Chapter 1

INTRODUCTION

OBJECTIVES

1. To understand the history of influences on addiction counseling
2. To learn the main theories of addiction counseling
3. To apply the history and theoretical knowledge of addiction counseling to current issues in the field

Current statistics support the concern for alcohol and drug use in America. The 2002 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2003b) found that about 120 million Americans (51% of the total population over age 12) drank alcohol, with 22.9% having a binge drinking experience at least once in the previous month and 6.7% reporting being heavy drinkers. Also, about 14.2% drove while drinking alcohol at least once in the previous year. The survey also found approximately 19.5 million Americans (8.3% of the total population over age 12) had used an illicit drug during the month before being interviewed. Marijuana was the most common illicit drug used.

These statistics underscore the importance of understanding the dynamics of alcohol and drug abuse and addiction. The high number of individuals using alcohol and drugs in America also supports the need for counselors to understand the dynamics of addiction: It is highly likely that a counselor will work with individuals who are abusing alcohol or drugs in any counseling setting. Understanding the dynamics of addiction can help the mental health professional more effectively meet the needs of the client. Working with the substance abusing population, however, can be difficult.

Mental health workers, both historically and currently, have not always liked working with alcoholics and addicts for at least two reasons: (1) the difficulty in treating them due to factors such as relapses, poor impulse control, emotional reactivity, and/or lying to protect their addiction; and (2) the lack of knowledge (techniques) on how best to treat them. However, an openness to treating addicts grew as information on how to treat addicts emerged and as additional funding for treatment became available. For example, addicts commonly deny the consequences of their usage to themselves and others (Levinthal, 1996). It became easier for counselors to deal with denial when the technique of intervention was introduced (Fields, 1995).

Counselors also have potential issues with countertransference. Many helping professionals have negative personal as well as professional experiences working with addicted individuals. This may cause them to avoid or hesitate working with this population. When working with addicts, they may be caught in familiar patterns of enabling or judging the addicted individual and their loved ones based on their own personal or professional experiences.

Changes in public policy also affected the work of counselors. In 1970, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was established to provide funding for alcoholism treatment and research, and in the 1970s, insurance companies began to reimburse agencies for providing addiction treatment (O'Dwyer, 1993). The Hughes Act (PL 91-616) established NIAAA, funded states that established alcoholism divisions and started maintained alcohol treatment programs for federal employees (Fisher & Harrison, 1997). This policy change expanded the field of addiction counseling.

As a result, states started to create credentialing and licensing bodies to ensure quality addiction counseling (O'Dwyer, 1993); being a recovering addict no longer meant immediate entry into the addiction counseling field. Instead, addiction professionals needed to document a combination of credentials regarding both counseling experience and training. In 1993 to 1994, the Commission on Rehabilitation Counselor Certification (CRCC) developed another certification to complement the Certified Rehabilitation Counselor (CRC) Certification: Certified Rehabilitation Counselor-Substance Abuse Counselor (CRC-SAC). Certification of addiction professionals expanded in 1995 when the National Board of Certified Counselors (NBCC) established an addiction certification specialty for mental health counselors, and in 1996, the American Psychological Association (APA) established a proficiency certification for licensed psychologists. As of January 1, 1997, counselors who are certified as addiction counselors by the CRCC, the NBCC, or the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) can apply for their master's in Addictions Counseling (MAC) certification ("New Credential for Addictions Counselors," 1996). Prior to January 1, 1997, CRC-SAC counselors could be grandfathered into the credential of CRC-MAC.

With the growth of research and treatment, there are now many routes of entry into addiction counseling. You may enter the field through a research, a grassroots network, or a certification/licensure process. As a result, there are numerous disagreements in the field of addictions on applicable theoretical models and effective treatment approaches. For example, some addiction experts emphasize the strengths of the disease model of addiction and Alcoholics Anonymous (AA; Gragg, 1995), whereas other experts point out the weaknesses of the disease model and AA (G. A. Marlatt, 1985b).

ADDICTION COUNSELING INFLUENCES

Currently, there are three main influences in addiction counseling:

1. The traditional addiction counseling approach of the *disease model* that asks: Is this approach healing for the addict within the scope of the disease model of addiction?
2. The *addiction research approach* that presents counselors with the question: Which addiction counseling approaches are supported in research findings?

3. A final, and more recent, influence stems from *managed care organizations* that confront counselors with the question: What counseling approaches provide the greatest benefit for the least cost?

Each of these influences has an important impact on addiction counseling; as a result, there are numerous areas of conflict in the addictions field. For example, disease model counselors may advocate use of the term *codependency* for the partners and family members of addicts, but the research community may respond by stating that there is not enough research to warrant the use of such a diagnostic term, and the managed care organizations may not be willing to pay for codependency treatment because of the disagreement among the professionals. It is important to understand the historical influences of both the disease model of addiction treatment and addiction research.

Disease Model of Addiction Treatment

The addiction counseling field has two main root systems: a grassroots addiction recovery network and a research community base. Lay therapy with this population began in 1913 when Courtenay Baylor was hired by the clinic of Boston's Emmanual Church (that began in 1906) after receiving treatment there. Many lay counselors became sober before AA or without affiliation with it once it emerged in 1935 (W. L. White, 1999). AA looked at alcoholics as having an allergy to alcohol, which results in a craving and a loss of control (AA, 1939). Other than Thomas Trotter and Benjamin Rush, who, at the end of the eighteenth century, viewed alcoholism as a disease, alcoholism was typically viewed as a moral weakness (O'Dwyer, 1993). AA's view of alcoholism as an allergic reaction helped shift alcoholism from a moral problem to a physical or medical problem: The alcoholic was no longer blamed for developing the addiction (G. A. Marlatt, 1985b).

The AA view of alcoholism as an allergic reaction affected treatment in a number of ways. First, defining addiction as a physical reaction (allergy, craving) allowed the addicted individual to feel less like a "bad person" and more like a "sick person," which preserved or restored self-esteem and self-respect. Second, viewing addicts as having an allergic reaction to mood-altering substances provided a simple, straightforward definition of their struggle that most people can readily grasp. Third, this grassroots model encouraged the use of self-help groups, thereby helping addicts develop a sense of community.

W. L. White (1999) describes the evolution of the professional addiction counselor role. With the birth of AA, members of AA began to be employed at treatment facilities. In the 1940s, boundaries between AA members and employers were clarified. The Minnesota model of treatment emerged from three programs in Minnesota that operated with an AA philosophy (Pioneer House established in 1948; Hazelden established in 1949; Willmar State Hospital established in 1950). In 1954, the Minnesota Civil Service Commission provided a title, Counselor on Alcoholism, that created a professional role for the addiction counselor.

Addiction Research

While the self-help group movement was growing, so was the research on addiction. About the same time as AA's development, the federal government began two drug treatment programs for prisoners, which facilitated research opportunities on addictions (O'Dwyer, 1993). Through his alcoholism research and the creation of the Yale School of

Alcohol Studies in 1942, Jellinek developed the disease model of alcoholism (Bowman & Jellinek, 1941; Gragg, 1995; Jellinek, 1960). The disease model of alcoholism fit well with AA's model of an allergy, and a significant bridge developed between the self-help group movement and the research community. In 1956, the American Medical Association (AMA) agreed that alcoholism was a disease (G. A. Marlatt, 1985b). Through the development of the disease model of alcoholism, both the self-help group movement and the research community guided mental health professionals in their work with addicts (Gragg, 1995).

In a manner similar to AA's view of addiction as an allergy, the disease model of addiction had an impact on treatment. The addict's self-esteem and respect is preserved or restored because the problem is framed as physically, not morally, based. Also, the disease model provided information about the stages of the disease's development, thereby enhancing the diagnostic process. Finally, the model provided counselors with a framework and terminology to provide clients with information about the current and eventual progression of the disease.

Managed Care Organizations

Significant concerns about the third influence, managed care organizations, abound in the addictions field. Armstrong (1997) summarizes three common areas of focus in managed care: accessing care, containing costs, and ensuring quality. The logic of managed care is to make sure services provided are necessary and that monies are used thoughtfully (Kinney, 2003). However, Margolis and Zweben (1998) underscore some of the concerns with managed care in the addictions field. They point out that research over the past 30 years shows that people improve the longer they are in treatment, yet managed care emphasizes less intense and shorter treatment duration. For example, managed care plans may not cover individual sessions or focus on outpatient treatment. Also, managed care plans may measure successful outcomes by "no immediate problems or complaints," which is a different treatment success measure than that used by an addiction counseling professional. Kinney adds two specific problems that have occurred in the addictions field regarding managed care: Treatment is not individualized so optimal care may not be obtained, and contracts are based on reimbursement for certain diagnoses rather than actual costs. This results in services being limited. The Physician Leadership on National Drug Policy (PLNDP) reported that coverage of substance abuse has been limited in managed care plans for a number of reasons such as ("Physician Group," 2002) (1) purchasers do not view themselves as able to negotiate for more comprehensive coverage, (2) both purchasers and health maintenance organizations (HMOs) may lack scientific data on substance abuse and not realize its cost-effectiveness, and (3) insurers may view benefits as long term so people would show the effectiveness of treatment after leaving their jobs and having different insurance.

The primary impact of managed care on addictions treatment is a shortened length of treatment. Due to limited funding, counselors increasingly need to use briefer therapy models as well as assist clients in accessing community supports, such as self-help groups, to provide effective, comprehensive care. Although counselors may experience negative reactions to the treatment control of managed care, they have no choice but to work with the economic realities of the managed care philosophy (Hood & Miller, 1997).

Austad and Berman (1995) state that counselors cannot operate separately from their economic environments. One factor they attribute this shift to is increasing costs: ". . . employers, insurers, and individual consumers are no longer willing to pay unlimited

amounts for health care without close scrutiny and accountability" (p. 3). Additionally, the authors state that mental health concerns became covered because of an awareness of the interaction between the mind and body. The counselor working in the area of addictions needs to find a balance between addressing the financial realities of managed care with the ethical commitment to client welfare. To work with this reality in the addictions counseling field, the history of managed care needs to be examined in terms of its current impact on the field.

Austad and Berman (1995) describe the history of managed care development in the United States. Managed care systems came with two emphases: to provide quality care and to reduce costs. HMOs began in the 1900s as alternative forms of health care for poor people, laborers, and farmers who might be obliterated financially by intense, sudden medical costs. Initially, HMOs were opposed by medical professionals; however, acceptability for the concept of "prepaid care" (health care is provided by specific individuals or groups for a specific fee predetermined in a contract) grew by the 1970s as evidenced in the passing of the 1973 HMO Act that decreased legal restrictions on these organizations and provided loans and grants. The basic models of HMOs are:

1. *Staff model:* Comprehensive medical services are provided by individuals (employees or contractors) who work out of a central location and receive a salary.
2. *Group model:* Group of practitioners who have a contract with an HMO to provide services (central location or private office).
3. *Independent practice model:* Practitioner provides specific service (private office).

The last two models have fees that are arranged previously or ones where the provider gives all necessary services for an agreed upon fee. With a preferred provider organization (PPO), the clients have monetary incentives to use providers who have been previously approved by a panel, and the providers have an established agreement to provide services at a certain rate. Managed care models are changing and HMOs are now part of this changing network.

In terms of mental health services, this same 1973 act required HMOs to provide mental health services if they wanted federal assistance. In the 1980s, less money, growing costs, and increased counseling demands by consumers resulted in an interest in more efficient and less costly counseling.

Because of the prevalence of managed health care, counselors need to work either within managed health care systems (as in the staff model described earlier) or with managed health care systems. An excellent resource for basic suggestions on general approaches in working with managed care in terms of practical realities is *The Elements of Managed Care* (S. R. Davis & Meier, 2001).

Counselors simply have less time to work with clients and need to practice under managed care directions (Whittinghill, Whittinghill, & Loesch, 2000). This reality raises concerns in areas such as confidentiality, reimbursement, and treatment needs that can impact the relationship between the counselor and the client (Hood & Miller, 1997). The responsibility of ethics falls to the counselor. The SAMHSA (1998b) makes some of the following recommendations:

1. Be aware of a commitment to both client and society.
2. Use the most effective and cost-effective treatment.
3. Promote the greatest good for the greatest number.

4. Use resources carefully.
5. Advocate for clients in terms of benefits in their best interest with the managed care company or through professional associations noting that such advocacy involves a risk.

As to prevention of ethical dilemmas, Haas and Cummings (1992) recommend that eight issues be considered before entering a contract:

1. Know who carries the financial risk.
2. Anticipate how the plan might impact the therapeutic relationship.
3. Know if there is flexibility to the rules.
4. Understand alternatives to treatment (needs different treatment or benefits will run out).
5. Clarify if the plan will provide training or help to the provider that will enhance obtaining treatment goals.
6. Know if there are incentives for hospitalization.
7. Clarify if concerns or suggestions can be made to managed care.
8. Understand if clients know the limitations of their benefit plan.

The counselor needs to work with managed care organizations with a sensitivity that anchors itself in the best interests of the client yet includes an awareness of cost containment. This sensitivity requires an open discussion of the constraints and provisions of the managed care organization in the counseling agreement. An open dialogue at the beginning of the counseling process can reduce misunderstandings or negative impacts on the counseling process. Maintenance of this dialogue throughout counseling is critical.

Hood and Miller (1997) raise the concern that counselors need to treat clients in an approach that combines integrity and compassion with the reality of a third party guiding treatment decisions based on cost. At the same time, G. Miller (2001) states that there is additional stress for counselors because of a shift to a more behavioral focus and a sense of having to do more with less. Specific stresses may involve financially related struggles for some counselors in terms of their practice, that is, service reimbursement, increased paperwork and accountability, and ethical dilemmas. Pipal (1995) presents the danger of "distressed triangles" where the counselor, client, and case manager show struggles with communication (indirect, secret), power, and emotions (anxiety, shame, confused loyalties). Sachs (1996) adds that the counselor can feel dehumanized in the process of working with these organizations; a contagion effect of dehumanization can then occur with clients.

Langman-Dorwart, Wahl, Singer, and Dorwart (1992) encourage counselors to provide the best services possible with an awareness of cost. How can an addiction counselor do this? Whittinghill et al. (2000) state that addiction counselors need to diagnose accurately and effectively match clients to an appropriate treatment rather than a general one such as practicing abstinence and working a 12-step program. Such interventions need to take into account the different levels of severity of addiction. Counselors need to have knowledge and access to addiction treatment services offering different levels of care. They also need to consider briefer treatment modalities and become trained in these areas. Finally, counselors need to evaluate treatment outcomes and develop treatment goals that are measurable. The authors state that the reality for addiction counselors is that they may be operating under these managed care pressures within a system that is designed for more long-term, generic care with vague approaches.

C. Weisner (2001) also states that demographic factors such as gender, age, income, drug use type, and severity along with motivation for treatment and abstinence need to be examined for how they may affect treatment beginning (readiness for treatment, enhancement of motivation) and how the system brings them into treatment, that is, intake process.

Gorski (2003) recommends that treatment programs need to be expanded for people who are relapse-prone in order to encourage managed care payment of services for them. At this point, the managed care provider may say it did not work once, why try again? However, if the condition is not effectively treated, there can be a worsening of the condition.

It can be equally frustrating to have an agency set a flat number of treatment sessions for a specific diagnosis. The counselor in this situation may feel like a worker at a fast food franchise: Every burger gets the same ingredients no matter what. The counselor needs people or places to vent the frustration in working with such organizations so that the client does not hear such negative views from the therapist or experience negative consequences about reimbursement due to the conflict between the counselor and the managed care representative.

In addition, the counselor can become involved in state and national groups that advocate against the negative impact of managed health care (Pipal, 1995). Such action may positively impact the counselor's sense of empowerment. For example, Dorfman and Smith (2002) analyzed 54 prevention behavioral health intervention studies for effectiveness and reduced cost impact and made six recommendations for managed care practices in this area: (1) prenatal and infancy home visits, (2) cessation-of-smoking education and counseling, (3) short-term mental health therapy, (4) self-education for adults, (5) presurgical educational intervention with adults, and (6) brief counseling and advice to reduce alcohol use. Two of these, self-care education and brief counseling, are directly related to the substance abuse area. Counselors can use such research to advocate for their profession through their involvement with professional organizations.

Hood and Miller (1997) also suggest that the counselor use a compassionate approach with the managed care professional: Attempt to understand that individual's role and responsibilities with regard to providing services to the client. Such an approach is an invitation to collaboration in an attempt to provide for the client's best interests.

This three-pronged approach can truly enhance the counselor's practice within the reality of managed health care. The practice of self-care, involvement in professional organizations, and a compassionate approach to managed care personnel can help the counselor decide what can be done to help each client and what cannot be done. Providing clients with such information in a professional manner can be a powerful role model for clients on dealing with life's realities: doing what we can do something about and letting go of the rest.

As a result of the increasing emphasis on cost containment by these health organizations where time-limited interventions are preferred over long-term counseling (Whittinghill et al., 2000), Chapter 9 focuses on brief therapy as it applies to addiction counseling. Other counseling approaches presented are suggested, in part, because of their fit with the managed care philosophy. For example, Chapter 7 focuses on relapse prevention. For clinicians to work with clients who have addiction problems within a managed care framework, clinicians need to include relapse prevention information early in treatment because of a limited number of treatment sessions. Also, because managed care funding may encourage counselors to make use of community services for their clients to augment the limited number of therapy sessions, we emphasize community counseling approaches. Chapter 8 focuses on self-help groups that provide counselors

with an opportunity both to learn about the philosophy of some of the national self-help groups and to assist their clients in making the best use of them.

THEORIES OF ADDICTION

Theories about addiction have changed. Some theories may be more popular in one area of the country than another. A counselor working with addicted individuals should find and become familiar with a model he or she is comfortable using for the assessment and treatment process. Also important are the theories of addiction advocated by the counselor's employer, the client's funding organization, and the state's addiction credentialing and licensing board. The theoretical models advocated by these organizations can have an impact on the counselor's employment, the client's treatment, and the counselor's liability, especially in court testimony. Because theoretical models vary, the standard classification of addiction found in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR;* American Psychiatric Association, 2000) can be used as common ground for discussion of addiction by professionals.

The *DSM-IV-TR* classifies mood-altering substances into 11 substance-related disorders: alcohol, amphetamine, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opiods, phencyclidine (PCP), and sedatives, hypnotics, and anxiolytics. Substance-Related Disorders in the *DSM-IV-TR* are divided into two categories: Substance Use (Dependence and Abuse) and Substance-Induced (intoxication, withdrawal, delirium, dementia, amnesic, psychotic, mood disorder, anxiety, sexual dysfunction, and sleep disorder). To meet the criteria for dependence, the client must have a maladaptive use pattern causing some type of impairment with at least three of the following occurring within one year: tolerance; withdrawal; more or longer use than planned; desire without ability to cut down or control usage; time spent on obtaining, using, or recovering from the substance; impact on activities that are social, occupational, or recreational (do less or not at all); and continued use in spite of physical or psychological problems related to use. Counselors need to refer to the *DSM-IV-TR* to understand more thoroughly the complexities of a dependence diagnosis.

In terms of addiction theories, McHugh, Beckman, and Frieze (1979) provide a four-part framework (moral, psychological, sociocultural, and medical) that helps link theoretical models of addiction to the diagnosis of dependence. Each theoretical model includes a view of alcoholism, cause of alcoholism, and form of treatment, yet each emphasizes different addiction components. Some of these components are (Leigh, 1985):

1. *Cultural factors,* which influence how a person decides to take a drug, attitudes toward taking the drug, the practices of a group/subculture, and the drug's availability
2. *Environmental factors,* that include conditioning and reinforcement principles (drugs are taken to experience pleasure and reduce discomfort), learning factors (modeling, imitation, identification, etc.), and life events
3. *Interpersonal factors,* that include social influences (lifestyle choice, peer pressure, expectations of drug use, etc.) and family factors (system maintenance, genetic influences, etc.)
4. *Interpersonal factors,* that include human development, personality, affect/cognition, and sex differences

The following six models incorporate different aspects of these factors. One of the main concerns in managed health care is cost containment, which has an impact on

developing specific therapeutic interventions (Austad & Berman, 1995). Some addiction theories are more amenable to this type of therapeutic framework than others and are highlighted in the following theoretical discussion.

Moral Model

The moral model views the alcoholic as a degenerate and sees alcoholism as a moral weakness (M. Keller, 1976). Punishment is preferred over treatment because a cure is not envisioned (McHugh et al., 1979).

Psychological Models

There are three main psychological theories: psychodynamic, personality trait, and behavior learning. Although each theory views the specific cause of alcoholism differently, they all share a similar outlook: The causal factors must be changed in order for treatment to be effective.

The psychodynamic theory focuses on the personal pathology of alcoholics. The goal in treatment is to uncover the unconscious conflicts. Because the conflicts are seen as fairly unchanging, treatment is not viewed as very effective. An example of such a conflict is parental rejection that results in dependency needs that cannot be met in reality (Zimberg, 1985).

The focus in the personality trait theory is on changing the personality traits of the alcoholic—for example, treating high anxiety (Barry, 1974). However, treatment is not very effective because of the stability of personality traits (McHugh et al., 1979). DiClemente (2003) states that while there has been an examination for a personality of an addicted person, there is not a clear or firm definition of such a personality.

The behavior-learning theorists emphasize the changing of reinforcements, since alcohol is reinforcing for alcoholics. For instance, a change in reinforcers may occur by changing environments (J. Wallace, 1985). This theory offers the best prognosis of the three because reinforcers can be readily changed.

Because the behavioral-learning theorists emphasize the reinforcements involved in alcohol/drug addiction, the counselor working within the framework of a managed care organization can use this theory in the treatment and recovery process (Tulkin & Frank, 1985). The counselor can develop a plan with the client that examines how the client is specifically reinforced by abusing alcohol/drugs. For example, if a client is psychologically addicted to marijuana because it reduces stress, the counselor can use this information to help the client develop a treatment and recovery maintenance plan that includes relaxation coping skills.

Sociocultural Models

The sociocultural model emphasizes social forces and contexts that give birth to and feed alcoholism. Cultural attitudes (G. A. Marlatt, 1985a), family structure (Bowen, 1978), and crisis times (Bratter, 1985) need to be addressed in order to have an impact on alcoholism. Treatment focuses on changing the environmental contexts for the alcoholic. DiClemente (2003) adds peer pressure, social policies, and availability as factors to be considered in this model. The author also includes family influences such as nature-based in essence (genetics) and nurture-based (system dynamics).

One example of a sociocultural model is Cushman's (1990) empty self theory. In this model, industrialization, urbanization, and secularism are societal aspects that

have resulted in the increasing loss of family, community, and tradition—those things that offer people shared meaning in their lives. The loss of these aspects results in an empty self, who views psychological boundaries as specific ("My mental health depends on me"), a locus of control as internal ("I am in charge of my life"), and a wish to manipulate the external world for personal ends ("I will be happy if I manage well"). Cushman (1990) believes that the active addict is using drugs to fight off feelings of alienation, fragmentation, worthlessness, and confusion (particularly around values). This theory can be readily applied in addiction counseling by assisting the client in recovering a lifestyle that involves a sense of family, community, and tradition, all supporting of the addiction recovery.

Medical Model

The medical model looks at specific physiological dysfunctions such as endocrine dysfunction (Gross, 1945). Although theories in the medical model may assist in defining and describing alcoholism, they fail to promote any specific treatments. The disease model of alcoholism is related to this category because of its basis in physiology (i.e., genetic predisposition, allergic reaction); however, it has a slightly different twist to it because of the individual's responsibility for future behavior and the need for spiritual help in recovery.

The disease model views alcoholism as a progressive disease with symptoms. The two key elements in this model are loss of control over drinking and the progression of the disease, which ends in death. This view, a shift from the moral view, is more compassionate and open to treatment and insurance coverage (S. Goodman & Levy, 2003). This view is partially accepted by AA (McHugh et al., 1979): Alcoholism is an illness that is physical, mental, and spiritual in nature, and the alcoholic is not responsible for the development of the addiction but is responsible for future behavior. The alcoholic enters into recovery from addiction by admitting a powerlessness over alcohol as well as wrongs done to others and receiving the help of a Higher Power—what might be called a spiritual solution. This theory of addiction, according to AA, has been implemented in the Minnesota Model of treatment: Professional services are combined with the 12 Steps of AA, using counselors who are often in addiction recovery themselves (O'Dwyer, 1993). This model, which was very strong in the 1960s and 1970s, encourages the treatment of the whole individual in terms of body, mind, and spirit (S. Goodman & Levy, 2003). Gragg (1995) highlights the benefits of using the disease model of alcoholism/addiction within an HMO framework: It reduces the client's guilt over the addiction, and it encourages community involvement to supplement managed care therapy.

Biopsychosocial Model

More recently, models of addiction have been presented as biopsychosocial (Perkinson, 1997). In this type of model, biogenetic traits and psychosocial factors are combined when addressing addiction in an attempt to provide an integrated, comprehensive model.

Ray and Ksir (2004) discuss the disease model argument as follows: While psychiatrists had viewed alcoholism as a secondary problem and focused on treating the primary mental health disorder (telling their patients to use alcohol less), AA viewed alcoholism as the main problem that required direct treatment. Allegiance to the disease model is based on this commitment to alcoholism being the primary problem that needs to be treated. The debate about alcoholism being a disease continues to the present day.

Some argue that alcoholism does not meet the criteria of being a disease because we cannot find the cause, directly treat it, or even know if there is a disease present. These critics also warn that the definition of the disease can be watered down by the view of seeing all excessive behaviors from this perspective. Some say it may be most appropriate to view the disease concept as a metaphor (G. A. Marlatt & Fromme, 1988). The biopsychosocial model of addiction may be a bridge across these conflicts.

The biopsychosocial model (Figure 1.1) is holistic in that it views biological aspects impacting psychological aspects impacting social aspects of the individual in an ongoing, interactive manner (G. W. Lawson, Lawson, & Rivers, 2001). It looks at causality in a complicated way with regard to how the person becomes involved in addictive behavior, stays involved in addictive behavior, and stops the addictive behavior (DiClemente, 2003).

Kumpfer, Trunnell, and Whiteside (2003) describe the components of these three areas as follows: Biological includes genetic inheritance, in utero damage, and temperament or physiological differences. Psychological and social factors are combined into psychosocial, which includes an interaction between the individual and family, community, school, work, peer, and social factors.

There are some benefits to this perspective. First, it accounts for the complicating, contributing factors of addiction. This perspective encourages an individual assessment of the alcoholic or addict that accounts for causes in varying amounts like pieces of a pie. For example, some alcoholics/addicts may have a significant biological component without much in the other two areas. The model encourages a complex yet individualized understanding of one's cause of addiction.

This broad assessment perspective also encourages a broader treatment perspective. As G. W. Lawson et al. (2001) report, treatment may then involve addressing more than one problem at a time. An example of this is when a woman in a domestic violence situation has a drinking/drug problem and needs to address both issues simultaneously since they impact each other. She can best protect herself if she is sober, and the experience of being battered may encourage or trigger her alcohol or drug usage. The model is one of the "Best Practices" where the counselor looks for the best fit between the client need and the available treatment (Addictions Foundation of Manitoba, 2000).

Yet, as DiClemente (2003) outlines, the drawbacks to the use of this model are threefold: First, typically an emphasis is placed on one aspect of the model without a solid integration of the three aspects. Second, it is difficult to make interventions on all aspects at the same time. Third, some factors, such as risk and protective factors, cannot be changed. While DiClemente's concerns are important to consider, the use of the biopsychosocial model in the treatment of addiction remains valid because of its emphasis on complicating factors interacting in order for an addiction to be born and

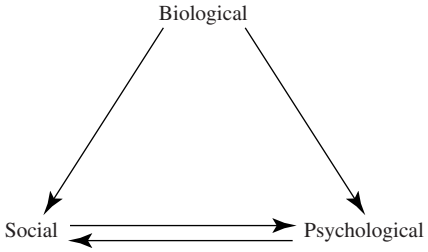

Figure 1.1 Biopsychosocial model.

live in an individual. Treatment and aftercare from this perspective invite a holistic, personalized approach.

Harm Reduction Model

The harm reduction model has a potential as a barrier or bridge with other theoretical models. Faupel, Horowitz, and Weaver (2004) provide a history of the harm reduction approach. They state that although it was used to guide policy in Europe and Australia, in the United States it was present only in an underground fashion in the 1960s and 1970s, becoming formalized in the 1980s. Erickson (1999) describes three phases of the harm reduction model in the United States: (1) In the 1960s, the first phase focused on health problems related to nicotine and alcohol; (2) In the 1990s, the second phase focused on HIV/AIDS prevention in injection drug users; (3) The third phase, in which we are currently engaged, looks at legal and illegal drugs from a public health view, that is, drug education to adolescents, programs that are harm reduction based or abstinence based. Although the harm reduction model runs counter to the moral model of addiction, it can be a bridge with the psychological, sociocultural, medical, and biopsychosocial models of addiction. Given the prevalence of the biopsychosocial model of addiction, the harm reduction model has the potential to enhance this model in terms of prevention, treatment, and aftercare of addiction.

In the harm reduction model, the emphasis is on reducing problems with usage rather than the amount of alcohol/drugs the individual is using (Kinney, 2003). It tries to approach use of drugs/alcohol as a reality that occurs. It is a benefit to the individual and society to reduce the harm connected to the using behavior. This model is based on public health principles avoiding judgment about using and focusing instead on reducing harm in practical ways (Cheung, 2000). Examples of a harm reduction approach include programs for designated drivers and needle exchange programs (Kinney, 2003).

One of the benefits to this model is the practical reality of treatment. Lifelong abstinence may not be attainable for some clients, or the clients may not be motivated by abstinence (Rotgers, 2003). The struggle with harm reduction approaches intensifies with illegal drug use and specific populations such as adolescents and pregnant addicts. Type of drug and drug use population can elicit moralistic responses to usage that advocate prohibitionist or abstinence-based approaches to education/prevention and/or treatment. Concerns that a harm reduction approach will result in legalization of a drug are argued by some ("Do Mainstream Treatment," 2001). The emphasis is on reduction of harm that can be done in a manner that fits a mainstream treatment model, for example, letting people stay in treatment after a relapse or stay when on methadone.

A harm reduction approach may assist the client in eventually achieving abstinence but does so in manageable steps (Rotgers, 2003). This approach is a good match for the motivational interviewing approaches discussed in Chapter 9. The counselor establishes goals collaboratively with the client to address the substance abuse problems (Rubin, 2003).

When adopting this type of approach, a counselor needs to be careful of two main dangers. First, there is the danger of going to an extreme and believing that all clients in all circumstances can be treated from a harm reduction perspective. Using the welfare of the client as a guide, a counselor may need to take a direct stand or intervention of abstinence in order to act in the best interests of the client. Second, the counselor needs to continually monitor enabling behavior toward the client. This may be offset by dialogue with colleagues, supervisors, and/or mentors to ensure that assessment,

treatment, and aftercare interventions are not reducing consequences to the using behavior and are keeping drug use as a primary focus.

Some recommendations for collaboration between blending mainstream addiction treatment and harm reduction approaches are ("Do Mainstream Treatment," 2001):

1. Respect the client (nonjudgmental).
2. Reduce consequences of drug abuse in the community.
3. Be creative in ways to reach potential clients.
4. Decrease consequences for those who use.
5. Provide treatment to clients and loved ones caught in the addiction cycle.
6. Do not view relapse as treatment failure.
7. Provide substance abuse treatment to clients receiving prescribed medication for medical/psychiatric conditions.
8. Provide comprehensive services by working with other systems.

SUMMARY

Theories of addiction play a critical part in the assessment and treatment process for the client. The counselor working with addicts needs to be aware of the biases of his or her theoretical orientation in order to determine exactly what aspects will be addressed as well as overlooked by the theoretical approach. An awareness of one's theory at this level can result in a holistic therapeutic approach.

Table 1.1 Theoretical Models of Addiction

Model	View of Alcoholic/Addict	Cause of Addiction	Treatment
Moral	Degenerate	Moral weakness	Punishment (ineffective)
Psychological/ psychodynamic	Personal pathology	Unconscious conflicts	Conflicts do not change (ineffective)
Psychological/ personality trait	Personality trait problems	Personality traits	Personality traits do not change much (ineffective)
Psychological/ behavior learning	Learning problem	Alcohol/drug and environmental reinforcers of usage	Change reinforcers
Sociocultural	Situation problem	Social forces and context	Change environmental context
Medical/disease	Patient/Client	Physiological dysfunction/Loss of control, progressive	No specific treatment/ Treat body, mind, spirit
Biopsychosocial	Client and environment factors	Biological/psychological/social factors (interacting)	Treat interacting factors (individualized)

This chapter has established a baseline for examining addiction by addressing different theories in the field. Table 1.1 on page 13 is a summary of the theories discussed in this chapter.

The remaining chapters focus on counseling theories assessment and diagnosis, treatment, relapse prevention, self-help groups, current and evolving therapies, special issues in treatment, personal and professional development of the counselor, and certification and licensure preparation.

QUESTIONS

1. What factors increased mental health workers' interest in working with addicted individuals?
2. What are three main influences in addiction counseling?
3. Which addiction theory served as a bridge between the research community and the grassroots network?
4. How have these influences affected addiction treatment?
5. What is an example of a controversial topic in the addictions field?
6. What are four common components of theories of addiction?
7. What are the four main theoretical models of addiction?
8. Which addiction models seem most amenable to managed health care?

CASE STUDIES

CASE STUDY 1.1

Jacob is a 30-year-old male who came to your agency for an addiction assessment. At his first session, he was diagnosed as addicted (according to *DSM-IV* criteria) to cocaine, his drug of choice. Jacob's HMO insurance coverage is limited to 5 days of inpatient treatment and 10 outpatient sessions with you. This is his first treatment for addiction. He tells you that all of his friends use cocaine and that his roommate started him on it. He says he likes cocaine because he does not feel depressed when he takes it. He also states that he feels like a failure because he became a drug addict like his father.

1. How would you use behavioral theories in terms of Jacob's recovery?
2. How would his culture be important to his recovery process?
3. What aspect of the disease model might be helpful to him?

CASE STUDY 1.2

You are an experienced counselor with a specialty in addictions counseling. You are approached by a counselor, who is new to addiction counseling, for advice on working with managed care organizations. What three main suggestions would you make to this counselor to enhance his or her survival in the managed care world?

EXERCISES

EXERCISE 1.1

Discuss with a peer the various theoretical models of addiction (moral, psychological, sociocultural, medical, biopsychosocial, harm reduction) in terms of:

1. Which one you feel most comfortable using in addiction counseling and why.
2. Which one you feel most uncomfortable using in addiction counseling and why.

EXERCISE 1.2

With a peer, discuss any concerns you have working with managed care with these statements/questions in mind:

1. My worst experience (or anticipated experience) in working with managed care was:
2. My best experience (or anticipated experience) in working with managed care was:
3. I can take action with regard to managed care by _____ .

SUGGESTED READINGS

Austad, C. S., & Berman, W. H. (1995). Managed health care and the evolution of psychotherapy. In C. S. Austad & W. H. Berman (Eds.), *Psychotherapy in managed health care* (pp. 3–18). Washington, DC: American Psychological Association.

This chapter provides a succinct summary of the relationship between therapy and managed care.

Davis, S. R., & Meier, S. T. (2001). *The elements of managed care.* Belmont, CA: Wadsworth.

This book provides a helpful overview of managed care organizations and their components.

Gragg, D. M. (1995). Managed health care systems: Chemical dependency treatment. In C. S. Austad & W. H. Berman (Eds.), *Psychotherapy in managed health care* (pp. 202–219). Washington, DC: American Psychological Association.

This chapter describes managed care's impact on and relationship to chemical dependency treatment.

McHugh, M., Beckman, L., & Frieze, I. H. (1979). Analyzing alcoholism. In I. H. Frieze, D. Bar-Tal, & J. S. Carroll (Eds.), *New approaches to social problems* (pp. 168–208). San Francisco: Jossey-Bass.

This chapter provides a helpful overview of theoretical models as they relate to addiction.

Substance Abuse and Mental Health Services Administration. (1998). *Ethical issues for behavioral health care practitioners and organizations in a managed care environment* (Vol. 5; DHHS Publication No. 98-3241). Rockville, MD: Author.

This publication outlines ethical issues that health care professionals face in working with managed care.