You Can Do It!: Psychologists as Frontline Providers of Addictive Behaviors Therapy

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"What does it take to be a good addictions counselor?" This is a question I've often asked supervisees and students. The simple answer is: BE a good counselor! Many psychologists and allied professionals do not realize that they possess the required skills to help people overcome addictive behaviors; they may assume that a client with an addiction problem needs to be referred to a specialized addiction treatment program, under the misconception that such programs provide a novel treatment that would be different from what they themselves would be able to provide. Certainly, group counseling is a hallmark of residential and intensive outpatient programs. But that's just a modality of service (and not shown to be any more effective in helping people overcome addictions than individual therapy). The para-professional addictions counselors and graduate-level therapists affiliated with addiction programs, if trained properly, provide various types of psychotherapy. Contemporary treatment programs often advertise that they offer evidence-based therapy such as motivational interviewing, CBT, DBT, EMDR, ACT, and Seeking Safety. In addition, they typically offer some form of family therapy, and various ancillary services like equine therapy or art therapy. Over the past 15-20 years, a commonly used buzzword used when marketing addiction treatment programs is "individualized therapy."

Like the title of book by distinguished addictions psychologist, Dr. Tom Horvath, Sex, Drugs, Gambling & Chocolate (2004) indicates, addictive behavior takes many forms. Addiction has very little to do with the drug or activity, and has a whole lot to do with the *relationship* the person has with that drug or activity. This fact often gets lost in the mainstream conversation about addiction, particularly when the focus is on some form of drug crisis, the current example of which is the Opioid Epidemic. Various drugs take center stage in the news media at different times, and then recede until their time in the limelight returns; examples of these over the years have been methamphetamine, crack cocaine, and marijuana. The problem with focusing on particular drugs is that it puts the focus of attention on the drug, thus demonizing the drug itself, and the solution to the problem takes some form of eradicating the demon (Szasz, 2003). This can take the form of condemning drug sellers (both "pushers" and pharmaceutical companies), trying to

prohibit access, and using scare tactics when reporting the dangers of the said drug. These scare tactics continue to be used, even by mental health professionals, with regard to prescribed opiates and benzodiazapines on the one hand, to medicinal or recreational marijuana on the other, often couched in the language of scientific discovery. With so much attention on drugs being the cause of addiction problems, it is no wonder that therapists assume that knowledge about drugs, and some unique way of working with people who have drug problems is required.

COGNITIVE SURPLUSES VS. COGNITIVE DEFICITS

In cognitive therapy, one way of conceptualizing client's problems is in terms of cognitive deficits or cognitive surpluses. Cognitive deficits denote a lack of knowledge about a particular phenomenon, as opposed to cognitive surpluses, i.e., having too much knowledge about a phenomenon. This concept applies to therapists' beliefs about working with clients with addictive behaviors in that many therapists assume they have a cognitive deficit (not having the skills or understanding to work with these people), when in fact they are more likely to have a cognitive surplus (believing that a different set of skills and knowledge then they have is required).

In his *magnum opus* on the psychological underpinnings of addiction problems, psychodynamically-oriented psychiatrist, Leon Wurmser (1978) goes into great detail about a wide range of psychological problems that create the framework for addiction to exist. [Similar perspectives are highlighted by Kaplan and Wieder in their book, Drugs Don't Take People, People Take Drugs (1974).]Historical perspectives on addictions treatment underscore the need for addressing the psychological aspects of addiction, i.e., a focus on the person using the drug and not the drug itself, in order to solve the problem. , Miller and Brown (1997) also attempted to shift this balance from cognitive deficits to surpluses by identifying the research that supports why psychologists are well suited to address addictive behaviors with their clients. The bottomline is that if you are a good therapist, you are likely to be a good therapist for clients who have addiction problems.

DO YOU NEED TO KNOW MUCH ABOUT DRUGS?

The short answer is no. While some knowledge of drug effects, withdrawal effects, and risks of use can be helpful, knowledge of specific drugs and their effects is not central to helping people overcome drug addiction. It is much more important to be a skilled listener, who can get their clients to confide in them their experiences of use, withdrawal, and anxiety about quitting or moderating their use. Understanding the client's personal experience of drug use and how that has impacted their life from their perspective, i.e., the *relationship* they have with the drug, is important to understand, in order to help them

make changes in that relationship. A client can have different relationships with different drugs, some of them problematic relationships, some, beneficial, and often, mixed.

PERSONAL EXPERIENCE WITH ADDICTION

The belief that a counselor with personal experience with addiction is better suited to providing addictions counseling continues to persist both in mainstream society and in the helping professions. Indeed, some clients may come to counseling with the belief that a counselor with his or her own history of addiction will understand them better. There is, however, no evidence supporting this belief, or indeed that having a personal history of addiction can yield stronger therapeutic alliances with clients with addictions problems or better treatment outcomes. ,

Having a personal history with addiction can, in fact, complicate the therapeutic relationship; first, the therapist's experience could have been quite different from client's, despite superficial similarities in their stories. Second, the assumption that the clients' experience is so similar to the therapist's can confound assumptions regarding the client's level of motivation to change and the goals and tasks from treatment. Over-identifying with the client can lead to countertransference wherein therapists become *less* effective, due to their personal history. All mental health workers need to be aware of their own countertransference issues as they emerge. Para-professionals may have a lower level of formal training and thus be less familiar with the concept and experience of counntertransference, and how it can manifest in their work with clients. That is not to say that therapists with a history of addiction themselves cannot be good addictions counselors, but that they need to be insightful regarding the boundaries between their own stories and that of their clients'. Therapists without a history of addiction themselves, may be better able to pay attention to their clients' phenomenological perspective without the constraints of over-identification.

WHAT TYPE OF THERAPY WORKS?

The therapeutic approaches that works to help client overcome addictive behavior is the same ones that facilitate other changes in clients. Different therapeutic modalities and approaches resonate with different clients, and just like in therapy with clients with other problems, therapists must find the ones that best suit what a particular client needs. As captured in the title of Bohart and Tallman's (1999) book, *How Clients Make Therapy Work*, it is not what we offer, but what clients do with what we offer.

As a general basis for helping clients through the change process of overcoming addictive behavior, the Transtheoretical/Stages of Change Model proposed by Prochaska et al. (1992) can be instructive in conceptualizing clients' psychological level of change

readiness along with the approaches appropriate to that level. A basic approach would be to use a Motivational Interviewing (Miller & Rollnick, 2013) approach for clients who are ambivalent about changing their behavior, and subsequently using a cognitive behavioral approach to relapse prevention (Marlatt & Gordon 1985) for clients who are actively making behavior change. Research indicates that Motivational Interviewing used tohelping clients resolve their ambivalence about change is enough to put them on track to overcome addiction, without requiring the skills training component of CBT. Psychodynamic approaches may also be effective in helping clients work through the underlying processes that sustain their addiction.

CO-OCCURRING DISORDERS

This is an area in which well-trained and experienced therapists are at a great advantage in helping people with addiction problems. Helping clients to develop and sustain motivation to overcome addictive behavior, and developing the skills to succeed is vitally important. All problems that clients bring to therapy are emotion-based problems (both intrapersonal and interpersonal), and this included addictive behavior. The hallmark of addiction is that it serves to change how the person feels in the moment; typical reasons for engaging in the addictive behavior include wanting to improve a sad or depressed mode, enhance a good mode, avoid withdrawal symptoms, overcome anxiety, and so forth. In each case, it is always a choice that is based on prioritizing current feelings versus consequences, both immediate and long-term.

Given the centrality of emotion in addictions, helping clients with emotional regulation is a key component to relapse prevention. All forms of therapy have ways of helping clients achieve better balance in their emotional regulation. Psychodynamic approaches that address anxiety and defenses, cognitive approaches that teach the connection between beliefs and feelings, behavioral approaches that instruct how behavioral activation affects mode, and humanistic approaches that provide experiential therapeutic opportunities for clients to connect with their feelings in session and develop more tolerance of those feelings.

YOU CAN DO IT!

As a good therapist, you know the importance of forming a solid therapeutic alliance with your clients that involves collaborating on the goals and tasks of therapy, and creating a strong bond. These are the same components that are necessary in helping clients overcome addictive behavior and become more psychologically stable. What do you imagine a client's response would be if you unilaterally determined the goals and tasks for them to change a problem that they aren't certain they have? Would you expect them to have a strong therapeutic bond with you? Of course not. Yet, traditional addictions

counseling has maintained that template. Goals are predetermined (abstinence being the goal expected of all clients who enter most addiction programs). Tasks are predetermined, often involving required attendance at both group counseling sessions and outside support groups. Consequently, the therapeutic bond can be weak when counselors take the opposite of a collaborative approach. With such failure in attending to the importance of the therapeutic alliance, is it any wonder that addiction "treatment" is often not effective ? Therapists who understand the importance of the therapeutic alliance and are willing to work collaboratively with clients, understand clients from their phenomenological frame, and can offer assistance in emotional regulation are in the best position to help people overcome their addictive behavior.

Does that describe your approach to practice ? If so, then you are likely to be an excellent resource for clients seeking recovery from addiction!

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