CHAPTER 1

Recognizing Alcohol Problems

You know something is wrong with your patient, but you don't know what it is. He looks depressed and anxious. His face is red and swollen, his eyes watery and red. If you look closely at his cheeks, you might see little red spider lines called *spider angiomas* that signal a failing liver. Something is wrong and it nags at you. That uncomfortable feeling inside you grows, and you don't like it.

You have been a natural born healer all of your life. When you were a kid, you cared a little more about injured puppies and kittens than others did. You didn't want to squash bugs. People in school talked to you when they wouldn't talk to anyone else. People recognize a healer when they see one.

There is another side of you that is different, though. It has been in trouble with patients like this before. Sometimes this healing thing is not what it's cracked up to be. Sometimes you have to tell people the truth when they don't want to hear it. They rebel against you and get angry. You have learned that sometimes it is best to let the truth go or to change it to make it more palatable. You hate that part of yourself, but you have learned how to live with it. After all, you live in a world full of litigation and managed care. Fear has overcome your best judgment many times.

And there's that patient over there, crying out to the healer in you. This time if you let the problem go, if you take the easy way out, the patient could die. Ninety-five percent of alcoholics die of their addiction, and the average alcoholic dies 26 years earlier than he or she would otherwise. To

let this patient out of your office without confronting the truth is to be potentially responsible for the patient's death.

Yet, you have confronted alcoholics before. Alcoholic patients have two sides: One side knows they are drinking themselves to death while the other side knows they can drink safely. You and your patients are in a war of lies, battling the truth. The trick is to help the patients win. You are up against a great enemy. The Big Book of *Alcoholics Anonymous* (2001) says this illness is "cunning, baffling and powerful" (pp. 58–59). At every AA meeting, someone reads how it works, which is the fifth chapter in the Big Book. The chapter ends with this statement:

> Our description of the alcoholic, the chapter to the agnostic, and our personal adventures before and after make clear three pertinent ideas: (a) that we were alcoholic and could not manage our own lives, (b) that probably no human power could have relieved our alcoholism, and (c) that God could and would if He were sought. (*Alcoholics Anonymous,* 2001, p. 60)

So the battle lines are drawn. The enemy, the disease, is confident of victory. It thinks that you will probably take the easy way out. You will handle the acute problem and let the patient go home. You will not ask the questions that could lead to the truth.

But the enemy doesn't know you. The enemy doesn't know that you are a natural born healer. You will not lie. You are not going to let the patient go home to die. You are going to fight. This is who you are inside, and it is who you will always be.

THE MOTIVATIONAL INTERVIEW

Your patient is sick and doesn't want to know the reason. Your job is to go with the patient toward the truth. It does no good to go against the patient. Arguing with the patient will not work because the alcoholic is an expert at giving every excuse in the world for abnormal behavior. If you argue, the patient will win because he or she will leave your office convinced you are a bad person. You need to gently walk with the patient toward the truth—patient-centered, not self-centered. You must connect with that gentle voice of reason inside patients that is telling them they are sick. That voice is there and your job is to connect with it, empathize with it, and pull for more. The other voice in patients' heads says something else is to blame. They might have a problem, but it has nothing to do with alcohol.

As a professional, you are used to your patients being honest with you, but this one is going to lie. The patient is not a bad person; he or she is a good person with a bad disease. The disease of alcoholism lives and grows in the self-told lie. Patients must lie to themselves and believe the lie, or

the illness cannot continue. Patients have a long list of excuses for their behavior. My spouse has a problem. The police have a problem. The school has a problem. My boyfriend has a problem. I have a physical problem. I'm depressed. I'm anxious. I have a stomachache. I can't sleep. The excuses go on and on, and they will confuse you if you get caught up in them. They are all part of a tangled web of deceit. Remember, your job is to walk with the patient toward the truth, not against the patient toward the truth. You are going to spend most of your time agreeing with the patient. When the patient is honest, you are going to agree with the patient. When the patient is dishonest, you are going to probe for the truth. If the patient is listening to you, you can work with him or her. If the patient is not listening to you, anything you say is worthless.

Watch the patient's nonverbal behavior very carefully. You are a healer, and you have been given the gift of supersensitivity. Your intuition will tell you whether the patient is going with you or resisting. When patients are going with you, you feel peace. When they are going against you, you feel fear. When the patient is ready, you will educate him or her about the disease. This is a gentle, loving process and it takes time. If you are in a hurry, it's not going to work.

The patient has been using alcohol for a long time and trusts it. All drugs of abuse tell the brain, "Good choice!" All organisms have an instinctive way of finding their way in a complicated world. What foods are good and what are bad? What is the best way through the jungle? What is safe and what is dangerous? We all learn these things deeply in the brain. What is good becomes quickly imprinted. If it is very good, it can become imprinted after one trial. Alcohol has been good to this patient for many years, and now it is destroying him or her. The very thing that gave the patient joy now gives nothing but pain. The patient is so fooled by this process that direct evidence of alcohol's harmful consequences are denied. Remember, alcohol has always said, "Good choice!" So how can it now be a bad choice? You are fighting with this patient's basic understanding of the world, and he or she will be convinced that you are wrong. You must help the patient see that alcohol is no longer a good choice—it's a deadly choice. The alcoholic cannot see this alone, but AA has an old saying: "What we cannot do alone, we can do together." The patient cannot discover the truth without your help. You must guide the patient toward a destiny he or she finds impossible. You need to help patients see that they need to stop drinking.

What you are looking for is the truth. The patient will rarely tell you accurate symptoms. You have to look for signs of the disease. You will continue to investigate—testing, smelling the air, ordering laboratory studies, and talking to family, friends, court workers, school personnel, and anyone else who can help you until you uncover the truth.

Your patient cannot tell you the truth because the patient doesn't know the truth. Addiction hijacks patients' spirit, mind, and body. They are trapped in a web of self-deception. They cannot tell you the truth even if they try because they don't know what it is. Remember, you are the healer. You love your patients even if they hate themselves. You are going to love them even though they are being nasty and deceptive. You are going to help them even though they don't understand what you are doing.

DEVELOPING THE THERAPEUTIC ALLIANCE

From the first contact, your patients are learning some important things about you. You are friendly. You are on their side. You are not going to beat them up, shame, or blame them. You answer any questions. You are honest and you hold nothing back. You are committed to do what is best for them. You provide the information and they make the decisions. They see you as a concerned professional. In time, they begin to hope that you can help them. The therapeutic alliance is built from an initial foundation of love, trust, and commitment.

You show the patient that he or she does not have to feel alone. Neither of you can do this alone. You must cooperate with each other to solve the mystery. Your patients know things that you don't know. They know themselves better than anyone else, and they need to learn how to share themselves with you. Likewise, you have knowledge that they don't have. You know the tools of recovery.

Your patients must develop trust in you. To establish this trust, you must be honest and consistent. You must prove to them, time and time again, that you are going to be actively involved in their individual growth. When you say you are going to do something, you do it. When you make a promise, you keep it. You never try to get something from patients without using the truth. You never manipulate, even to get something good. The first time your patients catch you in a lie, even a small one, your alliance is weakened.

If you work in a facility, the patient must learn that all of your staff works as a team. What patients tell you, even in confidence, they tell the whole team. Patients occasionally test this. They tell you that they have something to share but they can share it only with you. They want you to keep it secret. This is a trap that many early professionals fall into. The truth is that all facts are friendly and all accurate information is vital to uncovering the truth. You must explain to patients that if they feel too uncomfortable sharing certain information, they should keep it secret for the time being. Maybe they can share this information later, when they feel more comfortable.

Patients must understand that you are committed to their recovery, but you cannot recover for them. You cannot do the work by yourself. You must work together, cooperatively. You can only teach the tools of recovery. The patients must use the tools to stay sober.

CONDUCTING A MOTIVATIONAL INTERVIEW

In the first interview, you begin to motivate patients to see the truth about their problem. Questions about alcohol and other drug use are most appropriately asked as a part of the history of personal habits, such as use of tobacco products and caffeine ingestion. Questions should be asked candidly and in a nonjudgmental manner to avoid defensiveness. Remember, this is patient-centered interviewing, not professional-centered, and the interview should incorporate the following elements (Delbanco, 1992; Graham & Fleming, 1998; W. Miller & Rollnick, 1991; Ockene et al., 1988; Prochaska, 2003; Rollnick, Heather, Gold, & Hall, 1992):

- The patient should be alcohol-free at the time of the screening.
- Offer empathic, objective feedback of data.
- Work with ambivalence.
- Meet the patient's expectations.
- Assess the patient's readiness for change.
- Assess barriers and strengths significant to recovery efforts.
- Reinterpret the patient's experiences in light of the current problem.
- Negotiate a follow-up plan.
- Provide hope.

Example of a Motivational Interview

Professional: "Hello, Mr. Smith. I'm _____ (your name). Why did you decide to come in to see me today?" [The professional wants to understand what the patient expects from the initial visit.]

Patient: "My wife told me I had to talk to you."

Professional: "Why did she do that?"

Patient: "I don't know."

Professional: "I talked to your wife on the phone yesterday, and she said she was concerned about your drinking."

Patient: [Looking irritated] "She's always concerned about something I'm doing."

Professional: "Things are not going well at home?" [Professional mirrors the patient's feelings and facial expression. When you mirror a person's expression, you validate his or her worldview. Connecting

with what the patient feels is empathy, which gives the patient hope that he or she is being understood.]

Patient: "Oh, its okay. It's just that she gets all worked up about little things."

Professional: "Your wife said you have been drinking heavily every day, and she is worried about you."

Patient: "I don't drink every day. I drink once in a while, like most people. I work hard, and I like to come home and relax. Is anything wrong with that?" [The patient is obviously irritated with the interview, and the professional needs to listen and go with his or her feelings. So far, the patient is saying, "My wife has a lot of problems."]

Professional: [Reflecting the patient's point of view] "There's nothing wrong with relaxing. How do you relax?"

Patient: "I have a couple of beers."

Professional: "Your wife says you have been drinking a 12-pack of beer a day."

Patient: "It's not that much."

Professional: "Is it more than a couple?"

Patient: "Yeah, maybe a little more."

Professional: "Is it around 12?"

Patient: "So what if it is? I work hard and I deserve to relax." [The patient is resisting, and the professional knows to back off a little. It's important to keep the patient's ears open. Be empathic and understanding. Try to see the problem from the patient's point of view. Once you enter the patient's world and understand his or her point of view, you will get clues about what will motivate the patient to change. This patient is angry with his wife, and he needs some help with that, but what is his real problem?]

Professional: "I like to relax after a hard day, too. Everybody likes to do that."

Patient: "You're right about that. My wife just sits around all day and watches television while I'm working my tail off."

Professional: "So you really need to relax when you come home, particularly if you feel like you are pulling the load all by yourself?"

Patient: "Yeah, she sits around and thinks about things to argue with me about. That's her job."

Professional: "Do you think your wife loves you?"

Patient: [Visibly softening] "Yes, I think she does."

Professional: [Reinterpreting the patient's experience in light of the alcohol problem] "It's great to have a wife that loves you. If you are drinking too much, she should be worried."

Patient: "But I'm not drinking too much. I'm just drinking a few beers."

PROFESSIONAL: "What's the most beer you have ever drunk in a full day?"
PATIENT: "Oh, I don't know."
PROFESSIONAL: "Give me a guess."
PATIENT: "Well, on the weekends I can drink up to a case if I'm watching the game."

[The professional determines the patient is an alcoholic, but doesn't jump the gun. The patient is not ready yet.]

PROFESSIONAL: "That's a lot of beer."
PATIENT: "Not if it's all day."

[The professional believes the patient's ears are open, so it's time to try a little education.]

PROFESSIONAL: "Did you know that if you drink more than three beers a day more than three times a week, your organs are dying? Alcohol is a poison. It kills the brain, heart, kidneys, every cell in the body. If you are drinking more than three drinks per day, you're literally dying."

[Patient quickly looks away. He doesn't want to hear this. But he did hear it, and he can't make it go away. He has to rapidly deny your statement or admit that he has a problem. A part of him knows he has a drinking problem, and now it's confirmed. It's not only his wife's opinion but, now, also a professional's opinion. He hasn't admitted it yet, but he knows he has been drinking too much.]

[The professional assesses the patient's readiness for change.]

PROFESSIONAL: "Bob, have you been worried about your drinking?"
PATIENT: "No. Honestly, I haven't." [This comes across as real. When the words and the behavior don't match, the patient is being deceptive.]
PROFESSIONAL: "Maybe that's because you didn't understand how much you could drink safely. If alcohol is killing you, don't you want to know?"
PATIENT: "Yeah, sure."

[The professional takes the biggest chance of all. He or she has set it up, knows the patient, and now has faith it will work.]

PROFESSIONAL: "Do you think you have been drinking too much?"
PATIENT: "Yeah, maybe I have." [The patient has admitted that he drinks too much and that he has an alcohol problem.]
PROFESSIONAL: "Did you know that 95% of alcoholics die of their alcoholism? And they die 26 years earlier than they would otherwise."
PATIENT: "No."

Professional: "Knowing what you know now, would you like to learn how to drink less?"

Patient: "I didn't know it was that bad." [Now the patient is contemplating change. We are on the road to recovery. With a gentle and loving approach, the professional can negotiate and listen to the patient's life from his or her perspective, allowing the patient to move toward the truth. As this happens, the patient moves toward recovery.]

Professional: "Why don't we meet again with your wife and talk about what we can do to help you feel better? Would that be all right with you?"

Patient: "If you think it will help."

Professional: "Ninety percent of patients who work our program get better."

Patient: "Okay, let's do it."

QUESTIONS FOR THE ADULT PATIENT

The National Institute on Alcohol Abuse and Alcoholism (NIAAA; 1995) has developed the following low-risk drinking guidelines:

- For men, drinking no more than two drinks a day and no more than four drinks on a single occasion.
- For women and patients over 65 years of age, drinking no more than one drink a day and no more than three drinks on a single occasion.
- Pregnant patients and those with medical problems complicated by alcohol use should abstain completely.

During the first interview, certain questions need to be asked to assess alcohol problems. Those questions must be answered honestly to give you a clear picture of the extent of the drinking. Most patients who have alcohol problems are evasive or deny their alcohol abuse, so the questions should be asked of the patient, as well as a reliable family member.

The following questions and flags are taken from the American Society of Addiction Medicine (ASAM; http://www.asam.org):

1. Have you ever tried to cut down on your drinking?
2. Have you ever felt annoyed when someone talked to you about your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink in the morning to settle yourself down?
5. Have alcohol or drugs ever caused you family problems?
6. Has a physician ever told you to cut down on or quit use of alcohol?

Table 1.1
Patient History or Behavioral Observation
Red Flags for Adult Alcohol Abuse

1. Tremor/perspiring/tachycardia.
2. Evidence of current intoxication.
3. Prescription drug-seeking behavior.
4. Frequent falls; unexplained bruises.
5. Diabetes, elevated BP, ulcers nonresponsive to treatment.
6. Frequent hospitalizations.
7. Gunshot/knife wound.
8. Suicide talk/attempt; depression.
9. Pregnancy (screen all).

7. When drinking/using drugs, have you ever had a memory loss (blackout)?

If patients answer yes to any one of these questions, that's a red flag for alcoholism. If they answer yes to two questions, that's probable alcoholism. Make sure you don't ask only the patient. Ask family members, friends, and anyone else who can give you collateral information.

In addition, patient history or behavioral observation (see Table 1.1) and laboratory results (see Table 1.2) can reveal red flags for adult alcoholism. Red flags for adolescent alcohol abuse are listed in Tables 1.3 and 1.4, while Table 1.5 provides questions for adolescents who are suspected of alcoholism along with questions for the parent or caregiver. (See Chapter 7 for a discussion of adolescent treatment.)

Table 1.2
Laboratory Red Flags for Adult
Alcohol/Drug Abuse

1. MCV: over 95.
2. MCH: high.
3. GGT: high.
4. SGOT: high.
5. Bilirubin: high.
6. Triglycerides: high.
7. Anemia.
8. Positive UA for alcohol.

Table 1.3
Patient History or Behavioral Observation Red Flags for Adolescent Alcohol Abuse

1. Physical injuries; Motor Vehicle Accident (MVA), gunshot/knife wound, unexplained or repeated injuries.
2. Evidence of current use, for example, dilated/pinpoint pupils, tremors, perspiring, tachycardia, slurred/rapid speech.
3. Persistent cough (cigarette smoking is a risk factor).
4. Engages in risky behavior, for example, unprotected sex.
5. Marked fall in academic/extracurricular performance.
6. Suicide talk/attempt; depression.
7. Sexually transmitted diseases.
8. Staphylococcus infection on face, arms, legs.
9. Unexplained weight loss.
10. Pregnancy (screen all).

If you have one or more red flags, you have several important actions to take:

1. Advise the patient of the risk.
2. Advise abstinence or moderation. Men should be advised to drink no more than three drinks at a time and no more than three nights a week. Women should be advised to drink no more than two drinks at a time and no more than three nights per week. More drinking than this will result in progression of the disease. This is a harm reduction approach where you teach a patient how to drink responsibly but would not be appropriate for someone who has a serious drinking problem. People who are chemically dependent cannot cut down on their use because they are chemically dependent.
3. Advise against any illegal drug use.
4. Schedule a follow-up visit to monitor progress.

Table 1.4
Laboratory Red Flags for Adolescent Alcohol or Drug Abuse

1. Positive UA for alcohol/illicit drugs.
2. Hepatitis A-B-C.
3. GGT: high.
4. SGOT: high.
5. Bilirubin: high.

Table 1.5
Interview Questions for Suspected Alcoholism among Adolescents

1. When did you first use alcohol on your own, away from family or caregivers?
2. How often do you use alcohol? Last use?
3. How often have you been drunk or high?
4. Has your alcohol use caused problems with your friendships, family, school, community? Have your grades slipped?
5. Have you had problems with the law?
6. Have you ever tried to quit or cut down? What happened?
7. Are you concerned about your alcohol use?

Questions to Ask the Parent/Caregiver

1. Do you know or suspect your child is using alcohol or other drugs?
2. Has your child's behavior changed significantly in the past six months (e.g., sneaky, secretive, isolated, assaultive, aggressive, hostile)?
3. Has school, community, or legal system talked to you about your child?
4. Has there been a marked fall in academic or extracurricular performance?
5. Do you believe an alcohol or other drug assessment might be helpful?

NATURAL HISTORY OF ALCOHOLISM

Alcoholism develops slowly over a patient's lifetime, and it can begin at any age. It often occurs in individuals with no history of psychological problems. When the substance causing addiction is readily available, inexpensive, and rapid acting, abuse increases. Whenever the individual is ignorant of healthy alcohol use, susceptible to heavily using peers, or has a high genetic predisposition to abuse or to antisocial personality disorder, abuse may increase. This is also true if the patient is poorly socialized into the culture, in pain, or if the culture makes the substance the recreational drug of choice. Vaillant (2003) lists 11 risk factors for alcoholism:

Risk Factors

Risk factor 1: Alcohol is readily available.
Risk factor 2: Alcohol is cheap.
Risk factor 3: Alcohol reaches the brain quickly.
Risk factor 4: Alcohol is effective as a tranquilizer.
Risk factor 5: Alcoholism is more common in certain occupations (bartending).
Risk factor 6: Drinking peer group.
Risk factor 7: Alcohol is preferred in deviant subcultures.
Risk factor 8: Social instability.

Risk factor 9: Genetic predisposition.
Risk factor 10: Dysfunctional families.
Risk factor 11: Comorbid psychiatric disorders.

DIAGNOSING AN ALCOHOL PROBLEM

In the assessment, you must determine if patients fit into your range of experience and care. Do you have the ability to help them with their problem, or do you need to refer? Do they have a problem with chemicals? Are they motivated to get better? Do they have the resources necessary for treatment? Are they well enough to see you? Start by asking yourself certain basic questions: Does this person have a problem with alcohol? Does he or she need treatment? Is he or she motivated for treatment? What kind of treatment does he or she need? For the benefit of third-party payers, it is important to use assessment instruments to properly document (1) diagnosis, (2) severity of addiction, and (3) motivation and rehabilitation potential. Reviewers often have more faith in a test battery than your clinical opinion.

A number of companies sell inexpensive, disposable breathalyzers and drug screening instruments, including Prevent (800-624-1404); Bi-Tech-Nostix (888-339-9964); Random Drug Screens, Inc. (803-772-0027); and Drug Screens, Inc. (800-482-0693). Order a number of these tests and have them readily available for assessment, treatment, and continued care monitoring. Positive tests are only suggestive of drug and alcohol use; therefore, before any legal or workplace action is taken, the test should be confirmed by both an approved immunoassay and gas chromatography/mass spectrometry, which can be administered and analyzed by a health care provider.

Two quick screening tests for alcoholism have been developed: the Short Michigan Alcoholism Screening Test (SMAST; see Appendix 2) and the CAGE Questionnaire (see Appendix 1; Ewing, 1984; Selzer, Vinokur, & van Rooijen, 1975). The SMAST is a 13-question version of the original Michigan Alcoholism Screening Test (MAST). The SMAST has been shown to be as effective as the MAST. It has greater than 90% sensitivity to detect alcoholism. It can be administered to either the patient or the spouse.

The Substance Abuse Subtle Screening Inventory (SASSI; 800-726-0526; http://www.sassi.com) was developed to screen patients who are defensive and in denial. The SASSI measures defensiveness and the subtle attributes that are common in chemically dependent persons. It is a difficult test to fake, unlike the MAST or the CAGE. Patients can complete the SASSI in 10 to 15 minutes, and it takes a minute or two to score. It identifies accurately 98% of patients who need residential treatment, 90% of

nonusers, and 87% of early-stage abusers. This is a good test for patients for whom you are still unsure about the diagnosis after your first few interviews or patients who continue to be evasive (G. A. Miller, 1985).

The Addiction Severity Index (ASI) and the Teen-Addiction Severity Index (T-ASI; 215-399-0980) are widely used structured interviews for adults and teens, which are designed to provide important information about the severity of the patient's substance abuse problem. These instruments assess seven dimensions typically of concern in chemical dependency, including medical status, employment/support status, drug/alcohol use, legal status, family history, family/social relationships, and psychiatric status. The tests are designed to be administrated by a trained technician and take about an hour. The ASI is an excellent tool for delineating the patient's case management needs (Kaminer, Bukstein, & Tarter, 1991; McLellan, Luborsky, & Woody, 1980).

The Adolescent Alcohol Involvement Scale (AAIS) is a 14-item, self-report questionnaire that takes about 15 minutes to administer. It evaluates the type and frequency of drinking, the last drinking episode, reasons for the onset of drinking behavior, drinking context, short- and long-term effects of drinking, perceptions about drinking, and how others perceive the patient's drinking (Mayer & Filstead, 1979).

The Adolescent Drinking Index (ADI; 813-968-3003) is a 24-item, self-administered test that evaluates problem drinking in adolescents through assessment of psychological symptoms, physical symptoms, social symptoms, and loss of control (Harrell, Honaker, & Davis, 1991).

The Recovery Attitude and Treatment Evaluator-Clinical Evaluation (RAATE-CE; Mee-Lee, Hoffmann, & Smith, 1992; 800-755-6299) is a 35-item scale that assesses treatment readiness and examines patient awareness of problems, behavioral intent to change, capacity to anticipate future treatment needs, and medical, psychiatric, or environmental complications. The RAATE-CE determines the patient's level of acceptance and readiness to engage in treatment and targets impediments to change.

If assessment so indicates, intervention may be necessary, as follows:

How to Intervene

- *Nonproblem usage:* If the patient does not drink or is within the low-risk consumption, you should provide positive prevention messages that support the patient's continued positive lifestyle. Patients with a positive family history of alcoholism should be warned about their increased vulnerability to alcoholism and the need for vigilance.
- *Problem drinking/drug usage:* The patient who has had recurrent problems due to alcohol use should be encouraged to abstain from, or at

least reduce, his or her alcohol use. Such patients should be strongly encouraged to abstain from all illegal drugs. You should discuss the biopsychosocial complications of alcohol abuse (see Appendix 7). Patients who are encouraged to cut down on their drinking should be provided with the brochure from NIAAA (see Appendix 8). It is essential that these patients be reassessed frequently to monitor their ability to comply with your recommended limits.

- *Alcohol or other drug dependence:* Alcoholics need to have their diagnoses carefully discussed with them and a treatment plan negotiated. You need to be empathic and address the problems that seem to be caused by or exacerbated by their alcohol use. Patients need to hear that this illness is not their fault and that there is excellent treatment available to help them stay clean and sober. Patients need to hear that only 4% of addicts can quit on their own over the course of a year, but 50% can quit over the course of a year if they go through treatment. Seventy percent can quit over the course of a year if they also attend AA meetings regularly, and 90% can stay sober if they go through treatment, attend meetings, and go to aftercare once a week for a year (Hoffmann, 1991, 1994; Hoffmann & Harrison, 1987). Patients should also be told about the potential benefits of naltrexone and disulfiram when used along with formal treatment programs. Carefully discuss the ASAM patient placement criteria to help you and the patient negotiate the best treatment plan possible to bring the alcohol problem under control. The following questions may be helpful in negotiating a treatment plan:
  - —Is the patient a danger to self or others (suicidal and homicidal ideation, impaired judgment while intoxicated, history of delirium tremens)?
  - —Has the patient ever been able to stay sober for three or more days?
  - —What happened when the patient stopped drinking in the past? How serious were the withdrawal symptoms?
  - —Has the patient ever been able to stay completely abstinent for long periods of time?
  - —Why did previous attempts at sobriety fail?
  - —How does the family understand alcoholism and its treatment?

See Table 1.6 for a list of positive and negative prognostic factors.

ASSESSING MOTIVATION

Constantly ask yourself about the patient's stage of motivation, and introduce appropriate motivating strategies (see next section) to move

Table 1.6
Positive and Negative Prognostic Factors

Positive Prognostic Factors

- Lack of physical dependence.
- Intact family.
- Stable job.
- Presence of prior treatment (prognosis improves for patients who have been through one to three treatments).
- Absence of psychiatric disease.
- Presence of long-term monitoring arrangement, such as a Physician Effectiveness Program or Employee Assistance Program.

Negative Prognostic Factors

- More severe, advanced dependency.
- Presence of intoxication at office visits.
- Loss of job.
- Loss of home.
- Loss of family.
- Multiple, unsuccessful attempts at treatment.
- Severe physiological dependence.
- Coexisting psychiatric disorders.
- Absence of long-term monitoring.

From "Principles of Screening and Early Intervention" (pp. 325–335, 3rd ed.), by J. Conigliaro, C. D. Reyes, T. V. Parran, and J. E. Schultz, in *Principles of Addiction Medicine,* A. W. Graham, T. K. Schultz, M. F. Mayo-Smith, and R. K. Ries (Eds.), 2003, Chevy Chase, MD: American Society of Addiction Medicine.

the patient up a motivational level. No patient is alike, so you must be creative in helping the patient to see the inaccuracies in his or her thinking and move away from the lies toward the truth.

The Stages of Motivation

- *Precontemplation:* The individual is not intending to take action on his or her substance abuse problem in the foreseeable future.
- *Contemplation:* The individual intends to take action within the next six months.
- *Preparation:* The individual intends to take action in the next month.
- *Action:* The individual has made overt attempts to modify his or her lifestyle.
- *Maintenance:* The person is working a recovery plan and attempting to prevent relapse.
- *Termination:* The individual has zero temptation and 100% self-efficacy.

If you can move the person up one level, you can be sure that your treatment is working (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 1994).

MOTIVATING STRATEGIES

Patients at different stages of motivation need different motivating strategies to keep them moving toward recovery. Patients in the precontemplation stage underestimate the benefits of change and overestimate its cost. They are not aware that they are making mistakes in judgment, and they believe they are right. Environmental events can trigger a person to move up to the contemplation stage. An arrest, a spouse threatening to leave, or a formal intervention can all increase motivation to change. Persons in the precontemplation stage cannot be treated as if they are in the action stage. If they are pressured to take action, they will terminate treatment (Prochaska, 2003).

Persons in the preparation stage have a plan of action to cut down or quit their addictive behavior. These patients are ready for input from their doctor, professional, counselor, or self-help book. They should be recruited and motivated for action. In the action stage, patients are changing their behavior to cut down or quit the addiction. These are the patients who have entered early recovery and are actively involved in treatment.

In the maintenance stage, patients are still changing their behavior for the better and are working to prevent relapse. People who relapse are not well prepared for the prolonged effort it takes to stay clean and sober. All patients need to be followed in aftercare because they need encouragement and support to stay in recovery. Addicts typically do not have the skills to work a program in early recovery. This takes time, commitment, and discipline. You are constantly trying to raise the patient's awareness about the causes, consequences, and possible treatments for a particular problem. Interventions that can increase awareness include observation, confrontation, interpretation, feedback, and education. You consistently point out the need to reevaluate the environment and how behavior change can be beneficial. Encourage patients to reevaluate their self-image, and explain how their self-image is negatively affected by the addictive behavior. Encourage patients to learn the new skills of honesty, helping others, and seeking a relationship with a higher power.

To help motivate patients to progress from one stage to the next, it is necessary to know the principles and processes of change (see Table 1.7; Prochaska, 2003; Prochaska & DiClemente, 1983; Prochaska et al., 1992, 1994).

Guided by these principles, the processes described in Table 1.8 should be applied to patients in the precontemplation stage (Prochaska, 2003; Prochaska & DiClemente, 1983; Prochaska et al., 1992, 1994).

Table 1.7
Principles of Change for the Patient in Precontemplation Stage

Principle 1: The rewards for changing must increase if patients are to progress beyond precontemplation.

Principle 2: The cons of changing must decrease if patients are to progress from contemplation to action.

Principle 3: The relative weight assigned to benefits and costs must cross over before a patient will be prepared to take action.

Principle 4: The strong principle of progress holds that to progress from precontemplation to action, the rewards for changing must increase by one standard deviation.

Principle 5: The weak principle of progress holds that to progress from contemplation to action, the perceived costs of changing must decrease by one-half standard deviation.

Principle 6: It is important to match particular processes of change with specific stages of change.

From "Enhancing Motivation to Change" (pp. 825–837, 3rd ed.), by J. O. Prochaska, 2003, in *Principles of Addiction Medicine,* A. W. Graham, T. K. Schultz, M. F. Mayo-Smith, and R. K. Ries (Eds.), Chevy Chase, MD: American Society of Addiction Medicine; "Stages and Processes of Self-Change of Smoking: Toward an Integrative Model of Change," by J. O. Prochaska and C. C. DiClemente, 1983, *Journal of Consulting and Clinical Psychology, 51,* pp. 390–395; "In Search of How People Change: Applications to the Addictive Behaviors," J. O. Prochaska, C. C. DiClemente, and J. C. Norcross, 1992, *American Psychologist, 47,* pp. 1102–1114; and *Changing for Good,* by J. O. Prochaska, J. C. Norcross, and C. C. DiClemente, 1994, New York: Morrow.

AMERICAN SOCIETY OF ADDICTION MEDICINE PATIENT PLACEMENT CRITERIA

In their new handbook, *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders,* second edition, 1998 (PPC-2), the American Society of Addiction Medicine (ASAM) lists the following six areas of assessment for addicted patients:

1. Acute intoxication and/or withdrawal complications.
2. Biomedical conditions and complications.
3. Emotional/behavioral conditions and complications.
4. Readiness for change.
5. Relapse/continued use potential.
6. Recovery/living environment.

All professionals who work regularly with alcoholics need a copy of the ASAM's manual and should use their criteria in deciding the level of care

Table 1.8
Processes of Change for Patients in Precontemplation Stage

1. *Consciousness raising* involves increasing patients' awareness of the causes, consequences, and responses to the alcohol problem.
2. *Dramatic relief* involves increasing patients' emotional arousal about their current behavior and the relief that can come from changing.
3. *Environmental reevaluation* has patients assess the effects the alcohol problem has on their social environment and how changing would affect that environment.
4. *Self-reevaluation* has patients assess their image of themselves free from alcohol problems.
5. *Self-liberation* involves the belief that individuals can change and the commitment and recommitment to act on that belief.
6. *Counterconditioning* requires the learning of healthier behaviors that can substitute for drinking alcohol.
7. *Contingency management* involves the systematic use of reinforcers and punishments for taking steps in a particular direction.
8. *Stimulus control* involves modifying the environment to increase cues that promote healthy responses and decrease cues that lead to relapse.
9. *Helping relationships* combine caring, openness, trust, and acceptance, as well as family and community support for changing.

From "Enhancing Motivation to Change" (pp. 825–837, 3rd ed.), by J. O. Prochaska, 2003, in *Principles of Addiction Medicine,* A. W. Graham, T. K. Schultz, M. F. Mayo-Smith, and R. K. Ries (Eds.), Chevy Chase, MD: American Society of Addiction Medicine; "Stages and Processes of Self-Change of Smoking: Toward an Integrative Model of Change," by J. O. Prochaska and C. C. DiClemente, 1983, *Journal of Consulting and Clinical Psychology, 51,* pp. 390–395; "In Search of How People Change: Applications to the Addictive Behaviors," J. O. Prochaska, C. C. DiClemente, and J. C. Norcross, 1992, *American Psychologist, 47,* pp. 1102–1114; and *Changing for Good,* by J. O. Prochaska, J. C. Norcross, and C. C. DiClemente, 1994, New York: Morrow.

a patient needs. The manual details specific criteria for admission, continued stay, and discharge for all levels of treatment, adult and adolescent. (A copy of the criteria can be obtained from the American Society of Addiction Medicine, Inc., 4601 North Park Ave., Upper Arcade, Suite 101, Chevy Chase, Maryland 20815; 301-656-3920).

In my discussion, I concentrate on the criteria for admission and discharge of outpatient, inpatient treatment, and brief intervention—the criteria that you will use the most often. The criteria are as objective and as measurable as possible, but some clinical interpretation is involved. Psychoactive disorders are no different from any other evaluation. Assessment and treatment are a mix of objectively measured criteria and professional judgment (see Table 1.9).

Table 1.9
Six Dimensions of Assessment

1. Acute intoxication and/or withdrawal complications.
   A. What risk is associated with the patient's current level of intoxication?
   B. Is there significant risk of severe withdrawal symptoms, based on the patient's previous withdrawal history, amount, frequency, and recency of discontinuation of chemical use?
   C. Is the patient currently in withdrawal? To measure withdrawal, use the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA).
   D. Does the patient have the supports necessary to assist in ambulatory detoxification, if medically safe?
2. Biomedical conditions or complications.
   A. Are there current physical illnesses, other than withdrawal, that may need to be addressed or that may complicate treatment?
   B. Are there chronic conditions that may affect treatment?
3. Emotional behavioral complications.
   A. Are there current psychiatric illnesses or psychological, emotional, or behavioral problems that need treatment or may complicate treatment?
   B. Are there chronic psychiatric problems that affect treatment?
4. Treatment acceptance or resistance.
   A. Is the patient objecting to treatment?
   B. Does the patient feel coerced into coming to treatment?
   C. Does the patient appear to be complying with treatment only to avoid a negative consequence, or does he or she appear to be self-motivated?
5. Relapse potential.
   A. Is the patient in immediate danger of continued use?
   B. Does the patient recognize or understand his or her addiction problem or have skills to cope with the problems in order to prevent continued use?
   C. What problems will potentially continue to distress the patient if the patient is not successfully engaged in treatment?
   D. How aware is the patient of relapse triggers, ways to cope with cravings, and skills to control impulses to use?
6. Recovery/living environment.
   A. Are there any dangerous family members, significant others, living situations, or school/working situations that pose a threat to treatment success?
   B. Does the patient have supportive friendships, financial resources, educational, or vocational resources that can increase the likelihood of treatment success?
   C. Are there legal, vocational, social service agencies, or criminal justice mandates that may enhance the patient's motivation for treatment?

Patients must be able to understand treatment. They must be intellectually capable of absorbing the material. They must be physically and emotionally stable enough to go through the treatment process. They must not be actively harmful to themselves or others. They cannot be overtly psychotic. They cannot have such a serious medical or psychiatric problem that they cannot learn.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS CRITERIA FOR DIAGNOSIS

To make a diagnosis, use the criteria listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association. (Order a copy from the American Psychiatric Association, 1400 K Street, NW, Washington, D.C. 20005.) A new edition comes out every few years, so there will be changes in the criteria from time to time. The 2000 criteria for Psychoactive Substance Use Disorder are listed in Appendix 5. If you are unsure of your abilities to use the diagnostic criteria, an instrument such as the Structured Clinical Interview for *DSM-IV-TR* (First, Spitzer, Gibbon, & Williams, 2001) is the most readily available battery used in clinical evaluation.

Following is the *DSM-IV-TR* criteria for diagnosing Alcohol Abuse and Alcohol Dependence:

Diagnosis: Alcohol Abuse

A. A maladaptive pattern of psychoactive substance use leading to clinically significant impairment or distress indicated by one (or more) of the following, occurring within a 12-month period:
   1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
   2. Recurrent use in situations in which use is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
   3. Recurrent substance-related legal problems.
   4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

B. The symptoms never met the criteria for Psychoactive Substance Dependence for this class of substance (*DSM-IV-TR,* p. 199).

If you are unable to diagnose abuse, check with the family. This patient may be in denial, and you may get more of the truth from someone else. Family members, particularly a spouse or a parent, may give you a more accurate clinical picture of the problems.

If you diagnose abuse, move on to the dependency questions:

Diagnosis: Alcohol Dependence

A maladaptive pattern of substance (alcohol) use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

A. Tolerance, as defined by either of the following:
   1. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   2. Markedly diminished effect with continued use of the same amount of the substance.
B. Withdrawal, as manifested by either of the following:
   1. The characteristic withdrawal syndrome for the substance.
   2. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
C. The substance is often taken in larger amounts or over a longer period of time than was intended.
D. There is a persistent desire or one or more unsuccessful efforts to cut down or control substance use.
E. A great deal of time spent in activities necessary to get the substance, use the substance, or recover from its effects.
F. Important social, occupational, or recreational activity given up or reduced because of substance use.
G. The substance use is continued despite knowledge of having a persistent or recurrent psychological or physical problem that is likely to have caused or been exacerbated by the use of the substance (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption; *DMS-IV-TR*, p. 197).

Specify if:

- *With physiological dependence:* evidence of tolerance or withdrawal.
- *Without physiological dependence:* no evidence of tolerance or withdrawal.

Explain to patients that the diagnosis is your best professional judgment. It is important that patients make up their own minds. Patients

need to collect evidence and get accurate in their thinking. Do they have a problem or not? This is a good time to explain denial and how it keeps patients from seeing the truth.

DETERMINING THE LEVEL OF CARE NEEDED

Once you know the patient has a significant problem, you must decide the level of care the patient needs. There are four levels of care generally offered across the United States.

Level 0.5: Early Interventions

Early interventions are organized services delivered in a wide variety of settings. Early intervention is designed to explore and address problems or risk factors that are related to substance use and to assist the individual in recognizing the harmful consequences of inappropriate substance use. Patients who need early intervention do not meet the diagnostic criteria of either chemical abuse or chemical dependency, but they have significant problems with substances. The other treatment levels include patients who meet the criteria for psychoactive substance abuse or dependency.

Level I: Outpatient Treatment

Outpatient treatment takes place in a nonresidential facility or an office run by addiction professionals. The patient comes in for individual or group therapy sessions, usually fewer than nine hours per week.

Level II: Intensive Outpatient/Partial Hospitalization

Level II.1, Intensive Outpatient Treatment, is a structured day or evening program with nine or more hours of programming per week. These programs have the capacity to refer patients for their medical, psychological, or pharmacological needs.

Level II.5, Partial Hospitalization, generally includes 20 or more hours of intense programming per week. These programs have ready access to psychiatric, medical, and laboratory services.

Level III: Residential/Inpatient Services

Level III.1, Clinically Managed Low-Intensity Residential Services, is a halfway house.

Level III.3, Clinically Managed Medium-Intensity Residential Services, is an extended care program oriented around long-term management.

Level III.5, Clinically Managed High-Intensity Residential Services, is a therapeutic community designed to maintain recovery.

Level III.7, Medically Monitored Intensive Inpatient Treatment, is a residential facility that provides a 24-hour, daily structured treatment. This program is monitored by a physician who is able to manage the psychiatric, physical, and pharmacological needs of patients.

Level IV: Medically Managed Intensive Inpatient Treatment

This treatment is a 24-hour program with the resources of a hospital. Physicians provide daily medical management.

CRITERIA FOR EARLY INTERVENTION (ADULTS)

Early intervention is when the professional attempts to stop the patient's continued substance abuse. It is the first intervention attempted and should only be used when the patient shows early signs and symptoms of alcohol or drug problems.

A. *Examples:* Student assistance programs, employment assistance programs, one-to-one counseling with at-risk individuals, education programs for first-time driving under the influence offenders.
B. *Settings:* Any appropriate setting, including individual clinical offices, schools, work sites, community centers, or an individual's home.
C. *Support systems:*
    1. Individual may be referred to ongoing treatment for alcohol dependence.
    2. Individual may be referred for medical, psychological, or psychiatric services.
    3. Individual may be referred for an alcohol and drug assessment.
    4. Individual may be referred for community social services.
D. *Interventions:*
    1. Formal intervention may be conducted by any professional who is knowledgeable about intervention techniques.
    2. Planned educational programs designed to reduce or eliminate drinking.
    3. Helping the patient to recognize and avoid harmful consequences of inappropriate alcohol use.
E. *Criteria for Admission:*
    1. Any biomedical problems are stable or are being actively addressed and will not interfere with intervention.

2. Any emotional or behavioral conditions or complications are being addressed through appropriate mental health services.
3. The individual expresses a willingness to gain an understanding of how his or her current drinking pattern may be harmful.
4. The situation is characterized by one of the following:
   a. The individual does not understand the need to alter his or her current use pattern to prevent further harm related to drinking.
   b. The individual needs to acquire the specific skills needed to change his or her current pattern of drinking.
5. The individual's living environment is characterized by one of the following:
   a. The social support system is composed primarily of individuals whose substance use patterns prevent them from meeting social, work, school, or family obligations.
   b. Family members currently are abusing substances.
   c. Significant others express values concerning alcohol or drug use that create significant conflict to the individual.
   d. Significant others condone or encourage inappropriate use of alcohol or other drugs.

CRITERIA FOR OUTPATIENT TREATMENT (ADULTS)

An adult patient qualifies for outpatient treatment if he or she meets the diagnostic criteria for Psychoactive Substance Use Disorder as defined by the current *DSM* and if the patient meets all six of the following criteria:

A. Patient is not acutely intoxicated and is at minimal risk of suffering severe withdrawal symptoms.
B. All medical conditions are stable and do not require inpatient management.
C. All of the following:
   1. The individual's anxiety, guilt, and/or depression, if present, appear to be related to substance-related problems rather than to a coexisting psychiatric/emotional/behavioral condition. If the patient had psychiatric/emotional/behavioral problems other than those caused by substance use, the problems are being treated by an appropriate mental health professional.
   2. Mental status does not preclude the patient from comprehending and understanding the program or participating in the treatment process.
   3. Patient is not at risk to harming self or others.

D. Both of the following:
   1. Patient expresses a willingness to cooperate with the program and attend all scheduled activities.
   2. The patient may admit that he or she has a problem with alcohol or drugs, but the patient requires monitoring and motivating strategies. The patient does not need a more structured program.
E. Patient can remain abstinent only with support and can do so between appointments.
F. One of the following:
   1. Environment is sufficiently supportive to make outpatient treatment feasible. Family or significant others are supportive of recovery.
   2. The patient does not have the ideal support system in his or her current environment but the patient is willing to obtain such support.
   3. Family or significant others are supportive but they need professional interventions to improve chances of success.

CRITERIA FOR INPATIENT TREATMENT (ADULTS)

An adult patient needs inpatient treatment if he or she meets the *DSM* diagnostic criteria for Substance Use Disorder and meets at least two of the following criteria:

A. The patient presents a risk of severe withdrawal or the patient has had past failures at entering treatment after detoxification.
B. Patient has medical conditions that present imminent danger of damaging health if use resumes or concurrent medical illness needs medical monitoring.
C. One of the following:
   1. Emotional/behavioral problems interfere with abstinence and stability to the degree that there is a need for a structured 24-hour environment.
   2. There is a moderate risk of behaviors endangering self or others. Current suicidal/homicidal thoughts with no action plan and a history of suicidal gestures or homicidal threats.
   3. The patient is manifesting stress behaviors related to losses or anticipated losses that significantly impair daily living. A 24-hour facility is necessary to address the addiction.
   4. There is a history or presence of violent or disruptive behavior during intoxication with imminent danger to self or others.
   5. Concomitant personality disorders are of such severity that the accompanying dysfunctional behaviors require continuous boundary-setting interventions.

D. Despite consequences, the patient does not accept the severity of the problem and needs intensive motivating strategies available in a 24-hour structured setting.
E. One of the following:
   1. Despite active participation at a less intensive level of care or in a self-help fellowship, that patient is experiencing an acute crisis with an intensification of addiction symptoms. Without 24-hour supervision, the patient will continue to use.
   2. The patient cannot control her or his use as long as alcohol or drugs are present in the environment; or
   3. The treatments necessary for this patient require this level of care.
F. One of the following:
   1. The patient lives in an environment in which treatment is unlikely to succeed (e.g., chaotic environment, rife with interpersonal conflict, which undermines the patient's efforts to change, nonexistent family, or their environmental conditions, or significant others living with the patient manifest current substance use and are likely to undermine the patient's recovery).
   2. Treatment accessibility prevents participation in a less intensive level of care.
   3. There is a danger of physical, sexual, or emotional abuse in the current environment.
   4. The patient is engaged in an occupation where continued use constitutes a substantial imminent risk to personal or public safety.

CRITERIA FOR EARLY INTERVENTION (ADOLESCENTS)

Early intervention is when the professional attempts to stop the patient's continued substance abuse. It is the first intervention attempted and should only be use when the patient shows early signs and symptoms of alcohol or drug problems.

A. *Examples:* Student assistance programs, one-to-one counseling with at-risk adolescents, educational programs for first-time driving under the influence offenders.
B. *Setting:* Any appropriate setting, including clinical offices, treatment facilities, schools, workplace, community centers, or the adolescent's home.
C. *Support systems:*
   1. Adolescent may be referred for ongoing treatment for substance abuse or dependency.

2. The adolescent may be referred for medical, psychological, or psychiatric services.
3. The adolescent may be referred to a substance abuse professional for an alcohol and drug assessment.
4. The adolescent may be referred for community services.

D. *Interventions:*
1. Individual, group, or family counseling.
2. Planned educational programs focused on helping the adolescent recognize and avoid harmful consequences of inappropriate substance use.

E. *Criteria for Admission*

The adolescent's problems and risk factors appear to be related to substance use but do not meet the criteria for alcohol abuse or dependence.

1. Any biomedical problems are stable or are being addressed.
2. Any emotional or behavioral conditions are being addressed through appropriate mental health services.
3. The adolescent expresses a willingness to gain an understanding of how his or her current use of alcohol or drugs may be harmful.
4. The situation is characterized by one of the following:
   a. The adolescent does not understand the need to alter his or her current pattern of alcohol or drug abuse to prevent further harm.
   b. The adolescent needs to acquire the specific skills needed to change his or her current pattern of alcohol or drug use.
5. The adolescent's living environment is characterized by one of the following:
   a. The social support system is composed primarily of individuals whose substance use patterns are harmful.
   b. Family members currently are abusing alcohol or drugs.
   c. Significant others express values concerning alcohol or drug use that create significant conflict for the adolescent.
   d. Significant others condone or encourage inappropriate alcohol or drug use.

CRITERIA FOR OUTPATIENT TREATMENT (ADOLESCENTS)

An adolescent patient qualifies for outpatient treatment if he or she meets *DSM* criteria for Substance Use Disorder and the following dimensions:

A. Patient is not intoxicated and presents no risk of withdrawal.
B. The patient has no biomedical conditions that would interfere with outpatient treatment.
C. The patient's problem behaviors, moods, feelings, and attitudes are related to addiction rather than to a mental disorder, or the patient is being treated by an appropriate mental health professional. Patient's mental status is stable. Patient is not at risk for harming self or others.
D. Patient is willing to cooperate and attend all scheduled outpatient activities. Patient is responsive to parents, school authorities, and the staff.
E. The patient is willing to consider maintaining abstinence and recovery goals.
F. A sufficiently supportive recovery environment exists, which makes outpatient treatment feasible.
   1. Parents or significant others are supportive of treatment and the program is accessible.
   2. The patient currently does not have a supportive recovery environment but he or she is willing to obtain such support.
   3. The family or significant others are supportive but require professional intervention to improve chances of success.

CRITERIA OF INPATIENT TREATMENT (ADOLESCENTS)

To qualify for inpatient treatment, the adolescent must meet the *DSM* criteria for Substance Use Disorder, all of the dimensions for outpatient treatment, plus at least two of the following dimensions:

A. The risk of withdrawal is present.
B. Continued use places the patient at imminent risk of serious damage to health; or biomedical condition requires medical management.
C. History reflects cognitive development of at least 11 years of age and significant impairment in social, interpersonal, occupational, or educational functioning as evidenced by one of the following:
   1. Current inability to maintain behavioral stability for more than a 48-hour period.
   2. Mild to moderate risk to self or others. Current suicidal/homicidal thoughts with no active plan or history of suicidal/homicidal gestures.
   3. Behaviors sufficiently chronic and/or disruptive to require separation from current environment.

D. Patient is having difficulty acknowledging an alcohol or a drug problem and is not able to follow through with treatment in a less intense environment.
E. The patient is experiencing an intensification of addiction symptoms despite interventions in a less intense level of care; or, patient has been unable to control use as long as alcohol or drugs are present in the patient's environment; or, if abstinent, the patient is in crisis and appears to be in imminent danger of using alcohol or drugs.
F. One of the following:
    1. Environment is not conducive to successful treatment at a less intense level of care.
    2. The parents or legal guardians are unable to provide consistent participation necessary to support treatment in a less intense level of care.
    3. Accessibility to treatment precludes participation in a less intense level of care.
    4. There is a danger of physical, sexual, or emotional abuse in the patient's current environment.

SHARING THE DIAGNOSIS

You should discuss your findings with the patient and, if possible, with the patient's family. If you are in recovery yourself, this is not a good time to share much of your story because it may frighten patients and make them wonder about your own state of health. Patients need a stable, well-adjusted counselor. You can tell a patient that you are recovering, but don't get into specifics about your drinking and using days.

As you share the diagnosis with the patient, make sure you take the time to encourage and reinforce him or her for having the courage to come into treatment. Check out how the patient feels. It is not good to be suffering, and your patient has been in misery for a long time. It was scary to come into treatment, but he or she made it. You are proud of the individual. Most people who complete their first inpatient treatment ultimately achieve a stable recovery. They might have to come into treatment again, even again and again, but the first treatment is a major turning point. Patients learn things in the first treatment that they never forget. They learn that there is a disease called chemical dependency, there is treatment for it, treatment doesn't hurt, and people can live happy, sober lifestyles.

CONDUCTING A CRISIS INTERVENTION

Patients who are severely dependent and unwilling or unable to see the severity of their addiction need a crisis intervention. Crisis intervention is

a confrontation by a group of concerned family and friends. This confrontation must be loving, gentle, and supportive; and it is best to use a trained interventionist to help you develop the intervention strategy. If you want to do the intervention yourself, first read the book *Love First* by Jeff and Debra Jay (Hazelden, 800-328-9000). This is an excellent text that carefully discusses the intervention techniques. Basically, an intervention has to be carefully organized, rehearsed, and choreographed. Each member of the group should be a loving, caring significant other and not an alcohol abuser. Each person writes a letter stating exactly how the patient's alcoholism has negatively affected his or her life (see Figure 1.1). In this letter, group members share their love and concern for the patient and ask that the patient enter treatment. The patient is told it is not he or she who is the problem but the illness. It is a lethal problem and it needs treatment. Each person reads his or her letter of concern and love for the patient and asks the patient to go into treatment that day. The treatment setting has

Bob, you are my closest friend, and I can't tell you how much your friendship has meant to me. We have grown up together. Our kids love to play ball together, and you and I enjoy being the vocal coaches on the sideline. There is no one in my life who has had a more positive effect on my life and successful business than you. Thank you for all of the years you have stood by me. When I made mistakes, you were always there to comfort me and give me good advice like a brother. Now comes the hard part of this letter, and I might not handle this very well, so bear with me. Lately, I have been concerned with your drinking. I see you driving the car with the children after you have had too much to drink. In fact, after the Halloween party on Saturday, you were so drunk you could hardly walk, yet you insisted on driving your wife and your children home. We all tried to stop you, but you wouldn't listen to anyone. Bob, alcoholism is a disease, just like the alcoholism that killed your father. It's genetic and life threatening. I am here to ask you to get the treatment that you need to get well. It hurts me too much to see you suffer. You and I know you can't drink in a healthy way anymore. These problems have happened too much. My own kids don't want to go to your house anymore, and I avoid you myself. This hurts me too much for it to go on. Please help yourself and your family and get the help you need. The counselor has set up treatment for you today at _____ Treatment Center, and we would all be incredibly proud of you if you would go for help. I love you very much, brother. Please do this for all of the people who love you.

Love, Fred

Figure 1.1 Example of an intervention letter.

been arranged, and the patient's bags are packed. The intervention should be held at a neutral location when the patient is sober, not in the patient's home or office where the patient may feel more comfortable. It is difficult for the wall of denial to hold up under all of this love, and most of the time the patient agrees to go into treatment. If the patient refuses, the truth has still come out, which often leads to treatment at a later time. Each participant is encouraged to exhibit the following behaviors:

- Show positive regard for the patient and negative regard for the drinking.
- Give specific situations where the drinking negatively affected them.
- Validate that alcoholism is a disease and not the patient's fault.

Save the best letter for last. This is someone very tender and special to the patient. It might be the patient's child, a friend, or family member. It's someone whose letter breaks your heart. It is very difficult for denial to work in this tremendous atmosphere of love and truth. Most patients agree and go to treatment. Remember that no intervention is a failure. Even if the patient refuses to get treatment, the truth came out, and that's always a victory.

Interventions and treatment are going to take time. If you are a primary care physician, emergency room doctor, cardiologist, or surgeon, you might not have the time to struggle with this problem. All addiction treatment is a long journey toward the truth, and this journey is slow and painful. Patients have to face the demons they have hidden from for years. They need to walk into the dark forest of fear, and they need a trustworthy guide. They need someone with time, energy, patience, and love, a person who has been on this journey many times and who has come out alive. At some point, you need to decide if you are going to take on this problem yourself or refer to an addiction professional. Remember that alcoholism is a chronic relapsing brain disease. It is only at the five-year sobriety point that the relapse rate drops to around zero (Vaillant, 1996). So if you take this battle on, it's going to be a long one. If you look at addiction programs around the country, you will see that about half of the patients who leave treatment stay sober for the next year. This does not mean that they quit; this means that the person helping the patient quit. The recovery community was not tenacious enough to make sure the patient was working his or her program. Ninety percent of patients who work the program stay clean and sober. So if you want to take on this job, remember that you are in a five-year fight for the patient's life. You must do everything in your power to make sure that they work the program. Because of protracted withdrawal, dual diagnoses, organic brain syndrome, and many other factors,

about half of all alcoholics are not able to work their program. They do not have the spiritual, mental, or physical ability to work the program. These patients may need years in a structured facility.

Sometimes you will want to refer an alcoholic to an addiction professional. There are excellent alcohol and drug counselors and physicians who are used to the battle and have specialized training to deal with the special problems of addiction. A treatment facility locator can be found at http://findtreatment.samhsa.gov. Other times, you will want to try to help the patient yourself, but, remember, you are in for a five-year battle. Never forget that you are the healer, and you will do everything in your power to keep your patient sober.