# Innovations in Counseling: Working with Minority Populations- Part 6
# Session 1: Opioid Abuse and Addiction Multicultural Assessment and Treatment Approaches- Part 1

**Webinar Follow-up Question and Answer Session with Dr. Todd Lewis**

**Question from Gary Gallitz**
Please address pending legislation regarding physicians prescribing limits.

Answer from Presenter
I am not an expert in legal matters regarding prescribing physician's responsibilities or limits; however, such legal considerations seems to be a state by state issue. I would encourage the participant to explore legislation in his state related to laws restricting or setting limits on physician prescribing.

With that being said, there is no doubt that physicians have had a role in the opioid crisis within the United States. This is a difficult issue because doctors want to help their patients feel less pain, yet in doing so they may inadvertently contribute to a full blown addiction. Physicians need to follow best practices, stay within their legal and ethical guidelines, and report instances where patients may be gaming the system. Some states, such as my state in North Dakota, have a prescription monitoring system that helps keep track of medical prescriptions. Such a system is designed to reduce potential "doctor shopping" and thus reduce the incidence of addiction.

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**Question from Jim Jaksha**
Please touch briefly on the effect of alcohol on neurotransmitters.

Answer from Presenter
The neurotransmitters typically involved in alcohol consumption include GABA, glutamate, endorphins, and dopamine. GABA is a well-known inhibitory neurotransmitter, and alcohol tends to increase GABA. This is why drinking alcohol can loosen inhibitions; people might do/say things they normally would not. Glutamate is an excitatory neurotransmitter, so alcohol's effect is to decrease this excitation, leading to an overall drowsy, depressant effect. Dopamine and endorphins are both increased with the ingestion of alcohol, leading to a pleasant/exciting and pain numbing effect, respectively.

Interesting note: If alcohol is classified as a central nervous system depressant, then why do some people feel giddy or have excitation when drinking? The reason is because alcohol's initial effect is to inhibit inhibitory neurons in the brain. When one inhibits an inhibition, the net effect is excitation. However, over time, the physiological effects of alcohol (i.e., depressing) catch up with the psychological experiences of the drinker. Thus, after consuming the first few drinks, the overall depressant effects become visible (i.e., slurred speech, stumbling, falling over, etc.).


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**Question from Claudia Reiche**
Is the 12-step program effective for opioid addiction treatment?

Answer from Presenter
Yes, the 12-step programs can be effective for any drug of abuse (and the so-called process or non-substance addictions). For opioid abuse, I would recommend Narcotics Anonymous, which would address any substance of abuse other than alcohol. In reality, however, some clients addicted to opioids may get a lot out of AA, and some clients addicted to alcohol might prefer NA. I would work with the client to see what meeting/group is the best fit for their situation.

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**Question from Mylene Silva**
For someone who does not believe in a higher power or God, do you believe they would still benefit from the 12 step program?

Answer from Presenter
The short answer to this question is "yes." It is true that the spiritual aspects of AA, for example, can turn some people off. However, it is important to note the AA emphasizes a spiritual higher power, however one conceives him or her to be. So, there is no pressure to adopt a higher power consistent with a particular religion. A higher power could be nature, the universe, etc. Twelve-step groups, and AA in particular, gather and meet for one, and only one, goal: To help people stop drinking (or using drugs).

The above points might be something that I would suggest to a client considering a 12-step mutual help group and who has concerns about the spiritual/religious elements. In addition, some home fellowships may emphasize the spiritual more than others. If clients attend a meeting, and they felt uncomfortable, then I would suggest another home fellowship as not all are created equal. Some meetings may have a more structured, distant feel whereas others might have a warm, relaxed feel. Encourage the client to explore but not to give up only after attending one meeting.

There are numerous alternative programs to the 12 steps, such as rational recovery, women for sobriety, and SMART recovery. These approaches de-emphasize the spiritual elements, incorporate more CBT, and tend to be more gender neutral compared to traditional AA groups (although women certainly can, and do, benefit from AA attendance).

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**Question from Allen Vosburg**
In working with a client, how do you get the clients trust and factual understanding of the client's cultural and personal view of opioid addictions?


Answer from Presenter

Earning client's trust should develop as the counselor builds rapport with the client. In working with a client from a different cultural background, it would be important to avoid giving the client a simple screening or assessment tool and, based on that, telling the client that you think he or she has a serious substance abuse issue. The client may not come back again. To build trust, I would infuse my intake and diagnostic assessment with cultural sensitivity and exploration. For example, I would ask about the client's worldview, assess their cultural identity, explore relevant sources of cultural information relevant to the client, how the client makes meaning of what brings him or her into counseling, and get a sense of the client's context (family, work, etc.) and how that impacts the presenting concern. I also, when possible, would consult with collateral family members or friends who could offer insights into the issue. After this process, I would feel better about broaching the possibility of an opioid abuse problem. I would share my concerns, but also invite the client to offer their perspective. Even if opioid abuse/addiction is not what the client wants to discuss at first, it may be possible to negotiate a discussion about this down the road. In my experience, however, including family members and other collaterals, who can confirm the abuse, tends to reduce resistance to discussing these issues.

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**Question from Connie Eggers**

Atrophy - does this occur due to aging? Does drug use speed this up?

Answer from Presenter

I would imagine that some atrophy occurs due to age, although neuroscience research has seemed to clearly establish that neuroplasticity (the ability of the brain to remain flexible and create new connections) occurs throughout adulthood. This is exciting news in that it was once believed that brain development pretty much stopped before young adulthood. Perhaps a more accurate way to describe this process as we age is the brain's ability to make new neural connections as we gain in experience, wisdom, etc. and prune neural connections that are no longer needed or useful. So, one might say that we have a more efficient brain as we age!

There is no doubt that prolonged and intense drug use, consistent with addictive behavior, contributes to or speeds up the weakening of the brain, especially the pre-frontal cortex. Of course, any loss of brain matter is a cause for concern, but the pre-frontal cortex is our "executive center" responsible for making sound decisions, planning, social negotiation and behavior, and personality expression. This can help explain why clients struggling with substance addiction have difficulty making healthy choices, maintaining healthy relationships, and expressing themselves appropriately.

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**Question from Connie Eggers**

What is your perspective about harm reduction programs that seem to be on the rise in the country and across the globe?

Answer from Presenter

I believe harm reduction programs are a valid way to address the addiction crisis we see in the United States. The reason I believe this is because total abstinence may not be a realistic goal when one first enters treatment, especially if he or she has been addicted for a long time. In addition, the approach is generally based on CBT and motivational interviewing, principles that I typically align with. However, as you may know, there is great resistance to harm reduction models, because some feel that it is condoning substance use. If clean needles are handed out as a way to combat the rate of infection, opponents would argue, aren't we just encouraging or enabling more drug use; where is the personal responsibility? Opposition typically comes from the political and more conservative segments of society.

My stance on harm reduction is that it can be a viable option for some clients. For example, a client who is relatively young, healthy, does not have a substance use disorder, and is highly motivated would probably benefit more from a controlled drinking plan rather than total abstinence. When it comes to alcohol, especially, we must understand that abstinence is not the norm in our society. Asking some clients to completely give up drinking, when a controlled program would be more beneficial, may turn them away from treatment.

For harder or illegal substances, such as opioids, I do not believe that harm reduction should be used indefinitely. What is the end game plan? What is the treatment goal? In these instances, harm reduction could be a means to an end (i.e., abstinence).

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