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ADDICTION STUDIES: TO BE THE BAKER OR THE TAILOR

THE IMPORTANCE OF TREATING THE INDIVIDUAL RATHER THAN THE DIAGNOSIS

The only man I know who behaves sensibly is my tailor; he takes my measurements anew each time he sees me. The rest go on with their old measurements and expect me to fit them.

George Bernard Shaw

There are two types of people - those who come into a room and say, "Well, here I am!" and those who come in and say, "Ah, there you are."

Frederick L. Collins

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MASTER OF ARTS IN LIBERAL STUDIES
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TABLE OF CONTENTS

Abstract	1
Introduction	2
Stating The Position	3
Defining The Terms	5
How Did We Get Here?	12
What Are We Doing Here	15
What Is Working Here and For Whom	23
Case Studies	29
One Drink A Day – The Story of Fred	29
Cocaine and Karate – The Case of Nick	31
14 Years Old and The 12 Steps – Tim’s Struggle	34
Thank God It’s Not Drugs – Jack’s Drinking	35
Dope Makes Me Popular – Rick, Girls and Pot	36
Medical Complications – Triaging Tina	38
The Value of Seeking Wisdom – Jim’s Request	39
Wearing Suits to Treatment – Tom’s Makeover	41
Hung Up To Bleed – What About Max	43
Empowerment or Powerlessness – Matching Sue	45
Where Could We Be Instead	47
Conclusions	55

Works Cited

60

Author Biography

63

ABSTRACT

The objective of this paper is to illustrate the importance of using a highly individualized approach in addressing issues related to the prevention and treatment of alcohol and other drug abuse and dependence. Methods include the review of current literature and extensive case study examples from the author's clinical experience. The focus of the discussion is on increasing the effectiveness of prevention and treatment efforts. Recommendations include utilizing a broader range of methods, paying particular attention to the unique qualities of each individual.

INTRODUCTION

When I was first in training to be an addiction counselor, it was as if we were bakers. We believed we had a good recipe, and we took pride in the consistency and uniformity of our approach. After all, a drug was a drug and the only straight path to recovery followed the steps. The idea of a 'cookie-cutter' or 'one-size-fits-all' method was bound by the lore of tradition. It was just like the passing on of a favorite family recipe.

As time, experience and learning have passed it seems appropriate to exchange the image of baker for that of tailor. The best fit comes from careful consideration. Rather than consistency based on repeating the same recipe over and over, I now work to find the magic in the variety of differences. The challenge comes not from creating out of tradition, but from out of imagination.

This is a paper about alcoholism, drug addiction, treatment and recovery, but more importantly, this is about people. When a person develops serious physical symptoms, they will typically seek medical advice. A person with severe abdominal pain that persists without relief prompts a diagnosis of appendicitis from a physician. This diagnosis captures the condition while also suggesting a finite course of treatment. A period of recovery follows the surgery, and soon the person's health is restored. There is also no need for significant lifestyle changes to prevent the appendix from growing back, since once resolved, the problem disappears. Addiction is clearly not like this, and it is the goal of this paper to illustrate the difference between treating the person and treating the diagnosis.

In a zealous effort to provide help to as many as possible at one time, and to do so in the most cost-effective manner, treating addiction in a group setting has been the preferred approach. This has been driven in part by the belief that when people have the same diagnosis they can all benefit from the same treatment. The down side to this belief is that it ignores some of the best clues as to what will help each individual return to health. A “cookie-cutter” approach to treatment misses identification of the unique qualities of each individual that may be critical to recovery. Contrasting approaches between approaches to treatment, e.g. those that identify addiction as a disease (Jellinek, 1960; Milam and Ketcham, 1981) and those that see addiction as a response to living (Schaler, 2000; Trimpey, 1992; and Peele, 1992) will be explored. These perspectives will be compared to the belief that the most effective addiction treatment and recovery methods are those that are determined individually by the unique qualities of the person seeking help.

STATING THE POSITION

We are each a minority of one. Our individual collection of experiences, emotions, thoughts, and dreams that exist in each person provide unique imprints as to each person’s individual life. We may grow up in similar communities, attend schools that teach the same curriculum, invest our souls in the same religious community, and form relationships that on the surface may mirror our neighbors and family members as if we had been poured from the same mold. And while many of the challenges and burdens we bear may feel the same, in reality the truth is that we create our own sense of what is real. What makes us vibrate with life is as different as our fingerprints, and this is the central point of this paper. The keys to our recovery and restoration lie in those differences.

What takes a person from a healthy life and sends them spiraling into the depths of addiction is as varied as each individual. Factors that influence these differences include which

drug or drugs the person has used; their method of use and the duration and frequency of use; age; gender; emotional and psychological makeup; physical health and resilience; financial resources; strength of their relationships and the depth of their belief system. A slight degree of difference in any one of these factors could produce a differing of experience between two individuals that would demand a tailor-made response in order to best connect with each individual. Development of an individualized treatment plan needs to be a cooperative venture that takes into account the above factors, not merely diagnostic criteria. Forming a diagnosis is one very limited response. To suggest that this is all that is necessary to effectively treat someone is overly simplistic and ignores the unique nature of each person. What are critical to treatment and restoration are those things that may increase the likelihood of successful treatment (Prochaska, 1995; Miller, 2002). Assuming that a diagnosis of chemical dependency spells out a life-long permanent condition may reduce a person's hope that meaningful change is possible. A series of case studies taken from my own clinical experience will be presented later to illustrate how change is possible and a new model for recovery and restoration is needed.

In the first year of my work as an addictions counselor I was taught in supervision that there are three types of alcoholics or drug addicts: those that were already there, those that were on their way, and those who had died. The assumption being that once a person had used beyond their intentions, they had then begun an inevitable and progressive journey into addiction. Since this was held to be absolute truth, it followed that treatment of abuse would not differ from that of addiction, since it was thought to be only a matter of time before one led to the other (Jellinek, 1960). The insurance industry has added to this belief since coverage for in-patient treatment is only available for a diagnosis of dependence (White, 1998). This practice put clinicians in the awkward position of stretching the criteria to justify in-patient admissions. At a time when I was conducting assessments, I was told by a person from the marketing

department that it was expected that a certain percentage of my assessments would result in admissions to the in-patient unit.

The provision of treatment is also a business, thus creating pressure to admit people even in the absence of having true alcoholism or cocaine dependence. By contrast, the American Society of Addiction Medicine has recently published a revised list of placement criteria for five distinct levels of care (ASAM, 2000). These include: early intervention, outpatient services, intensive outpatient/partial hospitalization, residential/ inpatient, and medically managed intensive inpatient. These services are described on the ASAM web site as "...the type and intensity of treatment are based on the patient's needs and not on limitations imposed by the treatment setting" (www.asam.org/ppc/ppc2.htm). This is a recognition that a range of treatment services are needed due to the variation of clinical needs represented by people along a continuum of alcohol or other drug problems. Chemical dependence is not the same as addiction. Abuse is neither. These and a number of additional terms need to be defined as a preface to the discussion.

DEFINING THE TERMS

The following is an example of the potential process one may follow as their relationship with alcohol or another drug strengthens. This is not to suggest that this process is universal, or that once begun is an inevitable progression, or that there is only one way to prevent or stop such a relationship from occurring. These and subsequent terms in this section will be identified in italics.

NEVER

EXPERIMENTAL

REGULAR

ABUSE

PSYCHOLOGICAL DEPENDENCE

PHYSIOLOGICAL (CHEMICAL) DEPENDENCE

ADDICTION

Clearly there are those people who *never* use an illegal drug or consume alcohol before the legal age of 21 (in the U.S.). There are also circumstances in which a person may use a substance, have either a negative experience or no response at all, and never use it again. This is *experimental* use. When the person does have a reinforcing experience with a substance, the likelihood that they will use it again increases. *Regular* use exists when it is repeated without negative interference in the person's life.

Abuse exists when the person continues to use regardless of harm. For example, I may discover that there is a strong likelihood that enough drinking will result in vomiting, and I drink anyway. For this person, the perceived benefits outweigh any possible risks. There may be evidence that use does cause negative interference in the person's life, yet not enough to produce sufficient motivation for change. What propels a person to increase both frequency and amount of use is the development of *psychological dependence*, an example of this being when a person believes that the only way to manage their temper is by drinking. The significant point here is that the belief that managing one's thoughts, feelings and/or behaviors has been reduced to use of a substance.

Physiological or chemical dependence is identified when there is a withdrawal reaction if the person stops using. For some, repeated use becomes an effort to prevent the discomfort of withdrawal. This can become *addiction* when the connection to the drug is so strong that the

person will do anything, sacrifice anything in order to maintain a constant presence of the substance in their mind/body. This is a somewhat controversial term and is not used in the medical, diagnostic arena. The key in determining a diagnosis is making a distinction between abuse and dependence. On an individual basis, some may say that they have experienced addiction, as evidenced by the extremes of their behavior, while also claiming they have not experienced withdrawal. It may be critical for insurance reimbursement to establish a diagnosis, yet the process of returning to health for the person who is convinced by his or her own experiences, such a distinction may be irrelevant.

The most frequently used definition of *recovery* describes the person who has stopped using alcohol or another drug and is regularly attending meetings of a twelve- step group such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). This is a status that could continue throughout the remainder of a person's life, as it is generally assumed that attendance at AA or NA is ongoing. One could be in recovery for many, many years even though the actual use may have stopped decades earlier. To be in recovery is to be working out the damages from using, preventing relapse, and creating a life based on abstinence. There is a strong connection between this term and the notion that alcohol/drug dependence is a disease. This will be addressed further, but it is important to note that there are advantages in recognizing recovery as a process, not an event. Whether it is of value to see recovery as a life long process should be left to the individual, and it should not be set as a predetermined, inflexible definition either by addiction professionals or by members of any particular group. What matters most is the set of ideas and practices that work best for each individual. This is clearly the case regarding *treatment*.

Setting an appropriate course of treatment starts first with an assessment. This is not simply to determine which set of diagnostic criteria may best fit a person's symptoms. Most of the time, people know what they need and have a clear idea of which things they may be

motivated to address. An assessment needs to include the individual's sense of direction for his or her life. A critical aspect of this is to determine what it is that the person sees as benefits of their use. The perceived payoffs from the drug experience are what could propel the person back. It may not be the drug at all that the person craves, but rather a change in their thoughts, feelings or behaviors that occurs when they have used. The management of mind, mood, and action is often what the user is seeking. Recommendations from this assessment could include treatment among other resources that may help the person achieve their goals. When this is done effectively, it is art (*assessment, referral, treatment*). In an overly enthusiastic attempt to move someone quickly away from the damage of use, these steps might sometimes start in reverse order with treatment, followed by an assessment, then referrals. This reversed order may create a mess, since assumptions may be made about the client without first having the benefit of a thorough assessment. Then it is tar (*treatment, assessment, referral*). A third version of this process involves a person who is attempting to find treatment but keeps getting referred elsewhere until they finally find someone willing to help. They have been passed around, as unwanted as a rat (*referral, assessment, treatment*). The order of these events can be critical to the person's experience and clearly will influence the outcome.

Prevention does not need to be an educational, confrontational series of warnings about how quickly a person may develop addiction or die if they choose to experiment with mind-altering substances. The scared straight approach does not work on a mind that has not fully developed. In order for the warnings about possible damage to be effective, the listener has to be equipped with a mind that thinks sequentially. Prevention efforts of this type delivered to kids in grade school will not discourage drug use because the mind at that point does not process potential long-term effects. If adults do not always pay attention to significant risks, how can we expect children to do so? Prevention instead needs to focus on identifying and reinforcing those activities that provide access to acceptance, methods for responding to

boredom, and outlets for curiosity. This conclusion is based on over twenty years of asking people to recall the first time they used, whether it was alcohol, cigarettes or an illegal drug, and to consider what may have prompted that decision. The same three influences have been identified nearly every time: acceptance, boredom and curiosity. Interesting that these could be seen as the ABC's of prevention.

The role of acceptance needs special attention. When we say that kids use due to peer pressure, we are placing responsibility for the choice to use in the wrong place. We do what those around us are doing in order to either gain acceptance or to prevent losing it. Certainly there are examples of forceful peer pressure, such as the sometimes tragic results of fraternity hazing. More often are those situations in which kids decide completely on their own that they need to do what their peers are doing. The pressure is internal, not overtly applied to the extent that there is no choice but to comply. It may be that alarmed parents who find it impossible to believe that their child could decide to use a drug have supported this emphasis on peer pressure. Rather than individual responsibility for the decision, it may be easier when we can find someone else to blame. In any case, prevention efforts that focus on these ABC's do not even need to mention alcohol or other drugs.

There is a significant debate about the role of *spirituality* in both treatment and recovery. Even determining an operational definition of spirituality can be contentious. According to many who attend AA or other twelve step groups, recovery is not possible without a spiritual component. Supporters of Rational Recovery (RR), Self Management and Recovery Training (SMART) and Secular Organization for Sobriety (SOS) base their approaches on the thought process and do not see an influential relationship between spirituality and recovery. The relationship between spirituality and religion is often a key point in the debate. Is it possible for a person to have spirituality without a religious foundation? Is a belief in God necessary for spirituality? Is there spirituality in atheism? Does addiction exist

due to an illness of the spirit? For the purposes of this paper, spirituality is defined as the individual's beliefs about their relationship between their inner world and the physical world around them. As in other aspects of human life, there can be a highly unique quality to each person's spirituality. This is accepted as truth. Our beliefs are for us to determine, to nurture, and to experience. They are not to be imposed. To suggest that spirituality is required for successful recovery is to assume that without it a person cannot be fully human. Actualization is an individual process to be lived and not to be judged by an external evaluator.

A definition is needed here for *faith*. When someone asserts that they have faith, or encourages others to have faith or says that they are a person of faith, they are often referring to a faith in God. Not to diminish such a belief, but it is important to recognize other aspects of faith as well. Components of faith include trust, confidence, reliance, and patience. It is certainly possible to have faith in multiple sources. When one has faith in his or her self, they are trusting in the validity of their decisions. They have confidence in their ability to make reasonable choices. They believe they can rely on their own resources, and they have the patience to simply wait for an outcome that they believe will be beneficial. When one has faith in their family or friends these same components are in action. Some people will say that God will provide, while others say that the universe will provide. Faith is a belief in positive energy, whether it exists in the depths of the individual person or in some source outside of the self. The pursuit of practices that enhance one's faith is spirituality in action. The relationship between faith and fear will be addressed in a later section.

In recent years there has been new research that identifies how the neurotransmitter dopamine is affected by the intake of certain drugs, including THC, alcohol, nicotine, cocaine, heroin and amphetamines (Bohn, 2000). The increase of dopamine, which is responsible for the sensation of pleasure, is significantly greater due to these drugs than it is to food or sex. For

example, while sex can raise dopamine by 100% above normal, cocaine will cause an increase of 400%. This is the basis for calling addiction a brain disease.

The American Medical Association first classified alcoholism as a disease in 1956. The American Society of Addiction Medicine offered a further clarification in 1993, adding that "...a disease represents an 'involuntary disability' (Kinney and Leaton, p. 58). The basic components of any disease are that it has a recognizable set of symptoms and a specific cause. There has been considerable debate about whether alcoholism or drug dependence are in fact diseases.

Schaler (2000) calls addiction a choice. The position developed in SMART is that people experience problems due to alcohol/drug use because they base decisions on irrational thoughts and feelings, which is similar to the RR position (Trimpey, 1992). A significant difference with RR is that it is entirely individual and does not rely on groups at all. In addition, Trimpey (1996) has developed an approach called Addictive Voice Recognition Technique, which focuses on recognizing "Any thinking, imagery, or feeling that supports or suggests the possible or actual use of alcohol or drugs – ever". Peele (1992) has proposed a Life Process Program, asserts that addictions are not diseases, and goes into significant detail to disprove the entire disease model. Other aspects of the debate include whether there is a progression that is inevitable and whether this is a disease with a cure. It is quite clear that how these questions are answered will have enormous influence on the full spectrum from prevention, to policy, to treatment, to continuing care, and to how the recovery process is defined. When the disease model is not followed, there would be no such thing as recovery, since the person had not been sick in the first place. Abuse is not a disease. Chemical dependency and alcoholism are. To say that dependency automatically follows from abuse is no more accurate than to say that pneumonia is an inevitable result of a head cold. In the next section, the history of changing

ideas related to both the use of mind- altering substances and to the treatment process will be presented.

HOW DID WE GET HERE?

There is evidence to suggest that the Sumerians in 5000 BC had used opium, and that in 3500 BC the Egyptians had a brewery (Szasz, 1974). Grinspoon and Bakalar (1997) state, "...cannabis may have been cultivated as much as ten thousand years ago" (p. 3). Proverbs 31:7 suggests, "Let him drink and forget his poverty and remember his misery no more". Human beings have engaged in the use of alcohol and other drugs for a variety of reasons for many generations, whether that use was intended for the purpose of altering consciousness or simply engaging in a social event. Religious practices include the symbolic use of wine in the Christian church; the use of peyote as a sacrament in the Native American Church; the use of ayahuasca in South America; the use of iboga in West Africa; and the belief among Rastafarians that cannabis, or ganja, provides access to God. The use of alcohol in offering a toast for everything from birth to death seems so pervasive in Western culture that choosing another beverage instead may be interpreted as an insult. The assumption is that one always shares a drink under such festive circumstances.

Although there has been a significant increase in knowledge about the effects of cigarette smoke, particularly including the evidence of deaths associated with exposure to second- hand smoke, it was not very long ago that the act of blowing smoke in someone's face could have been seen as a flirtation. In each of these examples there is cultural permission that supports or encourages the use. Changes in the extent of influence from politics and religious beliefs have determined whether the use of alcohol or other drugs would be identified by society as acceptable or reprehensible. Montagu (1962) describes this potential difference depending on how a behavior may be interpreted.

What may be considered immoral when the individual chooses to act on his own initiative, murder, for example, may become perfectly acceptable when society sanctions it as in war or in the execution of a criminal (p.151).

Society has also developed a number of circumstances under which one could achieve an altered state of consciousness without the use of alcohol or drugs that are completely approved, honored and even celebrated. The opportunity to go beyond the so-called normal limits of perception is certainly not limited to whether one chooses the use of a legal or illegal substance in order to expand their consciousness. Examples of this include: the encouragement offered by coaching staffs and athletes to “play through the pain”; the clinical use of hypnosis as a treatment method; the extent to which psychotropic medications are prescribed; the pursuit of a religious state of rapture, sometimes referred to as ecstasy; the practice of meditation; and the enjoyment of movies and live theater, which depend on the suspension of reality. Whether one’s perceptions have been changed due to the presence of a chemical or due to an acceptable social experience, the event could have a range of consequences. What is critical at this point is when the use of alcohol or other drugs extends to the point of abuse or addiction and to examine how the process of conducting treatment has evolved.

William White (1998) has written extensively about addiction treatment, both in historical contexts and regarding current approaches. He describes how addiction was conceptualized in the 19th century as ‘inebriety’.

If one central idea was shared across the spectrum of early treatment programs, it was the concept of ‘inebriety’. ‘Inebriety’ encompassed a wide spectrum of disorders that resulted from acute or chronic consumption of psychoactive drugs. ‘Inebriety’ was the term that captured the morbid craving, the compulsive drug-seeking, and the untoward physical, psychological and social consequences of drug use (p.34).

This definition does not seem significantly different from the current description of substance dependence, which is referenced when developing a treatment plan and to collect insurance reimbursement. However, would either definition make a real difference to the person who is attempting to change his/her life? As one decides whether they have inebriety or the disease of

addiction, how will that decision result in a set of new ideas or skills that will enable the establishment of a new healthier lifestyle? White goes on to offer a statement that is consistent with the point of this thesis.

One of the most striking aspects of the stand taken by the inebriate asylum leaders was their belief in a highly individualized approach to the treatment of inebriety. The 19th century inebriety literature posited that alcoholism and other addictions sprang from multiple causes, presented themselves in different patterns of use and choices of intoxicants, and required highly individualized treatment approaches (p. 37).

How did it happen that while there once was the perception that “highly individualized” treatment should be the norm, the standards later became focused on the perception that group was the only viable approach and that addiction is a progressive illness that affects people in highly predictable ways? It is important to point out here that the influences of the growth of Alcoholics Anonymous, the nearly uniform adoption of the disease concept of alcoholism/addiction, and the role of insurance reimbursement for treatment have each contributed to the development and reinforcement of an approach very different from that of the ‘inebriate asylum leaders’. What was intended to be a goal of increasing access for help and decreasing stigma associated with addiction became a diagnosis-focused business, driven by money rather than by a change process with the central focus being the needs and character of the individual.

It does make sense that a move away from a moral perspective, and its accompanying stigma, would provide more relief and understanding to the person suffering from the consequences of their use. If this could open the doors for more people to get help, then it clearly would be beneficial. A treatment focused on science and research would also be more appealing to the insurance industry as it attempts to reduce costs. The increase in outcome driven approaches reflects this: as the likelihood of success increases, the frequency of relapse and additional expense decreases. This may be an interesting theory, but it still does not account for the vast variety of the human experience. One size never fits all.

WHAT ARE WE DOING HERE

An individual's use of any substance is in part due to the influence of the culture in which the person lives. It is important to point out some of those influences. There are unintentional contributions made to the extent to which people develop unhealthy relationships with alcohol and other drugs.

An often insidious attempt to manipulate the behavior of consumers spreads like wildfire from the desks of advertisers. In the last few years, for example, medications that once were only advertised to physicians are now regularly hawked on television, radio and in print. I have a distinct memory of the first such ad that I saw. There was a pastoral scene with rolling deep green grass and equally deep blue sky, dotted by mattress shaped clouds with the word *ambien* floating across the screen. A melodious voice deeply intoned, "Ask your doctor about ambien". There was no description of why a person might take this medicine, how much to take or any mention of the effects or potential complications from its use. The advertiser appears to have determined that a sale can be made by showing a pleasant scene, adding a seductive voice and suggesting that a doctor would know more. In another such ad, a man is seen walking through his yard and stopping by his shed to pick up a football. He then attempts to throw it through a tire swing and misses. The narrator then suggests that if he wants to "get back in the game" he might ask his doctor about a particular medicine. Again there is no mention of what this pill is intended to treat. The viewer is left to decide. Although it is never specifically mentioned, apparently the image of the football actually penetrating the tire swing is enough to reveal that the medicine is for erectile dysfunction.

The pharmaceutical industry has an annual advertising budget of fourteen billion dollars, while the tobacco and alcohol industries spend nine and three billion respectively on their advertising (Kilbourne, 2003). What this means is that we are confronted by twenty-six

billion dollars of ads encouraging us to take medicines, use tobacco products, and drink in order to make our lives more manageable. Even something as benign as headache medicine is presented in one ad as an invaluable solution to the staggering pressures of getting through an airport. Are we that incapable of tolerating stress? In my own work with college students and their family members I am often exasperated by learning that someone may have been given a prescription for a psychoactive medicine, such as anti-depressants, anti-anxiety, and anti-psychotic medications, with no concurrent therapy to assist in addressing the presenting complaints. The message appears to be that the solution rests in the pills, and that nothing else is necessary. This sets up a dangerous relationship, which once again encourages the use of a substance as a panacea for managing thoughts, feelings or behaviors. It is not ethical to simply offer a prescription without also adding the expectation that the person would be engaged in supportive therapy, even if it were just for a brief intervention. At least with that qualifier the person would not be getting the message that their solution comes in a bottle. As defined earlier, psychological dependence occurs as a person develops a relationship with a substance in that it becomes their method for managing thoughts, feelings or behaviors. Is it really that surprising then that these dependencies continue, in light of the twenty-six billion dollar effort? In this sense there is at least a portion of our culture that supports and expects our regular use of alcohol and other drugs.

Another related example of negative advertising, or at least advertising in very poor taste, can be seen in the titles of three perfumes. First, in 1977 Yves St. Laurent introduced *Opium*; then in 1985 Calvin Klein added *Obsession*; then completing the cycle in 2003, Christian Dior's new perfume was called *Addict*. By this time, a strong advocacy group (*Faces and Voices of Recovery*) had formed and through its efforts Dior was forced to change their campaign. There is nothing glamorous about addiction, nor should it be promoted in any way that diminishes the seriousness of how damaging it can be.

Although the campaign to encourage designated drivers does a good job reinforcing the dangers of drunk driving, it also offers the unspoken permission to get as wasted as one wants as long as someone else is there to be responsible. This is shown by two cab companies where I live in Madison, Wisconsin. One of the cab companies has often run an ad during the winter holiday season suggesting “Don’t be a drunk driver, be a drunk passenger”. As part of a recent ad for “The First Annual Bacardi Madbat Pub Crawl”, there is another cab company ad that says: “Drinking & driving don’t mix. Do you think crawling and driving do? Crawl safely with us”. In both cases there may be a genuine effort to decrease drunk driving, but there is also a clear support for heavy drinking. Even if the ads are presented in a satirical tone, the priority in both is not to reinforce safe, moderate drinking but is to simply keep the drunken person from driving. This is particularly risky in light of the fact that Wisconsin residents consume more beer per person than in any other state (Kilbourne, 2003). In addition, there was legislation recently suggested, only in Wisconsin, which would allow nineteen- year- old members of the Armed Forces special permission to drink. This was based on the notion that if a person can be trusted on the battlefield with deadly weapons, then they can also be trusted with a beer. Unlike military training, which provides months of detailed preparation before being placed in combat, there is no such training provided which helps people to establish responsible drinking habits or to recognize signs of alcohol impairment. This is an absurd argument.

It is very revealing to look at how television ads for beer have progressed. It has often been my experience in working with college students that there is a belief that as long as a person only drinks beer, they will not develop alcoholism. Can advertising have played a part in creating this belief? Michelob once had a campaign that said, “Holidays are made for Michelob”. This seems completely benign, assuming there may be ten holidays across a year’s time. Apparently this was not capturing the full value of Michelob as the campaign then

became, “Weekends are made for Michelob”. This progression went on to increase first to “the nights”, then finally “some days”. As the numbers of recommended beers increased from the occasional holiday to each night, and some days as well, there was no accompanying statement about any possible risk from this increased consumption. Not to be outdone, another ad then appeared from Miller announcing that it was “Miller time, 24/7”, in other words every hour of every day we should be having a beer.

Efforts to find an operational definition for “responsible drinking”, the phrase now included on most alcohol ads, only resulted in finding admonitions against drunk driving and in reinforcing the minimum drinking age of 21. This effort included an attempt by telephone with the Miller Brewing Company, which ended after being transferred countless times and finally being given the suggestion that the local distributor might be helpful. People are encouraged to drink, to drink frequently and heavily, and just to avoid driving when too drunk to do anything beyond crawling.

Regarding the use of drugs other than alcohol, it is important to address the positions taken by the federal government. The current director of the Office of National Drug Control Policy (ONDCP) is John Walters. This office produces, among other things, commercials directed toward prevention. President Bush appointed Mr. Walters, as previous Presidents have also done during their administrations, beginning with Nixon. In keeping with the “War on Drugs” theme, it is not surprising that an Army general has held this position (General Barry McCaffrey, in the Clinton administration). It is not the intention of this paper to address politics at length. However, there were three comments made by Mr. Walters at a national prevention conference in Washington D.C. in 2001 that need to be addressed. I had attended this conference with the expectation of hearing about how prevention efforts were done at various colleges. I was not sure why Mr. Walters was asked to speak, and was told by conference personnel that it was “the politically correct thing to do”. The first statement by Mr.

Walters was: “We have to find a way to make people stop”. It seems clear to me that any student of psychology would know that we do not have the power to control the behavior of others. Mr. Walters then said, “No one gets well on their own”. This is simply not true and is both disrespectful and insulting to those people who have independently stopped their use of a variety of substances, including nicotine, alcohol, marijuana and narcotics. The third comment clearly demonstrated a lack of understanding about how addiction develops. Mr. Walters said: “Casual users are carriers of the disease of addiction”. Does this mean that addiction is infectious? This is particularly alarming since it is the ONDCP that speaks for the White House regarding potential policy decisions related to the use of alcohol and other drugs. The person who directs that agency would be best prepared to do the job if he/she were an expert in the prevention and treatment of addictions. According to a biography available on the ONCDP web site, Mr. Walters does have a significant amount of experience working with the agency, but there is no evidence of experience as a treatment provider. Prior to his work with ONDCP, Mr. Walters taught political science. It is not necessary for a person to have overcome their own addiction in order to understand the process or to help others in their efforts to get healthy. It is also not enough though to simply have years of experience as a political appointee.

It seems there may be a certain amount of romantic fascination with the extent to which people can become intertwined with substances. There are countless examples of this in popular music, television, fiction and movies. For example, concert footage of an Eric Clapton performance may include the audience enthusiastically shouting “Cocaine” during the song of the same title. There was even a period in fashion when an extremely thin look was referred to as “heroin chic”. We are encouraged to make frequent use of alcohol, tobacco and a variety of other drugs. The process of becoming sick from excessive use is popularized. The opportunity to be under the influence is encouraged, as long as there is at least one person who chooses to

be safe and rational. If only the end result of requiring the benefits of treatment could be so strongly supported.

What we are not doing now is providing adequate help. The disparity between the need for treatment and actual access to treatment is noted by the Substance Abuse and Mental Health Services Administration (SAMHSA).

In 2002, 6.3 million of the 7.7 million people needing treatment for an illicit drug problem, never got help. Of the 6.3 million, only 362,000 reported that they felt they needed treatment for their drug problem, including 88,000 people who knew they needed treatment, sought help, but were unable to find care (available at: http://alt.samsha.gov/news/NewsReleases/040303fs_atr_facts.htm).

SAMHSA also makes a statement in this same report that is in direct support of the thesis of this paper: “When tailored to the needs of the individual, addiction treatment is as effective as treatments for other illnesses, such as diabetes, hypertension, and asthma”. Despite the focus on addiction as a disease, and the frequent relapses that often accompany it, there are significant limits placed on how much insurance will cover for treatment of addiction as compared to treatment for other forms of disease. Even when a person has health insurance, there is no guarantee that adequate coverage will be available. Both the National Association of Alcohol and Drug Abuse Counselors (NAADAC) and American Society for Addiction Medicine (ASAM) have taken positions on this issue, which is identified as parity. NAADAC offers a definition of parity.

Parity defined: If a plan offers a mental or addictive disorder health benefit, it must be equal to the medical benefit the beneficiary is entitled to. Parity does not mandate a plan to offer mental health and/or addiction treatment benefits, only to match what is offered regarding the medical benefit.

Addiction is a brain disease and the objective of enacting parity is to achieve the same medical coverage for brain disorders equal to those for other organ systems and medical conditions (relapsing diseases such as diabetes) (available at: <http://naadac.org/documents/print.php?DocumentID=119>).

The ASAM Public Policy position states specific recommendations as to the implementation of parity in insurance benefits and notes that "...addiction and other substance-related disorders are misunderstood and stigmatized conditions".

ASAM recommends that coverage for alcohol, nicotine and other drug dependencies should be non-discriminatory on the same basis as any other medical care. Caps or limits on numbers of treatment visits, days or payments should be applied in the same manner as with any chronic disease. Thus, there should be parity of health insurance benefits, such that addiction care benefits, copays and deductibles would be at-par with benefits, copays and deductibles for general medical care (available at: www.asam.org/ppol/Parity%20in%20Insurance%20Benefit%20Structure.htm).

The mention of stigma is an important point. While some medical issues are thought to have developed in a sense on their own, the development of an addiction is often seen as a failure of a person's self-control or as a sign of a weak character. Most people would not question that a person has no influence over the development of breast cancer. Therefore she is not seen as someone who has chosen the illness or who has been the victim of a self-inflicted disease. Treatment in this case is clearly seen as addressing a medical issue and is not weighed against a subjective measure of the woman's individual character. For example, when my wife was treated for her breast cancer, every intervention from medicines through surgeries was completely paid by our insurance. As this included specialist appointments, chemotherapy, radiation, two surgeries and three hospital stays, I can only guess at the actual total expense. The same policy when applied toward treatment of addiction allows for a maximum of \$6300 for a calendar year. Why is there such a significant difference? One answer rests on the fact that the addiction process is still seen by some as a condition that at the very least originates with individual choice, and for some people this position still includes the belief that addiction is a matter of moral weakness. Included in this belief is the contention that building a stronger force of character is not a medical issue, therefore addiction treatment should not be covered by insurance. As mentioned earlier, the advocacy group *Faces and Voices of Recovery* is now

focused on efforts intended to eliminate the stigma and to reinforce the research-based conclusion that addiction is a brain disease. One great irony here is that there is evidence to indicate just how effective treatment can be. This is described clearly by Wesa and Culliton (2004).

The costs of addiction treatment provide a return to society between three and seven-fold with respect to employment, health insurance and to society within three years after treatment (p. S-194).

As the treatment of addictions expanded, and as the perception of how addictions developed increasingly included the disease model, there was an effort in the field to reduce the stigma. The hope was that there would be benefits to the patients in reducing their feelings of guilt and shame, since now they could identify themselves as having an illness, with an additional benefit of being able to provide more treatment as the medical and insurance communities would increase their acceptance of addiction as another treatable illness. White (1998) describes how over zealous efforts in the addiction treatment field during the 1980's actually contributed to the limitations being placed on insurance reimbursement for treatment.

In response to inappropriate admissions, pre-admission approval by an independent assessor was now required. In response to the field's inpatient bias, some insurance companies required prior failure (or a designated number of failures) in outpatient treatment as a criterion for inpatient admission. In response to treatment programs' practice of recycling chronically relapsing clients again and again, companies set limits on the number of days or dollars that could be expended for addiction treatment in a year, or in a lifetime (p. 283).

This section has described how the use of alcohol and other drugs is in some ways encouraged by aspects of culture and advertising. The political forces that could have a positive influence on public understanding, prevention and treatment appear to be unqualified to do so. Even the addiction treatment field itself has contributed to a lack of progress in effectively addressing these issues. The next section will discuss a variety of treatment approaches, describe those factors that stand as challenges against success and will offer case studies to explore the question of whether the intervention fits the individual.

WHAT IS WORKING HERE AND FOR WHOM

There are different outcomes for success when it comes to the consequences of addiction. The insurance industry would define successful treatment as being the most cost-effective. Employers would identify increased productivity as a measure of success. To a family member, having the return of a predictable household, honesty, trust, and fulfilled promises would all be important indicators of success. The treatment field might include the completion of all the required steps in an imposed treatment plan as being successful. In the political arena, successful interventions would include the amount of eradicated fields of coca, marijuana and poppy plants, the number of drug arrests and convictions, the amounts of confiscated drugs, and decreases in crimes associated with alcohol and or drug use. Physicians and medical researchers would use decreases in the frequency of medical complications associated with alcohol and other drugs as evidence of success. Those people who utilize AA would identify the length of time spent sober as synonymous with success. Practitioners of harm reduction therapy would say that success exists with any change. And, while some of these are measures of quantity while others are of quality, attaining the desired result is ultimately what determines success. When there is a conflict or a disconnect between differing ideas about what constitutes a desired result, herein lies the critical question that begins our discussion in this section. Whether or not the individual has received the most effective and meaningful help in direct relationship to their unique circumstances and needs is the critical issue we will explore.

Although it would appear from the amount of references made to participation in AA and NA throughout the literature and in the media, nevertheless the majority of people find recovery elsewhere. Fletcher (2001) has written about the various ways people have overcome problems with alcohol. The contributors to her research were referred to as 'masters'. She

defines master as “continuously sober for five or more years” (p.3). Fletcher then summarizes the methods used by a total of 222 masters.

<u>Recovery Method</u>	<u>Number of Masters</u>
Traditional recoveries (twelve-step)	97
Nontraditional recoveries	125
Sober on their own	25
Secular Organizations for Sobriety (SOS)	18
SMART Recovery	13
Women for Sobriety	15
Went to AA, but quit	12
Multiple paths	25
Treatment center, then on their own	5
Psychological counseling	3
Religion	4
Moderation Management	1
Rational Recovery techniques	4 (p. 20)

This list is meant as an illustration of the range of ways in which one can find recovery. It is not intended to be all-inclusive, nor does it suggest that those methods with greater representation are in some way superior to the others. The point cannot be overemphasized: there is not just one successful route to recovery, but there in fact may be many.

Hester and Miller (1995) describe the results of their extensive literature review in supporting their conclusions regarding the effectiveness of alcoholism treatment approaches.

This led us to a third collaboration to review the literature on matching clients to treatments. Here, we found evidence that different people respond best to different approaches. This makes sense, of course. Why should any one approach be best for everybody? Yet in our observations, relatively few treatment programs were, in reality, putting this common-sense fact into practice. Instead, most programs offered a relatively consistent program to all clients. Worse, clients who failed to respond to the offered approach were often blamed for the failure because of being “unmotivated” or “in denial”. Would it not be more effective to offer a range of alternative approaches, from which each individual could be offered an optimal strategy for his or her particular personality and situation? (p. xii).

Hester and Miller reviewed a total of 219 studies regarding the treatment of alcoholism and evaluated the effectiveness of each treatment modality represented in the studies. Their results strongly suggest a very critical re-structuring of most traditional treatment programs. In fact, the primary aspects of many treatment programs were rated as the least effective. On the

bottom of the list as least effective were, in descending order, Confrontational Counseling, Psychotherapy, General Alcoholism Counseling, and as the very least effective was Educational Lecture/Films (p. 18). During the first seven years of my clinical experience, the main focus of treatment was confrontation. In addition, the patient population was given either a lecture or film at least once each day. In contrast to these methods, the modalities ranked on the top of the list included Brief Intervention, Social Skills Training, Motivational Enhancement and Community Reinforcement Approach (p.18).

The National Institute on Drug Abuse (NIDA) published a list of research based “Principles of Effective Drug Addiction Treatment” in 1999. In particular, four of these principles are specifically applicable to this discussion. These four principles are highlighted in bold as presented by the authors, including the additional commentary for each.

No single treatment is appropriate for all individuals.

Matching treatment settings, interventions, and services to each individual’s particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

Effective treatment attends to multiple needs of the individual, not just his or her drug use. To be effective, treatment must address the individual’s drug use and any associated medical, psychological, social, vocational, and legal problems.

An individual’s treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s changing needs.

A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual’s age, gender, ethnicity and culture.

Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

Although the importance of individualized treatment is clear, some critique of these four principles may be offered. First, the continual assessment and modification of the treatment plan needs to be a consistently negotiated process, with the focus on the patient's goals rather than on a clinician's imposed set of goals and objectives. Second, even though there is sensitivity to the value of long-term treatment, there is still the issue of parity. There is no mention in these principles of the issue of cost and the importance of reimbursement and payment systems and policies, which will actually support long-term treatment opportunities. Finally, although maintaining abstinence can certainly be a goal, it is not the only measure of success. Harm reduction principles support the idea that any change is progress. Effective treatments are those that bring about change.

Support of a highly individualized approach is further reinforced by Wesa and Culliton (2004), describing how an optimal healing environment (OHE) can be developed by practitioners as an outcome of conducting a thorough evaluation.

Because one specific treatment is not effective for all people and for all of the addictive disorders, using a holistic approach and individualizing the treatment regimen is the recommended approach to disease intervention and establishing an OHE (p. S-193).

In describing the variables that comprise an OHE, Wesa and Culliton provide a very complete list, including aspects of staff and facility functioning in addition to the specific details that determine an accurate assessment. What sets this work apart is that it includes a focus on the role of the counselor and of the treatment environment, which reinforces the notion that treatment should be a collaborative effort. The impact of the therapist is also referenced by Andreasson and Ojehagen (2003).

With psychological/psychosocial treatment in general, and with treatment for substance dependence in particular, the characteristics of the caregiver and his or her ability to involve the patient in therapy has an impact on the outcome. It has been found that the results from the same treatment of patients with the same characteristics may vary considerable among different therapists, and the importance of the therapist may even be greater than the methodology used (p. 78).

Hanninen and Koski-Jannes (1999) studied the differences in the way people would create a narrative description of their successful recovery. The results were categorized in five story types. The authors concluded that there was a significant variety in the factors that people identified as critical to their process.

The profound differences between the story types found in this study indicate that an addiction can stem from various kinds of problems and that there are many routes to recovery. This suggests that the attempts to find one all-encompassing explanation or one patent solution to all addiction problems might be not only futile but even harmful in repressing the deviant voices. Clients in treatment should be encouraged to create and express a story that fits their own experience, to make full use of the cultural stock of stories and not to comply blindly with any pre-existing narrative model (p. 1851).

In all fairness to the history of the treatment field, it should be noted that the research that has resulted in these recommendations and principles is fairly new. For many years addictions treatment programs were staffed by people who had found their way to health and sobriety by attending AA, and later NA, meetings and practicing the principles of recovery as suggested by the twelve steps. Perhaps these enthusiastic counselors were so thoroughly steeped in the value of their own experience that they were blinded by their success, and possibly even threatened by the idea that another approach could be equally as valid. Therefore an unshakeable faith in the effectiveness of the twelve steps formed the basis of the treatment programs. Even the simplest of slogans offered for support may have created resistance to new ideas. “It works if you work it”, “Keep coming back”, and “Don’t drink and go to meetings” each could reinforce the idea that the only way to find success would be through “working the steps”. There has been considerable effort over the last twenty years to honestly evaluate the process of treatment, and the implementation of new research into the field will continue to be slow.

There are a number of factors that can either prohibit or promote any individuals

efforts toward recovery. These can be summarized under four general headings: physical, psychological, social, and spiritual. Regarding the physical factors, not all treatment providers are equipped to provide accommodations for people who have physical or sensory disabilities. Even simple geography can be a barrier for people who may live some distance from the nearest available treatment. As has been said above, the lack of either insurance coverage or adequate cash to pay for treatment can be prohibitive. A major psychological factor, if not the most crucial issue, in accessing, participating in and completing treatment is motivation. An entire treatment modality, Motivational Enhancement Therapy, has been developed to address this critical point (Miller and Rollnick, 2002). In addition, goal orientation and level of self-esteem are also psychological factors. Social factors would include the extent of the support network the person may already have or can reasonably rely upon, their ability to engage in developing new friendships, their level of assertiveness in seeking assistance, and how well they will accept feedback from others. It has been evidenced in both my personal and professional experience that people who are not particularly social in nature may have a more difficult time securing recovery. Active addiction is often expressed in isolation, while recovery is about connecting.

The role of spirituality has been identified as part of the addiction process, has been included as part of an assessment, has been incorporated into treatment programs, and it is often set apart as the key ingredient in the formula for ongoing recovery. The merits of each of these points have been developed into lengthy articles and books. It does seem clear though that when a person has a clearly defined belief system, it can only add to their repertoire of effective resources. Throughout my twenty years of experience, I have consistently seen a powerful relationship between unresolved grief and either an inability to achieve healthy recovery, or a relapse even after what would appear to be a significant period of successful recovery. It seems that when faced with the reality of death, or of a traumatic loss, people are

often not prepared to process the intensity of their feelings. This may be somewhat easier for the person who practices a religious tradition, as they have a clearer framework from which to draw some understanding of what death means. In any case, retreating into the blur available from alcohol or another drug can become preferable to the weight of experiencing the full pressure of active grief. As a part of any assessment, I always ask whether the person has ever experienced a significant loss and whether they can say with certainty that they have effectively resolved their grief. This is one situation in which I might be more likely to push for the person to actively address this issue, even if they have not identified it as a priority. The next section will provide some examples of specific cases as illustrations of those elements that serve to either prohibit or promote the recovery process.

CASE STUDIES

These case studies are provided as examples to illustrate the need to match the approach to the person, not simply to treat the diagnosis. Most are specific cases, drawn from my experiences in various treatment programs, with names changed for confidentiality protection. The cases of Tim and Sue are composites, representing in one person the experiences and needs of adolescents and women respectively.

ONE DRINK A DAY – THE STORY OF FRED

Fred insisted that he could not have alcoholism because he only had one drink per day. He lived alone, had no immediate family, had no friends, and was marginally polite to his co-workers. He was thought to be dependable and efficient at his job. There had been a recent concern about mistakes in his records, but there was no significant evidence at work that Fred was either arriving drunk, becoming drunk during his shift or leaving early. It seemed he just kept to himself. It was finally reported to a supervisor that the powerfully strong smell of

alcohol from Fred and his deteriorating physical appearance were so alarming that co-workers were scared that he might have a heart attack. The supervisor told Fred that the extent of this concern meant that Fred would need to talk with the company's Employee Assistance Program and follow their recommendations.

Fred had been admitted for detox with the recommendation that he would continue on for in-patient treatment for alcoholism. His blood pressure was significantly high as was his pulse. Blood tests indicated that his liver function was minimal. Fred appeared to be morbidly obese, although this was actually the result of a condition called *ascites*. This is caused by pressure associated with cirrhosis, or scarring, of the liver. Fluids that are normally contained in the liver are essentially forced out and collect in the abdomen, causing severe swelling. Fred's one drink per day was 16 ounces of 98% grain alcohol mixed with fruit juice, while at work. At home he would consume 6 to 10 12- ounce beers, two glasses of wine and a shot of brandy. Fred did not identify the beer, wine and brandy as 'drinking'. For him, the beer was 'soda pop for adults', the wine was a part of dinner and the brandy was dessert. According to a math professor colleague, this calculates to 3.75 gallons of alcohol per day.

Despite the efforts of my counseling and the details of his medical condition as outlined by the medical director, Fred insisted that this was simply an overreaction by 'tea-totaling' co-workers and an ignorant supervisor. Fred was kept in medically managed detox for eight days, using valium to gradually take him safely through withdrawal. When he was told he was being discharged from detox and could move into the treatment program, Fred said he felt so good he couldn't imagine why he would need treatment. We attempted to convince him to stay, but Fred signed out against medical advice (AMA). It is not an exaggeration to assume that he returned to drinking, nor that he would eventually die from liver failure. This was clearly a case where the medical concerns were of primary importance. Fred had no interest in any form of treatment or continuing care, and was clearly only motivated by a short-term improvement in

his physical health. Attempts to access his emotional states, his sense of spirituality, or even his rational thinking process were not successful, as he simply wanted to feel good enough to leave the facility. The interesting question this raises is whether it should be possible under these circumstances to force a person to stay in treatment, as is done when he or she is determined to be in danger of harming themselves or someone else. Does Fred's case indicate a slower form of suicide? Could his insistence that he did not have a diagnosable condition be evidence of incapacity for reasonable judgment? Could these two questions form the basis for a highly individualized treatment plan, designed in Fred's best interests despite his disagreement?

COCAINE AND KARATE – THE CASE OF NICK

It is important to point out here that the treatment program where I was working, and where Nick was seen, was based on the twelve steps of Alcoholics Anonymous, and that continuing care was thought to exist primarily in a connection to AA, working the steps, having a sponsor and attending meetings as often as possible. There were also meetings of Narcotics Anonymous (NA) and Cocaine Anonymous (CA) in that area, for those people who were addicted to either narcotics or cocaine. Family members were referred either to Al-Anon or Families Anonymous, which used the twelve steps in a similar manner. In any case, recommendations focused on how the person would utilize the support of these groups. The belief in this approach was so strong that whenever someone might express resistance to attending 12 step groups, they were then promptly identified as highly non-cooperative, in deep denial or simply that they really had no genuine interest in getting well. Such a patient would be told that without attending meetings they would surely be back for more treatment or die, whichever came first.

Nick described himself as a person who had always been full of energy. He said that cocaine just fueled his personality and added to what was already a lifestyle characterized by risk and a certain tendency toward danger. Nick had developed some health problems from using cocaine, including a heart murmur and damaged gums, and had become convinced that if he continued to use it would only be a matter of time before he would be in prison. It was evident that Nick was very motivated to quit using cocaine. As his discharge date from treatment approached, we began developing a plan for his continuing care. The standard recommendations would have included daily CA meetings for the first three months, augmented by daily contact with a sponsor and attendance at a continuing care group at the facility. Nick had a job he didn't like, but he could return to work, and his home life was essentially supportive. The problem for Nick was that he could not imagine how sitting and talking would be energizing enough to equip him with the focus and drive he would need in order to prevent giving into the temptation to use. He felt he needed something in his life that would be physical, challenging and even potentially dangerous. CA meetings would not be enough.

As we discussed what activities might work for Nick, he said when he was younger he had started to study karate. This interest faded away as his drug use increased, but he did remember how exciting it had been to work out with people who were more advanced than he was. The challenge of keeping up with someone who had earned a higher belt had been inspiring and energizing. Nick thought that martial arts might be the right combination of action and structure that would help him succeed in developing a drug free lifestyle. The more we talked about this, it became very clear that this was an option Nick would pursue as he really believed it would help. He would still attend three or four CA meetings per week, but would also plan to work out on a daily basis, as this would address that part of his personality that would continue to crave high energy. This plan seemed to Nick to be more in balance than

just going to meetings and seemed to more accurately respond to his concerns about the temptation to use. Nick said he felt more confident and hopeful after including the plan to return to the studying of karate. He was excited about the competitive nature, the discipline, the physical demands, the potential to make new friends, and the opportunity to release his tensions in a controlled but possibly explosive manner. I then went to the staff meeting to present what seemed like an organized and thorough continuing care plan for Nick.

The position of the treatment team was that the only addition necessary to Nick's life was CA. The thought that he might spend time in a dojo studying karate was dismissed as if it was complete nonsense. The suggestion that Nick was concerned about how CA meetings would help with his need for excitement was also dismissed, based on the belief that he was simply nervous and needed to be surrounded by other recovering addicts who could offer the benefit of their "experience, strength and hope". The belief in the power of 12 step meetings was so unwavering, that the possibility that someone might need something else was inconceivable. The fact that I supported Nick's interest in karate was identified as a supervision issue, since I was relatively new to the field.

In retrospect, it should be noted that at the time of this example, the majority of the counselors in this particular facility, if not in most, were people who had found their way back to health through the steps of AA, NA, CA, or Al-Anon. For them, there was the sense that working the steps had saved their lives. As true as that may have been, to assume that all people would benefit in exactly the same way is presumptuous and unnecessary. Nick was the best expert on himself and deserved to be respected as he developed a plan he believed he could follow.

14 YEARS OLD AND THE 12 STEPS- TIM'S STRUGGLE

A typical treatment plan would include reading the first few chapters of Alcoholics Anonymous, and then writing summaries and discussing in group how the chapters applied to the person. This was a reasonable plan for someone who would identify themselves as having alcoholism. It was even better for someone who had experienced significant losses as a result of their drinking and seemed unable to quit even though they desperately wanted to do so.

Tim was very far from either of these extremes. At fourteen years old he had been drunk just a few times and had smoked marijuana for less than a year. His family had a history of alcoholism so when his parents discovered a small bag of pot and a pipe they immediately wanted an assessment, as they believed Tim was in the beginning of an inevitable progression toward addiction. Although the evidence was not there to support a dependency diagnosis, Tim was admitted for treatment and given the standard treatment plans. The notion of the progressive nature of addiction was part of the standard assumptions that drove treatment. The only difference between Tim and a late stage alcoholic was time. We treated all patients as if they were on the same downward spiral, with the same path ahead. Therefore, all patients were either addicted or just not quite there yet, so treatment planning focused on the addiction not on the person and was directed by the ideas presented in the twelve steps.

The first task for Tim was to read the first chapter of the “Big Book”, Alcoholics Anonymous. At fourteen, Tim was much more interested in doing tricks on a skateboard than in reading a book written decades earlier, which had never been intended for readers of his age and experience. Tim had great difficulty with the reading. It frustrated him that he could not understand some of the language and could not follow the reasoning of the ideas. He did not understand at all how reading this book could be useful. The following, from the words of Bill W., is an example from the Big Book that illustrates Tim's points.

My drinking assumed more serious proportions, continuing all day and almost

every night. The remonstrances of my friends terminated in a row and I became a lone wolf. There were many unhappy scenes in our sumptuous apartment. There had been no real infidelity, for loyalty to my wife, helped at times by extreme drunkenness, kept me out of those scrapes (p.3).

Did we really expect that a boy such as Tim would identify with this story? Where would the common ground exist that would allow Tim to see himself in this description of the grip of alcoholism? We simply assumed that since AA and the 12 steps had worked so well for others, and since Tim was only different by the amount of drink he had consumed so far, that the same approach would naturally fit. We failed to consider the real facts of who Tim was, the actual extent of his use, and the method of learning that might work best for him. Were we blinded by arrogance?

THANK GOD IT'S NOT DRUGS – JACK'S DRINKING

At age 17 Jack had already been charged with drunk driving three times. This was not the more typical under age alcohol possession charge that frequently came when kids became too loud at a party. Jack had developed a drinking pattern more consistent with someone considerably older. His parents had essentially just paid the fines for these tickets and were fully prepared to provide regular rides for him at the point when Jack would lose his driver's license. Their main concern for Jack was that nothing would prevent him from earning a scholarship to play football at the local university. The incident that brought Jack to treatment was that he appeared at his high school principal's office at ten in the morning, very drunk and attempted to pick a fight with the principal.

When Jack's parents were called, their first concern was that this could prevent the principal from writing a reference letter for Jack. They were more worried about Jack's access to college football than they were about his drinking. When Jack was admitted, he insisted he had never done any drugs, hated them and people who used them, and was only in trouble

because the principal was too weak. Jack enthusiastically admitted that he got drunk regularly, saying that this was normal for guys like him. A drug screen was done as a standard part of admission protocol. When the results were negative, Jack's parents were elated, "Thank God it's not drugs" was their pronouncement as they came to take Jack home. Now that it was established that Jack was not using drugs, he clearly did not need to be in a treatment program. After all, they said, "All kids go through experimentation with drinking. This is nothing to be worried about". It seemed Jack was well aware of his parents' opinion about drinking and may have used it to his benefit.

This case involves more than Jack and his parents. The imbalance between concerns about drinking and those toward use of illegal drugs is reflected in the law, in advertising, in prevention efforts and even in the language of recovery. If one achieves abstinence from alcohol, they are now sober. If one achieves abstinence from an illegal drug they are now clean. (This disparity is addressed in detail in another section of this paper). It is not surprising then that Jack and his parents would easily dismiss consequences from drinking, as this is so often referred to as normal behavior. It was within their rights to have Jack discharged as soon as the negative drug screen was determined. It seems sad at the least that for this family and for the bigger picture that the difference between legal and illegal would dictate the health of any one's lifestyle.

DOPE MAKES ME POPULAR – RICK, GIRLS AND POT

This is an example of working with the immediate consequences of drug use, rather than an approach that stresses the long-term possible damages. Rick was a sophomore in high school who had been arrested for possession of marijuana and given the option of completing a treatment program rather than going to a locked, detention facility. The court would receive regular updates from treatment, Rick would cooperate with random drug screens, and his

school would be involved for ongoing progress reports. If Rick could successfully follow this plan, then his charges would be reduced. The motivation for success also included the threat of going to jail if Rick violated any of the terms. Rick was scared of jail and seemed to be willing to cooperate if it meant he could stay in school. Accurate or not, he saw himself as a source of jealousy among the other boys in his class, based on Rick's perception that all of the girls were infatuated with him. Rick was convinced that the girls saw him as sexy and desirable, particularly because of his use of marijuana. As much as wanted to stay out of jail, he was afraid of losing his popularity if it became common knowledge that he had quit smoking. He was convinced that being known as a heavy pot smoker was what made him so attractive to the girls. Any warnings about the possible damages he could experience if he did not quit were immediately met with his grandiose claims of being more worried about losing his harem. Rick was a legend in his own mind.

It was obvious that Rick did not want to get into any more legal trouble. His thoughts about the value of smoking pot had been unchanged. He was just complying to stay out of jail. Once this was over, he said he would return to smoking whenever he had the chance. Any suggestions about possible harms that use might cause later were irrelevant to Rick. Immediate consequences were much more compelling. As Rick was convinced of the value of pot as a way to attract girls, even though there was suspicion that this attraction existed primarily in his testosterone fueled mind, it seemed this might be a good point to challenge. I suggested to Rick that he conduct some research to back up his belief in the power of pot. Rick agreed to ask as many girls at his school as he could about their interests in boys who smoked pot. He was absolutely convinced that he would come back to group with overwhelming proof that girls thought it was sexy and exciting to be around boys who were smoking pot. The next group session would be three days later, plenty of time for Rick to collect his evidence. When he returned, Rick was stunned and confused. He was unable to find a single girl who would agree

with him. Every girl he asked had said she thought it was boring, or stupid, or offensive to be around boys who smoked pot. As Rick was very interested in attracting the attention of girls, this feedback had an immediate influence on his behavior. Rick decided that if the girls didn't like it, then he had to quit smoking pot. This was the most effective piece of information Rick learned while he was in treatment. All of the warnings about amotivational syndrome, respiratory problems, damages to memory, increased risk of involvement with other drugs, or the possibility of the trap of addiction meant nearly nothing to Rick. It was the immediate consequence that held his attention and increased his motivation to change.

MEDICAL COMPLICATIONS - TRIAGING TINA

There are times when the traditional expectation of complete abstinence may not be realistic. One good example of this is working with a person who has severe mental health issues in addition to their addiction. In Tina's case, there was an enormous and tragic list of complications. I first worked with Tina when she attended a support group I was offering at the college where she was attending and I was working as the district addictions counselor. The challenge with Tina was in keeping her alive.

Tina had been abused by her brother throughout her childhood. Her family had never acknowledged this, apparently choosing instead to pretend it never happened. Her drug use had clearly started in response to both the abuse and her family's inability to address it. A motorcycle accident caused the amputation of Tina's right leg at the knee. Her addiction to cocaine and the subsequent dealing led to arrests, jail and eventually prison. Throughout this time Tina's smoking of cigarettes, pot and crack exacerbated her already severe asthma. She had been healthy for a brief time in the middle of all of this, long enough to earn some college credits but not enough to give her a chance at a decent job. After her release from prison for the second time, Tina got together with an old boyfriend. His dishonesty about his HIV status

resulted in Tina becoming HIV positive. As her health deteriorated, her fluctuating weight caused her prosthetic leg to rarely fit, and as a result she developed pressure sores and frequent infections. The addition of facing the possibility of developing AIDS stretched Tina's ability to cope. Her drug use became a pattern of binging, then sinking into shame, and then binging again. As far as I could tell, I was the only person in Tina's life who seemed to offer her any support. I stayed in contact with her while she was in jail and prison, seeing her again when she returned to college.

The legal system saw Tina as just another convicted felon. The treatment world labeled her a chronic recidivist. To the college she was another dropout, and to her family Tina was an embarrassing loser. The strength that persisted in her was a kernel of hope that if she could just maintain long enough, perhaps she could help someone else who might have gone through some of her pains and would need to be heard and understood without judgment. Tina enrolled in college again, bearing the weight of her history and her array of medical complications. She was a student in a class I was teaching at the time. On a night when she couldn't wear her leg, she was unable to get to her asthma medication, had a severe attack and fell into a coma. She did not return and actually died on my birthday. Too many treatment programs in this country would have discharged her in response to her many failed attempts to quit using. What a selfish system, to demand such loyalty as payment for a life so difficult to bear.

THE VALUE OF SEEKING WISDOM – JIM'S REQUEST

Jim was a Sioux Indian who had moved from the reservation in South Dakota to Chicago, with the hope of finding consistent work. Although he succeeded, his earnings ran down the drain as his drinking increased. The loss of a relationship, charges due to drunken fighting, and the threat of losing his job brought Jim to treatment. As was the case in other examples, the facility was myopically focused on the expectation and belief that the only way

to find health in recovery was through the 12 steps of AA. This insistence prevented the possibility of powerful help to Jim, as his request was dismissed with a patronizing “Maybe you’ll get to do that one day”.

Prior to moving from the reservation Jim’s life had apparently centered on the leadership and guidance of the elders of his tribe. He described how even though he had been poor, he had also been much more focused on happiness that came from feeling connected to his tribe and his culture. Jim was convinced that the physical separation that occurred when he moved to Chicago also resulted in a separation from his cultural values. Restoring that connection would be a critical part of Jim’s recovery. His request was for assistance in finding a Native American sweat lodge that he could visit often. He hoped that by doing this it would also put him in contact with elders, even if they were not specifically of his tribe, so that he could begin the process of reconnecting with his spirituality. Jim’s sense of what he needed was rooted in his culture and not in attending AA. It was not that he was opposed to AA, he simply felt that AA could not address his need to regain a stronger connection with his culture. As living in active addiction is often very isolating and can cause separation from the person and their family, Jim’s plan seemed consistent with the goals of recovery. The key here is in how the treatment facility would respond to Jim’s request.

As seen in previous case examples, the focus of the treatment program was on achieving recovery through AA. A specific diagnosis resulted in a specific treatment plan. The use of a sweat lodge was too obscure to be considered valid. Although there may have been some theoretical understanding of Jim’s desire to reconnect with his culture, there was no investment in providing tangible help. Jim was given a patronizing nod toward some future time when he might find resources on his own, and then forcefully told that all he really needed now was to go to AA. What Jim knew about himself was ignored in favor of what the facility believed to be true for anyone.

WEARING SUITS TO TREATMENT- TOM'S MAKEOVER

In most cases, when people knew in advance that they were being admitted for a three to four week stay in treatment, they would typically bring very casual clothes. It would not be at all uncommon to see sweatpants or workout outfits on both men and women. When Tom was admitted he brought a garment bag with suits. There was a daily morning meeting that included all of the patients and staff assigned to a specific wing of the facility. This was the Community Meeting. The first day Tom sat in the Community Meeting, the patients assumed he was a new counselor or administrator. His manner was just as formal as his clothes. Tom seemed like a man who had never learned how to relax, or perhaps never been given permission. Could it be that he thought of treatment as some form of extended board meeting? Tom had been urged to go to treatment after too many incidents of being drunk during the day at work. He was a Vice President for a large manufacturing company, accustomed to attending many meetings each day often including conducting business over a 'liquid lunch'. He described putting in a minimum of sixty hours per week and said he had no time for leisure activities. Tom seemed to think that relaxation was for people in lesser positions and with less education. Humility was not a familiar attitude. What makes this case compelling has more to do with the response of the other patients to Tom than it does with the treatment approach.

Tom was in many ways the antithesis of Tim. The words of the Big Book resonated with Tom's life in many ways. The values of recognizing being powerless over alcohol and in identifying a higher power were both of clinical and personal importance to Tom. He found the concepts presented in the 12 steps to be clear and easily acceptable. Tom's story had so many parallels to that of Bill W. that the treatment plans urging an immersion in AA seemed tailor-made. There was still the question of Tom's motivation to change, but the plans that were so foreign to Tim were right on target for Tom.

The individuals that make up a treatment group can be radically different as people are admitted and discharged. Sometimes there are strong bonds created as people recognize deep similarities, while other times it seems as if there are no connections at all. For Tom, there seemed to be a unifying commitment among his group members to find a way to help him learn to relax and loosen up. This is not something that could have been arranged or orchestrated. The combination of personalities was just right for some gentle confronting of Tom's overly formal persona. Another group may not have been as successful in creating enough trust for Tom to be willing to let others take some control. This was a case where the treatment team stepped back and stayed out of the way.

An irony in this story is that counselors were expected to adhere to a dress code, which was intended to help create the sense among patients that treatment was serious business. Although there may have been some instances where this was valuable, it was actually counter-productive for Tom. His life was so invested in the business world that he had become disconnected from his family and had the look of a man many years older. He moved through the halls like he was carrying a bag of burdens, a modern day Marley's ghost. This was not lost on the other patients.

Behind the building was a river where patients often walked and occasionally some would go fishing. It was not a particularly clean river, inhabited mostly by carp, and the banks were often muddy. On his own it would never have occurred to Tom to spend any time walking or fishing. He had taken to treatment like he was studying for final exams. It was the other patients who saw a value in teaching Tom how to relax. They prefaced this experience by giving Tom a fashion makeover. One day he walked in to the Community Meeting wearing an outfit created by the donations of his new friends: nothing really fit him, none of the colors matched, his shoes were barely laced and not tied, his shirt was untucked and not correctly buttoned, and to top off the look his hair was somehow arranged in a comb-over effect. It was

too comical to be seen as a helpful intervention, but Tom took it in stride. He was then loaned more clothes for his fishing lesson at the river. There was a transformation in him that seemed to lift years from Tom's face. This all could have been discouraged and prevented if the treatment team had stepped in to say it was inappropriate. To Tom's benefit though here was a time when something out of the ordinary was allowed to happen. Recovery happens in many ways.

HUNG UP TO BLEED – WHAT ABOUT MAX

Historically, given the same person with their collection of symptoms and consequences, whether he or she was assessed at a psychiatric facility or at an addictions treatment facility would determine the primary diagnosis. Having worked in both, I have seen similar symptoms in one place diagnosed as an anxiety disorder and in the other as cocaine dependence. The psychiatrist may see the drug use as a symptom of anxiety, which will naturally stop as the anxiety is treated. The addictions counselor may see the anxiety as a symptom of the addiction, which will certainly ease once the person achieves abstinence. The orientation of the person doing the assessment would determine how the presenting symptoms would be interpreted. The challenge is in being certain of this interpretation. When a person has a dual diagnosis and both are not treated simultaneously, each has an increased risk for relapse. The complexity of this dynamic is well noted by Rosenthal and Westreich.

There is no one-size-fits-all treatment for dual-diagnosis patients because there is little homogeneity within diagnostic sets, and even less across the many permutations of possible diagnosis of substance use and other mental disorders. Treatment must be individualized to the problem severity of the patient, rather than relying upon program-driven or philosophy-driven approaches to care (p.457)

When Max was assessed, it was assumed that his lack of affect was simply symptomatic of his drug use, so he admitted for addiction treatment with the assumption that the longer he was away from drugs the more range he would show in his expressions. The

possibility that Max also had psychiatric issues was not considered. He had a good opportunity to demonstrate that his assessment had been incomplete.

It was helpful for many patients to describe the extremes to which they had been taken by their drinking and or drug use. For some it had a cathartic effect, as they had not shared the details of their experiences with anyone. This is an example of the phrase “We’re only as sick as the secrets we keep”. As these stories would be told, group members would offer their encouragement for the person’s willingness to be honest. Having finally said out loud what had been eating away at a person, it often seemed this would help release feelings of guilt or shame and give the person the sense that they were indeed capable of change. Max appeared primarily bored while listening to his group. When he was asked if he had an example of something he had done related to his drug use, Max shrugged and said he could offer a story. The complete absence of any affect while telling his story needs special explanation. It was as if Max was talking about his shoes or about the details of the pattern in the sidewalk. There was absolutely no indication of any feeling while Max told his story.

Max began by describing how much money he and some others had made from dealing cocaine. He gave examples of the amounts he had been selling, the costs, how the cocaine had been transported, how he had managed to avoid arrest and where the cocaine had been stored before it was sold. It seemed the group was waiting for something more revealing or dangerous. Then Max told, in a nearly monotone voice, how he and two others had found someone who owed them thousands of dollars, took the person to an abandoned warehouse, strung him up by his wrists and used razor blades to cut the man while trying to persuade him to pay his debt. Max said the man bled to death before they got any useful information from him. He described the look of the blood as it ran down the man’s body, the fading of expression on the man’s face, and the twitching of his body before he was finally still. Then, again with no particular change in his tone or expression, Max asked if anyone knew how much longer they had to be in group.

During the time he told this story, the members of the group reacted with shock, disgust, and physical clenching as Max spoke. Many pulled their chairs back and curled their arms and legs as if to protect themselves. The group ended soon after that, and Max nonchalantly left the room. The other patients announced they would not attend any group from then on if Max were in it.

Myself and the other group leader were equally stunned. We had seen other patients sob in their attempts to tell their stories, or try to talk about something only to stop and say they could not speak it out loud, or finally with one day before their discharge announce that they had to talk or risk relapsing as soon as they left the building. In some cases the extreme shame that was strangling the person came simply from having been dishonest to a friend. The rest of the treatment team was told about what had happened, and Max was referred to the psychiatric unit for assessment and possible transfer. It was fortunate for Max and for the rest of the group that this was available. Max was moved to the psychiatric unit following his assessment, with the new diagnosis of anti-social personality disorder. The question remains as to whether or not this might have been determined earlier if the facility had not been so focused on seeing everything as symptomatic of addiction. Does it fit to say that if the only tool you have is a hammer, then everything looks like a nail?

EMPOWERMENT OR POWERLESSNESS – MATCHING SUE

Sue had grown up in a family filled with abuse. Her parents were so vicious to each other and fought so constantly it was as if they could not stop fighting long enough to realize how miserable they were. Bloodied faces, broken furniture, and screaming through long nights made up Sue's childhood memories. Included among the fights were attempts by her father and older brother to get Sue alone long enough to show her what "secrets" they could share. At a young age she had discovered the soothing numbness of alcohol, followed by an endless parade

of bitter, hateful men in whose beds Sue attempted to find some definition for love. The people who might have taught her about tenderness and respect only showed her threats and contempt. Sue had not learned that love was not the same as pain. She was drawn toward violent, hurtful relationships not because they felt good, but because they were familiar. Through a cycle of abuse, drinking to numb the damage, more abuse in an attempt to find some connection, then more drinking when the abuse would begin again, Sue eventually found herself in a shelter for domestic violence. She gained some support there and the very beginnings of enough confidence to allow her to enter treatment. Sue had hoped to learn how to manage her feelings and take charge of her life without the need for alcohol.

Sue was admitted to a program that followed the 12 steps. At that time there was no other option. The fact that a woman may have different treatment needs than a man was not as important as treating the diagnosis and working the steps. Sue would be expected to identify examples of powerlessness over her drinking just like anybody else. The problem here is that up until this point, Sue's entire life had been one continuous stream of powerlessness. Sue had been reminded in countless ways that she had no power over any aspect of her life. She could easily accept that this had caused her life to become unmanageable, but to reinforce a sense of powerlessness served only to chip away at what little confidence she had managed to piece together while at the shelter. As the majority of the patients in the program were men, Sue found it very difficult to feel safe enough to allow for the building of trust in her group. What she needed was an approach that would focus on identifying, reinforcing and actively acknowledging her strengths. This was in contrast to ideas typical in treatment at that time. Too much energy spent on claiming one's individual strengths could lead to overconfidence and rejecting the notion of a power greater than oneself. Affirming independence could move one away from the guidance of a sponsor and even the fellowship of AA. Seeing how one had

specific individual differences could result in not actively working the steps, which reinforced the value of we, not I.

Although not available at that time, Sue would have been much more directly served by an alternative to AA, the Sixteen Steps for Discovery and Empowerment. Charlotte Kasl developed this approach. She describes how her ideas are in contrast with those of AA, which often stress a need for ego deflation.

Many women, minorities, and some men need their egos built up through celebration, validation, and a system that is responsive to their needs. My goal in writing the sixteen steps in chapter 14 is to move toward a healthy ego in balance. For many people, this has to do with reinforcing intelligence, creativity, power, and strength. An underinflated ego thinks it is wrong all the time and doesn't trust its own intelligence (p. 19).

The contrast between the two programs of recovery is very clear by comparing the first steps of each. Step 1 of the twelve steps is: We admitted we were powerless over alcohol and that our lives had become unmanageable. The first of Kasl's sixteen steps is: We affirm we have the power to take charge of our lives and stop being dependent on substances or other people for our self-esteem and security. As for Sue, it also seems clear that empowerment would have been a better match than powerlessness.

WHERE COULD WE BE INSTEAD

As a preface to this section, it is useful to point out that decisions regarding how to address the continuum from prevention to treatment to recovery can be reduced to whether the decisions are based in fear or in faith. In fact, every decision made is done with its roots in one of these two foundations. When choices are made out of fear of a potential negative outcome, often the decision is to do nothing. When bolstered by faith – whether it is in the universe, the community, the family, the person's own strengths, a Higher Power, or simply in the possibility of a favorable outcome – decisions are often accompanied by action. This is illustrated in the following contrasts: fear of the disease versus faith in the person; fear of addiction versus faith

in recovery; and fear of progression of the illness versus faith in the process of change. Van Wormer and Davis (2003) have written about a strength-based approach to addictions counseling that provides a good comparison between their ideas and those of more traditional addiction counseling. This also illustrates the fear versus faith orientation. Three examples from Van Wormer and Davis are: first, the traditional approach assesses problems and losses, while the strength-based approach assesses and builds on strengths; second, traditional-confrontation used to elicit change, break denial, while strength-based rolls with the resistance and redefines resistance as a challenge; and third, according to the traditional approach one size fits all, while the strength-based approach is individualized treatment, with emphasis on client choice.

Prevention approaches have concentrated more on dramatic warnings about the consequences of use, rather than on encouraging individuals to explore and develop interests that could provide alternatives to use. The emphasis on the disease concept and its accompanying life-long risk of relapse reinforces the perception that although life can improve, the disease and its threats never go away. Peele (1989) stresses the importance of not over-identifying with the addiction, thereby overlooking new potentials.

This limited view of addicts, and of human beings, may be useful during peak periods of addiction and self-destructive behavior. But it is not appropriate for the large body of substance abusers and other types of addicts, a majority of whom can have fuller lives when they cease thinking of themselves exclusively as recovering addicts (p. 199).

This section will describe approaches and ideas that are currently available, although not nearly as frequently applied as the twelve steps. The results of research conducted in 1999 revealed this dominance in one of the findings: “More than 90 percent of participants base their treatment approach on the 12-step Model” (Roman and Blum). Even though many of the so-called alternative approaches have been in existence for some years, the field of addiction treatment has yet to accept them as valid.

In sharp contrast to the ideas represented in the disease concept and in twelve step recovery are the principles of harm reduction. People actually practice methods of harm reduction on a daily basis, engaging in behaviors that are intended to minimize either the risk of harm or the extent of harm. For instance, having a designated driver, washing dishes, brushing teeth, wearing seatbelts, using condoms, using sunscreen, and paying bills on time all are examples of harm reduction. These may not all be identified as such and are more likely to be seen as simply being responsible. Although it carries a degree of controversy, it is suggested that the use of alcohol and/or other drugs does not automatically spiral into addiction and that there can be use with responsibility and control. It should be noted here that simply because alcohol is a legal drug, that alone does not give it some special qualification as a substance that can be used with responsibility, nor does it make sense that other drugs by virtue of being illegal are therefore virtually impossible to be used in a responsible manner. Denning, Little and Glickman (2004) describe the intent of using a harm reduction approach.

The goal of our work is to help people develop a healthy relationship with alcohol and other drugs – in essence, to help them practice harm reduction. This term – *harm reduction* – means reducing any damage caused by drug use to the user, the user's family, and the user's community. For some people, the healthiest relationship with drugs, or the best way to reduce harm, is to not use them at all. For others, it means changing the amount, the frequency, or the way they use their drug of choice (p.xviii).

It is immediately apparent that this is radically different from the perspectives that hold that any use of an illegal drug is automatically harmful and that abstinence is the only valid goal. The point here is that since there is such an enormous range of experiences related to why people use and which consequences they may encounter, then the approaches taken to address these dynamics can also vary across a range of methods.

One often-contentious example of harm reduction practice is the use of free needle exchanges in response to intravenous drug use. Although some have criticized this practice by suggesting that it simply prolongs the addiction, the harm reduction perspective is that free

needle exchange programs reduce the sharing and reuse of needles and therefore act to reduce the potential for transmission of infectious disease. In addition, as the person comes into contact with program staff, there is the opportunity to offer intervention messages on a regular basis, thus increasing the possibility that the user may become open to assistance in seriously addressing their drug use. The goal is to reduce the level of harm, not to imply that drug use is completely without danger.

Miller and Rollnick (2002) have been instrumental in the development and application of Motivational Interviewing (MI). Again in contrast to the twelve-step model, which has relied heavily on the idea of breaking through denial, this method stresses a unified effort between client and clinician and specifically reflects the importance of a more individualized approach.

Motivational interviewing honors and respects the individual's autonomy to choose. It is a collaborative, not a prescriptive, approach, in which the counselor evokes the person's own intrinsic motivation and resources for change. Implicit is the belief that such motivation and resourcefulness do lie within each individual and need to be evoked rather than imposed. We believe that each person possesses a powerful potential for change. The counselor's task is to release that potential and to facilitate the natural change processes that are already inherent in the individual (p.41).

Another significant difference here is that MI stresses that each individual has powerful internal resources that can be accessed, while the twelve-step model stresses the need for acceptance of powerlessness and for the person to rely on a Higher Power as the source of their strength. The critical consideration here is not so much what the clinician believes to be the best solution or the most fitting philosophical viewpoint. As Miller and Rollnick point out, our job is to assist the client, and I would add that it is also our job to stay out of the way and not impose our own versions of truth as part of the treatment process.

In the teaching of Human Services students that I am currently doing, we have adopted what is called a solution- focused approach in our curriculum. More traditional forms of therapy begin with problem identification and attempt to unravel the cause. Solution-focused

therapy looks at what is maintaining a problem and works toward creating a more positive future. The application to addictions is in placing energy toward helping the person identify how to get closer to what they want in life, as opposed to determining how they managed to develop an addiction in the first place. Metcalf (1998) describes how this approach can instill hope, an essential element for successful change.

Thinking of substance abuse as a dangerous habit instead of a disease affliction promotes hope and helps both therapist and client talk about the situation more comfortably by lessening embarrassment. Instead of thinking of themselves as crippled by a problem or diagnosis, group clients in therapy for substance abuse can perceive their lives as reparable and are thus more likely to move forward and live their lives differently (p. 85).

This is not to diminish the extent of whatever damages the person may have suffered or caused but is a useful tool in helping the person to see that change is possible. I have experienced far too many treatment groups in which the entire process had focused on how horrible and lost the group members felt. They left the group in more despair than when they started. It is not necessary and can be very harmful to take a “break them down to build them up” stance. Why not simply start with building them up?

Change is a process and not an event. There are steps leading up to an eventual change and adjustments to that new behavior that follow. Just as people progress from experimental use to chemical dependency at very different rates, if at all, people also progress differently as they make the decision and eventual commitment to stop their alcohol or drug use. This is captured in the Stages of Change model (Prochaska, Norcross and DiClemente, 1994). There are six stages, with the first five being most applicable to addiction treatment: precontemplation; contemplation; preparation; action; maintenance; and termination. The last stage is somewhat controversial in this arena as it suggests the possibility of returning to use, since the original problem has been resolved. In specifically writing about the use of this model with substance abuse treatment, Connors, Donovan and DiClemente (2001) do not

include termination. The movement through the stages is described as often cyclical rather than as linear, recognizing that people may recycle back to a previous stage.

When in precontemplation, there is no awareness or connection made between a behavior and any negative consequences. As awareness changes, the person moves into contemplation and now gives thought to the behavior and may recognize a harmful relationship, but still with no intention of change. During the preparation stage, there has been sufficient change in thinking to warrant the consideration of change. This is the point where people often stall, accompanied by the statement “One of these days I’m really going to...”. It is in this stage that possible strategies for change would be identified. Having chosen a method, the action stage is characterized by actually implementing a tangible change. Maintenance is then the ongoing reinforcement of the change so that it lasts.

For example, I was a cigarette smoker for five or six years, well aware of the various health risks, before I considered that the risks could actually impact me. I recognized the cost, the coughing, the smell, and the discoloration of my fingers while I continued to smoke. Then my father died of lung cancer and I developed much stronger motivation to change. I went from preparation into action fairly quickly and then maintained abstinence for seven years. In an example of the recycling mentioned above, I returned to smoking for a brief period as a response to stress. For myself, after a maintenance period now of nearly twenty years without smoking, I am tempted to place myself in the termination stage regarding this problem. Instead, I simply describe myself as a non-smoker.

Utilizing the stages of change approach acknowledges each person at the point where they are in their own unique process of change. This allows for a much more individualized treatment strategy. Connors, Donovan, and DiClemente (2001) describe how this translates into the development of a treatment plan.

The treatment plan is unique to the individual because the presenting needs of clients vary considerably from person to person, as do their available strengths and resources

for effecting change. Not surprisingly, the better and more precise the tailoring of the treatment plan to the client's needs and resources, the better the potential fit and the greater the likelihood of achieving the specified treatment goals (p.83).

Treatment programs have been ineffective, and relapse rates have been high due to two failures in approach: one is when the key measure for the program is compliance with imposed expectations. The person who does not follow the prescribed treatment plan is seen as resistant, rather than as in need of a different approach. The second happens when people who are at an earlier stage of change are given action steps at an inappropriate time. In other words, I will not take action toward resolving a problem until I am convinced of the need and have examined my options. Addiction counselors need to be very patient as they assist people in moving through the stages of change. To demand change is to gain only compliance, if anything. That is not the same as change that has been internalized and freely chosen. In response to the title of this section, where we could be instead is actively responding from faith, utilizing harm reduction practices, incorporating Motivational Interviewing techniques, concentrating on finding solutions and paying attention to the Stages of Change.

Ever since the phrase was first spoken, the "War on Drugs" has missed the point. This is another area in which current policies and practices fail to consider the individual and is an area in which we could be doing much better elsewhere. When there is a parent in the household with a serious drinking problem, at least one family member may respond by trying to either throw away or dilute the alcohol supply. The fantasy is that if there is less alcohol available, the person will simply stop looking for it. Ironically, this seems to be the major focus of the "War on Drugs". If we can eliminate the supply, then people will cease their using. The only condition that will effectively do this is the end of life as we know it. The absence of fertile soil, sunlight and water will certainly eliminate all of the coca, marijuana, poppy, psilocybin (hallucinogenic mushrooms) and any other mind- altering plants from the planet. At that point we would only be left with the synthetic drugs, assuming that the current exceptions regarding

alcohol and nicotine would still be in place. Where we could be now instead is focusing on the demand side of this problem. As was previously discussed, we need to provide prevention efforts that start before use begins. Providing activities that address acceptance, boredom and curiosity will go farther to dissuade alcohol and drug use than will the threat of arrests or the dramatic warnings about possible consequences. We have a valuable opportunity to offer new directions through treatment, education or vocational training rather than relying on incarceration as a method for giving people incentives for change. Rather than a “War on Drugs”, which by its very language suggests threats and confrontation, we could instead wage an all out effort to encourage people to find alternatives to the use of substances as the method for managing thoughts, feelings and behaviors.

Reinarman, Cohen and Kaal (2004) offer a brief summary of how other nations have chosen to address their concerns about drug use, in particular the use of cannabis. It is important to note that these policies have not resulted in the dramatic increases in drug use that was predicted by strongly prohibitionist opponents of more liberal approaches.

During the 1990’s, Switzerland, Germany, Spain, Belgium and Italy shifted their drug policies in the Dutch direction. Portugal decriminalized cannabis in 2001, and England similarly reclassified cannabis in 2004. Canada and New Zealand are currently considering cannabis decriminalization. These shifts constitute the first steps away from the dominant drug policy paradigm advocated by the United States, which is punishment-based prohibition (p. 836).

It is unacceptable that while the United States may pride itself on being known as the nation with the best health care available in the world, it spends so much effort on arrests and incarcerations and in addition still has a significant number of people who want treatment and cannot get it. Where we should be instead is developing policies that are meant to address the demand side of this issue rather than simply to focus on a judicial approach and to provide for access to treatment services as an alternative to punishment. If addiction is indeed a disease, then our response should be similar to other health issues, after all, when a person develops lung cancer as a consequence from nicotine addiction, we do not sentence that person to prison.

Addiction is not a process that can be reduced to whether the drug of choice happens to be legal or illegal. One way to shift focus here would be to adopt a disease management approach, which would in effect treat addiction in the same manner that other chronic diseases are by ongoing symptom management. Kaplan (1997) has identified the benefits of the disease management model.

Disease management as applied to addictions treatment would be easy to implement. Because it is comprehensive, provides ongoing monitoring and care, allows for assistance on a regular basis, and integrates addictions treatment into primary care, it would be cost-effective. Disease management will move addictions treatment into the medical mainstream. Its stigma, in the process, will disappear (p. 15.)

In the final analysis, it is the person who sees a need to change their relationship with alcohol and/or another drug who is in the best and most meaningful position to decide if treatment has been effective. Measures such as cost-effectiveness, compliance with laws, or how many people may see addiction as a disease or as something else are features of research studies. The extent to which these things hold truth is not pertinent to the individual process of returning to a better state of health.

CONCLUSION

The most effective addiction treatment and recovery methods are those determined by the unique qualities and strengths of the individual. The emphasis on the disease concept has perpetuated an approach in most treatment settings that is rooted in the philosophy expressed by the twelve steps of Alcoholics Anonymous (AA), and in doing so has rejected the notion of the ability of each individual to utilize his or her own resources. Unlike other forms of treatment, when the twelve steps are incorporated into addiction treatment there is a decidedly spiritual component that critics describe as a form of religion. This is illustrated in the “Big Book” (Alcoholics Anonymous, 1976).

It is easy to let up on the spiritual program of action and rest on our laurels. We are headed for trouble if we do, for alcohol is a subtle foe. We are not cured of alcoholism.

What we really have is a daily reprieve contingent on the maintenance of our spiritual condition. Every day is a day when we must carry the vision of God's will into all of our activities. 'How can I best serve Thee- Thy will (not mine) be done.' These are thoughts which must go with us constantly. We can exercise our will power along this line all we wish. It is the proper use of will (p. 85).

It is ironic that even though there is the insistence on addiction as a disease, the most frequently followed treatment for this disease is built around an extremely moralistic point of view. This seems contradictory to what is usually seen in medical circles. The criticism of using the twelve steps as treatment has even extended to referring to AA as a cult. Trimpey, developer of Rational Recovery (RR), takes what can be described as a caustic view of AA.

AA is not only a religious cult, it is a radical cult, an evil cult, a widespread cult, and a dangerous cult. AA has become an engine of social decay posing as a noble, altruistic fellowship. Its perverse philosophy of sin-disease and deliverance by faith in an amorphous, heterogenous deity contradicts the fundamental values of a free society, but is uniquely appealing to people addicted to substance-pleasure (www.rational.org/Cult.html).

As this debate accelerates, what must not be lost in the process is that both AA and RR can play important and effective roles when the individual is able to choose which approach he or she finds is best suited to their thoughts and beliefs.

The focus of treatment is too often on establishing a diagnosis then providing a treatment plan that is imposed rather than negotiated. Even though addiction may be identified as a disease, treatment is not offered the extensive insurance coverage available for the treatment of other diseases. Stigma persists. We have developed a series of dichotomous messages; one set that strongly discourages the use of illegal drugs, while a second set praises the value of alcohol and various prescription medicines as handy tools to manage the extremes of our thoughts, feelings and behaviors. We celebrate individuality, as long as it is expressed in a uniform way. The message here is that there is a disconnect between what is said about the use of alcohol and other drugs and how the person is treated when that use results in a need for help.

William White (2001) has written that there is a need for a new definition of the disease concept. He outlines how current society has adopted the idea of addiction to such an extent that it minimizes the concept and dilutes its meaning.

The area of greatest trouble is the application of the concept of addiction and addictive disease to include process addictions, harmful relationships with food, sex, work, gambling, etc... It is the 'etc.' that is particularly problematic. Americans already speak of being 'addicted' to everything from bowling to television shows, self-describe themselves as 'chocaholics', 'shopaholics' and every other kind of 'aholic', and apply the term 'disease' to everything from violence to the use of profanity. The new disease concept will carefully re-establish and then guard its boundaries to prevent its continued over-extension and financial exploitation. To draw this boundary will require nothing short of defining the very essence of addiction and its roots (p.49).

As has been addressed throughout this paper, there are a variety of methods and approaches available for people to utilize in their efforts to break free of their addictions. White also refers, in his concept of a new disease model, to the value of clinicians having a variety of options from which to provide assistance.

What will flow out of the new disease concept is not 'a program' that everyone goes through, but a menu of professionally directed interventions, recovery support services, mutual-aid groups, indigenous healers/institutions, and self-engineered (potentially manual-guided) programs of recovery that individuals can select for personal and cultural fit.

The challenge for the treatment professional will be to remain continually aware of the evolving choices on this menu and to help match menu items to the needs of their individual clients. Rather than be defensive about the fact that people are finding a variety of ways to resolve AOD problems, it is time we celebrate the growing diversity of the culture of recovery (p. 51).

Morgenstern and McCrady (1992) point out that individual differences can indicate better responses to either a disease model or behavioral approaches. This is clearly in keeping with the theme that as people and their experiences are very different, treatment needs to be provided in a variety of ways.

For instance, individuals with strong affiliative needs may do better with a disease model approach, while those with weak affiliative needs may do better in behavioral treatment. In addition, individuals whose alcohol/drug use affects multiple areas of functioning and influences self-image, such as significant involvement in the drug

counter-culture, may do better in disease model treatment; whereas those whose alcohol/drug use has had a much lesser impact on self-image and lifestyle might do better with behavioral treatment (p. 910).

Saleebey (2001) suggests that another important change to consider is in what criteria are used to determine whether there is sufficient evidence to warrant making a diagnosis. The standard used throughout the field is the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association. The establishment of a diagnosis of dependence or abuse is reached through gathering enough information to satisfy the minimum number of criteria in each case. For example, the DSM-IV lists seven criteria for substance dependence with the requirement that three or more have been present during a 12-month period. This essentially rates the extent to which use has caused negative influence and/or impairment. It can be seen as a measure of what is wrong. Saleebey offers an addition to the diagnostic process that would assess strengths.

The DSM-IV and long-standing diagnostic habits make it virtually impossible to consider or make an accounting of the assets, talents, capacities, knowledge, survival skills, personal virtues, or the environmental resources and cultural treasures such as healing rituals and celebrations of life transitions that a person might possess – despite or, in some cases, because of their difficulties and trauma. To ignore these things is to disregard the most important resources in helping a person recover, adapt to stressful situations, confront environmental challenges, improve the quality of life, or simply adjust to or meliorate the effects of a devastating, chronic condition (p. 185).

This point is very well taken. In our efforts to provide effective help, how can we fully engage in the process if only the negative aspects of the person are to be considered? This is another indication of the fear versus faith dynamic. Whatever my personal beliefs about addiction and recovery may be, whatever philosophical position I may hold regarding the nature of disease, and however I may define and rely on a power greater than myself for guidance or support should be separate from the practice of endeavoring to offer help. What does matter is what will work best for the individual. The questions I need to ask are simply, what do you think you need to do, and how can I help.

The field of addiction treatment would see better results and would add to the decrease in stigma associated with alcohol and drug problems by placing the person first with a full and appreciative knowledge of the extent of the unique qualities and strengths of that individual.

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