Professionals' discourse on relapse in addiction

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THE HISTORY OF ADDICTION has been marked by a series of conflicting ideas regarding the true nature of the phenomenon (Volpicelli et al., 2001) and the term 'addiction' remains contested (Clark, 2011). However, the proposed reintroduction of the term 'addictive disorder' in *DSM-5* and the inclusion of behavioural addictions under this umbrella is testament to its continuing functionality. The concept of addiction as a chronic disorder, or a 'state' (Davies, 1997), requiring long-term management has been widely disseminated within the substance misuse treatment field (Volpicelli et al., 2001). However, more recently career models of addiction have been proposed (e.g. Clark, 2011) suggesting that addiction may be viewed as something that people do rather than something that happens to people (Davies, 1997). The linking of the term addiction to the abuse of substances favoured the dominant disease approach but more recently research has discussed the value of conceptualising a number of behaviours as potentially, facilitating the flourishing of a number of social psychological models that depart radically from the medical model and the disease concept.

To date, addiction is understood through four models or constructs including: the disease/medical model; the psychological model, influenced primarily by psychoanalytic thinking and more recently by cognitive psychology (Walters, 1990); the social model which views addiction as a learned behaviour; and the moral model that views addiction from a rational choice perspective (e.g. Frankfurt, 1971). Career models adopt a multi-factorial approach to the phenomenon, acknowledging the fact that motivation for engagement in the behaviour and contingencies supporting the addiction vary along the course of the addictive career. This issue becomes very pertinent in substance abuse agencies that employ multi-disciplinary teams including psychologists, social workers, psychiatrists, medical practitioners and ex-users. Professionals often differ in their paradigmatic background, thus it is not uncommon for them to view addiction through different models.

Most of these conceptualisations are insightful and capture important elements of what we understand as constituting addictive behaviour. 'However a critical read reveals that many a theory, viewed through the conceptual lens of the observer, seems to stem from a novel idea that accounts for only particular aspects of the phenomenon but does not account for others' (Clark, 2011, p.57). These differences become critical when one explores the significance and impact that a model might have on both client and practitioner. Such variations in understanding leave the practitioner in a state of confusion as to how to intervene with the addicted person (Johnson, 1999). The aim of the current study is to examine the domain discourses surrounding addiction and relapse in heroin addiction.

Method

Design

This study used a qualitative approach using the modified grounded-theory method of Strauss and Corbin (1990). Semi-structured interviews were used to gain an in-depth understanding of professionals' discourse on addiction and relapse, specifically relating to heroin addiction in order to examine whether professionals' paradigmatic backgrounds influenced their views on addiction and to hypothesise how this may potentially impact the service user and the addictive career.

Participants

Participants recruited were professionals working within the National Agency against Drug and Alcohol in Malta and had direct experience with working with clients with drug problems. A snowball sample was used. Various professionals were recruited with a final sample of 10 participants. These were: one counselling psychologist; two clinical psychologists; two youth workers; two social workers; one medical practitioner specialised in addiction; one psychiatrist; and one care-worker (also an ex-user). All interviews took place using English except for one, which took place in Maltese and was later translated by the researchers.

Materials and procedure

A semi-structured interview was used. All questions were grounded in previous research and literature increasing the study's reliability and validity. The interviews lasted one hour and were audio-recorded and transcribed verbatim. The data was then subjected to open and axial coding.

Findings and Discussion

Strong adherence to the medical model

Although conceptualisations regarding the nature of addiction and relapse are changing, the influence of the medical model still dominates. Participants tended to view addiction as being characterised by: (i) loss of control and functioning, a state whereby the patients basically lose control, of their life and their only option they have left in life is what time, and where and with whom I am going to take […] to regain the ability of function again (medical practitioner); and (ii) physical withdrawals and cravings.

These form the basis of the medical construct of addiction (Walters, 1999). Neuroadaptation was, according to some professionals from the medical field, one of the main insights into the addiction process and could directly explain the reason why relapse is viewed as being chronic. When asked about their understanding of addiction one particular participant stated that:

> *Addiction is when there is someone who utilises a […] psychoactive substance that alters the state of the brain and he [the client] will need to take it repeatedly […]. Usually what happens is that he will have physical withdrawals he will develop tolerance, the substance will become the main thing in his life and whatever he does is to pursue this substance (medical background).*

This quote illustrates that there is a limited view of addictive behaviour. The disease model fails to consider behavioural addictions in which no substance is involved such as compulsive shopping and gambling. Moreover, it is incompatible with the notion of controlled use and unassisted change, for which there is plenty of evidence (see Armor et al. (1976) for controlled drinking, Blaszczynski et al. (1991) for controlled gambling and unassisted change from heroin addiction). Controlled substance use was simply viewed as a precursor to later addiction or relapse.

> *Personally I don't think so from my experience, what I have experienced when it is possible when you have clients who would use for example once a week on Saturday. From Monday to Saturday all they do is wait for Saturday. So yes alright they haven't used the drug or the alcohol but who wants to live from Monday to Saturday looking forward to that one night? […] you are still trapped in the addiction (psychology background).*

Participants who viewed addiction through the medical model, spoke about relapse as being 'part and parcel of addiction' (psychology background), with one of the participants going as far as to say that 'addiction equals relapse' (youth studies background). This type of discourse was also found from participants working from a psychological background, one stating that 'you are working against something which is like a time bomb really, it's always there' (psychology background). Another professional also held that '[the client] will never truly be rid of this problem' (social background), highlighting the idea that addiction is 'chronic' (medical background). According to May (2001), 'As a medical phenomenon, addiction is founded upon the subordination of personal agency (and thus the possibility of individual control) to some hypothesised pathological mechanism (p.385).'

This model is in itself very limiting, mostly due to its simplicity which was once considered to be its strength (Walters, 1999). According to Clark (2011), *'Biological processes are necessarily involved in addictive behaviour as they are in all behaviour. People may, at times, feel constrained by their chemistry but humans are not controlled by chemistry alone. It is illogical to assume that once you have found the pharmacological correlates of behaviour, you have found the reasons for doing it since all behaviour has a psychopharmacological correlate'* (p.58).

Explaining addiction through neuroadaptation may lead professionals to see drug users as passive victims of the 'addiction disease'.

Addiction as a psychological construct

According to Clark (2011), *'Closely allied to the biological construct of addiction, its psychological counterpart also focuses on internalised processes'.* Many participants highlighted the role of trauma in addiction, attributing substance use, to a primary coping mechanism.

> *Behaviours that a person […] becomes dependent on as a means of coping, so ineffective coping somehow. So […] let's say […] you've been through a certain trauma and my way of coping is to numb my feelings […] to manage these anxieties which are too much for me to handle by […] using this substance (psychology background).*

This type of belief is consistent with the self-medication hypothesis (Khanztian, 1997) which states that a person uses substances to self-medicate emotional distress. When clients wish to escape from events that cause anxiety and psychic pain, engaging in

substance use may act as a temporary coping mechanism. Critics of this model state that *'negative affect may be more a consequence than a cause of addictive involvement'* (Walters, 1999, p.49) and that it is perhaps best suited at explaining maintenance of addiction. Participants with a psychology background viewed relapse as a form of regression. While some professionals might classify success as complete abstinence, others adopt a lower threshold. 'You don't judge whether a person is doing well based on if he's had a relapse or not, same as if a person has relapsed once or twice doesn't mean he's doing badly' (psychology background).

The social cognitive perspective has been highly influential and attests to the human capacity for self-regulation. Bandura (1999) postulates that perceived self-efficacy constitutes a crucial factor in human agency since it works on motivation and action not only in its own right, but through its impact on other determinants as well. Self-efficacy schemas influence one's goals, levels of motivation and persistence in times of difficulties. If an addict has self-efficacy beliefs regarding his/her ability to stop engaging in the behaviour, this influences the goals he/she sets in terms of recovery, the effort expended and his/her attitude to lapses. Addicts, faced with biological cravings use cognitive and behavioural self-regulatory strategies to help combat cravings. This view has positive implications for working with addicted individuals in that they may be instructed on strategies such as delay/distraction tactics as well as using imagery and guided visualisation to weaken cravings and finding activities to replace the addictive behaviour (Clark, 2011).

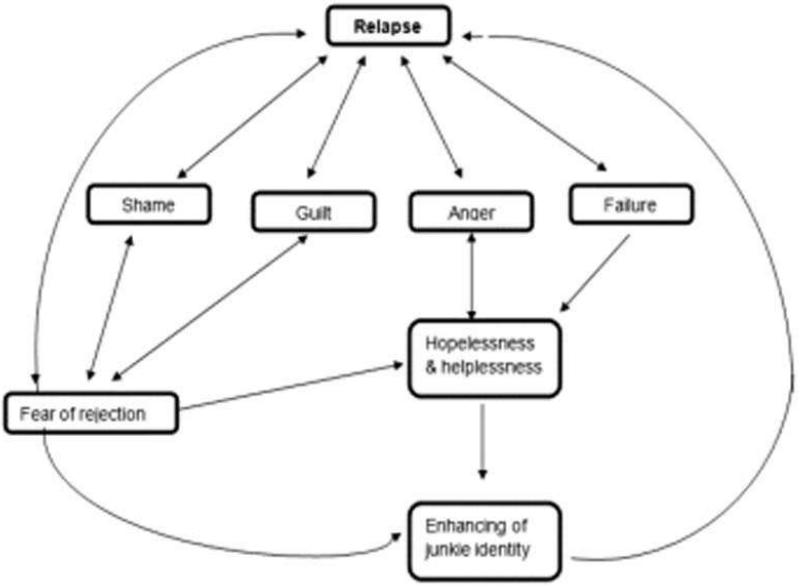
Experience of clients after undergoing a relapse

Careful analysis of the text shows that professionals are in tune with the experience clients go through after a relapse. Some highlighted a difference in experience and reaction to relapse depending on whether the client discloses a relapse, or whether he/she is found out. Professionals report that the main emotions expressed by clients who disclose a relapse are shame, guilt and anger coupled with feelings of hopelessness, helplessness and fear of rejection (Potter-Efron, 1989). Clients are reported to feel a sense of guilt at having let down those who have helped and believed in them the most. 'There will be that little bit of guilt because they say we let you down' (care worker). If guilt is internalised, along with negative feedback, shame can become deeply ingrained (Potter-Efron, 1989). Feelings of guilt and shame often lead to fear of rejection. Figure 1 illustrates the way in which emotions experienced after a relapse, may in themselves possibly act as triggers for possible future relapses (see Figure 1).

The triggers of relapse

The psychological triggers were more readily identified than biological ones. The main trigger discussed was trauma, also mentioned as a factor in initiation of substance use. Since the psychological construct often views substance use as a form of ineffective coping, the triggers highlighted by this model surround life adjustments that require coping such as bereavement and job termination, which were mentioned by professionals. If an addict faces an experience which causes anxiety, the experience in itself can act as a trigger to revert back to the old primary coping method.

Figure 1: Bi-directional cycle of relapse (Bartolo, 2009).



Societal reaction was also identified as a salient issue. 'They are emarginated from society. You have a bad conduct and so you can't find work, so they tend to give up […] then they need money, saying so I'm back to where I started – plus I need money' (social background). Stigma is a known precursor to internalised shame. When a client re-emerges into the world sober, he/she is in a vulnerable position while attempting to start afresh. According to one professional 'they might starting thinking 'I'm doing well, but what's my purpose in life?' (social background).

The data indicates that in Malta addiction is still deeply stigmatising (Ganado, 2007). Addicts are often attributed with a conduct stigma and held responsible for their 'wrong doings' (Goffman, 1963) which leads clients to engage in self-blame, in itself is a trigger for possible future relapse.

Relapse and the therapeutic relationship

After a relapse, the professional plays a key role in the future outcome. Many participants stated that following a relapse, motivation is low, coupled with intense feelings of helplessness. The professional may question the effectiveness of his/her work. One professional stated that working 'in this field for too long [...] can be very taxing […] you might not see results no matter what you try […] we need to keep believing that change is possible' (psychology background). Professionals' perception of clients who never admit to relapse is that they are in denial. Although defence mechanisms may

at times be interpreted as 'excuses' (care worker), clients might make use of such defences in order to avoid being overwhelmed by feelings of shame and soothe hidden feelings of worthlessness. Careful analysis of the text indicated a sense of futility and resignation from the side of the therapist:

> *If the relapse starts becoming ongoing, the therapeutic relationship doesn't really go anywhere because they are living happily on drugs so there is no way you can really work effectively with a person, then you might need to terminate the therapeutic relationship. Because obviously you need to assess their levels of motivation, what's really going on, […] maybe […] they need other type of help (psychology background).*

This quote seems to highlight transference phenomenon that may occur between therapist and client. Parallel processing may also occur when the client, therapist and at times supervisor all feel hopeless and helpless. If not addressed this may severely hinder the therapeutic relationship (Cashdan, 1988).The professional must be acutely attentive to differentiate between a client who is simply not ready to change, and a client who uses a myriad of defences as a way of escaping the negative emotions associated with relapse.

Conclusion

The study's main aim was to explore professionals' discourse surrounding relapse in addiction and its possible impact on clients. The data revealed that in general, addiction was attributed to internalised processes, influenced primarily by the medical and psychological models. In a prospective study of relapse in alcoholism, Miller (1995) found that beliefs surrounding the medical model of addiction were consistently linked with high relapse rates (Best, Day & Morgan, 2006). Although the results from this research cannot be generalised, due to the small sample size, they do warrant some attention and can be useful for professionals working within the substance abuse field to help them be more reflexive in their practice. This research adds to existing literature that the field of addiction has long been plagued with different models fighting to get more recognition in treatment 'with the disease controversy being simply a 'yes it is' or 'no it isn't' debate' (Shaffer & Robbins, 1991, p.391). The study showed that professionals still design their work with clients depending upon which model they draw upon. While it is clear that most of the professionals are well-informed about certain issues regarding relapse, analysis of the discourse revealed that many of the professionals seem to take on an expert stance. While it may be that one can recognise certain patterns over time it is important not to ascertain that those patterns will remain the same (Bateson, as cited in Mason, 1993).

Mason (1993) speaks of the importance of professionals working towards safe uncertainty; a state in which the professional can lead from a position which is sometimes uncertain about the dynamics and reasons behind a client's behaviour, all the while maintaining his/her power within the therapeutic relationship. Shaffer and Robbins (1991) put forward the idea that in order to instigate effective change, practitioners must understand the meaning behind one's addiction and help reframe the meaning to alleviate distress. 'If we decide not to adopt any one model of addiction as 'real' and 'true' we gain the opportunity to use a treatment approach that resonates with a patient's way of creating meaning' (Shaffer & Robbins, 1991).

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