-legal) drugs, while 25 million of these are drug dependent (World Health Organization, 2010). The World Health Organization (WHO) estimates that 39 deaths per 100,000 are attributable to drug and alcohol use and misuse. In addition, it estimates that drug use accounts for the loss of two disability-adjusted life years and 11 for alcohol (ibid.). In the UK it is estimated that there are approximately 262,000 problem heroin users, although numbers are slowly falling (HM Government, 2010). Also, it is estimated that there are 1.6 million people in the UK with mild, moderate or severe alcohol dependence. Alcohol costs the UK £18–25 billion every year, with the NHS alone bearing £2.7 billion of these costs. It is estimated there are 451,000 problem gamblers in the UK, with 73 per cent of the population taking part in gambling activities (Wardle et al., 2011). As these figures suggest, addiction is a large problem, costly to society, individuals and families, and is a problem encountered across almost all specialities clinical psychologists work in.

In addition to being a large problem, addiction is also a major challenge. It is a challenge not just to those who suffer from addiction, the so-called addicts, their families and the wider community; it is in addition a challenge to policy makers and the police, to society as a whole and is a health and social issue with global impacts (Degenhardt et al., 2013). Of considerable challenge are so-called dual diagnosis cases where substance misuse is comorbid with, for example, a learning disability, homelessness, offending behaviour or interacting with complex problems encountered in older age. To take just one area of dual diagnosis, mental health and addiction, it is estimated that in treatment-seeking mental health populations, 50–75 per cent are also using psychoactive substances (Weaver et al., 2003). In a large audit conducted in 2009 in one of our (RK’s) NHS Trusts, it was found that, of substance misuse service users, approximately 75 per cent would meet criteria for an anxiety or depression disorder. This does not include those with personality, trauma or psychotic spectrum disorders. So while specialist addiction services exist, substance misuse is nevertheless a significant challenge for the whole of mental health. It is very unlikely that clinical psychologists will not face the enigma of addiction, no matter what their specialty happens to be. And yet the importance of addiction in the training of clinical psychologists is often neglected. In a recent survey of clinical psychology training courses, conducted in 2014 by the Faculty of Addictions’ trainee representative Sophie Neech, we found that 50 per cent of courses offer a day of teaching or less throughout their course. Specialty placements in addiction were also sparse, with many courses commenting that they had no clinical psychologists in their area to place trainees with.

Looking back on the history of clinical psychology in the UK drug and alcohol treatment system, it sometimes appears to have
Introduction

always been a troubled one. In the days when clinical psychologists could choose their area of work post-training, the addictions field was populated by a small number of passionate individuals. The work tended to carry the stigma of the service user group. For those who did choose to work in addictions the role was very much for the making. However, the task was often finding a space for psychological thinking within services dominated by medical or social treatment narratives. In the eighties the concern that injecting drug users would act as a bridge between their HIV high risk group (via sharing contaminated needles, etc.) and the population at large (via their sexual contacts) led to new monies for developing drug treatment services (see Stimson, 1995). In the nineties and early noughties, political concern about the association between crime (mainly acquisitive crime) and heroin dependence led to significant funding for addictions treatment, which also enabled an increase in numbers of psychologists recruited to the field. An example of the political concern to increase community safety (i.e. reduce crime) by reducing drug misuse is shown in the then government’s publication *(Tackling Drugs Together*, Lord President et al., 1995), which quoted evidence of the crime reduction associated with drug treatment. This led (in England and Wales) to the development of new treatment services for diversion of drug users as an option for sentencing (such as drug intervention projects, arrest referral schemes and drug testing and treatment orders). In addition, drug and alcohol treatment services in prisons developed during the noughties. This strategy (providing treatment to reduce drug-related crime and improve health) was strengthened further in the government’s *Drug Strategy 2010 – Reducing Demand, Restricting Supply, Building Recovery* (Home Office, 2010) and evaluated (largely positively) for its effectiveness (National Treatment Agency for Substance Misuse, 2012). Alcohol treatment services were not prioritised for new funding, but did benefit from alcohol and drug services being commissioned together during the noughties. Unfortunately, this may well be viewed as our golden age. In England in the last ten or so years, addictions treatment has been at the forefront of commissioning activity (and is becoming increasingly so for Scotland, Wales and Northern Ireland). Contracts are often competitively tendered on three year cycles and most treatment services are now run by third sector organisations. Old NHS hospital trusts are in decline, and with this the structure and security that clinical psychologists may have been used to. The recent Health and Social Care Act (DH, 2012) has furthersed these changes for England, with commissioning being led by local authorities and public health. The new public health narrative and the major problems in local authority funding have the potential to create a perfect storm of disinvestment and financial pressure in an already stretched system. Unfortunately, psychologists have often been seen as an expensive luxury for a system dominated by more medical interventions, and there has been a major decline in posts across the country. Most of the members of the Faculty of Addictions work in specialist services which have undergone these major upheavals in the past five years. The newer third sector services have been slow to see the value of professional psychologists. While that is changing, many addiction posts have been cut and many prominent psychologists in the field have retired or moved into other specialities.

The picture so far is pretty bleak and we need to ask: Is there any cause for optimism? We believe there is. The current government’s focus on recovery, whilst no doubt politically motivated and lacking the nuanced understanding of the concept we would want, does provide a platform to challenge the hegemony of existing treatment provision. Psychologists have a key role to play in this, as the recent DCP document makes clear (BPS, 2012). Several policy reports and guidelines prioritise psychological aspects of substance misuse treatments (e.g. Scottish Government, 2008, 2012; NIC E, 2011) and clearly there is much work for the Faculty to do to provide leadership in implementing these reports.

There are signs that our potential is being recognised outside the NHS too, with some of the largest third sector providers recruiting
psychologists into senior leadership positions. The days of psychologists only doing direct clinical work may be over, but the potential to influence across the system has never been greater. The fact still remains that a psychologically informed view of addiction is where the exciting theoretical and clinical developments are emerging. For the clinical psychologist seeking a challenge in a dynamic and fast moving treatment sector there is no better place to work. The Faculty of Addictions remains active and determined, and this issue of Forum is an attempt to showcase some of the exciting and relevant work being done and developed across the field in the UK, both within a selection of specialist non-addiction services as well as addiction specialist teams.

Authors
Paul Davis, Consultant Clinical Psychologist and Teaching Fellow, University of Surrey; p.e.davis@surrey.ac.uk; Ryan Kemp, Consultant Clinical Psychologist and Clinical Director, Milton Keynes Mental Health Services; Luke Mitcheson, Consultant Clinical Psychologist, Head of Addictions Psychology and Lead Psychologist for Lambeth Addictions, South London and Maudsley NHS Foundation Trust

References
This article deals with the location of moral responsibility in relation to those who are described as having addictions, but especially those using substances, be they legal or illegal. I want to problematise the idea that this is solely about the personal agency of identified ‘addicts’. Instead, we should consider the ethics of other parties, which may be relevant to their actions for a range of current and historical reasons.

When faced with those with troubled or troublesome habits, psychologists understandably work carefully on the personal agency of their clients, in order to facilitate change. Some non-professionalised interventions, such as Alcoholics Anonymous, with its 12 Steps programme, muddy the waters a bit about agency. Is it basically a bootstrap exercise for a person with an addiction to exercise their free will to become and keep ‘clean’? Is that capacity for free will God-given? Does God give and take away our choices in life, including the ability and duty to make choices? (See Alcoholics Anonymous, 2015).

For those without God in their lives, who prefer secular accounts of cognitive operations, the bottom line is still one of ongoing desistance. The client must stop whatever it is that hurts them and/or others, and they must resist the temptation to return to their old ways. This is, as they say, and common sense reasonably tells us, ‘the bottom line’. In practical terms then, deists and humanists may end up in a similar individualised strategic position about personal change.

This reliance for psychological change upon client agency is not peculiar to working with people with addictions, but applies across the board for therapists. Without that general truism, the in-joke about numbers of therapists and light bulbs wanting to change would not have emerged, nor would the punch line make any sense. In this context, psychologists dwell in their professional reflections and tactics upon client agency and personal responsibility as the touchstones for both change and its maintenance.

So far, so good (if my reasoning is plausible), but the occupational hazard for psychological therapists is that of limiting their field of understanding to the dyad with their client, or clients if work is done in groups. If we expand our frame of scrutiny from clients and their therapists to the range of contexts in which addictive conduct emerges, then our ethical interrogation necessarily spreads to third parties as well.

Diagnoses and Formulations
Before we even think about this expansion into a field of moral complexity, we can check on our assumptions about the emergence of addictive conduct. The medical default position, which some psychologists might adopt uncritically, is that of addiction as disease. Whether that disease is genetically, epigenetically, or environmentally created, the patient is seemingly compelled to act in the way they do and they will be incorrigible in the face of moral appeals from others.

The high relapse rate of addictive behaviour gives some support to this position about therapeutic nihilism. Some people conceptualise alcoholism as a brain disorder, and so deem psychological interventions as totally futile, as the condition is on genetically determined tramlines. Presumably, those so inclined, if they were health service commiss-
sioners, would save money by simply shutting down drug and alcohol services.

If a disease model is not favoured by you then what is left is some attempt at formulation (a reminder here that psychologists are supposed to formulate, not diagnose – an ethical matter for a different article). Then it starts to get interesting, not just in terms of case-by-case complexity, but also in terms of the ethical question of responsibility or culpability.

As I noted at the start, the limited occupational purview of psychologists shepherds them into a form of methodological individualism in therapy. Understandably, that keeps a tenacious focus on the client’s responsibility towards themselves and others. However, of necessity such a formulation-led approach will also expose other moral agents operating in all of our social networks, past and present (Christakis & Fowler, 2010).

Smoking uptake and cessation are inflected by family and social network membership. A child at a school with drug dealers nearby, to offer first free hits to 14-year-olds on their way home, is in a different context of risk than those protected by more benign ecological factors. A child who is sexually victimised is at increased risk of feeling compelled later in their life to repeat the abuse with others or to turn their abuse inwards. The latter might include being emotionally demanding of others, episodically suicidal and seeking comfort in substances. A diagnosis of borderline personality disorder is more likely for those who were sexually abused in childhood (Otga et al., 1990). Moral agents to think about, then, are not identified patients but their abusers in the past.

**Moral individualism and contingent moral regimes**

Thus morality can be over-simplified by limiting our focus to individuals who offend social mores; in this case those with addictive propensities and habits. The matter of personal agency can be limited to the client’s confession of moral failure, and their compliance with distance and the maintenance of social conformity in relation to non-addictive conduct.

But psychological formulations expose others involved, which often, to the disappointment of psychologists, are outside of their influence. This might be because the determinants of addictive conduct are historical and so irreversible, or because, even in the current life world of the client, network effects are powerfully influential. A person recovering from a drink problem may have accrued their friendship networks in social settings of heavy drinking. To recover is implicitly to deviate from that learned context and the expectations of their friends and acquaintances. To give up drink might mean abandoning very important attachments. Chronic intoxication is deviant in some contexts but conformist in others.

And beyond the drinking buddies is the drink industry. Today in student bars cocktails can be bought for £2. Somebody makes a decision to set prices. Those people are moral agents who are creating the trajectory for alcohol drinking norms in late teenagers for their adult lives. Their responsibility is arguably more onerous than the drug dealer outside the school yard, given the scale of alcohol use nationally and internationally and its legality in most countries.

Alcohol pricing is bound up with the interests of profiteers. Their response (like those profiting in the gambling industry) is to offer a health warning to drink (or gamble) ‘responsibly’. So what is the difference in principle between the school gate drug dealer offering free trials from the gambling companies doing the same?

The profiteers in the drinks industry do not absorb the policing and health services costs of road traffic accidents, A&E attendance, sexual assaults, actual bodily harm, domestic violence, sexually transmitted infections, and unwanted pregnancies. These are the immediate behavioural risks of intoxication and do not take into account the increased incidence of cirrhosis and heart disease in young patients, compared to past days with lower consumption rates in new drinkers.

‘Drink responsibly’ is a rather weak moral response to this grim social reality. It reminds us that the explicit moral regimes of Alcoholics Anonymous and those implicit in therapeutic confrontations in ‘rehab’ are two of many we could invoke and reflect upon. Weak the drink or gamble ‘responsibly’
mantra may be, but it blinkers our scrutiny of the moral responsibility of the industries peddling their addictive wares. So from a commercial viewpoint the mantra is rhetorically not weak at all, but is actually very powerful because it diverts ethical scrutiny from big business.

When we turn to the arts industry we find adoring or prurient audiences at times willing on the excesses of ‘sex, drugs and rock and roll’. Recently on Desert Island Discs, Keith Richards described that image and expectation as a ‘ball and chain’ in his life. Our cultural image of the reckless and opiate-taking romantic poet dying early for their art remains a powerful trope (Pilgrim, 2015).

To live fast and die young is part of the artistic success story and substance use is often a central part, from Billie Holiday to Amy Winehouse. Their reputations and record sales were bound up with their addictions and this implicated the moral agents around them, as well as their fans looking on with a mixture of pity and fascination. It was only when they stopped singing, because of stupor or death, that the fans became despondent or angry.

Self-abuse and abusing others
When we turn from the layers of networks creating and maintaining self-destructive conduct to that which harms others, when the latter is compulsive and incorrigible, the same points apply. Recently, Esther Rantzen, the founder of ChildLine, tearfully said that: ‘We made Jimmy Savile who he was... We all blocked our ears to the gossip... In some way we colluded with him as a child abuser.’ (Rantzen, 2012). This eventual confession reflected a wider culture in the BBC of peers and managers who were wilfully blind to the abuse perpetrated by serial offenders like Jimmy Savile and Gary Glitter (Greer & McLoughlin, 2015).

Cultures of denial maintain bad habits in the population (Cohen, 2001). Complicity is as important in making sense of anti-social compulsive acts as the ‘psychopathology’ of the agents of the acts themselves. The only faulty logic in Burke’s aphorism that ‘the only thing necessary for the triumph of evil is for good men to do nothing’ is that in our post-feminist era, the same rule applies to good women as well.

The disease model of addiction ensures methodological individualism and a tunnel vision about moral responsibility. But, as I have argued above, the psychological preference for formulation only allows us to glimpse alternative moral contexts inherited from the past and powerful in the present. We cannot necessarily have any powers of influence at the individual level about those forces. However, we can be honest about what we face. The empirical complexity emerging about addictive conduct necessarily brings into view a range of parties who themselves are moral agents and can challenge or collude, help or hinder the labelled addict’s destructive or self-destructive ways.

Legal aspects of the principle of moral autonomy
Finally, this opening up of the moral question of multi-party culpability also exposes some subtle contradictions for our legal framework (Reeves, 2014). The latter operates a digital logic about moral responsibility (‘guilty/not guilty’). But psychological formulations only work in a persuasive and valid way if we operate analogue forms of (‘more or less’) reasoning and can accept alternative ways of construing the same agreed set of events.

For example, people drinking in a pub one mid-week evening say farewell to one of their group. They watch their friend stagger into the car park. The drunken individual gets into their car and speeds off. Up the road the driver mounts the pavement on a bend and kills a couple and their baby in a pushchair. The police interview those who saw the drunk driver leave. Are they key and innocent witnesses to the antecedents to a crime or did they aid and abet that crime? And, if alcoholism is a disease, then why could the drunk driver not be exculpated as an offender who was suffering from a mental disorder?

The law and the medical model are both hamstrung by completely opposite forms of digital logic about morality. The first renders us all equal and fully capable moral agents. It punctuates moral responsibility for alcohol
consumption at the point of the first sip by the individual compulsive drinker. The second argues that the latter suffers from a form of mental disorder (which according to some professionals would be beyond the individual’s control, as a genetically determined brain disease). The first attributes full moral autonomy and the second does the opposite.

By contrast, analogue reasoning means that not only are we all moral agents to some extent, but we are also embedded in inter-connected moral regimes, which vary in particular ways over time and place. We choose but we do so in a range of circumstances in our lives that we did not choose. As Sartre put it, ‘Freedom is what we do with what is done to us.’ And what is done to us enables or disables our freedom from one context to another. It is easy to rejoice in the tent of plenty, and sometimes circumstances do us in. Eventually we all die: we cannot choose to live forever. And so Sartre’s fair and generic point sets so many hares running about the contexts of our lives and our legacy of mental capacity. We are determined and determining beings and we are not all equal in this world of contingent and complex interactions. Life is not a level playing field.

Contingency is everything, and yet legalism requires tight universal definitions of the equal moral responsibility of named individual suspects in any context. However, our actions cannot be evaluated without reference to the conduct of others around us and even of moral agents we have never seen but who may remain influential in our lives. In the case of the killer driver, he had doubled his intake that evening because of mid-week ‘happy hour’. The latter was a policy promoted by the international brewery chain owning his local drinking house. The ripples of moral responsibility from the shocking event of the drunk driver killing a mother and baby spread out far and wide.

David Pilgrim
Professor of Health and Social Policy, University of Liverpool; david.pilgrim@liverpool.ac.uk

Declaration of interests
The author has no conflicts of interests affecting this article.

References


Substance misuse and older people

James Randall-James & Kim Edwards

Substance misuse in older adult populations is a significant social and health issue. This area requires urgent attention from researchers, clinicians, commissioners, and society as a whole. This article provides a discussion of the literature and important aspects of clinical practice.

Barrels and colleagues (2006) described an ‘aging tsunami’, whereby the older adult population will almost double by the year 2030 and rates of comorbidity, dual diagnosis and substance dependency among older people will increase. The demographics of aging are changing and older adults are drinking more alcohol than ever before, with 1.4 million of them consuming alcohol above the recommended drinking levels (Wadd et al., 2011). Those currently aged 45-65, also known as ‘the baby boomers’, have not only had greater exposure to illicit substances than previous generations, but are also more likely to continue their use into older age (Benshoff et al., 2003). Therefore, the issue of substance misuse by older adults is likely to get worse, and yet currently it continues to be under-identified, underestimated, underdiagnosed and undertreated (Crome et al., 2011). The literature indicates a need for further research and greater service provisions to cater to this inevitable ‘tsunami’ and increased substance (mis)use over time (Wu & Blazer, 2011).

Making sense of aging and substance use

The relationship between aging and substance use is complex, particularly when considering wider issues such as stigma and ageism. Older adults will often experience changes in their health, autonomy, identity, relationships, and work and family roles (Robins et al., 2002; Wadd et al., 2011). The majority will adjust to such circumstances as research has found that this period is characterised by optimum control and self-fulfilment, with ratings of self-esteem at their highest throughout the seventh decade of life (Robins et al., ibid.). However, some will not, and older adults who do struggle to adapt to these life changes and role transitions may be at greater risk of substance misuse as a means of coping (Boyle & Davis, 2006). It is not uncommon for some older adults to develop substance misuse problems in response to perceived losses or negative life events (Benshoff et al., 2003). These individuals are often referred to as late-onset users (ibid.). Several other factors put the older adult at increased risk of substance misuse: social isolation and loneliness, acute and chronic pain, deteriorating physical health, reduced senses, and bereavements (Snowdon, 1990). Older adults therefore may find themselves using substances to cope with issues related to changes in circumstances including social transitions, changes in health status, and practical and emotional problems faced such as moving into residential care (Wadd et al., 2011).

Early-onset substance users have been defined as older adults who used alcohol or drugs before they turned 65 (Benshoff et al., 2003). Early-onset users are more likely to have co-occurring medical problems and mental health difficulties alongside their substance use (Salmon & Forester, 2011). Older adults with a dual diagnosis often require a greater number of psychiatric admissions, and admission periods are lengthier. They have poor concordance with medication, struggle to adhere to treatment plans, are at greater risk of homelessness and violence, and are more likely to come into contact with the Criminal
Justice System (Bartels et al., 2006). Further discussion of dual diagnosis can be found in a review by Bartels and colleagues (2006).

A social milieu of ageism and stigma may also complicate what we know about substance misuse and aging, from therapeutic nihilism leading to non-referrals (ageism) to reluctance to seek help because of feelings of shame associated with the label of ‘addiction’ (stigma). The Royal College of Psychiatrists report *Our Invisible Addicts* explicitly sets out several factors relating to both practitioners and service users, which may impact not only on what we know about aging and substance use, but also on the assessment process itself (Crome et al. 2011).

**Assessment**

Assessing for substance misuse should form part of routine practice. Assessment should include establishing what someone is using, how often and, importantly, why. A substance misuse history is also vital as well as exploring past successes in addressing the problem. Additionally, it is important to establish whether the individual perceives substance use to be a problem, and if they do, whether they wish to address this.

The assessment process will be familiar to readers and many will already be conducting similar assessments throughout their practice. That being said, several risks are common in substance use for older adults, and present unique challenges for those assessing. For example, older adults misusing substances are at higher risk of completed suicide than other client groups (O’Connell et al., 2004). Further examples of risks associated with this population are listed below:

- Physical effects (e.g. the body’s ability to tolerate even moderate levels of alcohol decreases with age) (Kalant, 1998).
- Psychological effects (e.g. alcohol use can contribute towards low self-esteem, low mood, anxiety and memory problems) (Gossop & Moos, 2008).
- Contraindications with medication (e.g. there are significant risks attached to benzodiazepine use whilst drinking due to medication-alcohol interactions that include liver damage due to toxic metabolic changes (Kalant, 1998).
- Falls (e.g. alcohol consumption is independently associated with fall-related injuries in those aged over 65) (Grundstrom et al., 2012).

Assessment for substance misuse is like any psychological assessment, with the main aim being to establish the pattern of use and reasons why someone may be using. Ultimately, substance misuse is a coping strategy and key to any assessment of substance misuse is to establish why the individual uses this coping strategy. Motivational interviewing can be a helpful technique to explore the pros and cons of substance misuse, as well as providing an indication of someone’s motivation to change (Miller & Rollnick, 2013).

Clinicians will need to consider appropriate assessment measures, which are likely to involve a multidisciplinary approach that includes blood tests to identify any abnormalities, particularly in liver functioning. The National Institute of Health and Care Excellence (NICE, 2011) recommend the use of standardised screening tools to identify misuse, increase objectivity, comparability and information sharing. There are several validated screening tools available for use with older adults. For example, Fiellin et al. (2000) reviewed several alcohol screening tools for use with older adults. Screening tools also present the opportunity for brief intervention based on identifying and recognising consumption levels (Crome et al., 2011). Further discussion regarding the person-centred and strengths-based assessment of older adults misusing substances can be found elsewhere (Wadd et al., 2011; Crome et al., 2011).

Assessment should allow one to develop a framework for understanding the individual’s relationship with substances, integrating psychological theory and conceptual models. Of particular relevance to treating older adults is a holistic and person-centred framework that considers socio-cultural histories, systemic factors, and dominant discourses. A comprehensive review of CBT with older adults identified the need to augment assessment and treatment approaches with gerontological knowledge (Laidlaw et al., 2004). Explicitly, Laidlaw and colleagues propose that the assessment of older adults should consider sociocultural context,
cohort beliefs, intergenerational links, health status, beliefs about health, role investments and role transitions (ibid.). The above points are illustrated below in an adjusted conceptual and cognitive behavioural framework (Figure 1).

**Treatment and intervention**

Treatment for substance misuse should follow a comprehensive assessment, grounded in formulation and psychological theory; but brief interventions can also significantly improve clinical outcomes and cost effectiveness (Crome et al., 2011). For example, a meta-analysis found that brief interventions significantly reduce the risk of mortality and lower service costs (Cuypers et al., 2004). Motivational interviewing techniques may also be used to address substance misuse (Miller et al., 1998) and help individuals explore the pros and cons of substance use. This approach includes encouraging an appraisal of the ‘costs’ of not changing.

If brief intervention is ineffective, psychological therapy and/or formulation-based interventions may be the appropriate next step. For example, cognitive behavioural therapy is an effective treatment for substance misuse and complex comorbidities (Schonfield et al., 2000). Behavioural couples therapy can also be used to look at how language used and solutions attempted within the familial ‘system’ may help maintain vicious cycles of substance misuse (Fals-Stewart et al., 2009). Others have used more behavioural approaches or social network and engagement initiatives, helping individuals build new relationships and identities.

Recent initiatives have also recognised the value in transdiagnostic work that can treat other mental health problems or comorbidities, with hope of having a positive impact on overall mental health. A recent study found that individuals fulfilled diagnostic criteria for fewer comorbidities upon completion of treatment using a transdiagnostic group intervention rather than cognitive behavioural therapy based (Norton et al., 2013). For further discussion on this approach please see McManus et al. (2010).

Overall, there may be a case for a stepped approach to substance misuse treatment with older adults, whereby opportunistic screening and brief intervention are the favoured starting point (NICE, 2011; Crome et al., 2011). For a full review of treatment and interventions of substance misuse in older adults, please refer to Wadd and colleagues’ report, *Working with Older Drinkers* (2011).

**Evidence-based practice and the need for further research**

There is a need for further research regarding substance misuse and older adults in order to develop upon evidence-based practice.

We need further research into effective treatments and interventions specifically for older adults misusing substances. Further research into effective components of intervention plans may aid service provision for complex presentations involving chronic and enduring physical health problems, cognitive deficits and co-occurring substance (mis)use.

There is an urgent need to address the lack of specialist services for older adults, with only an estimated one per cent of alcohol misuse services offering specialist treatment for older adults in the UK (Wadd et al., 2011). With the projected increase in need for service provision, this cannot be acceptable. The feasibility of integrated and outreach service models within the NHS and other agencies in the UK will need to be established (Dar, 2006). Additionally, there remains an urgent need for basic training of frontline staff in identifying and addressing substance misuse in older adults.

**Conclusions**

Psychological work with older adults misusing substances presents a unique challenge to services. Treatment can be standardised, brief, or individualised thorough assessment and formulation. However, with the older adult tsunami fast approaching, it is estimated that
As adapted from Laidlaw et al’s conceptual framework (2004) and Liese and Franz’s cognitive model of substance misuse (1996). Examples provided are the authors’ own and do not represent an exhaustive list.

![Diagram of cognitive behavioral model of substance misuse](image-url)

**Figure 1:** The conceptual framework of CBT for older people integrated with the cognitive behavioural model of substance misuse.
the discussed complexities of comorbidity and dual diagnosis will become an even more common sight throughout mental health services. The implications of this are substantial.

The problem of substance misuse in the older adult population is getting worse. There is a significant lack of awareness, a severe lack of research, and a lack of service provisions. This lack of evidence will need to be addressed to enable our invisible substance misusers to be treated effectively and equitably.

James Randall-James
Trainer Clinical Psychologist, University of Hertfordshire; James.Randall-James@herts.ac.uk
Twitter: @James_RJ

Kim Edwards
Chartered Clinical Psychologist, South Essex University Partnership Trust; kim.edwards@sept.nhs.uk

References


Individual and social models of addiction

We argue that the psychology of addiction has been to some extent dominated by individual models, and the applied clinical psychology field within addiction and substance use in particular. Most theories and interventions for addiction problems emphasise individual deficits in behaviour, cognition or motivation. Despite more recent conceptual models stressing the complex nature and multi-component view of addiction problems, one could suggest that the field of practice lags behind with limited focus, development and implementation of interventions that move beyond the individually focused private room of treatment. One way of broadening our attention to the wider impacts and influences of addiction problems is to focus on the immediate social context of the substance user, which often includes close family and friends.

From a theoretical and practical point of view, there are two important factors to consider. The first is the fact that when a significant alcohol or other drug problem develops, this can have a serious negative impact on those who are concerned and close to the substance user. So the harm goes well beyond the individual user and produces ripples of harm to others. Family research has for a number of years attempted to highlight this and more recently the work of the World Health Organization project on ‘harm to others’ (e.g. Laslett et al. 2011; Casswell et al., 2011) has started to provide clear documented evidence of the large numbers of people affected by someone else’s substance use. As part of a large survey spanning many countries, the emerging findings suggest that when you look at the more serious impacts of substance use on others close to the user, the number of people affected is large. The impacts often manifest in the form of psychological and health symptoms of stress that lead to high health care use and associated costs. (For a more detailed description see Copello & Walsh, 2016.) Often a hidden problem, it presents in a number of different ways, including adults accessing generic mental health and primary care services, such as IAPT, with symptoms of anxiety and depression, or children displaying disrupted progress at school or behavioural problems.

The second factor is that there is also accumulating evidence of the potential benefit that can emerge when families and close social networks of those struggling to control alcohol and drug problems become more actively involved and supportive of treatment efforts within a collaborative framework. General social support, alcohol-specific social support and the drinking behaviour of the social network members, for example, have all been shown to be unique predictors of positive alcohol treatment outcomes. In her interesting review paper titled ‘To have but one true friend: Implications for practice of research on alcohol use disorders and social network’ Barbara McCady (2004) reviews the evidence that positive social networks can help and support changes in addictive behaviour before, during and after treatment interventions for substance users. The challenge remains as to how to successfully incorporate these processes into treatment interventions in order to strive for improved outcomes, both for substance users and family member affected.

The limitations of previous psychological family models and the Stress Strain Coping Support model

One possible hypothesis to attempt to explain some of the limited development and implementation of family interventions in addiction
Responding to families affected by alcohol and other drug problems

Responding to families affected by alcohol and other drug problems is that the types of models available to clinicians and health providers have not been on the whole ‘family friendly’. Models of addiction and the family in the past often considered family members of those with substance use problems in a somewhat negative way, suggesting that addiction is a result of long standing family ‘dysfunction’ or ‘instability’, often blaming the family members for their relatives’ problems. This could to some extent have limited the development of interventions for families that in contrast conceive the family’s involvement as potentially supportive, constructive and positive. An alternative model to the more pathological types is provided by the Stress-Strain-Coping-Support (SSCS) conceptual framework (e.g. Orford et al., 2013), drawing on the work of Jim Orford and colleagues in Mexico, England and Australia, and further informed by the emerging ‘harm to others’ literature.

The SSCS model perceives family members as ordinary people who are faced with a difficult and challenging situation and attempt to cope with stressful circumstances that are not of their making. The model avoids any attribution of blame to the family member for the development or maintenance of the addiction problem. Understanding the problem in this way gives back some of the control to family members that within other models is often lost, and also leads to the understanding that family members, perhaps with some additional support, have the inherent ability to improve their own health and wellbeing, and to have a positive impact on their relative’s substance use (Orford et al., 2013).

The SSCS model implies that if stress is not satisfactorily coped with then strain is likely to emerge in the form of poor health and wellbeing; and that support and information are essential ingredients in helping family members to cope with this stress.

Despite individual differences, the model assumes that the core experience of family members is fundamentally the same and has the potential to cause significant and long-term stress. Substance use in the family can cause family relationships to deteriorate and family life to be threatened, possibly leading to situations where family members worry about their relatives, where conflicts over money and possessions may emerge, and where there is potential for hostility and aggression (Orford et al., 2013). Each of the above, as well as a possible longer list of challenges, has the potential to cause significant and enduring stress for the family member regardless of their gender, age or socio-cultural group.

This stress in turn is capable of putting substantial strain on the family member. Research across countries suggests that addiction in the family is generally stressful enough to put the family members’ physical, mental and general health at risk. Family members often report signs of ill health which they attribute to the impact of the relative’s addiction, including an increase in both psychological symptoms (e.g. anxiety, depression) and physical symptoms (e.g. hypertension, pains, migraine), in addition to other experiences such as sleep problems, weight changes and continuous worry. Furthermore, in addition to the strain experienced, other domains of life can be affected by the stress, such as work or career, and the friendship network.

Family members are faced with the often challenging task of trying to understand what is going on and deciding how to deal with and respond to the situation. They want to find the best way of coping and there is not necessarily any right or wrong answer, although some ways of responding are considered by family members to be counterproductive. In summary, the model postulates that family members of relatives with alcohol and drug problems are at risk of increased stress that can lead to strain, a relationship that is influenced by coping responses used, available social support and knowledge and understanding of the problem.

From models and evidence to practice: Responding to the needs of family members and substance users

So far we proposed that in addition to the harm caused by alcohol and drug problems to the person using substances, those close to the user can also be affected and have important psychological needs. These needs can potentially be addressed and alleviated either through interventions delivered directly to those family members affected or through their involvement in the treatment for the relative with the
addiction problem. Two examples from our clinical and research work aim to respond to these needs by conceptualising substance misuse as a problem that both impacts on and is influenced by the close social environment. The two interventions, both supported in NICE guidelines (2008, 2011) are described below.

**The 5-Step Method to help family members in their own right**

Based on the stress-strain-coping-support model (SSCS) already discussed, the 5-Step Method aims to systematically provide help to family members affected by the addiction problem of a close relative. The five steps of the method include:

- **Step 1:** Active listening to elicit the family member’s experience.
- **Step 2:** The provision of targeted and specific information.
- **Step 3:** An exploration of coping responses.
- **Step 4:** Establishing and enhancing social support.
- **Step 5:** Discussing any additional needs.

(A more detailed description of the components of the method can be seen in Copello et al., 2010a).

In a number of research studies, the delivery of the method to individual family members has been evaluated and has shown both reductions of symptoms of stress and changes in important aspects of coping behaviours for family members, either when delivered over a series of sessions or as one individual session supported by a self-help manual (see Copello et al. 2010b for a summary of the research evidence). The method is somewhat unique in the focus on family members in their own right, an area that has not been developed as much as those approaches that aim to use families as a way of supporting the relative with the addiction problem or bringing the substance user into treatment.

Whilst the elements of the approach are not novel *per se*, the theoretical framework allows those delivering the method to follow a structured approach. The focus is on discussing and eliciting from the affected family member in a stepwise format their experiences of stress, their need for information and increased understanding, the dilemmas faced when attempting to cope and respond to the substance user and his or her behaviours, and the available social support and hopes and expectations for the future. In contrast to other approaches the method is brief, structured and focused. The premise is that family members are ordinary people caught up in highly stressful situations and trying to work out ways to respond to these realities, as opposed to suffering from deficiencies or causing the addiction problem themselves. Based on this understanding, the style of the person delivering the method should be non-judgemental and supportive, avoiding unhelpful language (e.g. ‘enabling’, ‘collusion’ and similar terms that unfortunately are commonly used to describe family members’ responses and are often experienced as critical by family members).

The 5-Step Method has shown promising outcomes and has the potential to be delivered in a range of healthcare setting, both specialist and generic, therefore developing responses within the settings where family members commonly present.

**Enhancing positive support for behaviour change by involving family members in interventions for the substance user: Social behaviour and network therapy**

This is a different approach which aims to enhance the support for substance users from important family members and friends. Social behaviour and network therapy (SBNT) is a psychosocial treatment approach developed in the UK that aims to use, and where possible develop and enhance, social support for a positive change in addictive behaviour. Originally developed to respond to those presenting for alcohol problem treatment and tested as part of the UK Alcohol Treatment Trial (UKATT), where SBNT was found to be as effective and cost-effective as the more established motivational enhancement therapy (MET). Both treatments led to significant reductions in alcohol consumption and improvements in mental health (UKATT research team, 2005) and significant health cost savings. The feasibility of delivering the intervention to drug users was later tested and established in a pilot trial.
The intervention is described in more detail in a published treatment manual that was used within UKATT to train therapists (Copello et al. 2009). The intervention starts with the social network identification of the client with the addiction problem coming into a service. Networks commonly include a mixture of family members as well as friends and colleagues. Early in the intervention it is important to establish who the client perceives to be potentially important and helpful, and if necessary and appropriate and with the agreement of the client, invite network members to future treatment sessions. Thereafter, using a mixture of core and elective session topics, the therapist and client (and network members if involved) work collaboratively to establish and enhance a good level of positive support for a positive change in substance use. Motivational techniques, communication and coping mechanisms, social support, and developing a network-based relapse management plan are all central to the intervention. The therapeutic approach also has scope to address client-focused elective areas; for example, educational requirements and the development of shared positive activities as alternative to substance use. The approach provides strategies to continue to support family members in the face of relapse.

Two research studies are underway to further test SBNT with two different client groups. An adapted, briefer version of the approach is being tested against treatment as usual in UK National Health Services adult drug treatment teams with clients attending opiate substitution therapy. In addition, an adapted version of SBNT is being tested with young people (ages 12–18) entering treatment for drug and alcohol problems.

The way of working inherent in SBNT offers different options and possibilities for those delivering treatment. Engaging with the social environment of the substance user opens new therapeutic possibilities and the opportunity to tap into the provision of on-going support outside of the treatment setting. Fostering and enhancing natural support systems can provide a long-term sustained mechanism for change and maintenance of change with the potential to act way beyond the treatment episode. Support can also be drawn from recovery groups and self-help where this is seen as important for and by the client. In our experience, through training and development of the approach, we have found that perhaps the most significant challenge in those delivering treatment is making a shift from an individual focus of treatment to one that actively incorporates and works with people within their natural social environment.

**Conclusions and future directions**

We started this article by attempting to make the case that addiction problems affect many more people than the person using the substances.

The two methods discussed are examples of attempts to respond to addiction problems that take into account and respond to harms to others as well as attempting to harness their potential to help and support the user to change. Service delivery, however, remains predominantly towards the focal alcohol or drug client. Family focused practice in addiction treatment should be informed by the evidence that an effective response to the needs of family members and others affected has the potential to significantly reduce harm and health problems in this group, and that involving family members in supporting the treatment of the user can also improve outcomes.

Given the high prevalence of these problems, it is unlikely that just a specialist response will be sufficient, as family members affected are a highly prevalent group and will continue to access other services for their stress symptoms. These services may, for example, be primary care or mental health service systems, where the nature of the problem may not be acknowledged or openly discussed unless those involved in those services are adequately trained to identify and respond to these needs. Clinical psychologists can play an important role in the delivery and training of family-focused interventions in addiction. Whilst we continue to identify more precisely the harms that addiction create for others, we also need to continue to develop adequate ways to reduce or minimise those harms.

**Authors**

**Alex Copello & Kathryn Walsh**, School of Psychology, University of Birmingham and Birmingham and Solihull Mental Health NHS Foundation Trust; a.g.copello@bham.ac.uk
Responding to families affected by alcohol and other drug problems

References


DCP Pre-Qualification Group
Annual Conference 2016

Community Psychology: Thinking more, speaking more, doing more
The Studio, Birmingham, Friday 11 March 2016

Confirmed speakers:
- Society President Jamie Hacker-Hughes
- The #WalkTheTalk team
- Psychologists Against Austerity
- Masuma Rahim

More speakers to be announced soon!

#PQGconf

For more information or to register, go to www.bps.org.uk/dcp and click on ‘Careers’ or e-mail dcppqc@bps.org.uk
IT IS ACCEPTED that individuals with substance misuse problems will frequently experience other forms of psychological distress, including higher rates of trauma and self-harm (Darke, 2013; Shora et al., 2009). Trauma has been identified as a ‘complicating factor’ that is commonly encountered by many individuals in treatment for addiction problems (Carruth, 2006). Service users experiencing addiction and trauma/post-traumatic stress disorder (PTSD) based difficulties do not fit neatly into mental health services as they are currently configured, and often have difficulty accessing psychological therapy for mental health issues. The extent to which trauma work forms a therapeutic focus in addiction settings varies widely. The lack of a clear care pathway increases the risk of individuals falling between the gaps in service provision, poorer treatment outcomes and disengagement from services (Bradizza et al., 2006; Baker & Velleman, 2007; van Dam et al., 2012). It is important therefore that clinicians who work with clients who have addiction problems can recognise the presence of trauma-based difficulties and incorporate an understanding of the impact of such factors into their work with clients.

Clear criteria exist for diagnosing trauma disorders such as PTSD and complex PTSD, though in a clinical setting an individual may not meet formal diagnostic criteria, yet still experience difficulties related to their trauma history. While estimates vary it has been suggested 11–41 per cent of clients attending addiction services will be experiencing symptoms consistent with a current PTSD diagnosis (Van Dam et al., 2013). A higher proportion will have a lifetime trauma exposure (Van Dam et al., 2013), and even though they may not meet formal diagnostic criteria they may well be troubled on an ongoing basis by aspects of their trauma history.

The relationship between trauma and substance misuse problems is complex. Those who struggle with co-existing difficulties do not form a homogenous group, and causal pathways are difficult to determine (Chilcoat & Breslau, 1998). For a minority of individuals with comorbid difficulties, their substance misuse and mental health problems may be unrelated. For others, one problem may lead to or cause the other. There is continued support for self-medication theories of addiction (Khantzian, 1985, 2012) which emphasise the role of substances in managing underlying psychological distress which can often be associated with early adverse experiences (Darke, 2013; Sartor et al., 2013).

The Department of Health has recognised the need for professionals working in mental health settings to screen for trauma related experiences as part of routine assessment schedules (NHS Confederation, 2008). Even when assessment protocols have been adapted to cap-
Character such information, when detailed or specific questions are not asked or when a sufficient level of trust has not been established in terms of the therapeutic relationship, it may not be possible to accurately ascertain the nature and extent of any such difficulties. As a result PTSD/trauma history can often go unrecognised in clinical settings (Van Dam et al., 2012). Clinicians in addiction settings can be wary of enquiring about such difficulties. Possible explanations proposed for this include:

- a belief that a premature focus on such issues could detract from what should be the primary goal of treatment (i.e. addressing the substance use);
- a fear that focusing on experiences of trauma could destabilise progress in other domains;
- a lack of clinician confidence/competence in their capacity to address such presenting problems; or
- a reluctance on the part of the client to disclose such information.

A number of previous studies in different clinical populations have explored the relationship between the reporting of PTSD/trauma exposure in clinical case note records and the incidence of such difficulties when self-report measures are administered (Wurr & Partridge, 1996; Shannon et al., 2011). In general, such studies have highlighted an underreporting/under-identification of trauma related difficulties, particularly experiences of childhood trauma/abuse. The present study sought to explore the relationship between the incidence of trauma exposure documented in case note records versus self-report measures in an addiction setting.

**Method**

A case note review was conducted as part of a broader exercise to establish the nature and extent of psychological need in clients presenting to an addiction service. For the case note review approximately one quarter of open files were randomly sampled over a four week period. Case notes were scrutinised by the third author (MK) for any reported disclosure of psychological distress, including traumatic experiences. A proforma developed for use in a previous study was adapted to assist with collating this information (Shannon et al., 2011). Concurrently, as part of an ongoing research study, 48 clients from the same treatment seeking population were recruited, using an opportunity sampling method, to complete a number of self-administered questionnaires, including the Hospital Anxiety and Depression Scale (HADS), the Adverse Childhood Experiences scale (ACE) and the Post-traumatic Stress Diagnostic Scale (PDS). Participants provided written informed consent. Ethical approval was obtained from the Trust Research Governance Department and the Regional Office for Research Ethics Committee (OREC) respectively. Information was collated using SPSS, and chi-square analysis conducted to explore possible discrepancies.

**Results**

There were no significant differences in terms of demographics between the two samples and demographic characteristics were found to be comparable to those found in a previous service audit carried out in 2007, in terms of gender ($\chi^2 = 0.018, df = 1, p = 0.983$), employment status ($\chi^2 = 0.001, df = 1, p = 0.973$) and substances used ($\chi^2 = 4.473, df = 2, p = 0.107$).

A comparison of the incidence of psychological distress and psychological trauma, as documented in case notes record versus that reported in self-administered questionnaires, is detailed in Table 1. With regard to general mental health, in the case note review difficulties such as depression ($n = 104, 60.1$ per cent) and anxiety ($n = 68, 39.3$ per cent) were frequently reported. Fewer individuals reached caseness for depression based on self-administered questionnaires (48 per cent). This contrasted with self-report for anxiety symptoms, with a higher proportion of clients reporting clinically significant symptoms (84 per cent). This contrasted with self-report for anxiety symptoms, with a higher proportion of clients reporting clinically significant symptoms (84 per cent). Self-reported anxiety/depression ranged from mild to severe, and was found to be significantly and positively correlated with childhood trauma ($\rho = 0.339, p = 0.035$, and $\rho = 0.426, p = 0.007$ respectively).

With regard to psychological trauma, there was a more consistent picture, with a much lower incidence of childhood trauma and PTSD documented in case notes than was reported in self-administered questionnaires.
Discussion
Consistent with previous research this study found a discrepancy between psychological distress recorded in case notes and that elicited via self-administered questionnaires. Possible explanations for such findings include:

- a belief that focusing on such issues could destabilise a client or distract from what should be the primary focus of work;
- a lack of clinician confidence/competence in addressing such issues; or
- a reticence on the part of the client in terms of disclosing such information.

Given the identified potential impact on treatment progress and recovery this project highlights the need for a more systematic approach to the identification of psychological distress, particularly in relation to trauma history. It is important that such factors are incorporated into psychological formulation, and considered in terms of treatment planning. Clinicians working in addiction settings should have training and support which enhance confidence and competence, and enables them to remain alert to the presence of co-existing difficulties. A limitation of this project was the opportunistic sampling method used to recruit participants who completed self-administered questionnaires. However, while this introduces the risk of selection bias, it is unlikely that this would account for discrepancies of this magnitude especially in relation to PTSD and experience of childhood trauma.

Sequential versus parallel treatment
When seeking to address comorbid difficulties a sequential approach to treatment has often been popular. From this perspective the initial focus is on attaining controlled use, avoiding problematic use or achieving abstinence from the problem drug, while a stance of ‘watchful waiting’ is adopted in relation to other mental health issues. Some authors have suggested this approach ‘underestimates the realities of the close and often mutually reinforcing relationships’ that exist between mental health issues and substance use (Finkelstein et al., 2004), especially when individuals are ‘self-medicating’ to help manage underlying psychological difficulties (Mueser et al., 2003). There is growing evidence for the benefits of adopting a more integrated approach to treatment that allows for presenting issues to be addressed in parallel (Baker & Velleman, 2007; Van Dam et al., 2012).

With regard to trauma-based difficulties there are now a number of established treatment packages available to clinicians who are seeking to work with individuals who present with comorbid PTSD and substance misuse (Van Dam et al., 2012). It is unrealistic to envisage that all practitioners in addiction settings will have the skills required to address the range of problems that can arise as a result of trauma exposure. Najavits (2006) has proposed a tiered approach in which a subgroup of practitioners should be capable of delivering protocolised treatment under supervision. Of note, many of the established treatment packages are non-trauma focused (Van Dam et al., 2012). Clinical psychologists working in addiction settings (or other adult settings) will generally be ‘trauma competent’ (Najavits, 2006) and as well as being well placed to conduct more intensive trauma focused work, can also support other staff through training, supervision and consultation.

No wrong door
Historically, services have tended to operate in discrete silos. While some clients may be hav-

Table 1: Comparison of frequency of case note versus self-report

<table>
<thead>
<tr>
<th></th>
<th>Case note</th>
<th>Self-report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>104 (60.1%)</td>
<td>23 (48%)</td>
</tr>
<tr>
<td>Anxiety*</td>
<td>68 (39.3%)</td>
<td>40 (84%)</td>
</tr>
<tr>
<td>Childhood trauma*</td>
<td>39 (22.5%)</td>
<td>40 (84%)</td>
</tr>
<tr>
<td>PTSD*</td>
<td>7 (3.9%)</td>
<td>16 (33%)</td>
</tr>
</tbody>
</table>

* Statistically significant
ing their mental health needs addressed in an addiction setting, adopting a service delivery system which attempts to bridge gaps in service provision will advantage individuals with co-occurring mental health and addiction problems (e.g. the ‘No Wrong Door’ model; Croton, 2006; CSAT, 2000). Greater communication and sharing of expertise present within addiction services and mental health services would benefit clients.

**The role of clinical psychology**

Clinical psychologists working in a variety of settings are likely to encounter, and be able to assist in the treatment of, individuals with comorbid mental health and trauma-based difficulties. A recent British Psychological Society publication (DCP, 2012) has highlighted the range of ways in which clinical psychology can contribute to treatment services in addiction settings. Clinical psychologists have high level skills and knowledge, and are equipped to tailor psychological interventions to address complex presentations (McCusker, 2013).

**Authors**

David Curran, Consultant Clinical Psychologist & Mairead Kelly, Assistant Psychologist, Addiction Service, Northern Health and Social Care Trust, Northern Ireland; d.curran@qub.ac.uk; Elissa McLaughlin, Clinical Psychologist, PTS, Northern Health and Social Care Trust, Northern Ireland

**References**


Division of Clinical Psychology (2012). The contribution of clinical psychologists to recovery orientated drug and alcohol treatment systems. Leicester: British Psychological Society.


An introduction to behavioural couples therapy

Andre Geel

Behavioural couples therapy (BCT) is a form of therapy designed to address alcohol and drug problems where one partner has the problem and both want to overcome it (O’Farrell & Fals-Stewart, 2006). This paper describes the development of this approach and how it is used, with some personal reflections on its strengths and weaknesses.

FIRST DEVELOPED in the 1980s to address alcohol problems, behavioural couples therapy (BCT) has recently experienced a resurgence in popularity, particularly in the UK after being referenced in the 2007 NICE guidelines on drug and alcohol abuse. It was included as it had one of the most convincing and extensive evidence bases for any therapy addressing alcohol and drug problems (NICE, 2007, 2011). Further literature and research reviews – notably Ruff et al. (2010) – confirmed much of that evidence, and BCT has continued to be recommended in the National Treatment Agency ‘Toolkit’ for Psychosocial Interventions (Pilling et al. (2010), the NICE quality standard for drug use disorders, (QS23; NICE, 2012) and the Joint Commissioning Panel for Mental Health Guidance for Commissioners of Drug and Alcohol Services (2013).

It should be noted that BCT is a manual-based, essentially behavioural, psychological treatment. It is designed to be administered in a fixed number of sessions by minimum graduate-level psychologists in a structured environment, with clear tasks and outcomes expected from both clients and therapists. The manual is scripted, even to the point of providing therapists with the words to use throughout the sessions. There are specific tasks for each session and all subsequent sessions are dependent upon the couple completing the tasks in the previous session. Each task builds on the next and progresses from the index patient (the term used in the manual) beginning to control their substance use, through helping the couple improve communication skills, and on to developing a joint relapse management plan to continue after treatment has ceased. There are ‘officially’ 12 sessions, but these can be seen as modules and spread over more than one session, so that the total number of sessions used might expand to around 20 with couples with more challenging problems. The treatment is divided into four phases:

- the engagement phase;
- helping the index patient manage the substance;
- improving the couple’s relationship; and
- ongoing recovery.

The engagement phase involves assessing whether the couple are suitable for BCT in terms of motivation, commitment and goals, and specifically in this regard, if both partners are aiming at abstinence for the index patient. The next phase, which is the first active phase of treatment, focuses on the management of the substance, with the couple keeping a record of substance use, urges and lapses, and ways they are using to stay abstinent, such as attendance at recovery meetings, treatment and day programmes and any other activities that promote abstinence. The treatment then moves on to the phase of looking at the relationship in relation to how it supports abstinence and how that can be

...one of the most convincing evidence bases for any therapy addressing alcohol and drug problems...

Clinical Psychology Forum 278 – February 2016
strengthened to manage the stress and strain that past substance use placed on the relationship. Communication skills, assertiveness, conflict resolution and problem solving form part of this phase. The final phase is working with the couple to develop a relapse prevention plan that they can use after the treatment has finished so that ongoing abstinence and recovery are assured.

Other specifics of the treatment include a signed contract, daily meetings for the couple, keeping a diary of recovery-orientated activities, planning shared activities, being present- and future-focused, learning communication skills, conflict resolution, and problem solving.

Essentially, BCT works best with couples where only one partner has the substance misuse problem and both partners want to achieve abstinence. However, it can be used with more complex presentations such as with both partners using, with dual diagnosis (comorbid mental health) problems, with families, with parenting problems, and with injecting drug users. Different versions of BCT have been developed over time, with a six-session version (down from the 12-session original), group BCT and a parenting-skills variation.

The outcomes of BCT treatment consistently indicate reduction in substance abuse (both in length of abstinence and level of subsequent use), reduction in domestic violence, and partners reporting greater relationship satisfaction (Ruff et al., 2010).

In ‘How to be an effective BCT therapist’ O’Farrell and Fals-Stewart (2006) specify a number of competencies required including:

- addressing the substance abuse problem first;
- tolerating and defusing strong anger;
- structuring and controlling sessions;
- empathising readily with both partners;
- not imposing one’s own beliefs;
- knowing common legal and money problems;
- avoiding blame and hopelessness;
- maintaining long-term contact with couples;
- forging a strong therapeutic relationship;
- and
- using a positive approach with humour.

All of these indicate the need for the therapist to lead the sessions, set the agenda and be a model and agent of change for the couple, highlighting the active behavioural nature of the treatment.

Some personal reflections on BCT

Initially, it was a surprise as to where BCT came from, as very few UK psychologists seemed aware of this intervention locally or were using it. It seems to me that a rather serendipitous series of events has led to the appearance of BCT on the local scene. Firstly, we have the establishment in England of the National Institute for Health and Care Excellence as a way of establishing the best evidence-base for treatments, primarily within the NHS, with equivalent systems and organisations for Scotland, Wales and Northern Ireland. With these new standards for an evidence base it has led us to look further afield to identify treatments that fulfil these more rigorous requirements, and has uncovered the BCT evidence base, which is extensive and convincing. Thus, BCT has effectively been ‘imported’ into the UK treatment system, and in many ways without local practicing clinicians initially being aware of this treatment.

Another factor which has narrowed the search to BCT has been NIC E’s focus on treatments that do not have obvious commercial links, so as to avoid the potential conflict of interests in a public-sector organisation. This has led to the selection of specific psychological treatments and the exclusion of others. That the research and therapeutic materials were in a sense ‘freely available’ has been a major factor in the accessibility of BCT.

A further factor in the success of BCT has been its extensive research base. Since the 1970s research has been conducted on what was to become BCT, and the first manualised version of it was produced around 1980, so that there is now some three decades of research and data available on the treatment. The fact that it is manualised means that it has established fidelity to the model, is easily replicated and can easily be compared across treatment settings with different client groups; and can also be relatively easily taught to prospective therapists.
The manualised approach is both its biggest strength and greatest weakness, in that it can easily be delivered by relatively inexperienced therapists, with clients following the manual in an almost ‘guided self-help’ fashion. Provided that the clients remain motivated, insightful and willing to complete the therapy tasks, the treatment will continue to be effective, session by session. If however the clients become challenging or ambivalent, or there is significant change in the substance use (relapse) or relationship (conflict), then this approach will become ineffective as the therapist is either not experienced enough to modify the treatment method to complement the changing presentation, or the treatment is modified to such an extent as to become ineffective.

In my experience of being involved in both the treatment of clients using BCT and of the training of it to other professionals, the overriding feature is the behavioural bias of the treatment itself. BCT includes many of the behavioural therapy techniques and approaches first developed in the 1980s and 1990s, and relies heavily on modelling and behavioural rehearsal and the repetition of simple behavioural tasks to improve communication in the relationship.

Having actually practised BCT for some years now and trained numerous students and colleagues in the approach, I am continually impressed by how positive and optimistic this method is. It allows the therapist to focus on the ‘good stuff’ in the relationship and the couple usually very quickly begin to adopt the same constructive attitude to therapy and to their relationship. The therapy and its techniques and homework can quickly become fun and rewarding for the couple and they often enjoy and look forward to each new session. Much of this does also depend on the skill of the therapist and their own attitude – mine being a positive psychology and solution focused stance.

Another aspect of the approach which requires the creative and ‘cultural’ skills of the therapist is the wording of the script in the manual, as this was developed primarily for a middle class and public health population in the US, and so requires some translation into British English. Although this might seem a challenge, it can usually be quite fun as the therapist and couple debate what are the most appropriate words to use to describe exercises and techniques. In my own practice I actually share the script and manual with the couple as we work, so they know where I am and what stage we are at in the programme. This also seems to help in the couple taking responsibility for much of the work, as well as highlighting the collaborative nature of the enterprise.

The therapy is definitely therapist-led, with the practitioner presenting the script for each session and working through it with the couple, covering the tasks to be completed for that week and a review of the tasks set for the previous week. There is very little reflection on issues that are outside of the agenda, as the sessions are more task focused and outcome orientated, with the therapist reviewing how well the couple learned the communication and behavioural skills in the intervening week.

In my view, one of the assumptions behind BCT is that the couple probably lack many of the basic social skills necessary for effective communication and problem solving, and for establishing a positive, affectionate and mutually respectful relationship, and that teaching them these skills is the foundation for a positive therapeutic outcome. In my own experience as therapist I have noticed that a significant number of my clients do indeed lack these skills, and that when presented to them in the therapy sessions respond in a very positive way.

Much of BCT is thus ‘psychoeducational’ and aims to ‘skill-up’ the couple to manage the challenges of substance misuse. It provides clients with practical behavioural skills to do this. It is not particularly cognitive, in that it does not explicitly deal with assumptions, thinking errors, interpretation or belief systems, or teach the clients to identify their thoughts and manage them in any particular way. It is not client-centred or humanistic in its approach at all, as it has a definite agenda to teach the couple particular behavioural skills. It is also not interpersonal, analytical or existen-
tial in its philosophy or approach. It is also not systemic in any formal sense and does not make direct reference to this as an influence, but could be seen as having some aspects in common with structural family therapy in the sense of its assumptions about what might be healthy and appropriate roles, relationships and communication. Nevertheless, it seems best to describe it as ‘behaviour therapy for couples’ (who also have substance misuse problems).

Until 2007 there had been little mention of couples therapy within this field, but with the arrival of BCT interest appears to have been reignited regarding this treatment and, following a series of discussions, an expert reference group was formed and a document was produced on guidance on couples therapy within IAPT – particularly focused on depression (Hewison, 2011). The competences for this therapy – described as an integrative treatment and add-on skill for experienced couple therapists – reflected an amalgamation of a number of other couple therapies, including traditional, integrative behavioural couple therapy, cognitive behavioural couple therapy, marital therapy for depression, conjoint marital interpersonal psychotherapy, and coping-oriented couple therapy. While this has increased the profile of couples therapy within the field, it has also led to some initial confusion with behavioural couples therapy for alcohol and drug problems being mistaken for the integrative cognitive behavioural couples therapy for depression (Clulow et al., 2014). Recent discussions amongst professionals have begun to clarify this misunderstanding, and indeed at the most recent British Association for Behavioural and Cognitive Psychotherapies conference, the newly formed Couples Special Interest Group hosted a discussion on the different forms of couples therapy now in vogue.

All this indicates the development and maturing of a new suite of therapies that are now available to clients across a range of services, and how psychological treatment in the UK has recently seen a revival of couple-oriented therapies, which should provide clients with a wider range of evidence-based treatments. At a more profound level it may also indicate a shift in thinking from the more traditional CBT focus on the individual and the intra-psychic, to the more systemic and interpersonal, with a broader view on the type of treatments used and the context in which they are employed.

Author
Andre D. Geel, Consultant Clinical Psychologist, The Junction Service, Central and North West London NHS Foundation Trust; andre.geel@nhs.net

References
Substance misuse and special groups

Adam Huxley

This article describes populations of people that misuse substances, who often face barriers into treatment services or who may find that traditional service delivery models do not always meet their needs. There are a number of groups within the substance misuse population who often require enhanced treatment experiences, joint working with other providers and adjunctive treatment options. Equitable provision of treatment forms part of modern healthcare delivery. This paper will discuss some of the groups that face barriers into mainstream substance misuse services. Specialist treatment pathways will be discussed, as an attempt to meet additional treatment needs.

SUBSTANCE MISUSE affects the lives of individuals, families, communities and organisations across the lifespan from various socioeconomic and cultural backgrounds. People who access substance misuse services typically have complex presentations and multiple difficulties including co-occurring mental health difficulties, cognitive difficulties, pain, and a variety of social, employment and network inequalities that can be seen as barriers for effective engagement with services and a contributor to impaired treatment outcomes. The task of managing such complex presentations falls to staff teams that have expertise in managing substance misuse but may lack the confidence to manage some of these co-occurring difficulties. The challenge for treatment providers is in accurately identifying and assessing co-occurring difficulties, allocating sufficient resources to manage them, and signposting and joint working when they reach the threshold for inclusion criteria for these services.

People who experience mental health difficulties

The relationship between the misuse of substances and the presence of mental health difficulties is well established. During their lifetime approximately 50 per cent of people with mental health difficulties will use substances at some point and experience problems as a result of this use, with alcohol and cannabis being the most common misused, and polysubstance use frequently reported (Weaver et al., 2003). The prevalence of substance misuse amongst people with mental health difficulties is higher than the general population. Regier et al.’s 1990 US population study estimated lifetime prevalence rates were 22.5 per cent for any non-substance misuse problem, 13.5 per cent for alcohol misuse, and 6.1 per cent for other drug dependence-misuse. Amongst those with a mental health difficulties, the odds ratio of using substances was 2.7, with a lifetime prevalence of about 29 per cent (including an overlapping 22 per cent with an alcohol and 15 per cent with another drug disorder). People with mental health difficulties use substances for many different reasons; understanding the context in which these difficulties co-exist is important for treatment services that aim to help reduce harms associated with both disorders and important for service users as part of developing a narrative/formulation of their experiences that support wider recovery goals and self-determination.

In the absence of specialist teams, psychological interventions have been developed to support service users to make sense of co-occurring difficulties rather than see them as separate issues. One such initiative is the Combined Psychosis and Substance Use Programme (COM-PASS; Graham et al., 2004), which aims to provide integrated treatment for people who experience coexisting mental health and substance use difficulties. The service delivers a structured training package based on a cognitive-behavioural integrated treatment approach to staff within mental health services. Evidence from data collected between the late 1990s and 2011 provide robust support for the model (Copello et al., 2012).
People with intellectual disabilities
People with intellectual disabilities are under-represented in substance misuse services (Huxley et al., 2005). The prevalence rate of use is lower than that in the non-intellectually disabled population, with approximately 0.02 per cent compared to 8.8 per cent (Taggart et al., 2006). Taggart et al.’s 2006 analysis of intellectual disability and substance misuse services in Northern Ireland found that alcohol was the main substance misused, with one-fifth of the sample found to be using a combination of illicit drugs and/or prescribed medication. Nearly three-quarters of the sample were found to be hazardously using alcohol for more than five years. Being male and young, having a borderline/mild intellectual disability, living independently and having a mental health difficulty were found to be risk factors for developing a ‘substance related difficulty’. Various problematic behaviours were also identified, including aggression, erratic mood changes, sexual exploitation, difficulties in maintaining relationships and loss of daily routine. Substance misuse also increased the risk of inpatient admission.

People with intellectual disabilities use substances for the same reason as their non-intellectual disabled counterparts as well as managing unpleasant psychological symptoms, belonging to an alternative peer network, escaping boredom and maladaptive attempts to manage emotional dysregulation (Taggart et al., 2007). There are current attempts to determine the perceived acceptability and usefulness of an extended brief intervention to address alcohol misuse in people with mild to moderate intellectual disabilities living in the community (Kouimtsidis et al., 2015).

Novel psychoactive stimulants

and men who have sex with men
There are an increasing number of people seeking treatment for use of novel psychoactive stimulants (NPS). While the prevalence of NPS use remains low in the overall population, its use is concentrated in certain populations including those experiencing wider health and social inequalities (Hunter et al., 2014). Modern drug treatments are designed to incorporate NPS into their treatment model. NPS use can be associated with more severe and multiple difficulties, including dependence, injecting and higher risk behaviours (McNabb et al., 2012). The pharmacological interventions for those misusing NPS seem limited at this stage and the primary foundation for interventions for NPS is largely psychological. NPS use is less frequent and severe compared to other substances (Winstock & Mitcheson, 2012) and therefore more suitable for ‘low intensity’ interventions, including identification, advice and sign posting.

There is a concentration of prevalence of NPS use among men who have sex with men ( MSM) (Hunter et al., 2011). Use of NPSs, particularly in a sexual context, has been linked to concerns regarding physical and psychological health. The ‘chemsex study’ by Bourne et al. (2014) explored drug use in sexual settings amongst MSM in South London. They examined ‘chemsex’ practices – taking drugs such as mephedrone before or during sexual activity. There is evidence to suggest that MSM are substantially more likely to use illicit drugs and other substances compared to their heterosexual peers when engaging in sexual activity in order to increase pleasure (Hunter et al., 2014). Later this year Public Health England is due to publish a document on best practice for MSM who engage in chemsex to sit alongside a framework for the health and wellbeing of gay, bi-sexual and other MSM aimed at reducing overall health inequalities.

People who experience persistent pain
There is a clear association between the misuse of illicit and over use of prescribed medication and persistent pain. Pain is prevalent amongst people accessing substance misuse services, with some estimates of 80 per cent describing pain of any type and 37 per cent experiencing persistent pain during the past week (Rosenblum et al., 2003). Correlates of persistent pain included age, persistent illness, psychiatric illness, time in treatment and inpatient status (Ives et al., 2006). Services often lack the knowledge to be able to identify signs of dependence in those experiencing persistent

---

1 MSM is a preferred term to references to sexual orientation in this context as it is behaviourally oriented.
pain (Ferrell et al., 1990). Pain management is often complicated with the overuse of prescribed medication and use of illicit substances. Individuals who fail to adhere to advised treatment protocols are often tapered off opioids and discharged from services; and as a result they often remain in-between pain management and substance misuse services (Jamison et al., 2010). Treatment options become limited due to reluctance to prescribe opiate based pain relief (Michna et al., 2004). Liaison with pain management services allows appropriate intervention for those people who experience persistent pain in addition to any substitute prescribing and allows access to non-pharmacological means to manage pain.

Pregnancy and substance misuse
The needs of women who are pregnant and who use substances presents a particular challenge for providers due to the potential for harm to the child (Huxley & Foulger, 2008). Approximately a third of people in substance misuse treatment are female and the majority are of childbearing age. Becoming pregnant during the course of treatment, as a planned or unplanned occurrence, requires careful monitoring by treatment providers. The use of illicit substances such as cocaine and heroin during pregnancy is common. Anonymous screening of consecutive urine samples testing positive for pregnancy from a UK inner-city clinic demonstrated that approximately 16 per cent of the women had taken one or more illicit substances (Sherwood et al., 1999). Misusing substances during pregnancy is associated with ante- and prenatal impairment such as prematurity, intrauterine growth restriction, neonatal abstinence syndrome, visual development and longer-term neurodevelopmental adverse outcomes. Continued use after birth limits parental capacity, exposes children to neglected environments and criminality, and impacts upon successful completion of developmental milestones during the child’s early years due to the potential disruption of a secure attachment between mother and child.

Safeguarding children remains a key target for service providers. For women who become pregnant whilst engaged in substance misuse services, there are a number of perceived costs around disclosure, including the involvement of social services and greater scrutiny of lifestyle choices and relationships. These factors may result in disengagement from services and therefore an inability to accurately monitor risk and offer appropriate treatment options. Services have a key role in identification early on in the pregnancy. Assessment needs to be continual and specific to pregnant women, and includes, amongst other things, assessment of parental knowledge and capacity and risk assessment during pregnancy (Day & George, 2005).

Conclusions
The preceding discussion highlights a number of adjunctive treatment requirements for people accessing substance misuse treatment services. There are other specialist groups that have not been discussed. It remains unlikely that any one treatment provider would have the capacity to deliver the expertise required to manage a cohort that is likely to present with some of the needs described above. A more pragmatic approach to comprehensive management is joint working and clearer referral pathways to partner agencies that complement existing case management. People who access substance misuse services often require additional sets of intervention and some do not. Allocating appropriate resources to manage ‘high risk’ groups is a key initial step for treatment services and promotes competent risk management, communication between specialist teams, service user engagement and joint working. Specialist treatment pathways support adjunctive interventions for ‘treatment as usual’. Developing specialist treatment pathways ensures needs are being met, supports retention in treatment, removes barriers and misconceptions around any potential adverse outcome associated with a disclosure and ensures that joint working occurs as part of a wider treatment plan.

Psychological interventions are ideally placed to help support service users, using formulation drawn from psychological theory that helps clients make sense of their difficulties. The value for service providers is in understanding the wider cultural, societal and organisational barriers that exist and ensuring that services attempt to manage co-occurring difficulties.
Acknowledgment
A section of this article was written with support from Dr Christopher Whiteley and peer reviewed by a service user council within Crime Reduction Initiatives. Their input is gratefully acknowledged.

References


Author
Adam Huxley, Consultant Clinical Forensic Psychologist, Spectrum Drug and Alcohol Recovery Service, Hatfield; adam.huxley@cri.org.uk
In case of emergency, take the (12) Steps: A clinical psychologist's view of Alcoholics Anonymous

Mani Mehdikhani

This paper considers Alcoholics Anonymous and its 12 Steps approach from a psychologist’s perspective. The terms and intervention components can be construed in language more familiar to psychologists; an overview of how the approach may help is given, followed by a consideration of overcoming some of the potential barriers to service users referring themselves to a group.

Alcoholics Anonymous (AA) is arguably the granddaddy of all mutual aid programmes, now thought by some to be an essential aid in the recovery journey of addicts. I will not delve here in any great detail into the origins of the 12 Steps (henceforth I will use the terms ‘12 Steps’ and ‘Alcoholics Anonymous’ and ‘AA’ interchangeably) or on the literature on the research into the effectiveness of AA (e.g. Moos & Moos, 2006; Humphreys & Moos, 2007; Moos, 2008, etc.) or on the many controversies surrounding this topic (see Bufe, 1998).

I must confess that I initially had strong personal reservations about AA. There was little in my religious outlook or professional background that prepared me to accept this. I had a problem with what I perceived to be the ‘religious’ aspects of this programme. I was troubled that AA appears to promote the idea that the ‘addict’ has no control over his or her substance use and that as a consequence all attempts at controlled use are futile and ultimately doomed to fail (which leaves abstinence as the only realistic goal). I disapproved of the seemingly stigmatising labels that people in 12 Steps groups attach to themselves, such as ‘alcoholic’ or ‘addict’, informed by a simplistic and distorted view of narrative therapy (cf. Diamond, 2000). I felt that such labels internalised the person’s problems with substance use, essentially turning that person into the problem. I initially had no fondness for the use of the slogans used by AA members nor for the idea that one should set aside ‘critical thought’ (‘analysis is paralysis’), given that as a (cognitive) therapist I saw a big part of my role in terms of helping clients develop insight into their behaviours. Over time I have shed many of these and other prejudices.

Gods and higher powers
Perhaps the most controversial, and at the same time most misunderstood, aspect of the 12 Steps is the focus on the concept of God, and in more recent adaptations on a ‘higher power’. In fact AA has been critiqued on the grounds that much of its philosophical underpinning was based on the Oxford Group Movement (a 19th century Christian movement) (Bufe, 1998). However, to attack an idea on the basis of its origins is a species of logical fallacy (the ‘genetic fallacy’, a cousin to the ad hominem attack). In reality, ideas should be evaluated on the merits of their argument and on their ability to withstand testing (Williams, 1996).

Flores (2004, p.193) has noted that ‘AA invokes a spiritual or religious vocabulary in the absence of perhaps a more accurate but inaccessible philosophical-ontological terminology’. Vaillant (2005, p.434) has further suggested that the quasi-religious terms used in AA are ‘designed to affect the reptile brain
In case of emergency, take the (12) Steps

[but] the rhetoric and the emotional language of the spirituality of AA leads journalists and social scientists to understandably fear that AA is a religion or cult. The term ‘God’ in this context serves to challenge the addict’s ‘narcissistic defences’ (Flores, 2004) and lead them to the realisation that they are, in fact, ‘not God’ (Kurtz, 1979; Diamond, 2000). In this view, God is the only being that can go it alone, without help from anyone. Everyone else needs the support of others to recover. As one AA slogan points out: ‘AA can help you if you believe in God; AA can help you if you don’t believe in God; but AA can’t help you if you think you are God.’

12 Steps: Who and what are they good for?
Relapse avoidance
There is little question that the main challenge faced by those trying to give up an attachment to a substance is not so much the initial giving up of problematic use but in remaining in control or abstinent after desistance. According to Vaillant (2005), relapse avoidance requires the presence of at least two of the following four factors: external supervision, ritual dependency on a competing behaviour, new love relationships, and deepened spirituality (Vaillant, 1988, 1995; Stall & Biernacki, 1986). These factors are thought to be compatible with cognitive-based relapse prevention models (Marlatt & Gordon, 1985; Vaillant, 2005). Although it is possible to achieve most or all of the above in other ways, AA and her sister organisations appear to allow the opportunity to access all of the above factors in one package.

Attachment
Flores (2004) has highlighted the potential benefits of the 12 Steps in the recovery of addicts who have had difficult attachment histories, arguing that for some clients the damage (disruption to the attachment system) may have been too severe or may have occurred too early (during a sensitive period) in development for individual therapy to be truly curative. This may in some respect be analogous to the ‘normalisation’ debate (Wolfensberger, 1980) in terms of striking a balance between ‘normalising the person’ versus ‘normalising their environment’. AA may therefore represent a long-term, perhaps even a lifelong, ‘holding environment’ for some clients (Flores, 2004).

Compassion and forgiveness
Shame (a self-attacking process) and guilt (driven by caring for others) can complicate the treatment of addiction and other disorders. Addicts, stigmatised by society and isolated from their loved ones, can experience tremendous feelings of shame and guilt, which may become triggers for relapse. By working through the 12 Steps (particularly Steps 4, 8 and 9; making a ‘fearless inventory’ of those they have wronged and seeking to make amends for those wrongs) addicts are offered formalised mechanisms by which they may address crippling feelings of guilt and shame (Worthington et al., 2005). Additionally, AA’s conception of God (‘as we understand him’ (or her)) bears striking similarities to the ‘prefect nurturer’ model (Lee, 2005).

Personality disorder
There is a sense in which AA may be viewed as an ‘intervention’ for personality disorder (PD). This is most explicitly stated in Step 6, which requires the addict to be ‘entirely ready to have God remove all these defects of character’. It is possible that the 12 Steps may have stumbled upon at least some of the features of effective and/or popular treatment for PD. For example, AA meetings tend to be quite structured, with many ritualistic elements that promote a sense of predictability, safety and containment. It may be argued that by taking ownership of the labels of ‘alcoholic’ or ‘addict’, the 12 Steps provide an opportunity for the addict to form a strong (and non-stigmatised) sense of identity (as a valued member of a ‘fellowship’), which may be particularly important for those with a fragile or poorly defined self-concept (e.g. those with ‘borderline’ traits). Platter and Cabral (2010) make the case that dialectical behaviour therapy (DBT; Linehan, 1993) and AA share many key elements in common (including Mindfulness) and that the five targets in DBT are mirrored in the philosophy of AA. Much like the 12 Steps, DBT taps into a large store of folksy...
slogans and metaphors (Palmer, 2002) and the two approaches have a shared focus on acceptance and change (the most important dialectic in DBT; Dimeff & Linehan, 2008); the latter is best encapsulated in the recitation of the ‘serenity prayer’ by members at the close of every AA session.

When and how to facilitate access to 12 Steps
There has been much recent interest in the facilitation of clients’ access to 12 Steps and other mutual aid groups, including a number of guidelines by Public Health England, NICE and others (e.g. Public Health England Publications, 2013; NICE, 2007). One approach might be manualised interventions such as Twelve Step Facilitation (Nowinski, Baker & Carroll, 1992) or Making Alcoholics Anonymous Easier (MAAEZ) programmes.

When considering referring clients to 12 Steps meetings it is important to familiarise oneself with the basic tenets of AA, including a range of slogans. There is considerable literature around this topic (e.g. the ‘Big Book’; Alcoholics Anonymous, 1995), but it is worthwhile attending open meetings as a visitor and making contact with AA leaders and members. It also means having an awareness of what is available in one’s locality. Although some may claim that ‘all you need to start your own AA meeting is a resentment and a coffee pot’, it is advisable to check online resources (e.g. www.alcoholics-anonymous.org.uk) to find out the location of meetings that are affiliated with the wider national and international AA or NA organisations. Clients are often cautioned to avoid meetings dominated by ‘AA Nazis’ (Flores, 2004) (differentiated from groups that appear to take a more ‘fundamentalist’ view of the 12 Steps, such as Drug Addicts Anonymous), and female clients are warned about the ‘13 Steppers’ (predatory men who target new and vulnerable women members).

In deciding whether to refer a client to a 12 Step programme, among the first things to consider might be whether your client indeed has an addiction or is ‘merely’ abusing or excessively using alcohol or drugs (‘if your drinking is getting in the way of your work you are a heavy drinker; if your work is getting in the way of your drink then you are an alcoholic’); nonetheless as one Narcotics Anonymous (NA) member once informed me such meetings tend to be ‘self-cleansing’, in the sense that those who do not truly belong will eventually vote with their feet. At first glance, it might make sense to refer clients with alcohol problems to AA, those with opiate problems to NA, and so on. But what to do when a client’s addiction profile features poly-substance use or ‘cross-over’ addiction (alternating or switching from one substance or addiction to another)? A further consideration is your client’s long-term goals for substance use; those who do not subscribe to abstinence are unlikely to engage with the 12 Steps in the long term. A related concern is the problem posed by clients who are maintained on opioid substitution treatment (OST); whilst the only requirement for NA membership is the desire to stop drug use (including alcohol), clients on OST are discouraged from sharing and full participation at meetings as it is thought that this would send a mixed message about recovery (Narcotics Anonymous World Services, 1996). Nevertheless, many people on OST continue to attend both AA and NA, but many of these may hide their OST status from other members, contributing to their feelings of shame and guilt (White et al., 2013). The gradual proliferation of Methadone Anonymous groups may be the answer to the above.

It is useful considering whether your client might be experiencing personality difficulties or disorder (diagnosed or not), particularly of the preoccupied or so-called ‘Cluster B’ types. It has also been suggested that clients’ attachment orientation may predict their engagement with such groups; unlike those with high attachment anxiety, clients with high attachment avoidance may be less likely to obtain a sponsor, to go through the Steps and to attend meetings (Jenkins & Tonigan, 2011).
Facilitating access

After deciding to refer a client to a 12 Step meeting, you are likely to face the hard part: actually convincing them to go to one. I have in the past made attending meetings a condition of the offer of therapy, particularly in the case of behavioural couples therapy (see Geel, this issue), which often includes this element as part of contracting. However, clients can display a myriad of rationalisations and defences when the topic of going to meetings is raised: they may say they do not like groups (‘you don’t have to like it [going to AA], you just have to do it’); they do not think they need help from other people; they may have had aversive past experiences with the 12 Steps or have misconceptions about them (i.e. the ‘religious’ aspect, or the belief that they might be forced to tell their life story at the first meeting); they may believe that they ‘heard it all before’; and so on. The key is not to lose heart at encountering this initial resistance and to keep in mind that there is no single right way that works with everyone.

I tend to employ a motivational interviewing informed approach (Miller & Rollnick, 2013), which one colleague has dubbed ‘elicit-permission-elicit’: begin by eliciting whether the client has been to such meetings in the past, what they already know about AA and what they think about going to a meeting. Then ask permission to share what you know about AA, socialising them to the model whilst addressing individual concerns. For example, if someone has had negative past experiences (and have generalised from one or a few bad experiences to all aspects of 12 Steps), find out if they felt ready for AA at that time and challenge in a non-confrontational way (as one AA member once told me: ‘If you don’t like the beer at your local pub, you don’t stop drinking beer; you find another pub’). For those who feel that they know it all and that the 12 Steps have nothing new to teach them, a useful avenue to pursue might be to find out if they would be willing to put their knowledge and experience at the service of others to help with their recovery; as Yalom (1995) has alluded, if the cutlery at your table is too long to get the food to your mouth, then use them to feed your neighbour. Where possible, gently challenge any myths and misconceptions about the 12 Steps, reflect any change talk and then elicit what they think about what they have learned from you. If after all that the client still refuses to consider going to a meeting, don’t give up. Acknowledge that they are likely not ready yet to try AA and ask permission to revisit the topic at future meetings.

Conclusions

The appeal of AA is easy to spot: it is cheap (members ‘pass the hat’ to collect donations), there is no waiting list, members can attend as often and for as long as they like, both individual and group support is available, there is little of the red tape plaguing professionals in healthcare settings, and it is run by and for addicts. Nonetheless, whilst there has been growing interest in Alcoholics Anonymous and her sister organisations, these remain both controversial and highly polarising. My own views have changed over time from deep scepticism to cautious acceptance. Do I believe that AA is a universal panacea for those struggling with addiction? Even AA members acknowledge that the 12 Steps are not for everyone. However, at present deciding who to refer to AA is as much art as science (e.g. SMART Recovery; see MacGreggor and Herring, 2010). The general rule of thumb seems to be that those struggling with shame and guilt, those suffering with personality difficulties (‘defects of character’), disrupted attachment (such that ‘normalising the person’ is a faint hope), or with affective dyscontrol may benefit from this approach. On the other hand, those for whom the above does not apply – those who are militantly secular or have controlled use as their goal; those who are heavy users but not addicted; and those for whom standard cognitive-based approaches are both suitable and possibly curative – may find a better fit in alternatives (e.g. SMART Recovery).

Author

Mani Mehdikhani, Chartered Clinical Psychologist, Specialist Services Network, Greater Manchester West Mental Health NHS Foundation Trust; mani.mehdikhani@gmw.nhs.uk
References
Reflections on implementing an enhanced psychosocial treatment package to opiate users in the community

Louise Noronha & Isabel Sweetman

This article reflects on our experience of delivering a psychosocial treatment package as part of a randomised controlled trial within a community drug and alcohol service.

There is strong evidence supporting NICE recommendations for the use of psychosocial interventions in the treatment of substance use problems (NICE, 2007). Given the divergent theoretical foundations underlying these treatments it is surprising that research into their relative effectiveness has shown largely equivalent outcomes (e.g. Project MATCH, 1997). This dodo bird paradox has raised questions regarding the active ingredients that effect successful behaviour change, with some calling for research to concentrate on identifying underlying common processes (Orford, 2008). These questions are particularly pertinent in light of pressures to successfully deliver recovery-focused outcomes under the current constraints of the NHS.

With this in mind, the Addictions Recovery Clinic (ARC) aims to optimise the benefits of current (NICE) recommended interventions, as well as the non-specific elements of therapy, by combining these into an individualised, formulation-based treatment package. This personalised behavioural intervention (PBI) consists of cognitive behavioural therapy (CBT; for relapse prevention, anxiety and depression), motivational interviewing (MI), social behaviour and network therapy, contingency management (CM), behavioural couples therapy and 12 Step facilitation. Over 12 weeks the PBI targets abstinence in opiate users who continue to take heroin and/or crack following a five-week stabilisation period on opiate substitution treatment.

In writing this article we hope to make a case for clinical psychology providing leadership and psychologically-led interventions within a typically medically dominated treatment pathway. We will reflect on our experiences as assistant psychologists of implementing this enhanced psychosocial package using Damshroder et al.’s (2009) Consolidated Framework for Implementation (CFIR), focusing on three of the five domains: the intervention characteristics; inner setting; and outer setting.

Intervention characteristics: What has it been like delivering the PBI?

Adaptability and acceptability

Perhaps the most important element of the PBI has been the adaptability of the intervention. Treatment has been individualised from the outset; baseline assessments inform a formulation driven treatment plan which is regularly reviewed. As a non-manualised intervention the flexible approach and range of therapies offered in the PBI has allowed us to respond to service users’ changing treatment needs more readily than rigid, protocol-based interventions.

Acceptability has been ensured by using the Outcome Rating Scale (Miller et al., 2003) and Session Rating Scale (Duncan et al., 2003) in each session, allowing service users to feedback on therapists’ performance. This has been empowering for some service users who...
present with low self-efficacy and self-esteem, partly resulting from repeated experiences of failure in their recovery. The relative changes in Outcome Rating Scale and Session Rating Scale have been invaluable in tracking progress and signalling problems in the therapeutic relationship, whereas suggested cut-offs have been less useful.

A possible downfall of this adaptable approach is fidelity to individual models. Given the number of interventions available and the competing needs of our service users, there can be difficulties in selecting, prioritising and adhering to interventions. As a result, delivery of the treatment package can feel piecemeal. Supervision has encouraged development of meta-competencies (Roth & Pilling, 2007) around what interventions to use and when.

Receiving a range of therapies may also be a challenge for service users with deficits in prefrontal cortex functioning. In these cases, mapping is a particularly useful tool for implementing psychosocial interventions. The visual representation not only serves as a memory aid for service users with poor retention of session content, but also facilitates a more focused, structured and manageable approach during therapy.

**Engagement and therapeutic alliance**

A major challenge in substance use treatment generally, and in the PBI, has been engagement and motivation. Given high attrition rates and the chronic, relapsing nature of addiction, 12 weeks is a short period of time in which to engage and facilitate behaviour change; in our experience it can take this long just to build a therapeutic relationship. Despite this, the PBI has improved service users’ engagement within ARC and the wider treatment service. Some have fed back that they would appreciate a longer duration of treatment, or would like to do it all over again!

Therapeutic alliance has been crucial in engaging service users. MI techniques, particularly reflection, and a non-judgemental, empathic and flexible approach seem to foster this relationship. For service users who present with specific interpersonal difficulties, setting boundaries has been important in building therapeutic alliances. In this sense the time-limited nature of the PBI has proven useful in imposing structure and containment.

Intrinsic motivation has been enhanced through exploring ambivalence and goal-planning. For service users who are excessively disengaged, contingency management for attendance has provided additional extrinsic incentives. Text message reminders have also been universally beneficial for those who have difficulty organising their time and remembering appointments.

Service users typically seen on the PBI have been males with depression and/or anxiety, limited social resources and low activation levels who feel ‘stuck’ in their recovery. Maintaining our own optimism and occasionally adopting a challenging approach has been pivotal in helping service users overcome failures and enhance motivation. Supervision has provided us with the space to reflect on the balance between our hopes for service user progression and the reality of what can be achieved in 12 weeks.

**Combining the interventions**

It has been helpful to construct holistic, biopsychosocial formulations when working with our service users, who not only struggle with addiction problems but also a host of physical, psychological and social difficulties. The PBI has targeted psychological needs (through CBT and MI), social needs (through social behaviour and network therapy and 12 Step facilitation), and biological needs (through discussion of cravings and the role of beliefs and attitudes in relation to optimising medication).

Generally, we feel the PBI interventions have been compatible, excluding some friction in implementing contingency management (CM) protocols for abstinence. We believe that the difficulty lies with the conflicting role of the therapist as an enforcer of a rigid protocol...
a flexible intervention and establishing a therapeutic alliance. The service user may therefore experience us as inconsistent, and hence less trustworthy. Other research has also shown that combining CBT and CM protocols for abstinence can worsen outcomes (e.g. Carroll et al., 2012). Despite this, CM can be a powerful tool for reinforcing attendance, abstinence and behavioural activation.

When considering behaviour change strategies, it has been helpful to combine various cognitive and behavioural approaches. For example, CBT for relapse prevention has been used to establish high risk situations, triggers and alternative coping strategies; behavioural activation provides specific activities to replace these high risk situations; and mindfulness helps build present moment awareness and decreases the impulsivity associated with relapse.

Overall, strategies we have found most helpful in facilitating change have been goal setting, creating routine, increasing activity, building social support, problem solving and relapse prevention techniques. However, informal feedback from service users has focused more on the relational aspects of the intervention rather than any specific techniques used. This is in line with suggestions that focusing on common treatment processes rather than specific interventions may be more helpful (Manuel et al., 2011).

**Inner setting**

When implementing the ARC within existing organisational structures, practical barriers, team attitudes and conflicting approaches to psychosocial treatment have been considered.

**Practical considerations**

We anticipated that conducting a pragmatic research trial within a busy inner London community substance use service would be challenging in terms of recruitment. Many key workers have large caseloads, so understandably recruitment may not be a priority. We have increased and maintained visibility of the trial through continued presence of the ARC as a standing agenda item in both clinical and general business meetings. Providing key workers with comprehensive information promoting the trial and training in screening procedures has been particularly important in boosting recruitment.

**Attitudes of staff and integration into the team**

Key worker buy-in and support has been integral to the success of the ARC, as service users are more willing to participate when introduced to the study by their key workers. Our physical presence in the same office as the opiate team (rather than in the psychology office) has proven invaluable in building mutually supportive relationships with colleagues, and has facilitated informal communications about service users receiving the PBI.

We have also been able to indirectly integrate into the team by supporting other service development projects such as revising initial assessment documentation, conducting audits and participating in group supervision consultations.

Another concern was the potential threat of our role to key workers, who have less time to engage in this type of intervention. Specifically, successful outcomes might be perceived as implicit criticism of pre-existing key worker relationships and competence. Therefore the PBI was positioned as an opportunity to relieve pressure from key workers and establish a team who share responsibility for managing more complex service users. Close joint working has been crucial in reducing key workers’ feelings of disempowerment and the potential for service users to split workers. By conducting three-way sessions and handovers with key workers we have effectively managed transitions between the PBI and standard care; hopefully improving longer-term outcomes for service users.

**Balance of medical AND psychosocial interventions – holistic care**

Historically, acute medical models have dominated addiction services, whereby short-term harm minimisation and stabilisation have been prioritised (White, 2008). This is appar-
ent in the prioritisation of risk management within team meetings and supervision of key workers. However, given a large number of service users re-entering treatment numerous times and remaining in treatment for a long time, recovery focused interventions are unquestionably necessary.

Readiness to change within organisations is, however, more difficult to address. Due to issues of safety in prescribing medication, service user preference and caseload pressure, opiate substitution treatment tends to take priority over psychosocial interventions. The PBI takes a holistic view, balancing biomedical and psychological perspectives, thereby dispelling the notion of a ‘right’ approach. Indeed, Mitheson et al. (2009) suggest that psychosocial interventions may actually bridge the gap between acute risk management and longer-term recovery. One way we have achieved this has been by using psychosocial methods to frame discussions around adherence and optimisation of opiate substitution treatment.

Another issue in implementing psychosocial interventions is capacity for reflective supervision. Regular supervision is essential for successful delivery of psychosocial interventions (Pilling et al., 2010) and clinical psychologists have a major role to play in providing this (BPS, 2012). Typically in services, monthly, management led supervision focuses on case management, risk and performance. Whereas the success of the ARC has been supported by the provision of twice-weekly, one-to-one and team reflective supervision with clinical psychologists, using audio recordings from sessions.

**Outer setting**
The ARC research trial was a timely response to the recent shift from harm minimisation to recovery in UK drug and alcohol strategy (Home Office, 2010; Public Health England, 2012). Given the demands on local authorities to commission services that deliver this recovery agenda whilst contending with shrinking budgets, the ARC could offer a targeted, cost-effective solution to providing recovery-focused treatment in the current political climate.

Current commissioning targets (e.g. completion of care plans) are perhaps an improvement on previous ‘opaque’ outcomes (i.e. treatment entry and completion). However, these outcomes can be perceived as a ‘tick box’ exercise. The design of the PBI lends itself well to meeting financially-driven targets in a meaningful rather than arbitrary way by setting weekly goals and incentivising achievements for service users, which could help attract future funding.

**Conclusions**
There have been significant advantages to implementing the PBI in terms of flexibility of the intervention, engaging service users and taking a holistic approach to treatment. This study design may also answer some of the questions posed regarding the common processes underlying behaviour change. However, there have been some challenges in embedding this into current organisational structures which we have resolved through heightened visibility of the ARC team in the service and close joint working with the existing team.

Our ambition is for the PBI to exist outside of a research framework and effectively offer enhanced psychosocial support in standard drug and alcohol services and other medically dominated fields of mental health. This paradigm is an opportunity to evidence the value of clinical psychology in services where future funding for this role is tenuous.

**Authors**
Louise Noronha, Assistant Psychologist, South London and Maudsley NHS Trust; Louise.Noronha@slam.nhs.uk; Isabel Sweetman, Assistant Psychologist, South London and Maudsley NHS Trust; Isabel.Sweetman@slam.nhs.uk

**Acknowledgment**
The authors would like to thank Dr Luke Mitheson for providing guidance and feedback on this manuscript and for his ongoing clinical support. We would also like to thank Dr Claudio Costanza and Dr Karen Meechan for their clinical supervision and support which has enabled us to write this reflective article.
Reflections on implementing an enhanced psychosocial treatment package


---

Research Digest

Blogging on brain and behaviour

Subscribe by RSS or e-mail
www.researchdigest.org.uk/blog

Become a fan
www.facebook.com/researchdigest

Follow the Digest editor at
www.twitter.com/researchdigest
Behavioural addictions? Evidence and reflections

Neil Smith & Ryan Kemp

The evidence for so-called ‘behavioural addictions’ is reviewed in the light of developing ways to conceptualise and treat such disorders. The authors argue that these problems are similar to substance addictions, often involve underlying complexity and are amenable to psychological interventions.

BEHAVIOURAL ADDICTIONS’ coverage in popular media and the research community has increased significantly over recent years. The relative youth of this area, and any consensus over findings, is neatly reflected in our choice to place the term at the start of this article. But aren’t all addictions behaviours?

The term ‘behavioural addictions’ risks implying volition; it’s just something that you do that you cannot stop, in contrast with substance use disorders being a difficulty forced upon the individual by exogenous and endogenous neuropharmacological agents.

Having worked with behavioural addictions within the NHS since 2008, primarily with the National Problem Gambling Clinic, then expanding focus onto broader non-substance addictions with the establishment of a pilot clinic, the Centre for Compulsive and Addictive Behaviours. Even in the naming of that service we faltered in settling on a single term for this area. In this article we provide an outline sketch of the varied literature on non-substance addictions, coloured in with our thoughts and observations based on our experience of working with clients in this area.

Gaming

Problem gambling moved to the addiction chapter in the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5; American Psychiatric Association, 2013). Of the other researched disorders Internet Gaming Disorder is the only non-substance addiction other than gambling to gain serious mention in DSM-5, appearing in Section III for further research (American Psychiatric Association, 2013). In that section it is defined as the compulsive preoccupation some people develop in playing online games, often to the exclusion of other needs and interests. Gaming addiction has a more mature literature than some other non-substance addiction disorders and there is stronger support for the existence of a problem, with studies starting to appear in the early 1990s (Keepers, 1990). Massively multiplayer online role playing games, such as World of Warcraft are now considered a major source of problems for gamers. Studies have suggested prevalence rates of 10–15 per cent of respondents meeting criteria for problematic usage (Grüsser et al., 2006; Longman et al., 2009). Despite ongoing problems with clear diagnostic criteria, a recent study of adolescents utilised latent class analysis of hours gaming and questionnaire responses to identify a distinct group of addicted gamers from a school population (Van Rooij, 2011). Cravings associated with video gaming addiction have been successfully treated with buproprion (Han et al., 2010). Individuals with gaming difficulties seen in the Centre for Compulsive and Addictive Behaviours are younger than a traditional addiction population. They commonly enter the service following some form of crisis where gaming played a role, usually relating to studies and/or relationship difficulties, and following a visit to a GP and/or IAPT service. It can be difficult to establish alternative social behaviours away from the online world. Gaming is often about competition, achievement and leader boards, but also about affiliation, socialising and peer group relations. Moving a younger person away from this world entirely has presented difficulties which can prove less amenable to a brief CBT intervention.
Internet
Non-specific compulsive internet use is also known as internet addiction disorder (IAD) and pathological internet use. It has been suggested that IAD be distinguished from addiction to things found on the internet, such as gambling or pornography (Griffiths, 2000). Young (1999) separates out ‘cybersexual addiction’ and ‘computer addiction’ (gaming) from ‘cyber-relationship’, ‘net compulsions’ (gambling, shopping) and ‘information overload’ (compulsive surfing). Young’s (1998) pioneering study found ‘dependent’ internet users spent an average of 39 hours a week online compared with 4.5 hours for non-dependents. Surveys have placed rates of IAD at 6–18 per cent (Greenfield, 1999; Rotunda et al., 2003) – although these methodologies are questionable. A single meta-analysis of studies investigating the treatment of IAD identified 16 studies, of which four were CBT, seven counselling and three medical interventions. Larger effect sizes were found for individual over group treatment, female over male samples and older participants over younger ones (Winkler et al., 2013). Individuals addicted to the internet have been rarer in our clinical experience. Those that have presented have had significant social and mental health issues leading to isolation and boredom, or with difficulties that might be better conceptualised as a technological form of procrastination, with a fear of failure as a predisposing cognitive factor.

The internet is a social phenomenon; possibly the largest change to the public’s habits since the appearance of a continuous television service in the 1950s and 1960s. Fears were raised then regarding the effect of excessive television on society, with studies still available in the early part of the current millennia on the subject of television addiction (Kubey & Csikszentmihalyi, 2002). It is unclear whether this shows a consistent vulnerability to compulsive use of technology, or an over-reaction by society and researchers to fundamental changes in the way we live our lives.

Buying
Compulsive buying disorder was historically known as oniomania in the early 20th century. It has estimated prevalence rates of 2–16 per cent of the general population (Black, 2006). Most studies utilise standardised scales such as the Compulsive Buying Scale (Faber & O’Guinn, 1989). Compulsive buying disorder is characterised by pre-occupation with shopping and spending considerable time on this behaviour. It is uncommon that excessive shopping is not associated with excessive spending and the behaviour is associated with an anticipatory urge that only completion of the behaviour can extinguish. A cognitive-behavioural model of compulsive buying has been developed; taking a lead from functional analysis models, it details antecedents, triggers and consequences as drivers to the behaviour (Kellett & Bolton, 2009). CBT group treatments have been trialled for the treatment of compulsive buying disorder and showed significant improvements in buying behaviours over a wait list control group (Mitchell et al., 2006). Few compulsive buyers have attended our treatment service, but those that have attended have presented with a pre-morbid or comorbid depression formulation that underpinned the onset of the compulsive behaviour. A clear working formulation is that the buying behaviour has served as a form of emotion regulation; a behaviour that got out of control and led to irrational decision making and unsuccessful attempts to cease the behaviour. A simple learning theory approach with stimulus control and extinction is difficult given the difficulty in totally blocking any buying behaviour. However, self-monitoring, budgeting, control of credit and other general relapse management methods (Muller & Mitchell, 2011) have proven useful in reducing the harmful behaviours.

Pornography
There are two main reasons why we have chosen to separate out pornography from other disorders in this article. Firstly, it raises questions concerning the use of an addiction model with non-substance use disorders; secondly, it has comprised more than sixty per cent of the referrals to our behavioural addictions service.

In terms of literature, we are again dealing with an immature database. Surveys have suggested that up to 87 per cent of western males have viewed pornography on the internet (Carroll et al., 2008). It is further estimated...
that 17 per cent of individuals who view pornography on the internet meet criteria for problematic sexual compulsivity (Cooper et al., 2000). The problematic use of pornography has been associated with depression, social isolation, damaged relationships, career loss and financial consequences (Schneider, 2000). A recent study has found favourable results from the application of acceptance and commitment therapy with this population (Twohig & Crosby, 2010).

Is it an addiction though? Neurological studies are beginning to appear from reputable institutions and researchers suggesting that brain changes seen in compulsive porn users mimic those seen in addiction (Voon et al., 2014). The website Your Brain on Porn (www.yourbrainonporn.com) certainly presents a worrying picture of a culture exposing young people to easily accessible extreme images, and the effects this may have on the developing brain. However, they choose to skip over some research, such as that by Steele and colleagues (2013) showing no increase in brain stimulation amongst compulsive porn users when presented with sexualised images.

Wood (2007), in a review of pornography and the concept of perversion, argues that to use the term addiction with a sexual dysfunction is to collude with individual denial of deeper conflicts. They ask whether an individual without dysfunctional views on women and relationships would become a compulsive pornography viewer purely on repeated exposure to the stimulus. In our experience, there are people who have benefited from a learning theory approach and maintained a distance from pornography, but there are an equal number that, when asked the right questions, will admit to broader difficulties than just the compulsive viewing of images and videos on a screen.

Why have we seen more porn users than other behavioural difficulties? Does this mean that pornography difficulties are more prevalent in the general population?

Perhaps, however, it is also worth noting that a higher proportion of referrals of porn users came via their GP or IAPT services. Individuals had been presenting at healthcare agencies rather than finding us on the internet. Scores on measures of anxiety and depression were higher, and in assessment individuals would present with greater distress over their difficulty. This was as a result of the guilt and shame experienced; however, it was as often the result of the consequences that the behaviour, or exposure of the behaviour, had on significant relationships.

**Conclusion**

Behavioural addictions, compulsive behaviours, excessive habits – call them what you will, but with the addition of gambling to the new DSM-5, it is likely that other conditions will see increased attention and research funding. Whilst there are voices of concern regarding the ‘addictification’ of society in general (e.g. Smith, 2012), we would support this increased focus on newer addictions. The main reason for this is that individuals do not present to our service as just irritated or annoyed at their behaviour, but rather in severe distress and often suicidal. As to the behaviours themselves, they:

- are used for mood regulation in the context of life difficulties or pre-existing psychological problems;
- are consistent with a conditioning model and respond well to extinction methods;
- bring pleasure when present and irritability when blocked or absent;
- result in significant distress over time;
- continue in the face of knowledge of problems caused;
- exhibited in larger amounts over time; and
- are marked by repeated attempts to stop and relapse prior to engaging in treatment.

With regard to the issue of ‘addiction’ raised in pornography use, we would say that it is no different to any other addiction in that there is often an underlying conflict. In our experience, we have seen that a brief CBT treatment can be helpful for individuals in distress, but longer-term, conceptualisation driven treatment is often required. We would encourage psychologists to be open to these difficulties and to adapt existing treatments for people who present with reports of uncommon additive behaviours. While there remains controversy about whether these conditions exist, psychologists have a role.
to play in getting ‘ahead of the game’ and gaining experience of some of the outliers in addiction. There is a need and treatment works.

Acknowledgement
We would like to thank Jolyon Poole for help with early research on issues discussed in the paper.

References

Authors
Neil Smith, Consultant Clinical Psychologist, Central & North West London NHS Foundation Trust; nsmith12@nhs.net; Ryan Kemp, Clinical Director, Milton Keynes Mental Health Services and Consultant Clinical Psychologist, Central & North West London NHS Foundation Trust; ryan.kemp@nhs.net
Knowing something about the bird: Formulating developmental trauma, its various relationships to substance misuse problems and service implications

Jo Stevenson

Developmental trauma (child abuse and neglect) is strongly associated with developing mental health problems, including trauma related symptoms and substance dependence (Enoch, 2011). This article highlights the importance of formulation and integrated interventions that address this dual presentation.

CHRONIC CHILD ABUSE and severe adversity are associated with multiple subsequent difficulties that are addressed in this article, including neurological deficits, poor physical health, mental health difficulties and interpersonal issues which may continue into adulthood. Children are further disadvantaged by a lack of support regarding learning difficulties and needs in school, a lack of mental health services to address their trauma and attachment difficulties (due to personal attachment style and/or multiple placements). The challenge to service provision for child and adult survivors of developmental trauma is where substance misuse and mental health are intimately entwined.

Formulating developmental trauma
Definitions of developmental trauma can be found on local authority safeguarding websites, but include the experiences of physical abuse, sexual abuse, emotional harm, neglectful care, domestic abuse and/or child sexual exploitation. Exposure to such risk factors can take place in the home, community or institutions in which the child resides, but are unique in that they usually take place in the context of close intimate relationships (Kisiel et al., 2014). However, the subsequent symptoms and difficulties are often complex and fluctuating, with children often assigned a range of different psychiatric diagnoses over the years, which creates another layer of complexity in trying to understand the experience for the child (van der Kolk, 2005). What is clear is that developmental trauma has a pervasive effect on the developing mind and brain, resulting in various diagnoses such as attention deficit and hyperactivity disorders, depression, somatic illnesses, oppositional defiant disorder, conduct disorder, generalised anxiety disorder, separation anxiety disorder, attachment disorders, and impulsive and self-destructive behaviours. The presentation becomes more like post traumatic stress disorder with age (Perry, 2009). However, frequently the child presents with a wide range of behavioural and neurobiological symptoms that do not fulfil a psychiatric diagnosis, resulting in them not being able to access services.

Therefore, the role of formulation has been essential in understanding complexity, rather than implementing a treatment plan based on a possible psychiatric diagnosis (Kisiel et al., 2014). As van der Kolk (2005) has stated previously, formulation remains pertinent to developmental trauma:

‘You can know the name of a bird in all the languages of the world, but when you’re finished you’ll know nothing whatever about the bird… so let’s look at the bird and see what it’s doing – that’s what really counts. I learned very early the
Knowing something about the bird

difference between knowing the name of something and knowing something. ’Richard Feynman, Physicist and 1965 Nobel Prize laureate 1918–1988

Developmental trauma is unique, as it interferes with the sequential developmental tasks, creating new difficulties in each succeeding stage of development, and complicates the clinical picture as the child develops (van der Kolk, 2005; Perry, 2009). The multifaceted sequelae experienced by children when violence, neglect or fear is significant in their early years affects developmental progress across a broad spectrum of developmental areas including cognitive, language, motor, emotional and socialisation (Perry, 2009). An integrated developmental trauma model can help inform an integrated understanding of developmental trauma and substance abuse, and subsequent interventions.

Developmental trauma effects on mental health and substance misuse

There is considerable evidence that severe childhood adversity places an individual at lifelong risk for a variety of problems including mental health, substance dependence, physical health, employment, offending behaviours and interpersonal difficulties (Warren, 1999; Putnam, 2006). The relationship between developmental trauma and substance abuse is examined here in regard to neurobiology, physical health, psychological and social difficulties.

Neurobiology

The plasticity of the developing brain in childhood places it at significant risk from the effects of trauma, as well as potentially being the period of the most effective repair (Perry, 2009). Early trauma has a long lasting effect on the stress response, including increased levels of the stress hormone cortisol, dysregulation in functioning of the hypothalamic-pituitary-axis and loss of inhibition of noradrenergic activity (Brady & Sudie, 2012).

The hypothalamic-pituitary-axis plays a critical role in the stress response and is believed to be involved in the pathophysiology of addictive disorders. In addition, developmental trauma has specific effects on the neurotransmitter systems involved in the positive reinforcing effects of alcohol and drugs, particularly the brain pathway for dopamine (Meaney et al., 2002) and potentially other neurotransmitters such as serotonin (Enoch, 2011). However, it is still suggested that the genetic susceptibility and environmental exposure together increase the risk for substance dependence (Brady & Sudie, 2014).

Children that have survived developmental trauma are more likely to be diagnosed with specific learning difficulties such as dyslexia, dyspraxia, dyscalculia and attention deficit hyperactivity disorder (Beers & Bellis, 2002). The hippocampus is involved in memory functioning, with hippocampal damage presenting in clients with depression and post traumatic stress disorder (Bremer, 2006; Gilbertson et al., 2002; Silva, 2004). Hippocampal volume loss in depression has also been associated with early life trauma (Majer et al., 2010). Developmental trauma survivors may have weaker verbal comprehension skills, and frequently associated reduced working memory functioning (Bremer et al., 1995; Majer et al., 2010). Numerous studies have addressed the issue that Looked After Children achieve less academically in school and are more likely to be excluded as a result of their behaviour issues (Warren, 1999; McAuley et al., 2006). However, the cognitive deficits linked to childhood trauma are not secondary to depression, psychiatric diagnosis or medical illness (Majer et al., 2010).

If survivors of developmental trauma are more at risk of developing learning difficulties, their chances to fulfil their potential will be reduced and their life chances negatively affected. Individuals will be more at risk of attaining fewer qualifications, working in lower paid roles, struggling to maintain employment and being less able to engage in traditional psychotherapies. This will place them at greater risk of social exclusion during adolescence and adulthood, and may negatively affect decision making if experiencing increased stress. Individuals that are socially excluded, struggling to maintain employment and having difficulty functioning are more at risk of presenting in the substance abuse population (Shaw et al., 2007).
Physical health
There are risks to young people regarding their physical health (including liver damage) if they have survived developmental trauma and misuse substances. If children binge drink they are also more likely to be binge drinkers as adults and be alcohol dependent (Drink Aware UK, 2014). Hormone changes in puberty also make young people more likely to take risks, and substances can further impair children’s judgment, leaving them more vulnerable in risky situations regarding physical harm, unprotected sex and alcohol poisoning. If young people abuse substances to make distressing thoughts or feelings stop, they run the risk that substances will interfere with sleep patterns, resulting in sleep deprivation. There are clearly measurable changes regarding physical health that have been noted in adulthood to be as a result of developmental trauma including increased risk of cancer, stroke (cerebral vascular accident), diabetes, skeletal fractures, heart disease and liver disease (Felitti et al., 1998). The relationship of physical health concerns and their management is complex in those with developmental trauma and substance misuse.

Psychological
In the toddler phase (2–7 years) children shift from right hemisphere dominance (feeling and sensing) and an egocentric perspective, as noted by Piaget. Therefore, during this developmental stage children begin to develop thought processes (language and reasoning) to enable different perspectives to be appreciated (Hare & Casey, 2005). Developmental psychologists such as Piaget noted that the process of decentation takes place when the child moves from being one’s reflexes, movements and sensations to having them (Ornitz, 1996). However, developmental trauma interferes with the integration of left and right hemisphere brain functioning, which explains traumatised children’s ‘irrational’ ways of behaving under stress (Perry, 2009; van der Kolk, 2003). Substances are frequently used by young people that are survivors of developmental trauma to self-medicate their mood by relieving anxiety or depression (Brady & Sudie, 2012). At times they are used to promote a sense of wellbeing and confidence before undertaking a task. However, by relying on the substance the young person is losing an opportunity to master new skills and increase confidence in coping. Developmental trauma, or prior deficits that manifest themselves during adolescence, in absence of sustaining relationships (adults or peers) may lead to disruptions in self-regulatory (eating disorders), interpersonal mutuality (conduct disorders), reality orientation (thought disorders) or combinations (personality disorder and addictions) (Perry, 2009).

Unfortunately, the risks regarding mental health increase with the presence of substance misuse for our young people. Instead of substances providing relief from negative emotions or thoughts, they can create increased levels of anxiety, depression and other negative emotions, resulting in social withdrawal or impulsive behaviours such as suicidal behaviours. Developmental trauma can leave a child out of touch with their feelings and with no language to describe their internal world. Dissociation is also a common unconscious coping strategy in response to abuse, but this can become habitual or sought through misuse of substances to escape distressing thoughts and feelings.

Socialisation
What is so challenging for the child is that at the time they are being abused by those closest to them, they also frequently lack a meaningful available attachment figure that can help them make sense of their experiences. This results in insecure attachment styles and disorders which affect how the child perceives themselves, experiences others and the process of relationships (Howe et al., 1999). Howe sums up this dilemma well by stating that: ‘The world of relationships is both the problem to be solved and the means to its solution.’ This vulnerability status makes abuse and neglect experiences more common and less likely to be noted. If the child experi-
ences closeness in relationships it can feel challenging for them, so sometimes substances are used to create a level of intimacy (Brady & Sudie, 2012). Sometimes substances can help individuals relax in social situations more, or help them feel more competent and desirable. However, dependence can develop through personal reliance as well as social group membership.

Reflections and challenge
Revisited formulations that inform our ongoing care plans for our clients can ensure that their needs are being best addressed, and that therapies are appropriately focused. It is important that cognitive deficits should be addressed in the care plan for survivors of developmental trauma, whether they are seen as having mental health problems or not. The earlier that interventions take place, potentially the greater reduction in the effect of the memory difficulties and subsequent learning issues for children and adults (Majer et al., 2010), resulting in greater ability to access psychotherapies and improving functioning. Integrative psychosocial interventions have been developed to address trauma symptoms and substance use disorders simultaneously (Back, 2010). In contrast to the ‘sequential model’ affirmation that trauma interventions were inappropriate until after a client has been abstinent from alcohol or drugs for a sustained period of time, an integrative model has shown that rates of relapse are not increased by the introduction of therapy for trauma (Kiesel et al., 2014). Brady and Sudie (2012) stated that unprocessed trauma symptoms may actually drive substance misuse into middle adulthood, through continuation of earlier substance problems, suggesting the need for interventions throughout the life course.

Therefore, attending to and treating the trauma related symptoms early in the process of therapy may improve the chances of long-term recovery from substance misuse. This is recommended whether the client is a child or adult, because the plasticity of the developing brain means that the earlier intervention can take place the better chances of repair (Perry, 2009). Kiesel et al. (2014) report on a developmental trauma model being implemented in North America that addresses developmental trauma risks through psychoeducation of staff and carers, establishing trauma-focused community-based health teams and trauma informed leadership teams to make longer lasting changes to services. Therefore, the negative effects of developmental trauma and the maximum level of repair possible are addressed earlier, reducing risk of, and improving management of, substance misuse. As Najavits (2002) states: ‘Integration is ultimately an intrapsychic goal for clients as well as a systems goal; to “own” both disorders, to recognise their interrelationship, and to fall prey less often to each disorder triggering the other.’ Therefore, the challenge for commissioning in the UK of services for clients regarding developmental trauma and substance abuse is to explore more integrative approaches for services that embrace complex formulation.

Author
Jo Stevenson, Consultant Clinical Psychologist, Children’s Services, Norfolk County Council; jo.stevenson@norfolk.gov.uk; Independent Expert Witness; drjostevenson@sky.com

References


---

**EMDR Training in the UK**

EMDR is successful in treating Post-Traumatic Stress Disorder and many other clinical conditions in which adverse life events are a significant component. Add this effective, NICE and World Health Organisation recommended evidence-based therapy to your existing clinical skills.

**Four-part trainings commencing with Part 1 at:**

**Bristol:**
- 5-26 February 2016
- 21-22 April 2016

**Edinburgh:**
- 28-29 January 2016
- 7-8 April 2016

**London (University of London):**
- 12-13 November 2015
- 7-8 January 2016
- 10-11 November 2016

All courses are fully accredited by EMDR UK & Ireland and EMDR Europe

[www.emdrworks.org](http://www.emdrworks.org)

Tel: 020 8441 2457

Email: admin@emdrworks.org
Inanimate attachments, dangerous desires: A psychodynamic view of addiction

Martin Weegmann

A puzzling absence at the heart of the psychology of addiction is the (relative) absence of contemporary psychodynamic perspectives. This paper gives an overview of the ways addiction can be conceptualised psychodynamically and outlines some of the advantages of psychodynamic understandings in formulation and treatment.

GOOD, contemporary psychodynamic models of addiction do exist such as: (i) Phil Flores’ (2004) use of attachment theory, ‘Addiction as an attachment disorder’; (ii) Edward Khantzian’s (1999) conceptualisation of addictive vulnerability, suffering and self-medication; (iii) the self-psychology approach of Levin (1991) and that of a small group of British practitioners developing pragmatic, modern dynamic approaches (Weegmann & Cohen, 2002; Reading, 2002; English, 2009; Sweet, 2014). In addition, therapies for borderline personality disorder (BPD), such as mentalisation-based treatment and dialectical behaviour therapy, have clear applications for substance misuse, given that addiction, like BPD, seriously undermines reflective self-function and causes atrophy in skills of self-care and regulation. As argued by Weegmann and Khantzian (2011), addiction can be similarly seen as a disorder of self-regulation. However, in the standard, somewhat de-personal language of ‘psychosocial interventions’ in substance misuse, psychodynamic approaches are seldom mentioned. This is regrettable, for several reasons:

- How practitioners work and how a client perceives us will differ; rational and non-rational, conscious and unconscious aspects are involved.
- Who we represent has significance in the internal worlds of our clients, beyond our control. Unconscious mental life is precisely about internal working models of the world and others, and a client’s ‘emotional conclusions’, as derived from life experiences (so far).
- All psychosocial approaches need an understanding of human unpredictability, complex (indeed contradictory) motivations, and varied sources of resistance to change.

Much responsibility for the neglect lies in the unhelpfulness of earlier, psychodynamic accounts, often based on single or small samples and expressed in reductive language; however, in the context of their eras they were also beginning. The relative lack of experience by psychotherapists with addicted persons is another factor, and relative absence of formal research is a major issue. Contemporary psychodynamic therapists with extensive experience in the field are often more active and interactive, less dependent on interpretations and more focused on affective life, self-regulation and interpersonal relations, with a premium placed on the therapeutic alliance.

Psychodynamic approaches help in at least three ways, as described below.

Formulation

Human life is complex and no single type of formulation or language can ever capture its
nature; something always escapes. Formulations can be thought of as working efforts (or ‘drafts’), that conceptualise disturbances in living, as derived from observation, theory and professional experience. Many dramas of human life are present in the addictions, including loss of health, dignity and social standing; damage to relationships and prospects; and seriously reduced repertoires of coping. As to the power and hold of addiction, there are simply ‘many reasons why’.

Psychodynamic case formulation adds depth, alongside other perspectives, and alerts us to the multiplicity – indeed contradictions – of self. It helps us conceptualise the chaotic nature of internal worlds and the person’s relationship with their drug(s) of choice, which acts as an inanimate container. Formulation includes understanding the paradoxical hold of addictive ‘solutions’. The suffering alleviated and caused by drugs addiction is itself a traumatising disorder-defensive complexities of self (I call them ‘extraordinary protections’) and the oscillations between different parts of the self. What is the nature of the person’s relationship to risk, to their dangerous desires, and how they fend off awareness of what they are doing? Formulation should also include strengths and potential interests which, damaged by using, can be re-built in recovery. Attachment formulations are helpful in explaining how ‘addictional bonds’ replace ‘affectual bonds’ (Reading, 2002); conversely, how are addiction attachments replaced by human affiliations, in recovery, from inanimate containment to social connection? If addiction is the ultimate ‘negative attractor’, how are new connections, activities and investments self-created? The self-medication hypothesis of Khantzian (1997) helps us comprehend how a person offsets the painful affects that are difficult to manage with drug-created states that feel at the time, paradoxically, more under their control. The self-medication hypothesis conceptualises addiction as a disorder of self-regulation. Finally, self-psychology helps us understand

...the addicted person is increasingly caught in patterns of enactment that bypass human distress...
ferring individual behind the disorder and support clinicians in practising that difficult art of ‘prolonged empathic immersion’. I have also argued (Weegmann, 2011) that psychodynamically-informed understanding provides us with a rich resource in terms of approaching the fast acting life and interactions of the therapy group, including those groups that are not analytic in aim.

**Psychoanalytic psychotherapy**

There is a continuum from short-term, goal-directed psychoanalytic psychotherapy to long-term and open psychotherapy; from the ‘supportive’ to the ‘expressive’ (or more exploratory) ranges. But all psychotherapy is premised on encouraging greater reflective capacity and in trying to contain the inevitable setbacks, impasses and ruptures which occur. Psychoanalytic psychotherapy needs to be calibrated to ‘stages’ of recovery, and the differing needs of the addicted person, from phases of active using to early, medium- and long-term recovery (Kaufman, 1994). Like Flores and Khantzian, I favour a supportive stance throughout treatment, including goal clarification, relapse prevention, abstinence maintenance and strategies to support the building of self-efficacy. Secure attachment creates growing confidence in self. However, emotional life is seriously blunted and stunted by addiction, with empathy for self and others damaged and truncated. Most clients simply need time to know themselves again as sober people, and to deal with unaddressed gaps and needs. It is important for other clients to address and begin to repair the impact of difficult or disastrous early relationships and other neglect in growing up. Encouraging a therapeutic conversation between different parts of the self, in contradiction, such as the ‘addict’ and the ‘person wanting change’, is critical. We should never underestimate how formidable the challenges are where there have been major life ruptures to trust and broken security, and in this respect recovery from substance misuse can be likened to a form of ‘post-traumatic growth’. One client told me: ‘I spend my life trying to climb out of a hole that was dug in my family… oh, and I dig many more by myself. As a result, my life feels like one huge, empty thing.’

I encourage the building of an active circle of support, taking many forms, such as fellowship groups and other social and therapeutic resources. With greater confidence in self, responsibility and improved flexibility of defences, including critically time away from using (‘time heals’, but not by magic), more aspects of a person’s life can be explored if they are willing. New narratives of self are essential, as individuals move beyond the ‘spoiled’ identity of drug using. Trajectories of change are not linear – the course of true therapy never ran smooth – and therapists need considerable experience, tact and timing to foster such change. Like all areas of mental health, stigma is amply present in response to addictions, which we ourselves need to unlearn or be aware of. Psychologists need to feel an affinity with the client group – not all psychologists are suited, and nor should they be.

**Helping the helpers**

All societies have intoxicants and we all have a relationship to drugs and alcohol, even if relatively few people become addicted. One of the first questions that I explore with trainee psychologists is connotations of drug/alcohol use within their own culture, family, peers, and so on. It is one way of exploring the ‘social unconscious’, and helps in clarifying our pre-reflective attitudes, prejudices, and so on.

Reflective practice in the wider sense encourages practitioners to stand back from immediate work pressures, observe the impact of those pressures and consider obstacles – within themselves – to better contact, care and understanding. Psychodynamic thinking is an aide to such ‘health checks’. A disorganised team mirrors a chaotic client group. The deficits in self-regulation at the core of addiction pose a threat to the individual therapist as well as general reflective team function (i.e. maintaining a thoughtful, considered response); demands for action and immediate response are a challenge to containment.
Toxic emotions can and do infiltrate teams and spread, so how teams attend to their own self-care is important; a kind of ‘emotional detoxification’ is often required, not only in response to specific incidents (e.g. violent incident, abuse, death of a client, etc.) but in response to cumulative stress. I offer formal and informal support to colleagues in response to crisis and strain (e.g. death or violent incident) and as preventive therapeutic practice, to avert unseen, accumulated stress and unconscious acting out in response to client disorganisation. Worker cynicism easily takes hold, along with other ‘parallel’ responses; we too are drawn into negative therapeutic cycles. Of course, many other factors act as burdens, increasingly so (e.g. overly risk-averse practice, mounting documentation, commissioning pressures, transfer of services to new providers). Tendering of services creates inevitable threats to existing teams and individuals, and how we build supportive and effective teams in such circumstances is a real challenge. Lamentably, bureaucratic and procedural layering can and does increase distance between workers and their clients.

Recovery: ‘An inside job’

Recovery is a process, not an event; and it is provisional, not guaranteed. Psychologists are important theorists of change and I concur with William White’s (2008) advocacy for a science of recovery from addiction.

If addiction is a disorder of self-regulation (inability to regulate emotions, reduced self-esteem and self-care, and damaged relationships) then recovery is the converse of this. Here, for the sake of brevity, are some general principles:

- Attachment based psychotherapy can help those with substance misuse to move from objects of addiction to normal attachments and healthy affiliations, and thus open up vital new pathways of learning.
- Clients in recovery need active support to (re-)experience and feel comfortable with sobriety. Addiction is intensely self-reinforcing, over-learned behaviour, whilst abstinence is unfamiliar, disorientating and frightening.
- Addiction and addiction lifestyles are in themselves traumatising and disconnecting. Recovery involves the building of a viable, non-using identity and a new narrative.
- Emotional reparation, to self and others, is critical as part of rebuilding shattered selves. Narrative competence and confidence in one’s inner and external life are important anchors of change.
- Insight is not enough; indeed, insight usually results from change rather than the other way round.
- Implicit memories around drug use, euphoric recall, etc., need modification. New memories, or access to older ones, not associated with drugs, are part of recovery.
- Improved regulation of self, emotion and relationships are critical treatment goals, according to the self-medication hypothesis. Improved reflective self-function is an outcome of change. Vulnerabilities and/or deficits must be addressed.
- Psychotherapy is not an intellectual exchange.
- Exaggerated emotional neutrality on the part of the therapist is unhelpful. The therapist aims to provide optimal responsiveness, feedback and repeated experiences of safety from which a client begins to trust their experiences again and explore choices in life with more security.
- Early damage is hard to repair, protected as it is by formidable psychic defences and compensations; more recent shame, humiliation and hurt, likewise. Considerable time is required, often over several treatment episodes, for individuals to work through disruptions in their lives and alienation from self and others.
- Painful, inaccessible, labile and confusing affects are at the core of addictive suffering. Emotional damage (e.g. alexithymia (no words for emotions)), dissociated states, exaggerations of affect (e.g. rage) and excessive emotionality (flooding) are hard to address and at best can only repair slowly. Recovery aims
at helping clients to better know their inner life and provides ‘know how’ in order to draw upon self-protective and nurturing capacities.

According to self-psychology and other approaches, people need to feel actively mirrored and confirmed in taking steps to change, however small they may appear. Therapeutic experiences hopefully provide successive opportunities for healthy mirroring and modelling of how to cope safely.

On the theme of recovery, I finish with two quotes. Firstly, that of a leading psychodynamic expert in the field:

‘Addiction is a disorder in which those suffering from it are unable to regulate their lives. Contemporary psychodynamic treatment, in the context of a supportive, interactive and empathic engagement with an attuned therapist, fosters an exploration, understanding and resolution of the self-regulation difficulties that predispose to and maintain addictive behaviour. Understanding and feeling understood are powerful antidotes to and correctives for the suffering, confusion, shame and chaos that predispose to and result from addictive disorders.’ (Professor Edward Khantzian, personal communication)

Finally that of Sally, talking in a six month follow up interview about psychotherapy and recovery, which had remained grounded and strong:

‘Consistency was really important. Needing to know that someone was interested, and committed to me, and not going to buckle from what I was saying – I’d gone through too much in my life without another person turning away. At first I had no idea that you (the therapist) would have any comprehension of my life, even a clue, or have any sort of consistent interest, but you did. I had to work very hard, and I think you (the therapist) did as well, in fact I know you did. I also had to accept care from others who matter to me and not be the one pushing them away either. I had burned a lot of bridges, lost lots of trust and could not trust myself when I was out there using. You (the therapist) used to say, “You know psychotherapy is just like a college for emotions and living”, which is true. So I can say I was ready to leave and take the learning with me. I have support now, know when I need to ask for help, and am so enjoying waking up sober.’

Author
Martin Weegmann, Consultant Clinical Psychologist and Psychotherapist, NHS and Independent Practice; weegmann.martin@gmail.com

References


Notes from the Chair

Richard Pemberton

Please vote
YOU SHOULD have received the call for nominations for a number of key DCP national executive positions. The next few years are going to be a defining time for clinical psychology, the DCP and the Society. We need really strong leadership to help chart the way forward. If you are tempted, please throw your hat in the ring. You would be joining a great UK-wide team and if elected would be in a position to help take the profession forward. We would particularly welcome nominations from people from minority backgrounds.

Recompense
The Society’s trustees, at their last meeting, failed to agree a new recompense policy. They will be discussing it again at the their March meeting. We have asked for the existing arrangements attached to roles to be rolled on for another year whilst the policy and its implementation is agreed. This is a key issue for the division as we have to be able to attract, from all levels, leading members of the profession into our executive positions. In order to achieve this their employers need to be adequately recompensed for their time. This is not rocket science.

Presidential election
If my soundings are correct, there may be an election for the next Society President, and you will shortly receive the voting papers. Peter Kinderman becomes President in April and the election is for the person to replace him in 2017. Please take an interest in this election and use your vote. The Division’s ability to function effectively will in large part be determined by the Society continuing to make progress, increasing its offer to members and raising its profile and contribution across all four nations and care groups.

Our 2015 Annual General Meeting
This was another lively and packed affair. My annual report can be found on my blog (richardpemberton.wordpress.com). Our membership numbers and finances are holding up well. We still have significant funds in reserve and we are thus able to support a raft of new projects and initiatives.

We need to increase our recruitment of new or returning members. I am particularly interested in the twenty percent of practising clinical psychologists who aren’t members. Some of these are in leadership positions in the NHS and our training community. Serious professions don’t treat membership of their professional body as an optional extra. We also need to improve our offer to newly qualified psychologists who are starting their careers at a time of increased demand. Many are having to manage increased expectations in the context of weakened supervision and support structures.

Motions tabled at the AGM
Members asked to raise two motions from the floor. The constitution does not allow for motions to be raised in this way, so there was a brief discussion followed by an agreement to discuss the issues at the next Executive meeting with a view to raising formal motions at the next General Meeting that we will be calling in April or May. The first of these pertained to Mike Wang’s presentation pro-
posing that a new clinical psychology organisation is formed outside the British Psychological Society. The Executive will take advice about whether or not the constitution allows us to consider this issue at a DCP General Meeting. The second motion pertained to reinstating the Faculty of Race and Culture. We held an indicative vote on the Faculty of Race and Culture proposal. A number of people voted in favour of the motion; a large majority of people abstained. No one voted against. We agreed to take the motion to the next DCP Executive meeting for reconsideration.

**Co-options**

Simon Gelse thorpe and Shelagh Rodgers were co-opted onto the Executive as interim Honorary Treasurer and Member Services Director respectively. Both will be reviewing these roles and suggesting changes to them. We have also refreshed the role profiles of the UK and England Chair posts. These can be found on our website (www.bps.org.uk/dcp).

The 50th Birthday Annual Conference was a big success. Great speakers, passionate debate, lots of young and aspiring members of the profession. It was a particular pleasure to help launch the *History of Clinical Psychology* monograph. The room was full of past division chairs and Society presidents. Tony Black, who was at the first ever DCP meeting, opened the proceedings. Peter Mittler spoke at our conference dinner, alongside Anita Raman, our outgoing Pre-Qualification Group Chair. She is now a first year trainee. There were too many to mention by name but it was great to have the likes of John Hall, Glenys Parry, Mike Wang and Graham Turpin at our celebrations and contributing fully to the conference proceedings.

**Inclusivity strategy**

Our new inclusivity strategy was launched at the annual conference and later this month in Birmingham we are holding our first annual inclusivity event ‘Inclusivity: Going beyond lip service’ (www.bps.org.uk/events/inclusivity-going-beyond-lip-service). It will be put more flesh on the bones of the strategy the DCP is as equally committed to tackling diversity and discrimination issues around race, sexuality, age and disability. We are keen to prevent silo working and grasp the nettle of intersectionality. We need members to step forward to help move this agenda forward. We are not prescribing the structures and work streams that will emerge. We are consulting members and the people who use our services as to what they want the Division to do and what networks and events will best meet their needs.

**Future conferences and events**

It isn’t confirmed yet, but it is likely that the next annual conference is going to be in January 2017 in Liverpool. We are critically reviewing our conference events and looking at how we can involve more members in them and stream more of the proceedings out live and on social media. If you have views or ideas about what type of events and conferences you want, please feed them into me or your local DCP representatives. We have been approached by the Social Psychology and Qualitative Methods sections to see whether we are interested in a joint stream at the conference. The AGM and keynote presentations will be accessible from our website, hopefully by the end of this month.

**And finally…**

Due to space limitations, the Christmas break and so forth, that’s all there is time and room for this month, but you can read the full version of this report, including items about the Hoffman report, Experts by Experience, classification, future training arrangements, strengthening our unions’ profile, and some good news on Band 7 posts, on my blog at richardpem berton.wordpress.com.

**Richard Pemberton**

*Chair, Division of Clinical Psychology*

dcpukchair@gmail.com; Twitter: @socratext
Run by therapists, for therapists, we’ve got you covered.

Here when you need us, we’re a not-for-profit organisation run purely for the benefit of our members. PPS Members benefit from:

• Quality, competitive Professional Protection & Public Liability Insurance
• Access to our Discretionary Trust Fund for when unforeseen circumstances arise
• FREE therapy-specific advice & support from experienced fellow professionals
• FREE legal helpline
• FREE CPD events

Don’t risk facing complaints alone. To find out how we can protect you as you practice, contact us to request a no obligation callback.

T: 0333 320 8074
E: enquiries@ppstrust.org
W: www.ppstrust.org

*Price valid for new memberships starting before 31/12/2016
Division of Clinical Psychology Contacts

National Officers
Chair Richard Pemberton – chair_dcp@bps.org.uk
Honorary Treasurer Steven Coles – dcptreasurer@bps.org.uk
Director, Membership Services Unit Cath Burley – cathburley@hotmail.com
Director, Professional Standards Unit Stephen Weatherhead – s.weatherhead@lancaster.ac.uk
Director, Policy Unit England Position vacant
PR & Communications Lead – Vacant
Chair, Conference Committee Anja Wittowski – anja.wittowski@manchester.ac.uk
       Dougal Hare – dougal.hare@manchester.ac.uk
Interim Leadership Group contact c/o Helen Barnett – dcpsuclc@bps.org.uk

Service Area Leads
Adult – Vacant
Child Julia Faulconbridge – dcpchildlead@bps.org.uk
Clinical Health Angela Busittil – dcpcclinicalhealthlead@bps.org.uk
Learning Disabilities Julian Morris – dcpldlead@bps.org.uk
Older People Reinhard Guss – dcplorerpeopleslead@bps.org.uk

Devolved Nations
Scotland: Ruth Stocks
       ruth.stocks@ggc.scot.nhs.uk
Wales: Beth Parry-Jones
       beth.parry-jones@wales.nhs.uk
Northern Ireland: Ciaran Shannon
       ciaran.shannon@qub.ac.uk

English Branch Chairs
East of England: Sue Pullan and Gillian Bowden
       dcpeasteng@gmail.com
East Midlands: Mary O'Reilly
       mjo11@le.ac.uk
London: Zenobia Nadirshaw
       zenobia.nadirshaw@gmail.com
North West: Lee Harkness & Kathryn Dykes
       dcpnorthwestchair@hotmail.co.uk
South Central: Judith Samuel
       Judith.Samuel@southernhealth.nhs.uk
South East Coast: Adrian Whittington
       Adrian.Whittington@sussexpartnership.nhs.uk
South West: Annie Mitchell
       annie.mitchell@plymouth.ac.uk
West Midlands: Jurai Darongkamas
       jurai.darongkamas@sssf.t.nhs.uk
Yorkshire & Humber: Simon Gelsthorpe
       simon.gelsthorpe@bdct.nhs.uk

Pre-Qualification Group
Anita Raman & James Randall-James
       dcppqc@bps.org.uk

Faculty Chairs
Children, Young People & Their Families:
       Julia Faulconbridge
       dcpchildlead@bps.org.uk
Psychology of Older People: Reinhard Guss
       dcplorerpeopleslead@bps.org.uk
People with Intellectual Disabilities: Julian Morris
       dcpldlead@bps.org.uk
HIV & Sexual Health: Alex Margetts
       a.margetts@gmail.com
Psychosis & Complex Mental Health: Che Rosebert
       drcherosbert@gmail.com
Addictions: Jan Hernen
       jan.hernen@turning-point.co.uk
Clinical Health Psychology: Dorothy Frizelle
       dorothy.frizelle@bthft.nhs.uk
Eating Disorders: Amy Wicksteed
       amy.wicksteed@shsc.nhs.uk
Melanie Bash
       melanie.bash@ntw.nhs.uk
Forensic: Kerry Beckley
       kerry.beckley@lpft.nhs.uk
Oncology & Palliative: Vacant
Leadership & Management: Esther Cohen Tovee
       esther.cohen-tovee@ntw.nhs.uk
Holistic: Jane Street
       jane.street@swlstg-tr.nhs.uk
Perinatal: Helen Sharp
       hmsharp@liverpool.ac.uk
Contents

Regulars

1  Introduction – Within and between: Understanding and treating addiction problems in diverse clinical settings
Paul Davis, Ryan Kemp & Luke Mitcheson

4  Ethics Column – Addiction and multi-party ethical responsibility
David Pilgrim

8  Pre-Qualification Group Column – Substance misuse and older people
James Randall-James & Kim Edwards

54  Notes from the Chair
Richard Pemberton

Articles

13  Responding to families affected by alcohol and other drug problems
Alex Copello & Kathryn Walsh

18  Psychological trauma in an addictions population: A case note and self-report comparison
David Curran, Elissa McLaughlin & Mairead Kelly

22  An introduction to behavioural couples therapy
Andre Geel

26  Substance misuse and special groups
Adam Huxley

30  In case of emergency, take the (12) Steps:
A clinical psychologist’s view of Alcoholics Anonymous
Mani Mehdikhani

35  Reflections on implementing an enhanced psychosocial treatment package to opiate users in the community
Louise Noronha & Isabel Sweetman

40  Behavioural addictions? Evidence and reflections
Neil Smith & Ryan Kemp

44  Knowing something about the bird: Formulating developmental trauma, its various relationships to substance misuse problems and service implications
Jo Stevenson

49  Inanimate attachments, dangerous desires: A psychodynamic view of addiction
Martin Weegmann