

SECTION ONE

Introduction

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CONCISE GUIDES
TO MENTAL HEALTH

Substance
Use
Disorders

Substance Use Disorders: Definitions, Treatment, and Misconceptions

While the use and abuse of psychoactive substances predates the printed word, it was not until 1821 that the Western world was presented with an extraordinarily new concept: drug addiction. It was then that Thomas De Quincey created a minor sensation with his autobiographical *Confessions of an English Opium Eater* (Jonnes, 1999, p. 15). Describing in disturbing detail his “tortured love affair with laudanum”—a liquid form of opium dissolved in alcohol—De Quincey’s work confronted, perhaps unwittingly, English men and women of that period with the consequences of drug use. Although opium usage was a common remedy for “sundry aches and pains,” the Western world seemed to have been in a state of mass denial.

De Quincey’s unsettling tale was the earliest documents to reveal the truth about drug use in a somewhat clinical manner. He invented the concept of recreational drug use, making it absolutely clear that opium’s value in society is more than medicinal or spiritual (Boon, 2002, p. 37). In doing so, he got society to consider two additional facts: Drugs are fun, and drugs are addictive. While many probably dismissed De Quincey’s *Confessions of an English Opium Eater* as “his problem,” it begged the soul-searching questions—Am I using drugs for pain or for pleasure? Are the consequences of my drug use negative or positive? Can I stop anytime, or am I dependent?

Almost two centuries later, we are asking these same questions. But because the answers are as elusive as they are important, such questions now take the form of qualifying criteria. The criteria are as quantitative as they are qualitative, rendering not simply the answers to such questions but the type and severity of the

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problem. While a diagnosis is just the first step in the treatment of a Substance Use Disorder (SUD), it is impossible to develop an effective treatment plan without first establishing what's being treated. A good start is to differentiate between recreational use and problematic use.

The Progression of Substance Use

Progression is viewed as either an increase in consumption or an increase in problems. Often imperceptible to the user, the psychoactive substance assumes an ever-more important role, and problems mount. The word *psycho* relates to the mind, and *psychoactive substances* are drugs that alter the mind. Acting on the central nervous system (CNS), such drugs are often referred to as *mood-altering substances*.

While innocent experimentation may prove harmless for many, for others it serves as an introduction to recreational drug use. Although we have observed cases where individuals had established an almost instantaneous problematic relationship with alcohol or other mood-altering substances, the progression to an SUD is more likely to happen in three stages. As the sidebar shows, we have discovered that each stage is totally independent of its succeeding stage. What separates one stage from the next? For example, when does experimental use progress to recreational use? Does using a substance for the second time mean one is now a recreational user? Does missing 1 day from work constitute problematic use? How about 1 day per month? Or perhaps one DWI? Progression is not always predictable, yet when the user arrives at the next stage, it was almost as if it *were* predictable.

Initially, psychoactive substance use is begun either for *medical* or *experimental*

SUD Progression

1. Stage one, *experimental use*, usually occurs in the preteen, teen, and adolescent years. The cocaine epidemic of the 1980s, however, challenged this notion. The 21 to 35-year-old age group accounted for countless new users throughout that decade. Not all who experiment progress to recreational drug use.
2. Stage two, *recreational drug use*, does not necessarily lead to problematic patterns of use. Ninety percent of the population, for example, enjoys alcoholic beverages without serious incident.
3. Stage three, *problematic substance use*, represents those who meet the criteria for an SUD.
 - a. Substance Abuse
 - b. Substance Dependence

(This is further discussed in the next section.)

Experimental Substance Use

Mary was offered marijuana at a party when she was 22 years old. She had never tried marijuana before. In fact, she never tried any other illicit substance in her life. Her parents instilled in her a fear of drugs. She, however, was curious about the drug. Several of her friends smoked marijuana and did not seem negatively impacted by regular use of it. She told herself, “Why not?” She tried marijuana at the party and did not like the effects. Mary never smoked marijuana again.

reasons. A substance may be prescribed by a doctor for the treatment of a physical or psychological condition. It is then discontinued once the acute condition has improved. The prescribed substance may be taken for longer periods of time if the condition being treated is chronic in nature. This pattern of use may or may not be problematic, depending on the patient’s ability to discontinue the medication once it is no longer medically warranted. Problematic use patterns of this type are known as *low-dose dependencies*. Some physicians, when prescribing psychoactive substances, underestimate the addictive qualities of the substances being prescribed. This can be especially problematic when the patient has a genetic predisposition to addiction. While trusting the training and experience of the medical professional is usually a good idea, we cannot always assume that the doctor knows best under these circumstances.

When the start of substance use is *experimental*, the substance is initially used out of curiosity for its mood-altering qualities. The person tries the substance to assess its effects. If the substance is not considered pleasing or beneficial in some way, the substance is likely to be discontinued. However, if the substance is considered to be rewarding, it may be continued. The determination on whether to continue using the substance is based upon a variety of psychological, social, physiological, and perhaps spiritual factors, such as prior beliefs or lack of understanding on the danger of the drug or past experiences with other substances. Experimental use is not considered problematic. One government study on adolescent drug use conducted many years ago showed that the vast majority of adolescents experiment with some form of mood-altering substance at some time during their adolescence. It considered experimental use of mood-altering substances to be a kind of rite of passage for adolescents. The study went on to say that the small minority of adolescents who did *not* experiment were found to display more psychopathology, as a whole, than did the experimenters. This is, obviously, a controversial finding that may have reflected a particular period in time.

If the person continues to use the substance

Progression of an SUD

Stage	Dynamic	Control
Experimental	Curiosity	Full
Recreational	Fun	Choice
Abuse	Denial	Limited
Dependence	Addiction	Impaired

Recreational Substance Use

John is a 36-year-old accountant. He began drinking beer at age 17. He has now become an aficionado of wine. He has a collection of expensive wines in his custom-built wine cooler. John likes to have dinner parties with friends about once a month when he presents several wines from his cooler. John appears to drink responsibly. He seems to know when he has had enough to drink and can easily refuse offers for more alcohol. He has not displayed any negative consequences (e.g., physical, social, occupational, or financial) around his wine drinking.

beyond the stage of experimentation, he or she is considered to be in the *recreational* stage of use. Recreational use typically involves using in the company of others, for example, in social situations such as parties, to enhance pleasurable situations. (This is not to say that problem use cannot occur while attempting to enhance pleasurable situations.) Sometimes the substance may be used when alone, such as when a person enjoys an alcoholic beverage during a meal. Recreational substance use involves significant choice and control. For example, the person who uses alcohol recreationally may decide not to drink on a particular occasion and, as a result, abstains during that occasion. Or a person who recreationally uses marijuana at a party decides only to have two puffs on a joint and is okay with that choice. The recreational user does not display any negative consequences regarding the substance use—socially, legally, occupationally, or physically. Sometimes the person may not be aware of the consequences of use (e.g., an alcohol user damaging his or her liver) or may deny the consequences (e.g., how cocaine use is affecting the marriage). Under these circumstances, the use is not considered to be recreational—it has begun to become problematic.

Substance Abuse

Peter is a 46-year-old building engineer. In our initial interview, he has been drinking alcoholic beverages since he was 15 years old. He began using cocaine when he was 18 years old. Peter is the first to admit he is a heavy drinker, but he would resist identifying himself as an alcoholic. He regularly drinks on the weekend and occasionally during the week. At least once weekly, usually on Friday nights, Peter uses cocaine along with his beer drinking and shots of tequila. Most Friday nights there are no problems related to his partying. Once in a while, though, Peter gets himself into trouble. He has been arrested twice for Driving While Intoxicated (DWI) and arrested once for assault after a bar fight. Additionally, Peter's girlfriend recently left him, complaining about his drinking and irresponsible behavior. Peter will admit that he has missed a few Mondays at work because of hangovers. He also began missing clinic appointments and dropped out of sight for 9 months. Peter remains ambivalent about stopping but is back in treatment.

Individuals recovering from SUDs often have difficulty accepting that some people can use psychoactive substances without consequence. Because they were unable to do so, they assume that others cannot as well, or they assume that recreational users will ultimately develop into problem users. While this is possible, it cannot always be assumed to be the case. Experimental and recreational users are not considered to have SUDs and may never progress to that point.

The next stage in the progression of use is known as the stage of *abuse*. We've observed that during this stage, the person may occasionally experience negative consequences associated with the use of the substance. Because the negative consequences only occur intermittently, the person has difficulty admitting to problem use. The person may justify the negative consequences as bad luck or as isolated incidents. Sometimes, the substance abuser actually admits to problem use. The person in this stage may occasionally consume too much of the substance and has to deal with the resulting consequences. The main point is that the person is not regularly experiencing negative consequences of use nor regularly experiencing loss of control and choice over use. Because of this, the person may have more difficulty admitting to the presence of an incipient problem.

The person in this stage usually finds the substance to provide a useful purpose beyond a social one. For instance, the cocaine user may associate cocaine use with an enhanced ability to make effective business presentations. The alcohol user may associate alcohol use with an enhanced ability to cope with the stresses of the household. The sedative user associates use with improved sleeping. In some cases, the benefits of use are not always conscious to the user. Many users cannot explain why they continue to use a substance despite the negative consequences associated with the substance.

The final stage in the progression of use is known as *dependence*. In this stage, the person exhibits signs of needing the substance for physical or psychological relief. There is a loss of control, and the ability to make rational choices—to use

Substance Dependence

Mary is a 44-year-old single female living alone. She is employed as an administrative assistant. Her drinking has progressed to the stage of Alcohol Dependence. She has a nightly ritual of visiting the neighborhood liquor store and purchasing a quart of vodka. On weekends she will purchase even more. She drinks in isolation and usually to oblivion. While at work, she thinks about getting home to drink. She has tried to moderate her drinking with little success. Miraculously, she makes it to work most days and is quite productive. There have been complaints by coworkers that she sometimes smells of alcohol, but her boss is too uncomfortable to discuss it with her. Recently she has been complaining of stomach pain and decided to go for a physical exam. The doctor discovered that she is in an early stage of liver damage. She continues to drink despite her medical concerns.

or not to use—becomes more difficult. As consequences emerge, the individual may be more apt to admit to experiencing substance-related problems. Depending on the substance, the person may also become physiologically dependent. At this point the primary reason for using may be to avoid withdrawal symptoms. Pleasure, the original reason for using, becomes elusive.

It should be noted that Substance Abuse does not always lead to Substance Dependence. While we use the word *progression* to underscore the progressive nature of the substance-related problems, it does not necessarily mean that the quantity of the substance ingested has also increased. The quantity (or quality) of problems may increase but the level of consumption may stay the same. A substance abuser that frequently drives a vehicle while under the influence poses a serious problem whenever he or she drinks—even if it occurs infrequently.

Defining the Substance Use Disorders (SUDs)

There was a time in the not-too-distant past when a cookie-cutter approach was used in the treatment of Substance Use Disorders. Even when we provided individual counseling, the message was the same: Your problem is alcoholism or drug addiction, your goal is abstinence, and your success lies in establishing a re-

Substance Abuse: *DSM-IV-TR*

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested 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 substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
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).

The symptoms have never met the criteria for Substance Dependence for this class of substance.

Source. (*DSM-IV-TR*, APA, 2000)

lationship with a 12-step program. If the patient did not comply, he or she was deemed unmotivated and needed to hit his or her bottom to get motivated. There was no differential diagnosis attempted. In other words, there was no attempt to assess for an additional diagnosis that might explain why the patient was relapsing, for example, anxiety or depression.

While such a limited treatment approach may work in some cases, it misses all those individuals who need a more comprehensive treatment plan. It ignores the individual treatment needs of not only those who are presenting concurrent psychiatric problems, but also those who simply need an alternative treatment approach.

In today's treatment environment, the more enlightened approach is to individualize treatment through assessment and diagnosis. Although there are likely to be many similarities in treatment plans, it is the individual differences that separate successful outcomes from failures. As in medicine, we are not expected to formulate a treatment plan before we determine exactly what is being treated. And to determine what is being treated, we are likely to depend on what is considered to be the bible of mental-health disorders: the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*. The two sidebars are for Substance Abuse and Substance Dependence. The manual, however, includes every conceivable psychiatric disorder, including those that will often coexist with SUDs, for example, Anxiety Disorders and Mood Disorders.

SUDs fall into two main categories: *Substance Abuse* and *Substance Dependence*. Such categories, while not perfect, provide us with a standard to assess and diagnose patients for SUDs. These criteria necessary to diagnosis or rule out such disorders are taken directly from the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision* ([*DSM-IV-TR*] American Psychiatric Association, 2000). While Substance Abuse and Substance Dependence are both defined as a "maladaptive pattern of substance use leading to clinically significant impairment or distress" (pp. 197 and 199), the qualifying criteria for each are different. Dependence is viewed as being more advanced than abuse; therefore, its qualifying criteria are greater. And although an earlier diagnosis of abuse can later change to a dependence diagnosis, the reverse is not true. A dependence diagnosis may change to "dependence, in partial remission," but not back to abuse. It's kind of like a pickle—it can never change back to a cucumber! As for the difference between abuse and dependence, dependence is simply more clinically advanced than abuse. This does not mean a less favorable prognosis (treatment outcome), however. In fact—as we will discuss later—a diagnosis of abuse may sometimes be more difficult to treat than a diagnosis of dependence. Other factors, including the behavioral consequences, are at least as important. An individual diagnosed as dependent, for example, may present few problems, while another person diagnosed with abuse might get arrested every time he or she drinks.

A Biopsychosocial and Spiritual Disorder

An SUD has biological, psychological, social, and spiritual components directly involved in its development. Some individuals present predominant biological factors leading to Substance Abuse and Substance Dependence, suggesting a physiological predisposition. With others, psychological and social influences may be contributing factors. More typically, individuals with SUDs are likely to present a unique mix of all three factors, forming an etiological basis for such a diagnosis. In other words, this may be a person who began drinking socially, discovered that alcohol also reduced stress, and ignored a family history of substance-related problems. The spiritual influence, a concept more difficult to qualify,

Substance Dependence: *DSM-IV-TR*

A maladaptive pattern of substance 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:

1. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
 - b. Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal.
 - a. The characteristic withdrawal syndrome for the substance.
 - b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Source. (DSM-IV-TR, APA, 2000).

Self-Medication

Barbara always thought of herself as a very sensitive person—perhaps a little high-strung. She would have liked to have been more social in college, but parties made her feel anxious. Besides, she didn't drink. At 37 she began to find it difficult to get off to sleep. Her days were becoming more and more stressful for lack of sleep at night. One of Barbara's coworkers suggested she try having a "Hot Toddy" before she went to bed—also suggesting that she double the whiskey in the recipe. It worked—and three jiggers of whisky worked even better! It wasn't long before Barbara also discovered that a couple of fancy drinks in the daytime also helped her to feel more relaxed and less anxious.

may incorporate family values, religion, character, or one's perceived place in the universe. This will be covered in more detail in Chapter 9.

As will be discussed in later sections, the scientific community has been aware for some time that physiological or genetic factors may play a role in the development of SUDs. Exactly what that role is, however, is not fully understood. For example, we are not quite sure which physiological defects or vulnerabilities are actually passed on. Genetic marker studies attempt to link Alcohol Dependence to other traits known to be inherited. Doing so might establish a genetic basis for the disorder. The mapping of the 23 pairs of chromosomes that make up the human genome may soon shed more light on this subject, as well as provide scientific insight into other devastating diseases. Initially, such information will be important to the prevention of SUDs and ultimately lead to improved treatment strategies.

Self-medicate is a term used to describe the practice of using a substance to relieve pain—psychological or physical. Alcohol is such a substance. While the intent may have been to enjoy the pleasure of a social drink, its sedating qualities will also quiet the distressing symptoms of psychiatric conditions that may exist. Similarly, a medication prescribed for back pain might provide a sense of well being long after the pain is gone. What had been prescribed as a short-term remedy for medical trauma is discovered to also alter the mood in a pleasurable way. Psychoactive substances function as coping mechanisms—albeit destructive when misused—to compensate for fragile personality traits. Anxiety, depression, trauma, obsessive-compulsive disorders and social stress are just a few of the types of disorders responsive to a variety of psychoactive substances—legal and illegal. The original intent of the individual may be recreational or medicinal, but the symptomatic relief rendered may drive the individual to misuse the substance.

Social influences include all those factors not identified as physiological or psychological. The individual's environment, both family and nonfamily, plays a role in the development of SUDs. Where heavy drinking is the family norm,

the rate of alcohol- or drug-related problems will be higher. In neighborhoods where alcohol and drug use is prevalent, the chance that an individual will experiment and eventually develop a problem is higher. A small town in northern Canada was devastated by the alarmingly high use of mood-altering substances. The abuse and dependence rates topped 75 percent—the adults were addicted to alcohol and the children to “huffing” gasoline and other inhalants.

There seems to be a relationship between substance use and work environments. Some occupations are associated with higher alcohol and drug consumption. Heavy alcohol use and illicit drug use is high among waitstaff, bartenders, and construction workers, while low among technicians and professional specialty workers (SAMHSA, 2005).

Although we are aware of biological, psychological, and social factors influencing SUD development, it is not easy to determine what the primary factor in any given case might be. The evolving understanding of the etiology of SUDs, however, is also aiding in the treatment of other addictive disorders (e.g., gambling, weight loss) and psychiatric disturbances (e.g., Personality Disorders, obsessive-compulsive disorders, Mood Disorders, etc.). And while we do not yet have this down to a science, one of the objectives of this book is to provide readers with a variety of assessment procedures to better help understand such influences.

An SUD is not only caused by biological, psychological, social, and spiritual factors, but it can also damage them. We are aware that SUDs can harm the biological systems of the body (e.g., cardiovascular, gastrointestinal, CNS, etc.). We are also aware of their psychological and social consequences (e.g., causing depression and shame and destroying families). As previously discussed, the pattern of damage caused by the SUDs varies from patient to patient. One person may develop more damage to biological systems; the next may have more psychological damage, while the next will suffer greater social or spiritual consequences. Treatment, to be covered in later chapters, will address such issues.

Because each patient we treat is expected to have a unique mix of these components leading to an SUD, as well as a unique assortment of consequences

Biopsychosocial

Biological: Connected by direct genetic or physical relationship rather than by adoption or marriage

Psychological: Directed toward the will or toward the mind, specifically in its conative function

Social: Of or relating to human society, the interaction of the individual and the group

Spiritual: Of, relating to, consisting of, or affecting the spirit

caused by an SUD, it follows that we need to treat each person uniquely. This is the basis of individualized treatment. Using the same approach for all patients may lead to positive outcomes for some patients, provide little relief for others, and may actually be detrimental to others. By assessing each component separately to determine causative as well as consequential factors, we can begin the process of individualized treatment, thus pinpointing specific areas needing attention.

The Disease Controversy

Merriam-Webster's Collegiate Dictionary (2003) defines *disease* in three ways. First, its synonymous reference is “trouble: to agitate mentally or spiritually.” One does not have to look far to find a relationship between “trouble” and an SUD. The second definition is “a condition . . . that impairs normal functioning and is manifested by distinguishing signs and symptoms.” The *DSM-IV-TR*'s criteria for SUDs include a definitive set of signs and symptoms. One such criterion is continuing to use in spite of social and interpersonal problems. The third definition is simply “a harmful development.”

If we were to use only Webster's definitions, we would have enough information to define an SUD as a disease. Other definitions of disease from various sources include “uneasiness; distress,” or a feeling of “dis-ease.” We can easily associate SUDs with this definition. It is quite clear that SUDs lead to uneasiness and distress. A disease is also a destructive process in the body, with specific cause(s) and characteristic symptoms. It is clear that the abuse of psychoactive substances can be destructive to the body. Unlike many other medical diseases, the specific cause(s) of SUDs is not yet definitive. However, science has made great strides in understanding the causative factors involved in this disorder.

Disease or not, SUDs are a departure from good health, and the consequential damage is likely to be physical, psychological, and social. As for the spiritual

Disease Concept Is Not a New Idea

Benjamin Rush (1746–1813)—a member of the Continental Congress, a signer of the Declaration of Independence, and a physician-general of the Continental Army—suggested that chronic drunkenness was a progressive medical condition. Rush's first professional recognition of the problem of alcohol involved the level of drunkenness among soldiers of the Continental Army—an issue of concern to George Washington as well. In 1777, Rush issued a strong condemnation of the use of distilled spirits, which was distributed to all soldiers. While a fully developed disease concept of alcoholism would not emerge until the 1870s, Rush's writings stand as the first articulation of a disease concept of alcoholism by an American (White, 1998, pp. 1–2).

Spirituality

One of the great gifts of spiritual knowledge is that it realigns your sense of self to something you may not have even ever imagined was within you. Spirituality says that even if you think you're limited and small, it simply isn't so. You're greater and more powerful than you have ever imagined. A great and divine light exists inside of you. This same light is also in everyone you know and in everyone you will ever know in the future. You may think you're limited to just your physical body and state of affairs—including your gender, race, family, job, and status in life — but spirituality comes in and says “there is more than this.”

Source. Adapted from *Spirituality for Dummies* (Janis, 2000).

aspect of the damage, many recovering individuals describe themselves as being “spiritually and morally bankrupt” prior to entering treatment. When asked to explain what this meant, they would talk of a deprivation and despair. Some described themselves as stripped of compassion, devoid of goodness, having a loss of empathy, incapable of forgiveness, lacking in understanding, being totally self-involved, selfish, and even evil. One recovering person used the Latin dictum to express her relationship with alcohol: *Spiritus Contra Spiritum*, interpreted to mean, “Alcohol Precludes Spirituality.”

Drug addiction and alcoholism are diseases recognized by the World Health Organization and by the medical community at large. However, the notion of an SUD being an illness is still a matter of heated debate in this country. There are two predominant views regarding the causation of SUDs: the *disease model* and the *moral model*. The disease model suggests that a person, without choice, acquires a disease of addiction or alcoholism innately. It is not a learned behavior, but inherited. The disease model assumes that an addict or alcoholic has some defect in the ability to control the use of mood-altering substances. Consequently, addicts and alcoholics who attempt to control their use of such substances are likely to fail. It is assumed to be incurable.

The most prolific resistance to the concept of the disease model is that it absolves the substance user of any responsibility. It is argued that even those who have this inherent defect in the ability to control their substance use still have a responsibility not to use a substance over which they have no control. If a diabetic knows that consuming sugar can be harmful but consumes it anyway, he or she must bear the responsibility of that choice. Individuals who meet the *DSM-IV-TR* criteria for an SUD cannot deny that they initiated the use of the very substance over which they have no control.

Another popular view is that SUDs are self-inflicted bad habits and are based on weaknesses of character or willpower. This has become known as the moral model; substance abusers are viewed as lacking the discipline to resist temptation. This model views intemperance as bad or immoral behavior. It places the onus of

responsibility for developing an SUD squarely on the user. This model fails to acknowledge any predisposing factors that may contribute to this disorder.

Because we believe SUDs comprise a variety of causative factors, the term should include elements of the disease model *and* moral model. As previously stated, some people with substance abuse disorders (PSUDs) are predominantly affected by biological or genetic influences leading to the disorder. These individuals seem to have some physiological defect in their ability to control the use of mood-altering substances. Although we have not yet been able to identify these biological defects (due to undeveloped measurement tools for genes and brain chemicals), once discovered they would provide significant credibility to the disease model.

Other individuals, who have never before shown a defect in the ability to control mood-altering substances, are introduced to a new drug and suddenly lose control. For these individuals, the primary cause of their Substance Abuse may be the innate power of a particular substance itself, such as cocaine or heroin. They may, at some point, discontinue the substance that caused the problems and return to nonproblematic use of other mood-altering substances, such as drinking socially, thus refuting the disease model.

Still others seem to lose control in a sporadic fashion. Their substance use does not appear as severe as that of the diseased person. These individuals appear to have more control and choice over their use and, consequently, more responsibility for the negative consequences associated with use. They appear to consciously choose a path of intemperance and the negative consequences associated with that choice. They also appear to more closely resemble the description provided by the moral model. There is no probable single cause or prototype for an SUD. It is the goal of clinicians to assess and identify the unique causative factors for each individual we treat so that we may provide the most effective treatment approach possible.

Treatment in Brief

Addiction Treatment as a Science

Addiction treatment encompasses elements from medicine, psychology, social work, sociology, and spirituality. It is no longer a field of recovering paraprofessionals looking to share their experience, strength, and hope. Those days are long gone. This field is evolving into a science requiring special skills for standardized assessment procedures, skills for diagnosing and treating psychiatric disorders, skills for level-of-care decisions, and an understanding of pharmacological and psychotherapeutic approaches.

Over the last several decades, there has been tremendous growth in the understanding and treatment of SUDs. The primary method of treatment in the past was behavioral (getting patients to conform to a particular way of behaving through positive and negative reinforcement) and often accomplished through

Therapeutic Communities

Drug-free therapeutic communities (TCs), got their start indirectly through AA. In 1958 Charles E. Dederich, a former AA member, established Synanon in California as a drug-free treatment center for drug addicts. This was an innovative approach, utilizing a powerful encounter component to treat the hard-core drug addict. Other therapeutic communities that followed, including Daytop, Phoenix House, Odyssey House, and Project R.E.T.U.R.N, were also structured on the Synanon model. Therapeutic communities have since modified their treatment approach to meet the needs of the changing drug culture (Scanlon, 1991, p. 13).

humiliating confrontational methods (e.g., in old-style therapeutic communities, wearing signs like “I’m a big crybaby,” or receiving harsh punishments for not conforming to house rules). While such approaches were effective in reaching a percentage of PSUDs, those successes were primarily limited to inner-city heroin addicts. Today, we have gained a greater understanding of the biological, psychological, social or environmental, and spiritual components encompassing this disorder, leading to greater treatment effectiveness.

Does Treatment Work?

According to the federal government’s Center for Substance Abuse Treatment (CSAT), individuals receiving alcohol and other substance use disorder treatment exhibit a wide range of benefits. These benefits include a decline in criminal activity by two-thirds after treatment, declines of approximately two-fifths in the use of mood-altering substances, a one-third reduction in hospitalizations, and significant improvements in other health indicators (SAMHSA/CSAT, 1993–2004), and this does not even account for the improvements treatment brings to job productivity, mental health, and family.

Common Misconceptions in the Treatment of SUDs

An Addict Is an Addict Is an Addict?

As previously discussed, the causative factors for SUDs are varied. One of the objectives of this book is to provide an understanding of the many causative factors of SUDs and, hence, the variety of ways of treating them. Treating all substance abusers (or addicts) similarly had been an early mistake in our field—a mistake that is, unfortunately, still perpetuated. No two people with substance abuse disorders are exactly the same. They may have similarities, but the causative and consequential factors for each person are unique.

As we now know, there are at least four main factors involved in the development and manifestations of SUDs: biological factors, psychological factors,

social or environmental factors, and spiritual factors. In time, we may even identify additional factors. The strength or influence of each of these factors, uniquely combined for each person, produces a multitude of different cases, each needing individualized attention. We had two new intakes in our orientation group that exemplify the importance of individualizing treatment.

Genetic Influences Eddie, a 29-year-old crack addict with a seemingly outgoing personality and a long treatment history, jokingly announced that he was born to a proud family of alcoholics and drug addicts. We were to learn that both his father and grandfather were alcoholics, and his three brothers all had SUDs. Eddie's mother, who he described as an "angel," didn't drink at all.

In spite of the initial impression that Eddie presented, we were also to later learn that the social and psychological consequences of this genetic malady were not a laughing matter. Eddie's father was unavailable emotionally, the numerous physical altercations between Eddie's parents caused personal trauma, and Eddie carried the burden of guilt for not protecting his mother from his father. He said he often felt depressed.

Eddie also talked about other social and emotional consequences of genetic and social influences, including physically abusing his wife and mistreating his children. Raised in a family wrought with drugs and violence, Eddie's choices were no surprise. Eddie's mother, however, had been a regular at Sunday mass. When asked about his own spirituality, he said he feels life has been unfair and suggested that perhaps he had been chosen by God to pay for the sins of his family. Eddie continues in outpatient care and had one relapse early on in his current 13 months of treatment.

Gender Differences Susan, a 45-year-old Caucasian woman with fingers stained from decades of cigarette smoking, presented us with a very different picture. She came to our program seeking continuing care following inpatient treatment for Alcohol Dependence. Susan admitted to developing a tolerance to alcohol, losing control over alcohol use, and being preoccupied with alcohol. She continued to drink despite recurring consequences, including physical and social problems. Susan admitted to consuming as many as two bottles of wine per day, usually drinking alone at home. (Women tend to drink more heavily in solitude, while men drink more heavily in social situations.)

Susan's recent discharge was her second inpatient rehabilitation within a 2-year period of time. She reported having a problem with alcohol for about 19 years and added that she was "taking several medications" for anxiety. At the time of her intake, Susan said she felt very anxious. Her longest period of sobriety ended 5 years ago when she remained alcohol-free for 12 months. Susan denies ever using illicit drugs.

Susan was divorced 4 years ago, and her 29-year-old son lives with her. She describes her relationship with her father as "distant," and her relationships with six siblings—four of them male—not much better. She revealed that her mother, who

died 17 years ago, was also an alcoholic. Susan is an office manager and has been with the same company for the past 9 years.

It is not difficult to see the differences in these two individuals. Their genetic and social histories are miles apart; their substance choices are not likely to find them in the same environments; and their gender, age, and collateral problems bear little resemblance. To treat Eddie and Susan using a similar treatment approach would be wrong. These are two cases with very different roots and developing factors. Each of them has different treatment needs and different issues to attend to. While there may be many similarities in their treatment planning, addressing their differences is critical to the likelihood of successful outcomes.

Just Go to Meetings; Motivation Will Follow?

Treatment programs currently emphasize the belief that action steps are necessary for treatment to be effective. Treatment providers emphasize the importance of attending 12-step support groups, obtaining a sponsor at 12-step meetings, making 90 meetings during the first 90 days of sobriety, having aftercare following inpatient treatment, and so on. Treatment programs teach cognitive-behavioral skills to cope with urges and cravings, how to handle difficult emotions, and how to prevent relapse. While these action strategies are valuable for the motivated patient, they are of little use for the patient still ambivalent about discontinuing the use of psychoactive substances.

Treatment providers, as well as managed care companies who demand these services, have not yet become aware that the first and most crucial step toward change is for the patient to develop an internal desire or commitment to change. This step must precede the initiation of action strategies. To begin action steps prior to developing a commitment to change is likely to lead to failure. (This will be explored further in subsequent chapters.) Many clinicians *assume* that their patients are truly committed to change and proceed from that belief. In reality, many patients initiating treatment—possibly the majority—have not sufficiently resolved their ambivalence about changing their substance-using behavior. They still perceive many benefits from their use despite acknowledging consequences attached to continued use. To ignore the patient's conflict (ambivalence) over continued use is to ignore the crux of the problem.

Relapses are often indicators of unresolved ambivalence about sobriety. Rather than being explored, and hopefully resolved, patient relapses are often punished. They are often discharged from treatment programs or cut off from insurance payments by managed care organizations for noncompliance with treatment objectives, for example maintaining continuous sobriety. Even Alcoholics Anonymous (AA)—its success in keeping millions of its members in sobriety notwithstanding—can be hard on those who relapse. It's not that its members aren't supportive of a fellow member that picks up a drink, but length of continuous sobriety is a measure of success in AA, and the relapser must begin counting days again. There is an innate sense of failure in losing the continuous sobriety that

Ambivalence

Ambivalence is a common human experience and a stage in the normal process of change. Getting stuck in ambivalence is also common, and approach-avoidance conflicts can be particularly difficult to resolve on one's own. Resolving ambivalence can be a key to change, and, indeed, once ambivalence has been resolved, little else may be required for change to occur. However, attempts to force resolution in a particular direction (as by direct persuasion or by increasing punishment for one action) can lead to a paradoxical response, even strengthening the very behavior they were intended to diminish (Miller & Rollnick, 2002, p. 19).

had been achieved. Marlatt calls this the *abstinence violation effect* (Marlatt & Gordon, 1985, p. 41). The failure can be so devastating that it often provides an excuse to continue drinking after a slip.

Many patients enter treatment under duress (e.g., coercion from an employer, spouse, courts, or child protective services). They do not initiate the change process on their own. Consequently, we cannot assume that they are truly motivated for change. However, the assumption that they are is commonly made, and patients are taught skills for remaining sober before they have even reached a sincere commitment to *getting* sober. Even those who voluntarily enter treatment cannot be assumed to have sufficiently resolved their ambivalence about using drugs and alcohol. Ambivalence, in fact, is very much a function of early to middle recovery and an important concept for the treatment professional to be aware of.

More Treatment Is Better than Less?

One's progress in resolving ambivalence toward change is much more important than the quantity of action steps taken prior to resolving the ambivalence. Making the decision to change is more significant than the number of treatment groups one attends or how many consecutive days one attends 12-step meetings. The quality of one's commitment to recovery is more crucial than the steps taken prior to or following that commitment. We have not found, for example, that those who attend an outpatient treatment program four times a week resolve their ambivalence faster than those who attend two times per week. And attending an outpatient program for 3 hours per day is not necessarily more effective than attending for 90 minutes per day. This is not to say that those who attend more treatment groups, or those who attend more 12-step meetings, do not do better than those who attend fewer support groups. We believe they do. However, the reason for their success is based not on the quantity or frequency of services attended but on their degree of motivation for change. Those who voluntarily attend treatment services or support groups more frequently do better because they are simply more motivated and committed to change than

those who are not willing to attend as frequently. It becomes the “chicken-or-the-egg” dilemma. Does the higher frequency and duration of support services lead to positive behavioral changes, or are those attending simply more committed to change? The latter is probably true.

Yet in a recent study published in the *Harvard Mental Health Letter* (2003, p. 7), stating one’s motivation for change does not necessarily ensure a commitment to change. The authors of the study, McKellar, Stewart, and Humphreys, suggest that “expressed intentions, especially in substance abusers, are not a reliable test of commitment to change behavior.” (Based on this study, it might appear that the road to hell is, indeed, paved with good intentions.) The study, which measured the effectiveness of AA, further reported that those in the study who attended 12-step meetings, “whatever their earlier [stated] feelings,” such meetings helped *create* that commitment to change (2003, pp. 302–308). While verbally committing to treatment is a good start, following through with action is a true demonstration of motivation.

Inpatient Treatment Is Better than Outpatient Treatment?

It would follow then that a critical factor in treatment effectiveness is not the services per se, but one’s level of commitment to change. Inpatient programs are often perceived as leading to greater success toward recovery than outpatient programs. Following discharge from inpatient treatment, however, patients often experience a *pink cloud* period. We have found that they appear fully committed to abstinence and promise to work on their recovery—wholeheartedly. Their resolve is sincere. But this level of confidence has not yet passed the litmus test. That determination to remain clean and sober needs to survive real-world challenges. Without the reinforcement and safety of the inpatient facility, fortitude can quickly change to ambivalence. That high level of motivation begins to wane as the idea of one last high becomes more appealing.

Early recovery’s challenges threaten what appears to be a solid grounding in sobriety. But ambivalence—literally, “of two minds”—gives cause to reconsider that earlier resolve. The treatment plan formulated while an inpatient begins to seem less achievable on the street. The commitment to 90 12-step meetings in 90 days is broken, and high-risk situations, by chance or choice, start to emerge. The ambivalence—to use or not to use—becomes lopsided, and the desire to use begins to seem like a good idea.

While any number of factors might impact one’s recovery, the concept of ambivalence is the sum of sobriety’s pros and cons. It is the vague, nebulous intrusion that emerges in the form of rationalization and justification. The real reason why ambivalence began to appear after discharge is because it was never really resolved—or perhaps never even addressed—while an inpatient. The person was probably taught action strategies for maintaining abstinence from drugs or alcohol but did not understand nor learn how to begin to resolve his or her ambivalence toward change. While relapse-prevention strategies are important to

recovery, ambivalence toward change requires ongoing monitoring. Even if the ambivalence of change *had* been the focus of inpatient treatment, it has to be dealt with through ongoing care. Change is the essence of recovery, and resolving ambivalence is the essence of change. For the PSUD, managing ambivalence is critical to managing recovery. No matter how long a person remains at an inpatient facility, ambivalence is an ongoing concern that can be effectively managed only after discharge in an outpatient treatment setting.

Inpatient treatment is necessary when a patient is unable to maintain sobriety without a protective environment. It is also important in stabilizing a medical or psychiatric condition. But such a setting is not a panacea for developing successful sobriety in the ambivalent patient. Ambivalence is resolved through experience, not through education in a protective environment. The educational experience provides a foundation, but the application of positive change in an outpatient setting reinforces recovery. If not outpatient treatment, then a commitment to a 12-step program or some other form of reinforcement will be necessary. This might include a spiritual or a secular program with a focus on lifestyle change.

Effective Treatment Must Include 12-Step Meetings?

Twelve-step meetings include any support groups that utilize the 12 steps originally developed by the founders of AA. These meetings now include support groups for myriad disorders and life problems, from Substance Abuse to baldness. For our discussion, we will be focusing on 12-step meetings that involve SUDs. These include Narcotics Anonymous (NA), Cocaine Anonymous (CA), Marijuana Anonymous (MA), as well as AA meetings.

Before the founding of AA, there was little help available for those whose drinking impacted negatively on their lives. Social services were available for

Alcoholics Anonymous

Cofounded by recovering alcoholics William Griffith Wilson (Bill W.) and Robert Holbrook Smith (Dr. Bob) in Akron, Ohio on June 10, 1935, Alcoholics Anonymous is an international fellowship of men and women who have had a drinking problem. It is nonprofessional, self-supporting, multiracial, apolitical, and available almost everywhere. There are no age or education requirements. Membership is open to anyone who wants to do something about his or her drinking problem. In the fall of 1935, a second group of alcoholics slowly took shape in New York. A third appeared in Cleveland in 1939. It had taken over 4 years to produce 100 sober alcoholics in the three founding groups. There are now more than 2 million members throughout the world. In addition, hundreds of other self-help groups have been started on the principles of Alcoholics Anonymous, including Narcotics Anonymous, Cocaine Anonymous, Marijuana Anonymous, and Overeaters Anonymous.

families, but little was done for the family member who had the problem. Family members would pray for the afflicted, and religious conversions often resulted in abstinence, but neither treatment nor self-help groups existed at that time. On June 10, 1935, all of this changed. William Griffith Wilson and Robert Holbrook Smith, members of the Oxford Group, a nondenominational, conservative membership organization, founded the program that became the prototype for all 12-step programs—AA (Kurtz, 1979). Alcoholics Anonymous now has a membership of more than 2 million worldwide and is considered the flagship program of all self-help programs. One might even advance the notion that had it not been for the founding of Alcoholics Anonymous, our advances in treatment and recovery might not have been realized.

While attendance in 12-step meetings is important to initiating and supporting behavioral change, they are not for everybody. The ability to share one's experience, strength, and hope in a meeting does not come easy for many. Some people resist the religious implications of the meetings and the organization's religious underpinnings. There are still others who report that the war stories actually increases their desire to get high. Individuals with more serious psychiatric disorders are often uncomfortable in group settings—individual counseling is almost always indicated before any kind of group activity is considered.

Mandating 12-step meetings is often counterproductive. Forcing individuals to attend AA, NA, or MA against their will is likely to increase their resistance to attending such programs in the future. Courts, employers, and managed care organizations sometimes require attendance as a condition of the individual's probation, employment, or continued insurance coverage. One school of thought is that leveraging individuals—the use of such force—to attend such meetings eventually leads to an acceptance. The adage, “bring your body, the mind will follow,” applies to this notion. While this may, at times, be true, it more commonly leads to the reverse effect. Once the coercive force has ended, the person ceases to attend and perceives the experience in a negative way. While this may appear to contradict the Harvard study previously cited, it really doesn't. The Harvard study stated that unmotivated individuals who attended AA meetings eventually developed the motivation to remain sober. Although unmotivated, however, these individuals attended voluntarily and were not *required* to attend.

In the absence of alternatives, such referrals may appear to be appropriate. But the ideal, and perhaps the more effective approach is to refer the individual to a treatment program or addictions specialist that will explore resistance, discuss ambivalence, and motivate the individual toward change. The prospect of becoming substance-free is a daunting one, and the resistance to such an initiative is complex. While abstinence is an achievable goal for most individuals on any given day, continued recovery is a process that begins with a willingness to change. Before such change is possible, the idea of such change has to become feasible. This is the first function of a treatment provider. When the notion of recovery becomes less daunting, the action steps necessary to achieve that goal

become possible. If 12-step meetings are to be in the treatment plan, it is here that the individual will be more receptive.

To Work in This Field You Have to Have “Been There”?

A treatment study by the National Institute on Drug Abuse (NIDA) finds a declining trend in both recovering counselors and certified counselors in the field between 1995 and 2001. The study also showed an increase in master’s-level counselors during those same years (NIDA, 2001). *Certified counselors*, as defined in this study, are those who are state credentialed or state certified but do not hold a master’s-level degree. In most treatment facilities, a recovering counselor without credentialization or certification is usually working toward that goal. While NIDA’s findings underscore increasing academic demands to qualify as an SUD counselor, many professionals in the field hold state certification, master’s degrees, *and* are themselves recovering.

Being in recovery from an SUD is not essential to being an effective clinician in this field. While having such an experience may serve to establish a unique credibility among patients, it can also be a handicap. Being in recovery without the benefit of education and training above and beyond personal experience may narrow the counselor’s treatment perspectives. Recovering clinicians are sometimes limited by their own treatment experience, depriving the patient a full range of possible treatment options better known to the trained and experienced professional. As in any profession, rigid, dogmatic beliefs can be counterproductive to growth. What worked in the counselor’s personal treatment may not necessarily be what works in the treatment of his or her patients.

Being an SUD Professional

Self-Disclosure

As for sharing personal experience with the patient, there are no hard and fast rules on this subject. Kinney and Leaton, however, add a cautionary word about the technique of self-disclosure (1991, p. 252). The authors consider self-disclosure to be a *counseling technique* and “as such, it requires the same thoughtful evaluation of its usefulness as any other counseling tool.” It may seem only natural to allay some of the client’s nervousness or resistance with the news that the clinician has been there and knows how the patient feels. The recovering counselor also becomes proof of successful recovery. But what seems natural, Kinney and Leaton go on to say, “may be totally inappropriate or even countertherapeutic. Therapists need to remember that their *professionalism* is important to the client, particularly in the early days of treatment—that professionalism is comforting” (1991, p. 253).

When the counselor self-discloses appropriately and ethically, it can be a model of hope for the client and become extremely useful (Bissell et al., 2003). On the other hand, it should be very clear to the counselor why he or she believes

Peck on Psychotherapy

We are now able to see the essential ingredient that makes psychotherapy effective and successful. It is not “unconditional positive regard,” nor is it magical words, techniques, or postures; it is human involvement and struggle. It is the willingness of the therapist to extend himself or herself for the purpose of nurturing the patient’s growth—willingness to go out on a limb, to truly involve oneself at an emotional level in the relationship, to actually struggle with the patient and with oneself. In short, the essential ingredient of successful deep and meaningful psychotherapy is love (Peck, 2003, p. 173).

this action will benefit the client. When self-disclosure is employed, it should be very specific and relevant to current discussion (Bissell et al., 1987–2000). In other words, such action should make a clinical point, by example or reference. Sharing one’s experience, strength, and hope is not likely to be of therapeutic value and might even undermine the relationship between the client and the counselor. While the counselor might be well-intentioned, it could be interpreted by the patient as *one-upmanship*, for example, “My story is worse than yours, so why can’t you get clean and sober like me?”

Miller and Rollnick state that there could even be a compromise of a counselor’s ability to provide “critical conditions of change” because of overidentification (2002, p. 7). If the clinician elects to self-disclose, such action should result in increased credibility, hope, wisdom, or inspiration.

Counselor Prerequisites

In addition to the academic and profession-specific credentials often required to get a job in this field, the SUD professional should possess other qualities. These include a genuine concern for the well-being of others, the ability to consistently manage personal emotions, an openness to new ideas, and the personal discipline to read and keep up with changes in the field. Good communications skills, including speaking and writing, are also important. As for counseling skills, Carl Rogers regarded accurate empathy, unconditional positive regard, and genuineness as more significant than any specific therapeutic techniques (Rogers, 2004). In other words, whatever approach to treatment the counselor embraces, being empathic, respecting the client, and being sincere should never be compromised. M. Scott Peck (2003) takes this one step further. He states that “love,” not positive regard, is an essential ingredient of successful deep and meaningful psychotherapy.

Empathy Research indicates that counselor empathy can be a significant determinant of clients’ response to treatment (Miller & Rollnick, 2002, p. 7). Empa-

thy includes “such therapist characteristics as warmth, respect, supportiveness, caring, concern, sympathetic understanding, commitment, and active interest” (p. 25). Perhaps empathy can be taught, but for most practitioners in this field it is probably more of an inherent quality. Before starting a career in this field, it might be wise to do a serious self-inventory, preferably with a therapist present, and explore the reasons for choosing this profession—or choosing any helping profession for that matter.

Control of Emotions As discussed in the preceding section, an important personal quality for working in this field is the ability to be even and consistent in our display of emotions. Working with families and individuals with SUDs can be emotional work—frustrating, physically draining, and even anger provoking. Our patients are often emotionally inconsistent and may not have dealt with their true feelings in years—relying on mood-altering substances to avoid the discomfort. Now they are turning to us to provide the emotional consistency they lack. And their ideals and values may not be compatible with those of the SUD counselor. Nevertheless, the counselor must always be respectful, regardless of the patient’s beliefs, values, character flaws, and physical or mental disabilities. Being respectful of others and of oneself is a lesson from which even the most challenging patient is likely to learn.

Openness Being open to new ideas is another important quality for the clinician treating addictions. Rigid views and closed-mindedness are always countertherapeutic, limiting the patient’s potential for growth and recovery. This field is in a process of perpetual evolution, with scientific and behavioral breakthroughs developing regularly. A clinician who is resistant to change will not grow as a professional and will not remain current on developments in the field. As in any profession, ongoing education is not only recommended, but it is also required in order to maintain clinical certification.

Communications and Organizational Skills Finally, clinicians in this field are required to do a great deal of writing, including chart notes, treatment plans, progress reports, and clinical summaries. They must also discuss cases in clinical team meetings with colleagues and talk with referral sources, community resources, employee assistance programs, and managed care organizations. The ability to communicate effectively on several organizational levels is also important—an often overlooked function that comes with the job. And besides having good communications skills, SUD professionals need to have excellent organizational and time-management skills to stay on top of administrative and paperwork demands, case conferences, and regulatory agency requirements.

With all of its requirements and challenges, or perhaps because of them, this is a profession filled with rewards, opportunities for growth, and advancement. As with any career choice, the question must be asked: Is this the right job for me?

References

- Bissell, et al. (1987–2000). In Dual Relationships and Self Disclosure. Essay Database: www.essays.cc Retrieved October 9, 2005.
- Boon, M. (2002). *The road of excess*. Cambridge, MA: Harvard University Press.
- DSM. (2005). Answers.com. Retrieved October 5, 2005, from www.anserx.com
- How effective is Alcoholics Anonymous? (2003, December). *Harvard Mental Health Letter*, p. 7.
- Janis, S. (2000). *Spirituality for dummies*. Hoboken, NJ :Hungry Minds/Wiley.
- Jonnes, J. (1999). *Hep-cats, narcs, and pipe dreams: A history of America's romance with illegal drugs*. Baltimore: Johns Hopkins University Press.
- Kinney, J., & Leaton, G. (1991). *Loosening the grip: A handbook of alcohol information*. St. Louis, MO: Mosby Year Book.
- Kurtz, E. (1979). *Not God: A history of Alcoholics Anonymous*. Center City, MN: Hazelden.
- Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford.
- McKellar, J., Stewart, E., & Humphreys, K. (April 2003). Alcoholics Anonymous involvement and positive alcohol-related outcomes: Cause consequences, or just a correlate? In *How effective is Alcoholics Anonymous?* (December 2003). *Harvard Mental Health Letter*, 20, 7.
- Merriam-Webster's collegiate dictionary* (11th ed.). (2003). Springfield, MA: Merriam-Webster.
- Miller, R, & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. New York: Guilford.
- National Institute on Drug Abuse. (2001). *Research Grant RO1-DA-13110*. Rockville, MD: NIH-NIDA.
- Peck, M. S. (2003). *The road less traveled* (Rev. ed.). New York: Simon & Schuster.
- Rogers, C. (June 2004). In What Is Supportive Therapy? *Harvard Mental Health Letter*, 20,(12).
- SAMHSA. (2005). [Chart]. Percentage of full-time workers, age 18–49, reporting current illegal drug and heavy alcohol use, by occupation categories, 1994 and 1997. Retrieved October 5, 2005, from www.samhsa.gov
- SAMHSA/CSAT. (1993–2004). TIP Series 44. *Substance abuse treatment for adults in the criminal justice system*. Rockville, MD: U.S. Department of Health and Human Services.
- Scanlon, W. F. (1991). *Alcoholism and drug abuse in the workplace: Managing care and costs through employee assistance programs*. New York: Greenwood.
- White, W. L. (1998). *Slaying the dragon*. Bloomington, IL: Chestnut Health Systems/Lighthouse Institute.