

## CHAPTER

## 1

## INTRODUCTION

## PERSONAL REFLECTIONS

As we approach addiction counseling, it is important, as clinicians, that we have as clear an understanding as possible of who we are both personally and professionally in relation to addiction. We need to be brave enough to examine our own experiences with addictive tendencies within ourselves and our loved ones as well as our professional experiences with addicts. These experiences color and shape our work with our addicted clients. If we engage in a thorough self-exploration, we can enter encounters with addicts using a clear, balanced approach and avoid being thrown off balance by the intense force of addiction as it has expressed and expresses itself in our client's life.

I also need to comment on the terminology I have chosen to use throughout the text to describe those clients who struggle with addiction. I use the term *addicts* or *addicted clients* even though some readers may prefer the terms *person with addiction* or *people with substance use disorders* in order to emphasize the "personhood" of the client. I have chosen these terms because, in my experience of addiction counseling, experienced therapists tend to use the terms I have chosen as well as the clients. By no means is the term meant to be disrespectful to the client. For example, in clinical meetings, I always insist that the person's name be used before their disorder is discussed because, as I tell my students, "They were a person before they developed the disorder and their name is important. They are not their disorder." My hope is that I do not offend the reader with my choice of terminology, but rather, I encourage the reader to choose a term to discuss the addicted client that they believe is most respectful to their population. I believe that what is important, so critical, so necessary, is that we find terminology and an approach that powerfully invites our clients and their loved ones to heal from the destructive force of addiction.

## OBJECTIVES

1. To learn the main models of addiction counseling.
2. To understand the history of three influences on addiction counseling.
3. To explore how one's own models of addiction and understanding of influences impact the view of the addicted client, the cause of addiction, and treatment approaches.

Current statistics support the concern for alcohol and drug use in America. The 2011 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA]) found that about 133.4 million Americans (51.8% of the total population over age 12) drank alcohol, with 22.6% (one quarter;

58.3 million people) having a binge drinking experience at least once in the previous month and 6.2% reporting being heavy drinkers (15.9 million). The survey also found that approximately 22.5 million Americans (8.7% of the total population over age 12) had used an illicit drug during the month before being interviewed.

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Marijuana was the most common illicit drug used. One area of alarming concern is prescription painkiller medication. The number and percentage of persons aged 12 or older, who were current nonmedical users of pain relievers in 2011, was 4.5 million or 1.7%. The Centers for Disease Control and Prevention (2013) reported that in 2010, the amount of prescribed painkiller medication could result in every American being medicated through an entire day for one month; while they were prescribed for medical reasons, they were misused or abused by others. Overdoses of the prescription painkillers (opioid or narcotic) have tripled in the past 20 years in the United States (SAMSHA, 2010, 2011). Their abuse/misuse has doubled in emergency room visits (SAMSHA, 2010) and teens and adults use them to experience a “high” or use them for other nonmedical reasons (SAMSHA, 2011).

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

Working with the substance-abusing population, however, can be difficult. Mental health workers, both historically and currently, have not always liked working with alcoholics and addicts for at least two reasons: (1) the difficulty in treating them because of factors such as relapses, poor impulse control, emotional reactivity, and/or lying to protect their addiction; and (2) the lack of knowledge (techniques) on how best to treat them.

However, openness to treating addicts grew as information on how to treat addicts emerged and as additional funding for treatment became available. For example, because addicts commonly deny the consequences of their usage to themselves and others (Levinthal, 1996), it became

easier for counselors to deal with denial when the technique of intervention was introduced (Fields, 1995).

Counselors also have potential issues with countertransference. Many helping professionals have negative personal as well as professional experiences working with addicted individuals. This may cause them to avoid or hesitate to work with this population. When working with addicts, they may be caught in familiar patterns of enabling or judging the addicted individual and their loved ones based on their own personal or professional experiences. Also, professionals can have concern they are being conned by addicts to enable their addiction and, as a result, may approach the addicted person in a manner that invites anger and manipulation from the client (Compton, 1999).

Changes in public policy also affected the work of counselors. In 1970, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was established to provide funding for alcoholism treatment and research, and in the 1970s, insurance companies began to reimburse agencies for providing addiction treatment (O'Dwyer, 1993). The Hughes Act (PL 91-616) established the NIAAA, funded states that established alcoholism divisions, and started alcohol treatment programs for federal employees (Fisher & Harrison, 1997). This policy change expanded the field of addiction counseling. As a result, states started to create credentialing and licensing bodies to ensure quality addiction counseling (O'Dwyer, 1993); being a recovering addict no longer meant immediate entry into the addiction counseling field. Instead, addiction professionals needed to document a combination of credentials regarding both counseling experience and training. Up to the present day, different mental health professional groups have increasingly developed certification and licensure processes for addiction counselors. A general approach to certification and licensure is presented in Chapter 14.

This general expansion of the addiction field (effective treatment, research, certification/licensure) now allows for many routes of entry into

addiction counseling. A professional may enter the field initially through research, a certification/licensure process, or additionally through a grassroots network experience of their own addiction recovery. As a result of various starting points of interest and involvement, there are numerous disagreements in the field of addictions on applicable models and effective treatment approaches. For example, some addiction experts emphasize the strengths of the disease model of addiction and Alcoholics Anonymous (AA; Gragg, 1991), whereas other experts point out the weaknesses of the disease model and AA (G. A. Marlatt, 1985b). The influences on and models of addiction counseling are explored in the remainder of this chapter.

This chapter is intended to set the tone for the entire book and is divided into two sections. In the first section of this chapter, three addiction counseling influences that have and continue to shape the addiction counseling field are explored. These are the disease model of treatment, addiction research, and managed care. This exploration is meant to expose the reader to the different forces that have shaped and continue to shape the field of addiction counseling.

The second section presents a view of models used in understanding addiction; these models shape the view of the alcoholic, the cause of addiction, and the focus of treatment. The model is like the foundation of the house, the theory (theories) makes up the structure of the house, and the different rooms in the house are the treatment intervention techniques.

## **ADDICTION COUNSELING INFLUENCES**

Currently, there are at least three main influences in addiction counseling:

1. The traditional addiction counseling *disease model approach* that asks: Is this approach healing for the addict within the scope of the disease model of addiction?
2. The *addiction research approach* that presents counselors with the question: Which addiction counseling approaches are supported in research findings?
3. The *managed care approach* that confronts counselors with the question: What counseling approaches provide the greatest benefit for the least cost?

Each of these influences has an important impact on addiction counseling and because of their different orientations, there may be confusing messages sent to addiction counselors. For example, disease model counselors may advocate use of the term *codependency* for the partners and family members of addicts, but the research community may respond by stating that there is not enough research to warrant the use of such a diagnostic term, and the managed care organizations may not be willing to pay for codependency treatment because of the disagreement among professionals. To facilitate working within these influences, it is important to understand the historical influences of the disease model of addiction treatment, addiction research, and managed care. Such understanding can enhance the treatment strategies of the counselor. Note that the section on managed care is longer due to the stressful impact of this influence on the addiction counselor and its potentially negative impact on the client.

### **Disease Model Approach**

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**Influence on Counseling:** Is this approach healing for the addict within the scope of the disease model of addiction?

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The addiction counseling field has two main root systems: a grassroots addiction recovery network and a research community base. Lay therapy with this population began in 1913, when Courtenay Baylor was hired by the clinic of Boston's Emmanuel Church (that began in 1906) after receiving treatment there. Many lay

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counselors became sober before AA or without affiliation with it once it emerged in 1935 (W. L. White, 1999). AA looked at alcoholics as having an allergy to alcohol, which results in a craving and a loss of control (AA, 1939). Other than Thomas Trotter and Benjamin Rush—who, at the end of the 18th century, viewed alcoholism as a disease—alcoholism was typically viewed as a moral weakness (O'Dwyer, 1993). AA's view of alcoholism as an allergic reaction helped shift alcoholism from a moral problem to a physical or medical problem: The alcoholic was no longer blamed for developing the addiction (G. A. Marlatt, 1985b).

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

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

#### Addiction Research Approach

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**Influence on Counseling:** Which addiction counseling approaches are supported in research findings?

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While the self-help group movement was growing, so was the research on addiction. About the same time as AA's development, the federal government began two drug treatment programs for prisoners, which facilitated research opportunities on addictions (O'Dwyer, 1993). Through his alcoholism research and the creation of the Yale School of Alcohol Studies in 1942, Jellinek developed the disease model of alcoholism (Bowman & Jellinek, 1941; Gragg, 1995; Jellinek, 1960). The disease model of alcoholism fit well with AA's model of an allergy, and a significant bridge developed between the self-help group movement and the research community. In 1956, the American Medical Association (AMA) agreed that alcoholism was a disease (G. A. Marlatt, 1985b). Through the development of the disease model of alcoholism, both the self-help group movement and the research community guided mental health professionals in their work with addicts (Gragg, 1995).

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

#### Managed Care Approach

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**Influence on Counseling:** What counseling approaches provide the greatest benefit for the least cost?

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Austad and Berman (1991) describe the history of managed care development in the United States. Managed care systems came with two emphases: to provide quality care and to reduce costs. HMOs began in the 1900s as alternative forms of health care for poor people, laborers, and farmers who

might be obliterated financially by intense, sudden medical costs. Initially, HMOs were opposed by medical professionals; however, acceptability for the concept of “prepaid care” (health care is provided by specific individuals or groups for a specific fee predetermined in a contract) grew by the 1970s, as evidenced in the passing of the 1973 HMO Act, which decreased legal restrictions on these organizations and provided loans and grants. In terms of mental health services, this same 1973 act required HMOs to provide mental health services if they wanted federal assistance. In the 1980s, less money, growing costs, and increased counseling demands by consumers resulted in an interest in more efficient and less costly counseling.

Although significant concerns abound in the addiction counseling field about this third influence, the managed care orientation is currently fused with service delivery. Whether one works at an agency or in a private practice, each treatment funding source increasingly asks for monitoring throughout treatment and has its own standards regarding treatment limits, accountability, audits, and reviews. Such momentous accountability is frustrating and overwhelming for addiction counselors. Also, there may be additional stress due to a behavioral focus, a sense of having to “do more with less” (G. Miller, 2001), and generally feeling dehumanized throughout the process (Sachs, 1996). Although counselors may experience negative reactions to the treatment control of managed care, they have no choice but to work with the economic realities of the managed care philosophy (Hood & Miller, 1997).

The logic of managed care is to make sure services provided are necessary and that monies are used thoughtfully (Kinney, 2003). However, Margolis and Zweben (1998) point out that research over the past 30 years shows that people improve the longer they are in treatment, yet managed care plans emphasize less intense and shorter treatment duration (they may not cover individual sessions or focus on outpatient treatment). Also, managed care plans may measure

successful outcomes by “no immediate problems or complaints,” which is a different treatment success measure than that used by an addiction counseling professional. Van Wormer and Davis (2008) state that managed care is more of a management of costs than care and has significantly limited substance abuse treatment in terms of type of treatments, shorter length of outpatient treatment, and emphasis on medication rather than individual therapy.

Because counselors simply have less time to work with clients and need to practice under managed care directions (Whittinghill, Whittinghill, & Loesch, 2000), this reality raises concerns in areas such as confidentiality, reimbursement, and treatment needs that can impact the relationship between the counselor and the client (Hood & Miller, 1997). The counselor working in the area of addictions needs to find a balance between addressing the financial realities of managed care with the ethical commitment to client welfare.

The responsibility of ethics falls to the counselor. The SAMHSA (1998b) makes five recommendations:

1. Be aware of a commitment to both client and society.
2. Use the most effective and cost-effective treatment.
3. Promote the greatest good for the greatest number.
4. Use resources carefully.
5. Advocate for clients in terms of benefits in their best interest with the managed care company or through professional associations, noting that such advocacy involves a risk.

With regard to living within the realistic restraints of managed care, the counselor in this situation may feel like a worker at a fast-food franchise: Every burger gets the same ingredients no matter what. A three-pronged approach of self-care, professional organization involvement, and

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a compassionate, collaborative approach toward managed care providers can truly enhance the counselor's practice and client welfare. First, in terms of *self-care*, the counselor needs people or places to vent the frustration in working with such organizations so that the client does not hear such negative views from the therapist or experience negative consequences about reimbursement as a result of the conflict between the counselor and the managed care representative. Second, the counselor can become involved in state and national *professional groups* that advocate against the negative impact of managed health care (Pipal, 1995). Third, the counselor can use a *compassionate approach* with the managed care professional: Attempt to understand that individual's role and responsibilities with regard to providing services to the client in order to encourage collaboration to provide for the client's best interests (Hood & Miller, 1997). The practice of self-care, involvement in professional organizations, and a compassionate approach to managed care personnel can help the counselor decide what can and cannot be done to help each client. Providing clients with such information in a professional manner can be a powerful role model for clients on dealing with life's realities: do what we can and let go of the rest.

This text's response to the increasing emphasis of cost containment where time-limited interventions are preferred over long-term counseling is: Chapter 7 focuses on relapse prevention, Chapter 8 focuses on self-help groups that are free and community-based, and Chapter 9 focuses on therapy approaches that may be a good match to this orientation. (See Case Study 1.1.)

## MODELS OF ADDICTION

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As stated in the personal reflections section, the model of addiction can have a strong influence on the counselor's approach to addiction counseling in terms of view of the addict, cause of addiction, and treatment—it can be considered the foundation of the counseling. These models have changed and expanded over time; however, each currently exists in various counseling contexts. Some models may be more popular in one geographical area, or one counselor training approach, etc. than another. A counselor working with addicted individuals should find and become familiar with a model he or she is comfortable using for the assessment and treatment process. The models are the underpinnings of the views and policies of the counselor's employer, the client's funding organization, and the state's addiction credentialing and licensing board and legislature, to name a few, and the models indirectly or directly impact the counselor's employment, the client's treatment, and the counselor's liability, especially in court testimony.

Models, as stated in the personal reflections section of this chapter, are different than theories. A historical four-part framework (moral, psychological, sociocultural, and medical), developed by McHugh, Beckman, and Frieze (1979) is presented here with the biopsychosocial model added because of its widespread acceptance in the field for its incorporation of different models. Although each of the five models includes a view of alcoholism, cause of alcoholism, and form of treatment, each one

### CASE STUDY 1.1

You are an experienced counselor with a specialty in addictions counseling. You are approached by a counselor in your agency—who is new to addiction counseling—for advice on working with the managed care aspects of your organization. What suggestions would you make to this counselor to enhance his or her survival in the managed care world?

emphasizes different addiction components. Four components are (Leigh, 1985):

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

The models are summarized in Table 1.1. Those aspects of models that are usable in addiction treatment are noted both in the table and at the end of the section describing that model.

### Moral Model

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

### Psychological Models

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

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

The focus in the personality trait model is on changing the personality traits of the alcoholic (e.g., treating high anxiety) (Barry, 1974).

**Table 1.1 Theoretical Models**

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

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However, treatment is not very effective because of the stability of personality traits (McHugh et al., 1979). Although the personality of an addicted person has been examined, a clear or firm definition of such a personality does not exist (DiClemente, 2003).

The behavior-learning model emphasizes the changing of reinforcements, because alcohol is reinforcing for alcoholics. For instance, a change in reinforcers may occur by changing environments (J. Wallace, 1985). This model is the most treatment-friendly of the three psychological models because reinforcers can be readily changed. The counselor can develop a plan with the client that examines how the client is specifically reinforced by abusing alcohol/drugs. For example, if a client is psychologically addicted to marijuana because it reduces stress, the counselor can use this information to help the client develop a treatment and recovery maintenance plan that includes relaxation coping skills.

### Sociocultural Models

The sociocultural model emphasizes social forces and contexts that give birth to and feed alcoholism. These include: cultural attitudes (G. A. Marlatt, 1985a), family structure (Bowen, 1978), crisis times (Bratter, 1985) as well as peer pressure, social policies, availability, and family influences of genetics and system dynamics (DiClemente, 2003). In this model, treatment focuses on changing the environmental contexts for the alcoholic.

One example of a sociocultural model is Cushman's (1990) empty self theory. In this model, industrialization, urbanization, and secularism are societal aspects that have resulted in the increasing loss of family, community, and tradition—those things that offer people shared meaning in their lives. The loss of these aspects results in an empty self, who views psychological boundaries as specific ("My mental health

depends on me"), a locus of control as internal ("I am in charge of my life"), and a wish to manipulate the external world for personal ends ("I will be happy if I manage well"). Cushman (1990) believes that the active addict is using drugs to fight off feelings of alienation, fragmentation, worthlessness, and confusion (particularly around values). This theory can be readily applied in addiction counseling by assisting the client in recovering a lifestyle that involves a sense of family, community, and tradition, all supporting the addiction recovery.

### Medical Model

The medical model looks at specific physiological dysfunctions such as endocrine dysfunction (Gross, 1945). Although theories in the medical model may assist in defining and describing alcoholism, they fail to promote any specific treatments. The disease model of alcoholism is related to this category because of its basis in physiology (i.e., genetic predisposition, allergic reaction); however, it has a slightly different twist to it because of the individual's responsibility for future behavior and the need for spiritual help in recovery. Addiction is seen as the primary disease that is caused by a loss of control, and denial of having the disease and treatment requires abstinence (Denning, 2005).

The disease model views alcoholism as a progressive disease with symptoms. The two key elements in this model are loss of control over drinking and the progression of the disease, which ends in death. This view, a shift from the moral view, is more compassionate and open to treatment and insurance coverage (S. Goodman & Levy, 2003). This view is partially accepted by AA (McHugh et al., 1979): Alcoholism is an illness that is physical, mental, and spiritual in nature, and the alcoholic is not responsible for the development of the addiction but is responsible for future behavior. The alcoholic enters into recovery from addiction by admitting powerlessness over alcohol, as well



as wrongs done to others, and receiving the help of a Higher Power—what might be called a spiritual solution.

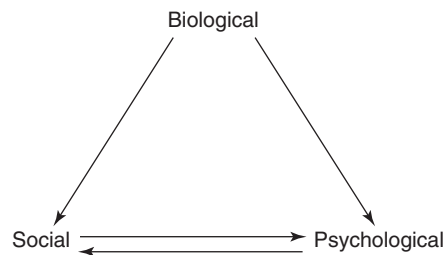
This theory of addiction, according to AA, has been implemented in the Minnesota Model of treatment: Professional services are combined with the 12 steps of AA, using counselors who are often in addiction recovery themselves (O'Dwyer, 1993). This model involves the components of education, fellowship, and therapy (Schulz, Williams, & Galligan, 2009). It was developed at Minnesota's Hazelden guesthouse program for alcoholic men that had five simple expectations: (1) be responsible, (2) go to AA 12-step lectures, (3) interact with other clients, (4) make one's own bed, and (5) stay sober (Shaw, Ritvo, & Irvine, 2005).

It shifted the treatment of alcoholics from custodial care to one based on dignity and respect of the alcoholic with an emphasis on peer assistance, particularly in the sharing of personal stories (Shaw et al., 2005). This model, which was very strong in the 1960s and 1970s, encourages the treatment of the whole individual in terms of body, mind, and spirit (S. Goodman & Levy, 2003). Gragg (1995) highlights the benefits of using the disease model of alcoholism/addiction within an HMO framework: It reduces the client's guilt over the addiction, and it encourages community involvement to supplement managed care therapy.

### Biopsychosocial Model

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

Ray and Ksir (2004) discuss the disease model argument as follows: While psychiatrists had viewed alcoholism as a secondary problem and focused on treating the primary mental health



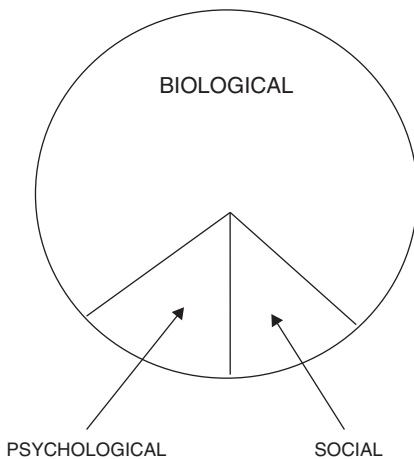
**Figure 1.1** Biopsychosocial Model.

disorder (telling their patients to use alcohol less), AA viewed alcoholism as the main problem that required direct treatment. Allegiance to the disease model is based on this commitment to alcoholism being the primary problem that needs to be treated. The debate about alcoholism being a disease continues to the present day.

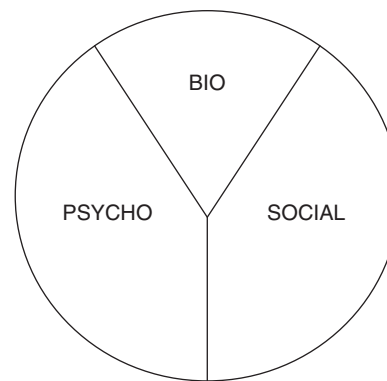
Some argue that alcoholism does not meet the criteria of being a disease because we cannot find the cause, directly treat it, or even know if there is a disease present. These critics also warn that the definition of the disease can be watered down by the view of seeing all excessive behaviors from this perspective. Some say it may be most appropriate to view the disease concept as a metaphor (G. A. Marlatt & Fromme, 1988). The biopsychosocial model of addiction may be a bridge across these conflicts. The biopsychosocial model (Figure 1.1) is holistic in that it views biological aspects impacting psychological aspects impacting social aspects of the individual in an ongoing, interactive manner (G. W. Lawson, Lawson, & Rivers, 2001). It looks at causality in a complicated way with regard to how the person becomes involved in addictive behavior, stays involved in addictive behavior, and stops the addictive behavior (DiClemente, 2003).

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

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**Figure 1.2** Contributing Factors of Addiction: Example 1.



**Figure 1.3** Contributing Factors of Addiction: Example 2.

includes an interaction between the individual and family, community, school, work, peer, and social factors.

There are some benefits to this perspective. First, it accounts for the complicating, contributing factors of addiction. This perspective encourages an individual assessment of the alcoholic or addict that accounts for causes in varying amounts like pieces of a pie. For example, some alcoholics/addicts may have a significant biological component without much in the other two areas (Figure 1.2) while other alcoholics/addicts have a small biological component (Figure 1.3). The model encourages a complex yet individualized understanding of one's cause of addiction. Figures 1.2 and 1.3 demonstrate these differences.

This broad assessment perspective also encourages a broader treatment perspective. As G. W. Lawson et al. (2001) report, treatment may then involve addressing more than one problem at a time. An example of this is when a woman in a domestic violence situation has a drinking/drug problem and needs to address both issues simultaneously because they impact each other. She can best protect herself if she is sober, and the experience of being battered may

encourage or trigger her alcohol or drug usage. The model is one of the best practices, where the counselor looks for the best fit between the client's need and the available treatment (Addictions Foundation of Manitoba, 2000). Yet, as DiClemente (2003) outlines, the drawbacks to the use of this model are threefold: (1) typically an emphasis is placed on one aspect of the model without a solid integration of the three aspects; (2) it is difficult to provide interventions on all aspects at the same time; and (3) some factors, such as risk and protective factors, cannot be changed.

Although DiClemente's concerns are important to consider, the use of the biopsychosocial model in the treatment of addiction remains valid because of its emphasis on complicating factors interacting in order for an addiction to be born and live in an individual. Treatment and aftercare from this perspective invite a holistic, personalized approach. It provides humanistic care to the individual (Smith, Fortin, Dwamena, & Frankel, 2013). Also note that some authors have advocated that different aspects be added to this model, i.e. spiritual (Amodia, Cano, & Eliason, 2005) to enhance the holistic view of the client. (See Case Study 1.2.)

## CASE STUDY 1.2

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

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

## SUMMARY

Models of addiction play a critical part in the assessment and treatment process for the client. The counselor working with addicted clients needs to be aware of the biases of his or her model orientation to determine exactly what aspects will be addressed as well as overlooked by the model's approach. An awareness of one's model at this level can result in a holistic therapeutic approach that incorporates a respectful view of the addicted client, the cause of addiction, and the treatment approaches and interventions.

This chapter establishes a baseline for examining addiction by addressing different models in the field. Table 1.1 is a summary of the models discussed in this chapter.

Finally, three excellent resources for the addiction counselor are: the National Institute on

Alcohol Abuse and Alcoholism [NIAAA]; the National Institute on Drug Abuse [NIDA]; and the Substance Abuse and Mental Health Services Administration [SAMHSA]. These organizations provide reliable, current, research-based information—including treatment approaches—regarding the field of addictions. These groups provide a variety of information both online and in hard copy that can be mailed to the reader.

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

## QUESTIONS

1. What are the main models of addiction?
2. What are three main influences on addiction counseling?
3. How have these models and influences affected your view of addicted individuals, the cause of addiction, and addiction treatment approaches?

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**EXERCISES**

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**Exercise 1.1**

Discuss with a peer the various models of addiction (moral, psychological, sociocultural, medical [disease], biopsychosocial) in terms of:

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

**Exercise 1.2**

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

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

**READINGS/RESOURCES/WEBSITES**

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**SUGGESTED READINGS**

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Coombs, R. H., & Howatt, W. A. (2005). *The addiction counselor's desk reference*. Hoboken, NJ: Wiley.

This book is divided into eight sections: substances, conceptual tools, assessment and treatment, clinical skills and resources, treatment resources, professional management, career enhancement resources, and information resources.

Shaw, B. F., Ritvo, P., & Irvine, J. (2005). *Addiction and recovery for dummies*. Hoboken, NJ: Wiley.

This book has five sections: overview of addiction, assessment, treatment, recovery, and resources. It is written in layperson's terms and yet is based on sound clinical information.

E-mail: [niaaweb-r@exchange.nih.gov](mailto:niaaweb-r@exchange.nih.gov)  
[www.niaaa.nih.gov](http://www.niaaa.nih.gov)

NIAAA conducts and funds alcohol research. Most publications are free (fact sheets, journals, videos, classroom resources, and clinical guides).

National Institute on Drug Abuse (NIDA)  
 (301) 443-1124  
[www.drugabuse.gov](http://www.drugabuse.gov)

NIDA utilizes science to research the effects of drug abuse and addiction on health and provides its findings on the website through podcasts, publications, e-newsletters, and public education projects.

Substance Abuse and Mental Health Services Administration (SAMHSA)  
 (877) 726-4727; TTY (800) 487-4889  
 (240) 276-2420 Prevention; (240) 276-1660 Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

SAMHSA works to minimize the impact of substance abuse and mental illness on society. Free publications and reports of research are accessible through the website (printed materials are charged shipping).

**WEBSITES**

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**Addiction Information Resources**

National Institute on Alcohol Abuse and Alcoholism (NIAAA)  
 (301) 443-3860