Counseling Male Substance Abusers

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"Give me Librium or give me meth," John boomed in his best early American accent as he walked down the halls of the state mental hospital. John Thompson was young, articulate, and intelligent. He was also a drug addict.

"My whole identity is wrapped up with drugs. If I didn't take drugs I don't know who I'd be," John confided during a therapy session. In 1965 there were few resources available in hospitals for people like John and shortly after he left the hospital he was arrested for selling drugs and was sent to prison.

Gary never used drugs, though he drank a bit. He was the youngest chairman of the county board of supervisors and was looking forward to becoming the youngest senator in the country. Gary's rise in politics was slowed by the loss of a close election. He was killed in an automobile crash shortly before his thirty-fifth birthday. The newspapers said it was an accident. Only a few friends knew how despondent Gary was after losing the election, that the few drinks had grown to many, and how much of his manhood was tied up in his shattered dream of political power.

It is my belief that those who work in the field of substance abuse treatment came to the work because of some personal experience. Some grew up in families where one or both parents were alcoholic. Some are recovering alcoholics or addicts themselves and have a strong desire to help themselves by helping those in need. Others had close friends whose lives were ruined or lost as a result of drugs. John and Gary were the catalysts that drew me into the field.

In order to be most effective in counseling male substance abusers, expertise must be developed in six areas. First, we must become effective counselors. Second, we must develop expertise in the special issues that face men. Third, we must know about the various substances that men abuse. Fourth, we need to become expert in understanding and treating abuse or addictive relationships to these substances. Fifth, we must understand what does not work as well as what does. Finally, we must experience the fact that all healing is mutual.

Becoming an Effective Counselor

Until the advent of Alcoholics Anonymous (A.A.) there was little effective treatment for alcoholism and drug abuse. The 12 Step program of A.A. has been the most effective in helping substance abusers. According to William Mayer, M.D., of the American Medical Association, "A.A. by and large works better than anything we have been able to devise with all our science and all our money and all our efforts" (Brown, 1985, p. 25).

In 1975 a small handbook, *Becoming Naturally Therapeutic* by Jacquelyn Small (1981), began circulating within the alcoholism treatment community and has become a classic in stating clearly what is needed to be an effective counselor. Small lists the following 10 characteristics as being essential for those working in the field: empathy, genuineness, respect, self-disclosure, warmth, immediacy, concreteness, confrontation, potency, and self-actualization.

The primary difference between more traditional counseling approaches and this one seems to be the increased willingness of counselors to reveal aspects of themselves.

Brown (1985), while suggesting that all approaches have something important to offer, has developed a new theory of recovery that allows an integration of the various treatment practices. This is valuable for the therapist dealing with substance abuse.

Special Issues for Men

Although addiction does not discriminate against women, it does seem to be a disease that is closely associated with men. According to Richard O. Heilman, M.D., whereas 1 in 50 females become alcoholic, 1 in 10 males do (Heilman, 1973). A national study on mental health concluded that "throughout their life-time 19.2 percent of Americans will suffer from alcohol or drug abuse." The study went on to note that "men are four to eight times more likely to abuse alcohol than [are] women" (Time Magazine, 1984).

Men's special susceptibility to addiction was borne out by other studies that have shown that at least 25% of male relatives of alcoholics, but only 5% to 10% of female relatives, become alcoholic (Men's Health, 1986). As other drugs are used and abused by men we can expect similar patterns to those found

with alcohol. Research on high school students has shown that males use and abuse all drugs more frequently than do females (Johnston & O'Malley, 1986). Although heredity undoubtedly plays an important part in the prevalence of male addictive behavior, the masculine role is very important.

We might think of male conditioning as a set of spoken and unspoken rules that dictate what a man must be and what he cannot be. Neitlich (1985) says that men are conditioned to be economically powerful, always sure, physically strong, courageous, controlled, cool and stoic, silent, protective, aggressive, and tough. She goes on to say that men are taught not to be loving, nurturing, tender, feeling, soft, passive, sweet, spontaneous, quiet, and giving. If addiction is a constant search for something one feels is necessary in order to be whole, a better understanding of why men get hooked on various substances emerges. If men think they have to be strong all the time, for instance, they will seek substances to give them the strength that they do not always feel. If men cannot be feeling, they will seek a drug that allows them to express emotions (Peele & Brodsky, 1975).

Cocaine, for example, is a perfect drug for men who cannot express feelings and think they need to be "supermen." It gives them a feeling of power. On cocaine men feel like super-lovers, super-achievers, super-providers, super-athletes (O'Connell, 1985). The drug gives men the illusion of being all the things they "must" be, and at the same time offers them a chance to express the things they are taught they "cannot" be.

Substances Men Can Abuse

When Alcoholics Anonymous was started in 1935, the primary substance of concern in this country was alcohol. Shortly thereafter two federal hospitals—one in Lexington, Kentucky, and the other in Fort Worth, Texas—were started to deal with heroin addiction. Most theories of treatment and programs for help are still focused on these two drugs. Yet the "drug scene" has changed dramatically, particularly in the last 25 years.

In 1960, valium didn't exist. In 1980,5 billion valium tablets were taken. The number of people who have tried marijuana has gone from a few hundred thousand to over 50 million. We are also in the midst of a cocaine epidemic unprecedented in the nation's history. Every day 5000 people try cocaine for

the first time. “Crack,” a very concentrated smokable form of cocaine, is a source of even greater concern (Mecca, 1984).

These drugs aren’t just damaging kids on the streets but are threatening the stability of those who are supposed to be able to help. “Physicians have a rate of addiction that’s four to six times higher than the general population’s,” says Dr. David Smith, founder director of the Haight-Ashbury Free Medical Clinic, and an authority on drug abuse treatment (Gallagher, 1986).

The advent of “designer drugs” will force us to change our entire way of thinking about drug abuse. Gary Henderson (cited in Gallagher, 1986), pharmacologist at the University of California at Davis, who coined the term *designer drugs* says, “There’s just one bright aspect to the development of these drugs. They make it absolutely clear that the drug supply is now infinite, and that the measures we’ve used to deal with drug abuse have been to no avail.”

Understanding and Treating Substance Abuse Problems

For those offering treatment it is important to understand the difference between “abuse” and “use.” At present our national policy is virtually to ignore alcohol, nicotine, caffeine, and tranquilizer abuse as problems. We lump the use of all illegal substances together, regardless of the degree of impairment, and assume that any use constitutes abuse.

After 20 years of research into all aspects of substance use and abuse, Dr. Norman E. Zinberg, director of psychiatric training at the Cambridge Hospital and professor of psychiatry at the Harvard Medical School, had this to say:

> The leading recommendation to come from my years of research on controlled drug use is that every possible effort should be made—legally, medically, and socially—to distinguish between the two basic types of psychoactive drug consumption: that which is experimental, recreational, and circumstantial, and therefore has minimal social costs; and that which is dysfunctional, intensified, and compulsive, and therefore has high social costs. The first type I have labeled “use” and the second type “misuse” or “abuse.” (Zinberg, 1984)

Although treating various substance abuse problems can be confusing, it is helpful to remember that if one becomes effective in treating one type of problem, such as alcoholism, then about 80% of what is needed to treat any abuse problem is known. What follows is an outline of the 12 steps I use in working

with those with abuse problems.

WORKING WITH DENIAL

All those who have a problem with drugs at first insist that they do not, despite evidence to the contrary. Men who abuse alcohol usually insist that they can handle their booze, that they do not drink all that much, that they only drink because of a demanding wife. As the problem gets worse the denial increases. The first step in engaging people in treatment is helping them see that their use may be getting out of control. The therapist must be careful because pushing too hard may increase resistance and denial, while not pushing hard enough may allow continuation of an unhealthy pattern.

EXPLORING THE CONCEPT OF ABUSE OR ADDICTION

For most men the idea that there is something in their lives that they cannot control is very frightening. To admit that they have lost control brings up fear that they may be addicted. Everyone has a frightening image of addiction. For one it is the "man with the golden arm," a hopeless junkie. For another it's a skid-row bum slumped on the sidewalk, with a cheap bottle of wine stuck in his ragged coat.

Demystifying the notion of addiction is valuable; perhaps by telling clients that people can become addicted to anything (Wilson-Schaef, 1987). The addictive process stems from our desire to become a whole person. The desire is healthy and positive. The problem is that wholeness can only come from within. Whether it is alcohol, drugs, gambling, eating, sex, or love upon which one is dependent, that addiction occurs when people believe that happiness can be found or pain avoided through outside means. As the notion of addiction becomes less frightening, the therapist can help the person see what substances or processes are depended upon.

ASSESSING RISK

Having overcome the denial and fear, clients are now ready to assess the risk factors in determining how dependent they have become. Exploring how deeply they have become enmeshed in three related aspects (the 3 C's) of their relationship to their addictive substance is next. The first C is compulsion. The degree to which the person feels he needs the substance is assessed. How preoccupied is he? Does he

think about getting high or having a drink when he is doing other things? To what degree does he begin to reorient his life around the substance of choice? Does he go to certain parties or begin to spend more time with certain friends because he knows his substance of choice will be available?

The second C is loss of control. In the late stages of chemical addiction, the loss of control is complete. One drink leads to a week of oblivion. One line of cocaine leads to the next, until all the coke is gone and all the money has been spent. In the early stages the loss of control is more subtle. A man may decide to have two drinks on a Tuesday night because he has to get up early the next day and he ends up having four and wakes up late with a hangover.

The third C is continued use despite adverse consequences. For most of us, if we have a bad experience with a substance, we stop using it in a negative way or stop using it altogether. Someone who has become dependent on the substance finds that he continues to use it even though it is causing problems.

The alcohol abuser continues to drink and drive even though he may have been arrested more than once, spent time in jail, paid a good deal of money for lawyers' fees, and so on. Despite his best intentions —and his intentions are usually genuine—he goes back to his destructive use.

This is one of the most difficult ideas for non-addicts to understand. "Why doesn't he just stop drinking like that if it's causing so many problems?" they wonder. What they do not realize is that the characteristic of addiction is the inability to change use pattern despite the problems experienced.

GETTING READY TO DO SOMETHING ABOUT THE PROBLEM

Often a man realizes that he, in fact, is addicted to a substance. He recognizes the 3 Cs—compulsion, loss of control, and continued use despite adverse consequences—but continues to resist getting help. This can be a confusing time in the treatment process. It can be very frustrating for a counselor who has helped the man to admit he is having a problem, but not be able to help him to take the actions that would solve the problem. It seems odd that someone would continue to remain in a situation that is causing him so much pain.

The explanation may be found by exploring unconscious motivations. There are often hidden benefits derived from drinking, along with hidden fears of stopping. Once the therapist is able to bring to the surface these unconscious reasons for continued involvement with a problem causing substance, the client can intelligently weigh the positives and the negatives of continued use and have a clearer picture of the situation.

Trying to force the client to change before the whole picture is made clear often leads to a surface acceptance of the help offered with an underlying resistance. Dealing directly with the benefits and the drawbacks of change enables these issues to be dealt with early on in the treatment process with a much better prognosis for successful outcome.

FINDING A GUIDE

No one stops a longstanding pattern of relationship such as substance abuse without outside guidance, although frequently people at first try to do it on their own. The people who are successful have guidance. The guide may be a spouse who has gotten guidance, a counselor, a member of A. A. or some other self-help group, an employer, or a friend.

DECIDING WHERE ONE IS IN THE ADDICTIVE PROCESS

There are nine possible positions that a person might occupy in beginning the treatment process:

1. low risk/no problems
2. high risk/ no problems
3. minor problems
4. serious problems, not ready for help
5. serious problems, ready for help
6. those in early recovery
7. those in middle recovery

8. those in late recovery

9. those in continuing recovery

Traditionally, treatment began when people with serious problems, who were ready for treatment, voluntarily came for help. A period of intense medical intervention followed that focused on getting the person abstinent and involved with A. A. or other 12-step programs. Now counselors need to see the addictive process as beginning earlier and lasting longer if treatment is to be most effective.

DECIDING ON A TREATMENT PROGRAM

I have found that there is a need for as many different treatment programs as there are people who need help. Most programs try to fit each person into an already existing program. However, no program has all the answers for everyone and a specific, custom-designed program for each person is generally best.

DOING THE PROGRAM WITH GUIDANCE

Once an individual program has been decided upon, the guide helps engage the person in the program. Since a complete program may take as long as seven years, the guide needs to have a long-term commitment to this work to be most effective. A case example will illustrate the treatment process.

THE CASE OF BARRY S.

Barry S. was referred by the courts after being arrested for the second time on a drunk driving charge. Barry was 27 years old, married for five years, and had one small child. He had been drinking since he was 14, heavily in the last five years, and acknowledged that his father also drank heavily. Although he said he felt he was an alcoholic, he wasn't sure he wanted to stop drinking and hated the thought of going to A.A. "Those people are a bunch of losers. I don't want to associate with people like that."

Barry was seen once a week individually and every other week in a group therapy session with seven other men who were at various stages in their recovery. His wife, Nancy, was contacted and

encouraged to get involved with Alanon (a support group for spouses of alcoholics). Barry was encouraged to keep an open mind about A.A. and to go to six or seven meetings before deciding whether it was useful. Over a period of six months, Barry began to talk about his fears of stopping drinking and the primary position alcohol had in his life. “Sometimes I think it’s my only real friend.” Gradually the times between drinks increased and one day he announced in group that he had attended an A.A. meeting and was planning to stay sober “one day at a time.” “A.A. isn’t what I expected,” he said. “Those people really are just like me.”

Group sessions ended after a year. Individual therapy continued for two years and Barry got quite involved with A. A., attending meetings three to five times a week. He said he felt it provided the social support to stay sober, while the therapy sessions helped him look at his life and deal with his feelings of anger, resentment, fear, and guilt. Gradually individual sessions were used for a once-a-month “check-in” and A.A. became the primary support.

Although A.A. encourages people to abstain from all mind-altering drugs, Barry continued to smoke marijuana occasionally during the first five years. He also drank a good deal of coffee laced with sugar, which was a staple at most A.A. meetings.

Barry returned again for weekly individual sessions to talk about his marijuana smoking and the effect it was having on his work. He had been a house painter since his early twenties, always made enough to get by, but now felt he wanted to become more successful and felt smoking marijuana was getting in the way. Over a period of six months he was able to stop smoking and also to stop drinking coffee, which kept him awake at night, and his work began to improve. Once again therapy sessions were spread out and Barry was seen every six months for a review session.

Six years after Barry started therapy, he returned for weekly individual sessions to focus on his sexuality. Although the marriage had improved greatly since he stopped drinking, he was unhappy that their sex life was so limited. He said Nancy didn’t seem interested in sex and they made love once every three or four months. He found himself fantasizing about other women and said he was spending more and more time away from work following pretty women in his car. This brought up memories of early experiences with his mother and father. He remembered times his father had beaten him and his mother

took him into bed with her after his father went to work. He said he always had a mixture of sexual desire and repulsion to women he became intimate with. Gradually he began to see how he contributed to the lack of sexual involvement between him and Nancy. As the issues became clear, they were worked with as a couple and their sex life began to improve.

The last time Barry was seen he invited the therapist to a special A. A. meeting where he was acknowledged by the group for being seven years sober. He seems to have worked out many of the issues that were causing problems. He no longer drinks or uses drugs. His work and family life have improved greatly. His feelings of self-esteem are at an all-time high. "Life," he said, "seems sweeter than ever before."

What Does Not Work in Counseling Male Substance Abusers

We can often learn a great deal about success by focusing on failure. Some of the most important lessons about being an effective substance abuse counselor with men have come from making mistakes. What follows is a summary of the most glaring mistakes I have made over the past 22 years:

1. *Failure to address "drug use "as the primary issue in treatment*. Trained in "psychodynamic" psychotherapy I would focus on "underlying issues," believing that if I got at the root of the problem the person would stop using drugs. Meanwhile, the drug use continued and therapy was ineffective.

2. *Failure to relate diagnosis and treatment*. In the early days working in a clinic, getting the proper diagnosis was important. I would spend hours reading manuals trying to decide if I should classify the person as having "Alcohol Idiosyncratic Intoxication" or "Organic Brain Syndrome," for instance. There never seemed to be a relationship between how we labeled a person and what treatment we provided.

3. *Failure to develop treatment that fits the unique needs of the client*. Positive I understood what treatment was most effective, I assumed that those who didn't fit in were "unmotivated" or unready for help. I came to believe that "substance abuse" was a unitary disease entity and my program was the right one for every one with that problem.

4. *Failure to understand mutual support groups such as Alcoholics Anonymous*. At first I found it difficult to believe that no-cost "self-help" programs could be effective. When more clients reported success with these programs, I grudgingly sent a few people who could

not afford to pay for treatment. I went to one or two meetings myself, but never tried to understand how these programs worked.

5. *Failure to understand the different needs of women and men*. If a person has a broken leg, the pain is the same whether it's a man or a woman, and likewise, the treatment doesn't vary. I first assumed that alcoholism and drug addiction were problems that were experienced the same by both sexes. Later, as the women's movement spread, I could see that women had special needs, but was unable to see that men had unique issues as well.

6. *Failure to discuss my own life experiences*. I was taught in school that a good therapist must keep a professional distance from the client. I never talked about my own life. I thought the experiences I had had with drugs and alcohol were private and of no value in helping the client. I worked in an office that revealed little about my own life and I saw my client's problems as different from my own.

Acceptance of Mutual Healing

The most effective counselors understand that all healing is mutual. Contrary to what many believe, the therapeutic process works both ways. Therapists' own lives are enhanced as they help those who seek their counsel. One of the primary reasons Alcoholics Anonymous is so effective in treating addictions is that members know that in helping each other they are helping themselves.

Sheldon Kopp (1971) reminds us that therapist and client can see each other as equals.

> My pain hurts as yours does. Each of us has the same amount to lose—all we have. My tears are as bitter, my scars as permanent. My loneliness is an aching in my chest, much like yours . . . . You say you've had a bad time of it, an unhappy childhood? Me too. You say that you didn't get all you needed and wanted, weren't always understood or cared for? Welcome to the club!

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