Counseling Challenge: "Hardcore" Drunk Drivers

Much attention is paid to the so-called 'hardcore' multiple recidivist. Usually that designation refers to those with 3 or more convictions, especially if they had high blood alcohol levels, and who have proven resistant to previous interventions (sanctions and counseling). Of course, since the nature of addiction is to continue use in spite of adverse consequences, that last is pretty much a given. If the substance use continues, so will the problems it causes.

A closer look reveals considerable diversity in the population. Some examples from our experience:

Carlino, *four DWIs in nine years, three treatments.* A science instructor at a local college, Carlino believes that it is possible for an alcoholic to reestablish control. He believes he succeeds for long periods, only to 'fall off' in the face of some environmental stress. His goal in treatment isn't to stop drinking. It's to modify his drinking behavior to avoid further arrests.

Manny, *six DWIs in thirteen years, four treatments.* A heroin addict in his youth, Manny hasn't touched drugs in years, and has several long periods of abstinence from alcohol. But something invariably happens (most recently, a funeral) to set him off on a binge that can last three to six months. He's known for showing up drunk at AA meetings and asking to serve as a bad example for newcomers. A deeply religious person, Manny believes only God can save him. He's puzzled that God has yet to intervene.

Janis, *five DWIs in nine years, four treatments.* A depressive, Janis abstains for a year or so, then, gripped by craving, binges for a few days. She blacks out almost immediately and at least once has awakened in the hospital following an accident. Janis believes she will never succeed in recovery until she finds relief for her cyclic depressions.

Thad, *four DWIs in nine years, two treatments.* A veteran who dropped out of treatment for PTSD, Thad regards the ability to drink when and where he chooses as an essential personal freedom. He is defiant in Court and as a result has served two jail terms. He sees himself as a political prisoner.

Carole, *three DWIs in three years, two treatments.* Acknowledges her alcoholism, but says it escalated following the unexpected death of her daughter. She's in therapy but can't stay away from alcohol for more than a few months. "I don't even know why anymore," she admits.

It's a group that presents very different issues in counseling.

First, a few guidelines for working with recidivist drunk drivers:

1. Assume you're facing a real challenge. No point in pretending that this client is like all the others. He/she has already demonstrated poor response to conventional treatment.
2. Assume the likelihood of relapse, and that it may be concealed. Chronic recidivist offenders require advanced monitoring and supervision. Some clinicians just aren't willing to take that step. They're probably better off avoiding this population. As one counselor put it: 'You need to be far more compassionate and far less trusting.'
3. Negotiate at the beginning. The key to a successful outcome may be agreements made in the first few sessions -- where boundaries are set. If we fail to negotiate the right parameters, we can find ourselves paying the price later.

In particular, four issues need to be negotiated early in the counseling relationship:

- First, *attendance and compliance*. It's one thing to hand the client a set of rules and regulations, quite another to expect them to be followed. Make sure the client knows your fixed and firm boundaries, since you'll almost certainly have to defend them during the course of counseling.
- Second, *a monitoring system.* Hopefully the Court provides leverage to convince the client to agree to a system of monitoring that is likely to work

even in the event the client wants to undermine it. Our job is set up such a program. Details vary depending on the client's circumstances. We'll provide a few illustrations as we go through the cases.

» Third, *identify the client's agenda*. We know what the Court wants. What does this particular hardcore drunk driver want? From treatment and from you. Make sure to ask. If it's unreasonable, address that up front. Otherwise work out some exchanges -- something the client wants in trade for something you feel will advance the goals of treatment.

» And fourth, you need *access to enablers*. Most alcoholics have at least one primary enabler. Be sure to insist on some level of communication with him/her. Expect some resistance from the alcoholic, however.

Now let's revisit those cases. They involve several different programs and clinicians, so you'll find variation in counseling approach and philosophy.

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Case Studies

Carlino and Manny

A popular conception of the hardcore drunk driver is someone who simply doesn't care. That's certainly not true in our first two examples.

Carlino, age 54, is a small, neat man who favors sweater vests and bow ties. Manny, 39, is built like a pro wrestler and prefers biker colors. They're both recidivist drunk drivers. Carlino has four convictions in 9 years, the most recent only 18 months apart. Manny has six in 13 years. Carlino has completed three prior treatments. Manny finished four, including five months in a rehab facility.

Carlino informs the counselor that as a scientist, he's researched the literature and is convinced an alcoholic can regain control through method and discipline. "I am fine for many months, drinking every evening after dinner, with no problems. Then something unexpected happens and I lose focus and allow myself to drink more than usual. I get in the car and after that it's mostly bad luck that I am arrested. I take full responsibility, of course," he warns, "but with better luck it wouldn't have happened."

Manny's experience couldn't be more different. When he was in his early 20's, he found himself strung out on heroin and other illegal substances and prayed to God to remove the affliction. A few months later he stopped using drugs completely. Now, years after, he's been praying hard for relief from his alcoholism and is surprised it has not come. His last binge lasted about twenty weeks. That's when he started showing up bombed at AA meetings, exhorting others to fall to their knees and pray.

The two have several things in common. Both are engaged in a fierce struggle with alcohol, albeit using different approaches. Neither appears close to victory.

Carlino

We shouldn't be fooled by the scientific trappings. Carlino regards his drinking as a moral problem -- evidence of some weakness in his own character that must be hunted down and vanquished. He's a devotee of willpower. He does blame some of the consequences on outside forces—such as bad luck—in a way typical of alcoholics.

In counseling, the clinician will help Carlino **reframe** his experience using the model of a progressive disease instead of a moral failing. She'll cite the decreasing gap between arrests, and the escalating BALs (.27 and .32) suggesting severe intoxication. Carlino's wife provides a valuable bit of information: despite 'successfully' completing several intensive outpatient programs, he's never actually stopped drinking for more than a week or two. In effect he's used the monitoring and structure provided by treatment to re-establish control over his alcohol use. When treatment ends, it creeps back up.

We might characterize Carlino as a longtime maintenance alcoholic advanc-

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ing to a later stage with accompanying loss of control. He hasn't had a physical in ten years, so that's something we want to encourage—to check the condition of his liver, for instance.

As they negotiate at the outset of treatment, the clinician has two main objectives. One is the physical exam, with disclosure of its results. Another is close monitoring for abstinence. She assumes Carlino will be tempted to cheat. She uses leverage based on his fear of consequences imposed by the Court to convince him to agree to work with a local program that ordinarily monitors impaired physicians and airline pilots. He has to pay out of pocket, but she insists. She knows that if Carlino can cheat, therapy will have no impact and become yet another waste of time and effort.

The counseling helps, but it's the monitoring that makes the difference. Carlino relapses once, but this time, he was trying to stay sober. His failure brought home the reality of compulsion in a way he hadn't grasped before.

Manny

Like Carlino, Manny views alcoholism as a moral problem, but related to sin rather than weakness of will. He expects prayer to banish it the way it did with his drug addiction. Only this time, it doesn't seem to be working. Nobody's more puzzled than Manny.

From a disease perspective, Manny simply abandoned heroin some years back, in favor of heavy drinking. Took a while to escalate, and the consequences were fewer because the drug was legal. But drunk driving has changed all that, and now he's in trouble again.

An in-depth interview with Manny's longtime girlfriend and his 18 year old daughter—over Manny's initial objections—strongly suggests a bipolar disorder that becomes obvious during periods of sobriety. When his mood changes, he has little control over his behavior, including the choice to drink.

So a psychiatric assessment becomes the first objective for negotation. The counselor also wants him on injectable naltrexone. That's expensive but the girlfriend has a good job and agrees to help pay. Third, the counselor wants a contract where Manny gives permission for his family members to inform her if Manny returns to drinking. He reluctantly agrees to all three, as jail appears to be the alternative. Manny had enough of jail when he was younger.

Sure enough, the psychiatrist assesses him as bipolar and places him on medication, with clear benefits. The naltrexone seems to reduce his craving and when he does relapse (which happens several times, usually on a Sunday), he's able to stop on his own. Manny eventually celebrates a year off alcohol and goes off the naltrexone. He's been dry before, but as his girlfriend notes, for the first time he seems sober.

An observation: The saying goes that when something you do is no longer working, stop it and try something else. That's the lesson both these hardcore DWIers needed to learn.

What if the counselor's approach hadn't been successful? Try something else.

Like the first set, these next two have something in common: an apparent co-occurring disorder. In the first instance, one that isn't responding to treatment. In the other, one apparently left untreated.

Janis and Thad

Janis, 33, has five drunk driving convictions in nine years, accompanied by four treatments. She views her alcoholism as a result of chronic depression. In therapy since her late teens, Janis has fallen into a pattern of abstaining for long periods, then, gripped by craving, bingeing for a few days. She blacks out shortly after she begins drinking and awakens in jail, sometimes following an accident. She wonders why her depression has not improved and is convinced she will never succeed in recovery until she finds relief for these cyclic depressions.

Thad, 41, has five convictions over nine years, with only two treatments, although one was during a six month jail term. A combat veteran who reports dropping out of treatment for PTSD, Thad regards himself as a revolutionary and his right to drink as an essential freedom. His view of drunk driving is that he is being targeted by the state because of his radical views.

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Janis

Given her years on different meds, Janis' psychiatrist advises it's unlikely she will experience the dramatic relief from depression that she seeks. Meanwhile, her annual or semiannual binges will probably result in further convictions and/or a far more serious accident.

Janis is mostly concerned about avoiding more sanctions. Her counselor quickly divines that Janis wants to fall back into passive compliance, the way she did in prior treatments. She's willing to show up on time for sessions and performed required assignments, but her motivation for change remains minimal. She gives the impression that she is convinced that for her, change simple isn't in the cards.

The clinician builds a treatment plan around active skill-building and motivational enhancement. She believes that Janis could stop her binges if she wanted to. "Janis has iron self-control," her therapist explains. "I'm convinced she gives herself permission to fall off the wagon when she feels she deserves a break. I want her to ask herself, 'how's that working'? The consequences are escalating the worst is yet to come. I hope to develop discrepancy between her stated goals and her pattern of behavior."

Of course Janis' real problem isn't during the six months she spends in addiction treatment. It's down the road when she next feels the desire to binge. Monitoring's not the issue. Janis is perfectly capable of completing yet another program and still relapsing on schedule. So in counseling sessions, they devote considerable time to possible alternatives to another drunken episode.

Thad

It's clear from the outset that Thad is next to impossible to treat in group. He's too defiant. He doesn't curse or yell, but neither does he allow anyone to express an opinion without intense disagreement. When Thad's around, group therapy becomes a debate. Rather than endanger the group, Thad's counselor decides to enroll him in individual sessions and required AA meetings. I imagine the other AAers weren't always glad to see him, but they let him stay.

The counselor decides that Thad uses intimidation by argument to distract from his own issues. That's easier to manage in individual counseling. For treatment, the counselor sets three objectives. First, a mental health evaluation for untreated PTSD. Second, close monitoring using an ankle bracelet to detect alcohol use of any kind. Third, strict documentation of attendance at all sessions (a problem for Thad in the past).

It was the mental health evaluation that redirected treatment. Thad indeed had a mild form of PTSD, but the primary diagnosis turned out to be antisocial personality. Thad had never been in combat. "I don't know how he got in the military, given his history of conduct problems", the psychiatrist told the program staff. Seen in this context, his behavior looked very different.

As for outcomes: Janis completed treatment and with support, went two whole years without relapse. Then she went on yet another binge. But this time, instead of getting in a vehicle, she called for help to visit the local detox. The counselor's comment: "Something must have got through, at least."

Thad also completed treatment. He did have one major weekend relapse that nearly got him thrown in jail. Still, he picked himself up and returned to counseling. At some point, he found a home in a support group for former offenders. Despite occasional slips, he hasn't been arrested in a number of years.

Carole's Case

Carole, 38, collected three DWIs in just three years, all with high BAL's, followed by two intensive outpatient treatments. Carol readily acknowledged alcoholism since her late teens, but claims drinking escalated sharply following the death of her teenage daughter. She'd been faithful to weekly psychotherapy and felt she'd made progress on grief issues. She couldn't seem to refrain from periodic relapses -- a few of which had resulted in arrest.

Carol was more motivated than most repeat offenders. She agreed to monitoring and expressed clear personal goals. And things went well for the first month and a half of treatment.

Then Carol began flirting with one of the male clients. Her counselor addressed this. The behavior seemed to stop. Another month passed. The male

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client's wife called to complain he and Carol were now dating. The clinical team confronted them. The male half of the couple dropped out. Carol seemed to improve. Yet another month passed. A client reported that Carol was living with a different man, an active alcoholic, and they were drinking together. Despite repeated attempts, the case managers were not able to contact Carol.

A year later, they learned she was in jail on yet another charge.

When asked what happened, her counselor shrugged. "Carol had a goal for treatment, but I guess it was to find some guy to drink with."

No point in pretending that this client is like all the others. He/she has already demonstrated poor response to conventional treatment.

Some observations by way of summing up:

1. Use leverage. Multiple recidivists are challenging to treat. But since they're often facing jail time, there is leverage that can provide additional motivation for treatment. Granted, it's external motivation, but maybe that's all we have.
2. It's not uncommon for recidivists to face multiple barriers to recovery. It's important to identify and hopefully address those problems to the best of our ability. Otherwise they can interfere with the course of treatment.
3. Chronic recidivist does not mean 'hopeless'. For the most part, these offenders are not all that different from others -- as one counselor put it, 'they're alcoholics, but more so.' Their recidivism may just be a reflection of some formidable barriers, or perhaps an inadequate intervention. Sometimes an adjustment in the treatment plan and the addition of close supervision can make a big difference in outcome.