

A moral deliberation on the tragic stand-off between the substance dependent client and the therapist

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Abstract

Substance dependent patients are trapped within their addictive behavior. They must deny, minimize, rationalize, intellectualize and project to keep going. Therapists see this as poor motivation in 'difficult' patients with a chronic relapsing disorder. Patients 'avoid' therapists and therapists 'avoid' patients. The problem for patients, love-ones and society lingers on. Society (patients) must trust caregivers in order to seek help. Caregivers must be committed to caring for substance dependent patients. This gap can only be bridged if the caregiver accepts this 'chronic relapsing illness', is skilled in motivational interviewing, and is able to balance duty of care and beneficence with the respect for autonomy (self determination) and the right to refuse treatment. The essence of the moral dilemma lies within the concept of patient competency to make informed decisions in the face of being 'trapped within his/her illness. The argument that the patient, at some stage of his/her illness, is not competent to make a rational treatment decision will be discussed. The paper will focus on motivational interviewing, autonomy, virtue, human rights, duty to care, justice and common good, and the need to induce sound moral arguments in the treatment strategies of patients with substance dependence.

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The increasing level of substance abuse in our society constitutes a crisis because of its social consequences. Available management approaches appear to be inadequate, failing both the client and the community. There is disagreement amongst policy makers and health service planners on whether the management at various levels (primary, secondary and tertiary) of people with substance abuse disorders would be best dealt with by social services or health services. If therapists themselves reflect honestly on their approaches to the treatment of substance dependent clients in practice, I dare say most, or at least some, of us would fall short of adequate and efficient client care. I believe that therapists want to help their clients. Helping people to heal is what we do. How, then, did this tragic standoff between the substance dependent client and the helping professions develop? Perhaps we as therapists should revisit our own assumptions about who should be treating these people, and how, as well as the very concept of the 'treatability' of these 'difficult' clients. The philosopher Warburton

warned, "If you do not doubt the soundness of the assumptions on which your life is based, you may be impoverishing your life by not exercising your power of thought".¹ I would add that we may also be impoverishing the lives of our clients and indeed entire communities.

During our professional lives, through learning, experience and rational thinking, we form concepts and develop belief systems. We come to believe that we 'know' certain things. But our concepts and belief systems can, for many reasons, be wrong or become outdated. Knowledge of the causes, course, treatment and outcomes of substance abuse disorders has advanced significantly over the last few decades, and even now, we do not have the perfect explanation or the optimal 'language' that would give us a definitive answer to the problems we experience in the management of our substance dependent clients. We are still forced to work in a context of scientific uncertainty and we still have to practice with limited knowledge of human behaviour. It is thus important that we should recognize the need regularly to scrutinize our concepts and beliefs about substance dependence disorders.

This paper attempts to challenge some of the assumptions that some therapists may have made about the substance dependent client. Do we really understand the nature of this chronic relapsing illness? Are we comfortable with clients who deny

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that they have a problem while causing so much pain to themselves, their families and the community? Maybe, with time, we as therapists have become disempowered, disillusioned and 'helpless' in our endeavour to treat these clients successfully. Or perhaps our own idealized concept of 'successful treatment' is one of the assumptions that contribute to the standoff.

Drug dependence revisited

No client ever decides to become a drug addict. We know the risk factors (temperamental, physiological, psychological and social) that operate during adolescence, the usual age of initial substance use. If substance dependence is not intentional, then why do so many young people become addicted? There are, broadly speaking, four reasons that a person may become drug dependent. For the sake of simplicity, let us use the example of one of the most common forms of substance dependency, alcohol addiction.

Firstly, alcohol is a drug. A drug, in this context, can be defined as a mind-altering substance (leading to a state of intoxication) to which a person may develop tolerance (a need for more of the drug to achieve the desired effect) and on which s/he eventually may become dependent (experience withdrawal symptoms on sudden cessation of the drug), which may lead to a 'craving' for the drug and behaviour that is aimed at obtaining supplies of it. We conclude from this that any use of any drug, legal or illegal, opens the door to the development of dependence and addiction. Not all people who use alcohol become addicted, but some use too much, too regularly and for too long, and develop a physical and psychological addiction.

Secondly, people drink alcohol not for the taste (I can hear the rationalizing!), but for the effect. Alcohol is known to affect mood. It can reduce tension, anxiety, frustration, tiredness, anger or depression, and temporarily erase life's problems, providing an escape from the stresses of our everyday existence. This apparently benign effect may perpetuate the use of alcohol in many people. Use may become a habit and eventually the development of tolerance and dependence may ensue.

Thirdly, it is widely accepted that all people have enough 'reason' to use this mood enhancing drug. Life in the twenty first century is tough! The accumulating stresses of survival, whether they be poverty, violence, unrealistic expectations or personal pain, may lead to alcohol use and then abuse. It is regarded as 'normal' to drink alcohol in most societies. Alcohol consumption is part of the western lifestyle and in South Africa forms part of most people's everyday life.

Fourthly, it is clear that some people have a genetic predisposition towards the development of addiction. Volkoff², in a paper delivered at the American Psychiatric Association Congress in New York, May 2004, shared her findings on the relationship between individual differences in the central dopamine reward systems and drug taking behaviour, clearly supporting the theory of genetic vulnerability. This new information adds further weight to the work of Schuckitt³ on the shared positive family history of addicts and Cloninger⁴ on type I and type II addiction behaviour. It is now clear that addicts are individuals with a polygenetically inherited vulnerability to the development of addiction.⁵ Individuals with a genetic predisposition will, in most cases, experience a more positive response to the effect of the drug of choice. This strongly posi-

tive reinforcement can perpetuate drug taking behaviour.

Considering the above four factors known to contribute to the development of addiction, the therapist needs to internalise the fact that becoming an addict is not a matter of choice. This does not mean that an individual is simply a victim of the effect of a drug. Not all individuals with a genetic predisposition who start to use alcohol and enjoy the effect, even in the context of severe psychosocial stresses and in a drinking culture, become alcohol dependent. There are other perpetuating as well as protective factors. I am merely suggesting that no addict plans the eventual addiction and that many factors may play an "add-on" role in its development. In a perfect world, armed with knowledge of the final outcome, no vulnerable individual would start to use habit-forming drugs. In the real world, by the time such an individual realises s/he is 'hooked', physical and psychological dependency is firmly established.

Understanding addicts

We need to understand the nature of this illness. Addiction is an acquired illness, developed over months and years by neuro-adaptation. These neuronal changes are permanent. Experience has taught us that once physically addicted, defined by tolerance and withdrawal, a dependent person will almost always revert back to the previous dependency state if s/he uses the drug again after a period of abstinence. These clients are trapped in their illness and their daily behaviour confirms this. Some therapists find it very difficult to understand the rationalization, minimizing, projection, intellectualisation and denial of the addict. These are coping strategies and defence mechanisms used by people who are suffering. We know that all addicts go through stages of internal motivation during their dependency. During the initial stage, they experience an internal conviction that they have 'no problem'. As the negative consequences accumulate, they may acknowledge that they have a 'problem', and become 'determined to stop'. There follows a period of 'stopping only to start again', with an increasing realisation of addiction and helplessness, which may finally lead them to make the decision to become 'sober' and to ask for assistance.

Because addicts are trapped during the "no-problem", "determined" and "stop-start" phases, use of the above defence mechanisms helps them to maintain some degree of psychological coherence while the nature of addiction drives their ongoing substance abuse. The only way many addicts can respond to the disapproval of society, their loved ones and sometimes even their therapists, is with denial, promises, emotional 'games' and threats.

Why is it that they cannot 'just stop'? They may be afraid of the withdrawal process and find it very difficult to admit to this 'weakness'. They may not have any idea what a sober life-style will be like and may fear that they will be unable to deal with it, that they will not be able to cope without the 'escape effect' of drugs, will suffer an eternity of craving. They may also fear (often rightly) the social stigma attached to open acknowledgement of their illness. Addicts do wish to stop using drugs, but the perceived odds and the power of addiction are usually overwhelming. Therapists commonly feel that addicts simply do not want to change their behaviour. This is a misperception. Indeed, addicts are usually painfully aware of their need to stop using, but they feel unable to do so.

As therapists, we may speak glibly of an addicted person

having 'no motivation' without really understanding that what the addict communicates to us and society may be far removed from his/her real inner suffering and needs. The therapeutic standoff arises as the therapist abandons these "unmotivated" clients on the grounds that they have the right to refuse treatment and that their autonomy must be respected. We need to consider the possibility that it is a deficiency in us as therapists if we cannot see beyond the 'difficult', 'unmotivated' client in denial. The "real" client may be suffering, desperate for help, but powerless to take a step towards it. S/he may be terribly afraid, feeling helpless and hopeless, and struggling with remorse and guilt. Believing that there is no way out, they survive psychologically by being 'grandiose' about their substance use, hostile, resentful, accusing, oppositional and 'difficult'. Every therapist needs to be able to see beyond this 'mask' and be willing to equip themselves with the necessary skills to help such clients. Understanding the nature of addiction, exercising extreme patience, acquiring motivating skills and keeping up to date with current treatment approaches are some of the areas which we as therapists may need to explore.

Barriers to treatment

Once therapists have re-motivated themselves through a deeper and updated understanding of addiction, they may be willing to invest more in the treatment of the client with a substance use disorder. Alas, there may be further barriers to treatment! To begin with, the available services for the treatment of these clients are in general inadequate. Managed health care schemes and medical aids on the whole provide extremely limited benefits for the treatment of substance abuse disorders. Currently available state-funded in- and outpatient substance dependency programmes do not come close to addressing the need for treatment within our society.

Even if treatment can be made available, we encounter an institutionalised moral and ethical standoff between the substance dependent person and society. A great deal of emphasis is placed on the right of the client to refuse treatment and respect for autonomy. In South Africa we value individual rights and autonomy very highly, largely because of our recent past in which violations of human rights and disrespect for self-determination were institutionalised and widespread. Any argument would have to be overwhelmingly powerful to overcome our now deeply entrenched determination that individual rights and autonomy must never again be so abused. I believe that as therapists we are today more afraid of attempting to treat a client who needs treatment but can not bring him/herself to be treated than before. The following argument may be egodystonic, but I believe that we need to question our assumptions around this issue, lest we be disempowered by them, or worse, use the client's refusal to be treated as a convenient excuse not to take on the burden of a difficult and time-consuming therapy.

Addicted clients usually refuse treatment because of the nature of their illness. Their actions and interactions are focused on maintaining their addictive behaviour. As mental health professionals, we accept that many illnesses can render patients incompetent to make informed decisions. I am of the opinion that drug addiction is one of these illnesses. The need to maintain access to the substance of addiction prevents addicted people from requesting treatment. The very essence of addiction is physical and psychological dependence on a drug. Treat-

ment refusal by an addicted person does not appear to be rational. Irrespective of the hardships, pain, losses and self-defeating consequences of their addictive behaviour, the power of addiction seems to be stronger than common sense. As therapists we see this inexplicable behaviour every day. Such irrational, self-destructive and fatalistic behaviour can be explained by an illness that leaves the sufferer unable to make rational decisions on treatment and much else. If an illness renders a client incompetent to make major life decisions, should a therapist not consider such a client to be incompetent to consent to treatment?

Moral deliberation

In making moral and ethical decisions as therapists, many factors may contribute to the process. We may consider what action would result in the best outcome for the most people in the long run; in other words, what course of action would promote the 'common good' within society. In making such deliberations, we also, as members of a community, have to decide what kind of society we actually want. Such an action would aim at optimising the outcome for society, no matter what means were used to achieve the end. However, as therapists we cannot merely focus on the best general result but also have to treat every person as an end in him/herself and never as the means to an end.

We may also consider what would be the 'good' deed or the 'action of good intent'. We may reflect on historical ethical models and consider what 'a person of good character' would do. All therapists probably have role models who helped shape their professional behaviour. We may consider an action "morally good" because it is what such a person would have done. Our moral deliberation may also take account of past experiences of similar situations and all that we have learned about the consequences of various actions and decisions in such contexts.

And what of individual rights? We believe that all individuals have the right to the basic needs in life, that every person in South Africa has a constitutional right to physical safety and to opportunities for constructive participation in society. The results of such constructive participation would include a sense of belonging to, and being cared for and nurtured by members of that society, something we regard as essential to emotional health. As mental health professionals, we commit ourselves to fighting for the rights of those clients who cannot fight for these rights themselves. This includes fighting for the rights of those clients who are rendered temporarily incompetent through mental illness. Therapists have a duty of care. This obligation to care for others derives first from our mutually dependent relationships with other people, and is adopted in an intensified form when we take our professional oaths. As therapists we are bound by the four principles of ethical client-therapist relationships, namely: respect for autonomy, beneficence (to do good), non-maleficence (not to do harm) and fairness (to do what is fair or just).

This process of building a moral argument encapsulates the moral theories of utilitarian ethics or consequentialism, deontology or rule based ethics, virtue ethics, liberal individualism, communitarianism, the ethics of care, casuistry and the four pillars of principle-based ethics.⁶ It is clear that some of these moral arguments may be in opposition to one another, and that no specific theory or rule can be applied in isolation. For in-

stance, respect for client autonomy (self-determination) may be in conflict with what would be fair in a certain situation, if we define "fair" as what would be in the client's best interests as well as what would be fair to the family and society. How does an addicted client's right to continue drinking stack up against a mother's right not to have her child killed by a drunk driver or a child's right not to be abused by an intoxicated parent? In such a situation, the best result for the most people may well outweigh the right of the addicted individual to refuse treatment. Keeping all of these tools of moral deliberation in mind, perhaps we should revisit the treatment options for the 'poorly motivated' addict who refuses treatment, in the context of what we know about the power of addiction.

Putting moral theories to work in considering treatment options for people with addictions

Allow me to recapitulate what we have so far determined: Drug addiction is an illness. It has multiple causes, a characteristic course, a predictable pattern of clinically significant morbidity, co-morbidity and complications and an associated mortality rate, and effective treatments for it exist. People with addictions may refuse treatment because of the effect of their addiction on their perceptions, cognitions, mood and defence mechanisms. A strong case can be made for considering the client, at least at some stage of his/her illness, as incompetent to make informed decisions regarding his/her own health and welfare.

Contemporary moral debate strongly favours the client's right to have his/her autonomy respected and supports the right of the addicted individual to refuse treatment. This leaves the therapist, the client's family and society with the options of either abandoning the client or continuing to tolerate and accommodate the damaging behaviour that s/he displays. But does the client not have a right to treatment, a right to receive necessary care in his/her own best interests? Should we as therapists not 'do good' and treat such clients? Would a good person not treat the client? Does failing to treat such a client

not translate in the long run into actually harming the client, his/her family and society? Does our obligation to help the client not increase with the degree of helplessness s/he experiences? If a client is not competent to give informed consent to treatment by reason of mental illness, should we not temporarily suspend his/her right to refuse treatment in order to restore his/her competency and well-being?

Effective internal motivation to ongoing sobriety only develops after successful treatment. I offer the opinion that, in the case of addiction, we should, as an act of beneficence and in accordance with the client's right to treatment, care for the client, striving for the best result for both the individual and the community, with the good intent of restoring personal integrity, individual health and community safety and prosperity, as a good person would do. I believe that this would be the action of a community that truly cares for the individual and is brave enough to act in accordance with that care. I believe that such action would accord with ubuntu, the African philosophy that "I am because we are". The duty of care should impel the therapist to action on behalf of the client. We should treat our addicted clients, because we care and because we can.

References

1. Warburton N. *Philosophy: The Basics*. 3rd edition: New York; Routledge; 1999.
2. Volkow ND. *Why does the human brain become addicted? Presented at the 157th Annual Meeting of the American Psychiatric Association, New York; 2004.*
3. Schuckit, M.A. *Drug and Alcohol Abuse: A Clinical Guide to Diagnosis and Treatment*. 7th edition: New York: Kluwer Academic/Plenum Publishers, 2000.
4. Cloninger, C.R. *Neurogenic adaptive mechanisms in alcoholism*. *Science* 1987; 236: 410-416.
5. Kaplan, H.I. & Sadock, B. J. *Concise Textbook of Clinical Psychiatry*. New York: Williams and Wilkins, 1966.
6. Beauchamp, T.L. & Childress, J.F. *Principles of Biomedical Ethics*. 4th edition: 1994; Oxford: University Press Oxford, 1994.