The elephant in the room?

The question of addiction as it relates to drug/alcohol use and sexual behaviours: raising the issue with patients

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Just in the hopes [sic] *of feeling a glimmer of love or affection or connection, you do things that you would never have done before* [1].

Addiction. Arguably one of the most contentious, controversial and even reviled constructs known to humankind. Whether we embrace the multi-dimensional 'disease' model favoured by classic 12-step philosophy (Alcoholics Anonymous *et al.*) [2], the medical model with a focus on biological and genetic factors [2], or one of the therapeutic hypotheses which I will reference at times throughout, it is a construct that can stir defensiveness, debate and denial in individuals and communities alike. However, addiction (as I understand it) is known to me both as a professional and personally, and I will integrate my experience of them both in the hope that I can provide at the very least a backdrop of information, ideas and reflections that may be of use to you in your work and life beyond. For the sake of clarity, please take it as a given that this article is focused upon addiction as a specific and very real phenomenon, a million miles away from those individuals who choose to use substances and/or alcohol and feel that their use remains both an option and controlled.

As a therapist, clinical supervisor and group work facilitator, I have specialised in the field of addiction for 12 years, working in a variety of settings ranging from statutory drug services, sexual health organisations like Terrence Higgins Trust, through to university environments where young people from the four corners of the globe constantly remind me that it is near impossible to rewrite the next edition of a drug dictionary fast enough to keep up with global recreational drug trends. While the thrust of this article will provide a more experiential investigation into the issues of addiction and how the *relationship* some gay/bi men develop with certain drugs can result in precarious and sometimes catastrophic consequences, the medical diagnostic criteria for what is now referred to as substance use disorder can be found in the DSM-5 [3].

Alcoholics Anonymous refer to alcoholism as 'free will run riot' [4], though that could accurately be applied to any addiction. For our purposes, a useful and accessible definition – sometimes referred to as the three Cs – describes addiction as 'the loss of control over the compulsion to use, irrespective of the consequences' and that will be a reference point for us throughout. It is a definition flexible enough to be applied to any of the philosophies that inform my practice and which together seek to examine the following in an addicted person's life:

- The ways and means by which a person finds meaning and purpose, or not, in their life [5]
- The quality/abundance of human relationships which could be family, friends, partners etc. and any blocks to establishing and maintaining them [6]
- A person's relationship with their HIV-positive status
- The extent to which they feel able to explore and embrace choice and free will [5]
- Their sense of self (that is, their relationship with themselves and to what extent they rely on and employ external sources to validate, assess and quantify who/how they are; drugs are one of these 'sources'). Also known as 'identity synthesis' [7]
- Internalised homophobia/heterosexism and the impact of this on how gay/bi men relate to themselves and other men emotionally, physically and spiritually
- Shame considerations
- Other mental health considerations, also known as dual diagnosis [8]

The list might well be endless but these highlights will serve us for now.

It is no longer news fresh off the press that a heady combination of chaotic drug use and often equally anarchic sexual behaviours will create conditions for one of life's perfect storms, especially when one of those storm fronts is addiction. When you create this convergence, which combines the disinhibiting, reality-altering effects of substances with psychological vulnerabilities and patterns of one or more addictions, it could be argued that the odds are stacked against you. Therefore, a thorough initial analysis of what addiction means to any one storm-tossed individual is key [5], along with an appraisal of its physical implications. In his excellent book *Gay Men & Substance Abuse* [7], Michael Shelton lists the impact of addiction on gay/bi men who are HIV positive, including the reduced interest and attention to personal care and wellbeing, with specific attention given to a

person's meds regimen, the paradoxical use of substances to ease guilt/shame in relation to their status/sexuality, increased levels of the virus within the body specifically where meth is concerned and, again in the case of meth, the deliberate transgressing of boundaries because, to quote one of the talking heads in Todd Ahlberg's benchmark documentary *Meth*, 'there's an embracing of all things dangerous and all things bad and wrong' [1].

When active addiction kicks in, with all its drama, chaos, grief, urgency, self-destruction and a promise of the ultimate 'peak experience' [4], anyone who has been there will know that it is a lie you are ready to believe time and time again. Having been there, I can relate and, from that vantage point, I can attest to the mesmerising power of that which lies at the dark heart of addiction – denial [9].

Addiction's weapon of choice: Denial

While still in this 'pre-contemplative' stage, the addicted individual is unlikely to feel motivated towards change [10]. Recognised trans-theoretically as the human defence mechanism that leaves little room for manoeuvre, pre-contemplation or denial provides one of the greatest blocks to recovery. However, a shift can happen, and being familiar with the cycle of change can help inform you in terms of a patient's readiness (or not) for action. I was a card-carrying denier but my therapist knew that without the planting of the seed, simply achieved via an enquiry, no defence could be challenged and no responsibility would be taken. Denial often takes the form of self-justifying statements that combine classic defence mechanisms such as minimisation, rationalisation and, of course, denial itself into addict-friendly self-talk [9]. This self-talk can range from 'I can stop anytime I like. I just don't want to stop' exclamations to the pathologically narcissistic likes of 'I'm different to everyone else. It's not a problem. You should see so-and-so. Now *he's* a hot mess!'

Exploring a patient's relational world

Finding time to explore the quality of relationships can be essential. The combination of living with addiction, HIV and a gay/bi identity can pose a profound challenge and addiction is not known for promoting or enhancing strong, congruent, intimate relational connections with others. It provides what is known as an 'I-it' as opposed to an 'I-thou' relationship [4], which, in its simplest form, means that an addicted person's primary relationship is with an object (or in the case of sexualised drug use, behaviours and attitudes that result in the objectification of others). While talk abounds of the extraordinary levels of intimacy and intensity that are often achieved to almost mystical proportions when sex and drugs are coupled, this remains inauthentic. And yet, if it is all we know, fearing either rejection or intimacy in our real world, the addict will be too terrified to explore other choices, a prime example of what existential philosophy refers to as 'living in bad faith' [5].

Case vignette: David

I illustrate this with the example of David (name changed in line with British Association for Counselling & Psychotherapy protocols), a client I worked with during my time at Terrence Higgins Trust. Brutalised and emotionally neglected as a child by an alcoholic father, David had developed a precarious relationship with many drugs over time, but felt that his alcohol/cocaine use was out of control and that this had directly led to his diagnosis. The objectification – inclined as he was, towards 'I-it', relating to having been a sex worker for some years – manifested by way of flirting, flattery and fawning behaviours because that had always been how he related to most men. It was a transaction. Men and sex were his business. Clients/patients do not change their brains when they come to see us and so inevitably patterns from other relationships will play out unconsciously [6] and this is something to be aware of, regardless of our role.

David was unable to have sex with his partner sober. It was perfunctory, frequently unsuccessful and often ended bitterly with arguments about, amongst other things, who passed the virus to whom. The therapy offered David the opportunity to explore a different way of being with a male figure, who did not objectify him or collude with his own inclination to objectify others, someone who would not see him as an object of sexual gratification and would challenge the patterns of relating with empathy and a 'tough love' stance that would target the 'bad faith'. However, and regardless of our role in the health and wellbeing professions, an empathic relationship with clients/patients needs to be our bedrock 'and there is little chance for trust to develop without empathy' [6]. By the time our sessions concluded, David was 6 months clean, committed to attending Narcotics Anonymous and passionately pursuing the creative, artistic career he had always hoped for.

Every little step: How 12-step philosophy can help you

The vignette offers a natural segue into further exploration of the philosophy of the 12-step tradition and its place in treatment and recovery for addicts. In addition, we can clear up some misconceptions that HIV-positive men have faced, regarding both HIV medication and any other prescribed drugs when they start their 12-step journey. For the record, data collated in the 1990s in the US indicate that Alcoholics Anonymous and its derivatives had at

that time collectively amassed a membership of up to 45 million [4]. An ironically sobering figure.

As a resource, 12-step meetings are an invaluable aid. Steeped in influences from existential philosophy, spirituality and some psychoanalytic traditions, they provide an easily accessible option when considering signposting and implementing an integrated care pathway for those who fulfil the three Cs criteria. While it may be verging on the sacrilegious to veteran 'steppers', I never encourage clients to become too concerned with the philosophy itself when suggesting they 'road test' a meeting. The power of meetings lies in the relational potential of being with others in a non-judgemental and empathic community, where acceptance lies at the heart of all things, along with a significant emphasis on personal choice and responsibility.

Personal testimony indicates, however, that for many HIV-positive men, who have attended *some* groups, confusion has reigned when they have been discouraged from using *any* medications of any kind. This advice indicates an incorrect and inaccurate reading of the philosophy and Tradition 10 (as it is known) indicates this clearly by stating that 'AA has no opinion on outside matters'. So to be clear, a prescribed medication, in and of itself, is 'an outside matter' [7].

The 12-step model is a classic 'disease' paradigm. But, while it may take this view, it does not seek to divest the addict of his or her part in recovery for while '… an addict may not be 100 per cent responsible for an addiction … he is completely responsible for his recovery' [7]. In other words, this is not some dark external entity visited upon the addict but something born internally as a result of what psychoanalyst, Heinz Kohut, called 'empathic failures or self-object failures' [4], where empathy is considered the critical factor in all human relationships but has been lacking or absent in the early life of the addicted individual. And this is where we all come in, perfectly positioned as we are to offer professional, appropriate and boundary-sensitive empathic connections to patients and clients, who are struggling with the triple-edged sword of addiction, diagnosis and relationships. This is supported by outcomes research conducted among wellbeing professionals (nurses, therapists, GPs *et al.*), which indicates clearly that the majority of patients/clients see the quality of relationship as the number one priority, in terms of engagement with services [11].

Dual diagnosis considerations for MSM living with HIV and addiction

In the last section, I mentioned the triple-edge. However, as if that were not enough, we need to add another – dual diagnosis [8]. A specialist area in the mental health field, dual diagnosis focuses uniquely upon co-occurring mental health and addiction/substance disorder conditions. In an article for *Healthline* in 2014, David Heitz drew attention to the prevalence of depression amongst the HIV-positive population in the US. He refers to research from 2001, which states that '… it showed that people with HIV run twice the risk of depression as those who are at-risk for HIV but remain uninfected' [12]. This figure, combined with robust evidence from a variety of sources, is substantiated by a 2012 study *Living On the Edge: Gay Men, Depression And Risk-Taking Behaviors* by Spencer Cox [13], Executive Director of the Medius Institute for Gay Men's Health in New York. He states that '… gay men with depressive disorders are at substantially increased risk for a variety of other negative health outcomes, including alcoholism, drug addiction and HIV infection', and as there appears to be a parallel replication here [14], awareness of service integration and signposting is the way forward. However, at risk of becoming the harbinger of bad news, the downside of the dual diagnosis where-does-one-end-and-the-other-begin conundrum is two-fold. Cuts over the past decade have found this specialist arm culled from most community mental health teams and most CMHT services are reluctant to take referrals for patients who are still using/in active addiction. So while it may not be perfect, knowledge of local statutory drug/alcohol services will at least provide alternative, additional resources and, if you are lucky, some form of psychological intervention strategy. It is not the perfect model, or anywhere near, so we all need to get creative, pulling strands of support from a variety of sources and never forgetting that no patient or client will need to go too far to link in with an appropriate 12-step meeting network.

Is the issue addiction? Broaching the subject

There are none greater at deflection, expressing defensive attitudes and self-justification, than those in the grip of active addiction. Holding on to the behaviours that have come to define them feels like life-or-death and, if those behaviours are to change, it is critical to recovery that something comes to replace them for '… whether people resist the experience depends on whether they have good reasons, or no good reason, for doing so' [5]. In addition, when addicts talk of the 'boredom' that often triggers their use, it is actually a state of non-being and non-feeling that they fear most and this is explored at length in John Firman's book *The Primal Wound*, which focuses upon this 'Without this, who/what am I?' dichotomy [4]. Again, this is where the role of 12-step programmes with their sense of community and belonging can never be over-stated. Encouraging the addict to see the bigger picture of their potential can be exercised by employing a concept from the

Psychosynthesis model of therapy, one of many humanistic approaches. Known as the identification/disidentification technique, which can also be successfully introduced to bypass the 'I hate labels' issue, it is, simply put, based on the notion that no one person is one thing and no one component of a person's psyche can define that individual's being all on its own, as overwhelming as that part may have become.

Psycho-educational and cognitive behavioural approaches can be very useful, as can motivational interviewing skills (this person-centred, directive approach is often the first choice for drug and alcohol professionals), but I believe these can be most economically and effectively used in group situations, where there is also a replication of the community, relational qualities of 12-step involvement. It formed the backbone of the addiction groupwork programmes I designed and delivered at Terrence Higgins Trust, the success and longevity of which might well suggest that this 'double whammy' approach certainly works for MSM in this particular format. Ideally, a more thorough, integrated approach needs to be in place that particularly addresses the therapeutic needs of addicted gay/bi men, those living with HIV, the many who may be working with the challenges of a mental health diagnosis, and finally those trying to juggle all three. As Alcoholics Anonymous wisely states: 'The roads to recovery are many.'

Spencer Cox's paper is overflowing with highly relevant information which is pertinent to this article, and I highly recommend it, should you feel inclined to investigate these issues further [13]. And if, as Cox has found, 'substance use and associated risky behaviours are generally highly correlated with depression,' we have little to gain by maintaining a conspiracy of silence around those gay/bi men who have often perilous relationships with addiction and their mental/physical wellbeing. As far as any patient is concerned, there might well be a weeping, wailing and gnashing of teeth when you introduce the issue of addiction as a possibility or something you are wondering about, but that need not stop you going there. The drama of denial is simply part of the addiction process. Patients/clients have survived much worse than an empathic yet challenging enquiry about their drug use, so a little compassionate scrutiny by way of clear questions on how they see their relationship with their drug(s) of choice and what their understanding of addiction is will not result in spontaneous combustion. It is unlikely the relationship they maintain with their 'love affair' substances will simply be about having a good time or aerobic sex sessions. As Michael Shelton references 'A 2007 study found that meth use not only increases sexual arousal and pleasure, but that it also temporarily clouded over any feelings of internalized heterosexism, sexual unattractiveness and concerns about HIV' [7].

But for HIV-positive men, when you combine the psychological factors with the unpredictable reactions likely when fusing combination meds, prescription drugs for mental health issues and recreational substances, there is a greatly exacerbated likelihood that something may well career off the rails at some point. Most will use drugs in their lifetime without any long-term adverse consequences as far as we know at this time. It will not trigger an addiction that lurks in the shadows and they will, for all intents and purposes, be fine. However, in the light of the issues raised here, our concerns therefore need to be firmly focused on the many who will not.

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