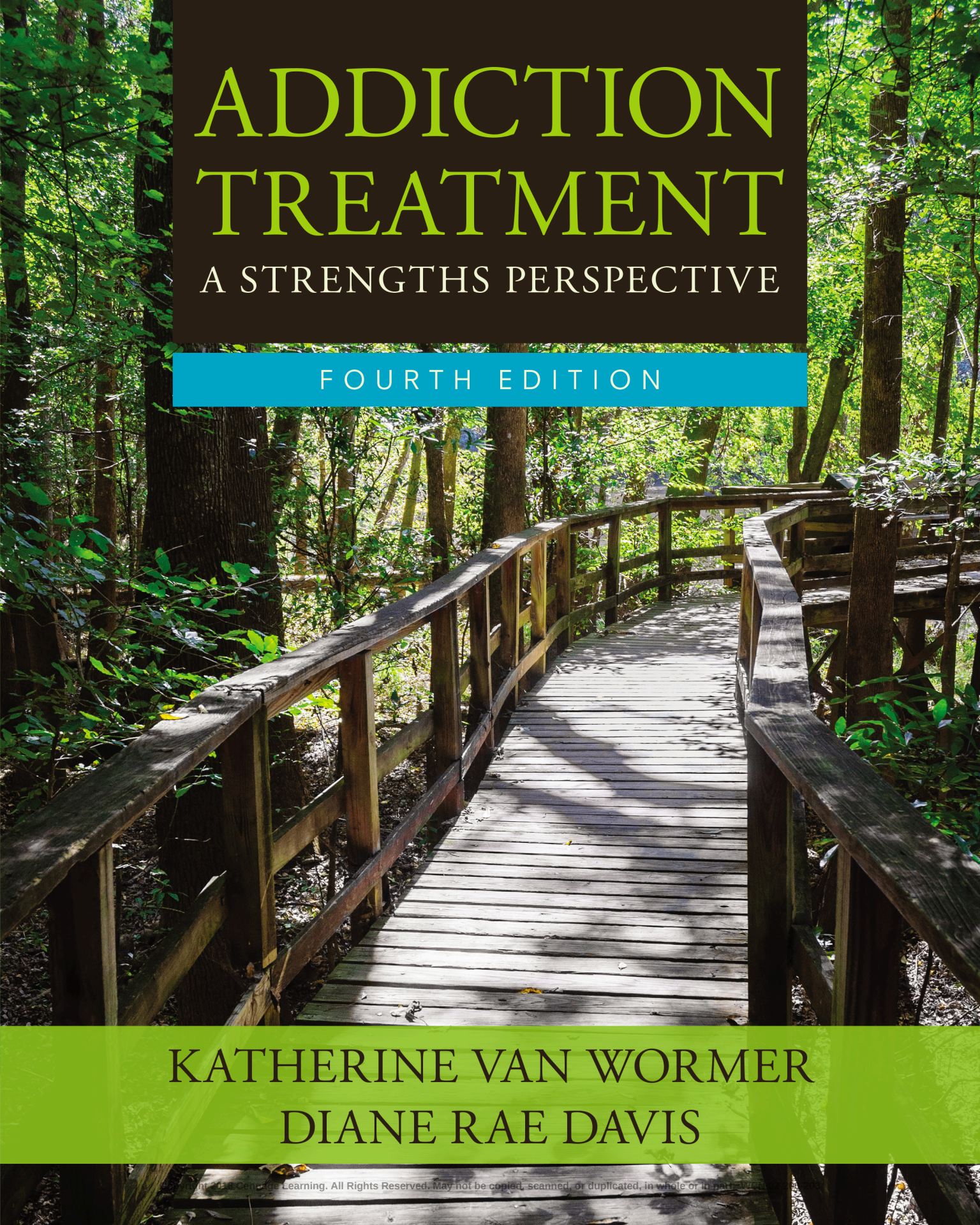

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***Addiction Treatment: A Strengths Perspective*, Fourth Edition**
Katherine van Wormer and Diane Rae Davis

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To the frontline workers in the field of addiction, to the men and women for whom substance abuse treatment is not only a profession but a mission, who so often "have been there" themselves, persons who care so much that they may even burn out eventually, but who in the meantime will help save people from the demon that is addiction. We need to keep in mind that for every individual helped, one whole family is spared—from child abuse, violence, bankruptcy. Therefore, with gratitude to the professional helpers and AA/NA sponsors alike, I dedicate my contribution to this book to you.

And, in particular, to my son, Rupert van Wormer, MSW, with extensive experience as a mental health case manager and harm reduction specialist who is now a medical social worker at Harborview Medical Center, Seattle.

—Katherine van Wormer

To my family, who support me no matter what with their love—Zach, Andy, John, Jayne, Mike, Kelley, and Donna—and to the men and women who are taking their lives back from addiction.

—Diane Rae Davis

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PREFACE: ABOUT THIS TEXT

In the 13 years since the publication of the first edition of this book, the interest in the development and refinement of a strengths-based approach to work with addicted populations has continued to impact the field. Strengths-based practices increasingly are being adapted by mental health agencies and other fields of practice (see, e.g., Clark, 2013; Franklin, 2015; Rapp & Goscha, 2012; Saleebey, 2013). Even more striking is the parallel growth and heightened attention devoted to harm reduction as a goal and as a process. Books have been published, conferences held, articles written in mainstream journals, and university courses shaped to focus on or at least incorporate principles of harm reduction (Fillmore & Hohman, 2015). Workshops and lectures on the related principles of motivational interviewing and on treatment interventions tailored for the individual's stage of motivation to change have proliferated exponentially.

At the same time, and quite recently, the 12-Step approach to treatment has received a new respectability in research circles thanks to improved research findings on treatment effectiveness that can no longer be ignored. We have not gotten there yet, but the ideal arrangement would be to tailor the treatment philosophy to the special needs of the client. Note the bridge chosen for the cover design of this text. Our choice was a bridge to signify our attempt in this book to bridge the gap between the traditional 12-Step approach and the teachings of harm reduction. The bridge also symbolizes a way to cross over water (as in a "Bridge over Troubled Water") or a swamp or a steep decline, as a way of easing or expediting one's travels. In this sense, we can think of a bridge to recovery.

The response to the first edition of *Addiction Treatment:* A *Strengths Perspective,* both by readers of the book and by critics, was gratifying. In fact, the only criticism was that the theoretical framework of harm reduction was not emphasized to a greater degree than it was. Because of the consistently positive response to the book's theme of harm reduction, in the second edition we bolstered our harm reduction emphasis both in terms of policy and practice through a motivational enhancement model.

Critics of the second edition also responded highly favorably to the harm reduction approach. The major suggestion was to provide more information on assessment, especially strengths-based assessment for clients with alcohol and other drug problems. Taking this suggestion to heart, we added a chapter to focus primarily on assessment and other interventions.

Critics of the third edition again responded well to the focus on harm reduction. In response to their suggestions, we have made the following changes in the text:

- Beginning each chapter with a list of learning objectives;
- Reduction in length of the biology chapter by moving the lengthy biologically based interventions section to the strengths-based intervention chapter—Chapter 8;
- Expansion of the history chapter to include recent historical developments;
- Moving the chapter on co-occurring disorders to the section, Biology of Addiction;
- Expanding the chapter on mutual help to include spiritual and religious resources, and moving the chapter to directly follow the strengths-based intervention;

- Retitling the chapter on race, ethnicity, and culture as Social and Ethnic/Cultural Determinants of Addiction, and completely rewriting the chapter within a framework provided by the World Health Organization on the social determinants of health;
- Expanding content on working with transgender populations in the chapter on gender and sexual orientation and relocating this chapter to Part 4, The Social Aspects of Addiction.
- The addition of a section on trauma-informed care to be included in Chapter 8;
- The inclusion of more minority content in Chapter 10 on families and in Chapter 6, Addiction Across the Life Span;
- Updating the text through the addition of content from the *DSM-5*.

As in the previous edition, all of the content of the text has been carefully updated to reflect scientific advances in the field and in research as well as advances in the conceptualization of the nature of addiction itself.

In this fourth as in the third edition, we continue to stress the prominence of co-occurring disorders in the substance use disorder population as in the population of persons with mental illness. Hence, this edition continues to infuse content throughout the chapters on the treatment needs of substance using persons with mental health disorders.

The favorable mass media coverage of moderation efforts, the volume of professional critiques of the disease-model premises, and the slew of harm reduction workshops are all signals of impending change and a paradigm shift of sorts. Central to this shift is the realization that so many people in desperate need of treatment—with binge drinking, compulsive cocaine use, and other high-risk behaviors—will never seek help under present circumstances and that many literally will die as a result.

Hence, this book: a new book for a new day. Consistent with the strengths approach, this is not a book that lambastes, denigrates, or ridicules contributions of pioneers who have charted the course in substance abuse treatment. Indeed, many thought-provoking and volatile critiques of the addiction-as-disease model have already been written. Much that needed to be said has been said. It is our belief that now is the time to move forward, to reconcile differences, and to get on with the task of helping people in the throes of addiction. So, no, this is not a book to tear down methods that have a history of success, methods in the promotion of which both authors have been personally involved. In our fascination in determining which faction is correct and who owns the soul of chemical dependence treatment—the abstinence or individual responsibility folk—we lose sight of the complete picture.

The primary task of *Addiction Treatment* is to shape a text grounded in a strengths or empowerment perspective, a theoretical framework that is inclusive and holistic. We hope to achieve this task by providing a digest of the theory, facts, and guidelines necessary for direct practice in a field whose practitioners and administrators have been traditionally resistant to change.

The basic organizing framework of this textbook—harm reduction—is closely aligned with the National Association of Social Work's (NASW's) (2015) policy statement – "The harm reduction approach is consistent with the social work value of self-determination and meeting the client where the client is. Harm reduction principles are applied in the interests of promoting public health" (p. 296). With respect to treatment, NASW further supports "the use of a holistic approach considering all treatment options to determine the best course of treatment for the individual, including, but not limited to clinical intervention, medication therapy, harm reduction approaches, and alternatives to

incarceration" (p. 297). Adopting such a comprehensive public health approach should enable social workers to focus on the prevention and treatment of alcohol, tobacco, and other drug problems.

ORGANIZATION AND FRAMEWORK

In common with the disease model, this text puts an emphasis on biology as a key factor in understanding the nature of addiction. It is our belief that human behavior can be understood only in terms of its biological, psychological, social, and spiritual components. The biopsychosocial framework, accordingly, has been chosen as the organizing framework for this book. *Biologically,* we will be looking at recent developments in neurobiological and pharmaceutical research related to addictive behavior. From a *psychological* standpoint, we will want to consider motivational and cognitive-based treatment innovations and evidence-based research on treatment effectiveness. And *sociologically,* we always consider the fact that any specific individual who enters into treatment does not live in a vacuum but is both shaped by and a shaper of his or her social and political environment.

Divided into four parts, the first of which is introductory, *Addiction Treatment* includes three core sections that cover the biology, psychology, and social aspects of addiction, respectively. The spiritual dimension is included in the psychological and social parts of the book.

STRENGTHS-BASED THERAPY

The terminology, ideology, and conceptual framework for this undertaking derive from the strengths perspective. This client-centered approach is compatible with the harm reduction model in that the overriding purpose is to help the client reduce the harm to himself or herself or others. Harm reduction therapy allows for creativity in the design of treatment strategies. Total abstinence from dangerous drug use is certainly not discouraged, nor is total abstinence from alcoholic beverages by those with a genetic predisposition to get "hooked." But starting with "where the client is" rather than where we think the client should be is the basic principle underlying harm reduction. Placing faith in the client's ability to make choices is a related concept.

BASIC ASSUMPTIONS OF THE TEXT

Congruent with the biopsychosocial, ecosystems configuration, the perspective advanced in this book is that addiction, to be a viable concept, must be viewed interactionally. Each component of the system, in other words, is seen in constant and dynamic interaction with every other component; reality is rarely linear; cause and effect are intertwined. Related to addiction, the nature versus nurture controversy is resolved through an understanding that steers away from a dichotomized "either–or" type of logic, as seen in the pointless is it nature or nurture arguments, for example. Our preference is for logic of the "both–and" variety. Consistent with this perspective, addiction is viewed as both a biological and a psychosocial phenomenon. There is, further, a spiritual dimension as well. The simplistic, adversarial view of human phenomena leaves us with only partial truths and fierce loyalties that hinder us in our understanding of complexity. To advance knowledge,

we need to hear from a multiplicity of voices. That the nature of addiction is infinitely complex will be revealed in the pages of this book. Essential to the study of addiction is a theoretical approach that is eclectic; such an approach is inclusive and broadening. One might even say that it is friendly rather than antagonistic toward diverse models.

To summarize, a major theoretical assumption of this book is that in our pursuit of knowledge concerning addiction and its treatment, our goal is to build upon the professional literature in the United States, Canada, and abroad and from old models and new models, whether psychodynamic or sociological, abstinence-based or experimental in nature. Some other basic assumptions that underlie this presentation are:

- Addiction exists along a continuum; many people may be addicted to one substance or product; one person may be addicted to multiple substances or activities involving risk (in relationships).
- Much of the criticism concerning various models of addiction (e.g., the disease model and individual responsibility theory) is valid; these models do tend to be unidimensional and narrow, but then, much of the criticism itself is unidimensional and narrow.
- There are hereditary tendencies toward addiction, but with work, these tendencies can usually be controlled.
- Socioeconomic determinants greatly influence the path into addiction and the possibilities for recovery.
- Better than forbidding adolescents from drinking is to have them learn moderate drinking from parents who drink moderately in the home.
- Whether alcoholism or addiction is regarded as a disease depends on the definition of disease; that addiction can be regarded as *like* a disease is a fact to which we can all agree.
- Involvement in mutual-help groups such as Alcoholics Anonymous can be invaluable in enhancing recovery and providing support to family members.
- When the focus is on promoting healthy lifestyles and on becoming motivated to change rather than on the substance misuse per se, many clients can be reached who would otherwise stay away.
- The war on drugs is politically and ethically misguided; issues of race, class, and gender define the parameters of this "war."
- Because there will never be a drug-free society, the only pragmatic approach is a public health or harm reduction approach.
- Addiction counselors who are themselves recovering have some advantages over counselors who "have not been there"; however, this kind of personal involvement is no more essential in this field than in related fields such as health and mental health. A continuously self-reflective stance is necessary for all counselors to be effective.
- Addictive behaviors are highly destructive to the family as a system and to each family member within that system; treatment, therefore, needs to include strong family counseling components.
- Professional training in counseling skills and neurobiological and psychosocial knowledge is just as essential for work in this field as it is for comparable fields of practice.
- Specialized training in substance misuse and the various addictions should be a requirement for practitioners in this field; such training should take place outside the treatment center and be scientifically based.

- Treatment must be tailored to the needs of the individual seeking help and include family and community support for recovery.
- Treatment ideally should be offered in all systems across health and human services and juvenile justice systems, not only in specialized substance abuse treatment centers.
- Treatment effectiveness is most accurately measured in terms of the reduction of harmful health-related practices rather than by total abstinence from drinking and drug use.

Addiction Treatment: A Strengths Perspective is intended for use as a primary text in courses related to substance misuse or as a secondary text in courses, graduate or undergraduate, related to health, social work, mental health, offender rehabilitation, and family counseling. Suffused with case examples and summaries of the latest scientific research, this book is directed to many types of practitioners in the addictions or related fields—from those who work with addicts and their families on a day-to-day basis to those who rarely see an addict but who are in positions of supervision, management, and policymaking related to addiction issues.

In the same way that hope is offered by counselors to even the most down-and-out addicts, we wish to offer hope (and appreciation) to the practitioners who dedicate their lives to work with those for whom other practitioners have little empathy or use. The hope that we would offer is ingrained in the strengths perspective itself. An approach that seeks resilience in clients and encourages workers to focus on possibilities rather than problems should go a long way toward preventing exhaustion and burnout in a field that is often characterized by both. The strengths perspective is not new to the chemical dependence field; in fact, as we argue in Chapter 1, empowerment has been inadvertently used by caring counselors for years. What we are providing here is its formulation and, ideally, reinforcement. In any case, working with addicts on the verge of self-destruction is a tough assignment. We constantly have to remember that the phoenix rose from a pyre of ashes, not a soft pillow, and that it is in those ashes that we find the embers of hope and change. That is what this book is about.

A word from Katherine van Wormer, MSSW, Ph.D., Professor of Social Work, University of Northern Iowa, Cedar Falls. Website: www.katherine-vanwormer.com

Being from an alcoholic background (my father) and an alcoholic city (New Orleans), I had no desire to do substance abuse counseling initially. But then in the 1980s, equipped with a brand new degree in social work, I ventured to Washington State in search of scenery and a job. After an inauspicious beginning in community home health and hospice, I found myself working at the community alcohol center in Longview, Washington. This treatment center was fairly laid back as far as substance abuse treatment centers go. Unlike my previous job, the work was fun and highly creative, and the clients got progressively better instead of progressively worse. The two-year outpatient program brought palpable results that were gratifying to see.

About five years later, I found myself in another scenic part of the world, Norway. As part of a mini-migration of Americans to Norway and Sweden to bring the Minnesota Model or 12-Step-based treatment, I trained counselors in group skills and actually learned the rudiments of the American disease model from a fellow American in Norway. Although the inevitable personnel crises abounded in a program that was run by ex-clients with limited periods of sobriety, I again witnessed the miracles of recovery and experienced the joy of seeing lives on the mend. In my public relations capacity, I spoke through translators to various community groups about alcoholism as a personal disease and as a family disease. Today, I coordinate the substance abuse certificate for social work students at the University of Northern Iowa. Relevant books I have written include *Alcoholism Treatment: A Social Work Perspective* (1995; Cengage) and *Working with Female Offenders: A Gender-Sensitive Approach* (2010), published by Wiley & Sons.

I have coauthored Restorative Justice Today: Practical Applications (2013, SAGE) and *Women and the Criminal Justice System* (4th ed.) (2014; Pearson). My most recent book is a two-volume set, *Human Behavior and the Social Environment: Micro Level* and *Macro Level,* (3rd ed.) published by Oxford University Press (in press).

A Word from Diane Rae Davis, MSW, Ph.D., Professor Emerita of Social Work, Eastern Washington University, Cheney

It seems that my entire life has been intertwined with one addiction or another. If you looked at my genogram, you would see addiction all over it and the subsequent deaths, illnesses, and divorces that follow. You would also see pockets of recovery. My own recovery from alcoholism was a terrible struggle. It took 3 years to get clean and sober from the time I was absolutely convinced I was an alcoholic. When I finally did, I had no job, no husband, no home to live in, and a son in my care. Yet my middle-class background had protected me from many of the consequences that women who are addicted face: jail or prison, prostitution, bankruptcy, infectious disease, and so on.

During the years of my own recovery, I have witnessed hundreds of men and women recover from the direst circumstances, and I have also witnessed the death or suicide of others who didn't make it. The effect of all this history may seem contradictory. On the one hand, I have a strong conviction to "never to give up" on even the worst scenarios—I have seen way too many miracles to ever "close the case" on anyone. On the other hand, I have learned the hard way the futility of hanging on to my own agenda regarding someone else's recovery. People make changes on their own timing, doing the best they can and surviving how they can. Behaviors that look like "resistance" and "noncompliance" from the outside may have completely different meanings when viewed from the inside. I have learned about "letting go." And finally, I've learned that there are many paths to recovery and that "recovery" means different things to different people. It took a while for me to give up the idea that what saved *my* life is the path for everyone. Having given that up, I find I have increased my capacity to help others. I have a profound belief in the strengths perspective and the possibilities of change. Similarly, I support the harm reduction model because of its many paths to sobriety, including abstinence, and because it honors a person's dignity by offering choices over and over again, no matter what.

Professionally, I have stayed close to the addiction field in social work practice and academic teaching, publishing, and research. In 1992, I received my Ph.D. at the University of Texas at Austin under the mentorship of Dr. Diana DiNitto. Until recently, I taught a variety of courses at the School of Social Work and Human Services at Eastern Washington University, including Addiction Treatment and Motivational Interviewing for MSW students. The publication of my article (with Golie Jansen) "Making Meaning of Alcoholics Anonymous" in *Social Work* (1998) allowed me to fulfill a personal mission to address the massive misunderstandings about mutual-help organizations among professional helpers. One of my most interesting research projects was "Women Who Have Taken Their Lives Back from Compulsive Gambling." This project involved an online research survey and qualitative interviews from women around the United States who are recovering from compulsive gambling. The result of this effort was several scholarly articles and the book *Taking back Your Life: Women and Problem Gambling* (2009), which was written for women who are currently experiencing gambling as a problem. My current mission is to help bring the problems of compulsive gambling to the attention of social workers and other helping professionals.

My other areas of research and publications include women's addiction and recovery, rural substance abuse treatment, ropes course treatment, harm reduction, alternative "sobriety" schools, and methadone maintenance.

Note

We both share responsibility for this book as a whole, and each chapter is a collaborative effort by both of us. However, the Preface; Chapters 1, 2, 3, 5, 6, 10, and 13; were the primary responsibility of Katherine van Wormer. Chapters 4, 7, 8, 9, 11, and 12, were the primary responsibility of Diane Rae Davis.

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PART 1

Introduction

On the surface, our application of the strengths perspective to the field of addiction treatment marks a dramatic departure from the past. Our notion of reinforcing strengths in a self-directed program of harm reduction is seemingly a more extreme departure still. And yet the tone of this writing is intended to be conciliatory rather than adversarial; the focus is "building upon" rather than "tearing down."

Part I of this text, comprising Chapters 1 and 2, summarizes the current state of knowledge concerning the nature of addiction. A major task of the first chapter is definitional: to offer a conceptualization of addiction specific enough to be usable yet broad enough to encompass seemingly disparate behaviors such as compulsive overeating, disordered gambling, excessive devotion to work, and out-of-control spending. In these chapters and throughout the book, attention is paid to the biological, psychological, social, and spiritual aspects of addictive behavior.

The nature of addiction is complex. Its assessment and treatment represent such an inexact science that numerous theories exist, each one convincing in its own right, each with a school of followers, and each explaining only a part of the whole. The questions in the field run deep: What is addiction? Why are some people more addictive than others? How can addiction be controlled? Our perspectives—moralistic, scientific, and just plain oppositional—help shape our answers concerning the nature and treatment of addiction.

The nature of public policy is complex as well. Despite spending billions of dollars and arresting millions of Americans, the U.S. government has been unable to stop the flow of illegal drugs. Meanwhile, the harms associated with substance misuse—addiction, drug overdose, drug-related crime, the spread of HIV/AIDS—continue to mount. Add to this the casualties of the war on drugs—the broken families, children in foster care, lost worker productivity, homelessness, overcrowded prisons—and it is easy to see why so many of us are calling for change to reduce the social and psychological harm. We are calling for harm reduction and treatment availability and advocating for counseling techniques that motivate people to get help when they need it.

To learn where we are going, we need to look back to our cultural and historical roots. The purpose of Chapter 2 is to trace the roots of today's policies concerning drug use and society's attempts to control it. Two basic themes are central to this historical review. The first theme is technology, and the second is ideology. In prohibition, as we will

see, these themes converged. (Technologies such as alcohol distillation created a climate for change in public opinion about drinking.) Other forces, such as the Puritan legacy of the New England colonies, were involved as well. That there is a new prohibition movement today in the form of a war on drugs is a major argument of this chapter. That the drugs of choice that are most harshly punished and apt to be outlawed are those associated with poor minority groups is a second major argument.

The political and historical context of addiction treatment are among the issues tackled in the first two introductory chapters. Our journey to exploring these dimensions begins with Chapter 1, The Nature of Addiction. The first task of this book, in short, is to explore the nature of addiction and its conceptualization. The second task, which is the subject of Chapter 2, is to put today's conceptualizations in historical and theoretical context.

CHAPTER 1

The Nature of Addiction

LEARNING OBJECTIVES

- **LO1** To offer a survey of the contemporary context of addiction therapy with attention paid to social, ideological, and economic factors;
- **LO2** To show how alcoholism and other drug addiction affect us all;
- **LO3** To introduce definitions of key terms in the addiction field;
- **LO4** To show how substance use disorder is diagnosed in the most widely used manual of mental disorders;
- **LO5** To discuss addiction as a biopsychosocial-spiritual phenomenon;
- **LO6** To introduce the concept of harm reduction as a flexible, public health approach that is compatible with the strengths perspective;
- **LO7** To explore the strengths in various treatment options and what evidence-based research tells us.

"We have three words to define what harm reduction expects from an addict," says Dan Bigg of the Chicago Recovery Alliance. "Any positive change."

—Shavelson (2001)

"The suffering of a soul that can suffer greatly—that and only that, is tragedy." So wrote Edith Hamilton (1948, p. 131), the foremost authority on ancient Greek culture of her day. She was talking about Greek tragedy. The purpose of classical Greek tragedy as acted out on the stage was to explore human psychology and to dramatize situations in which the hero met his or her fate. The hero in classical Greek tragedy possessed a tragic flaw, *hubris,* that ultimately would be his or her undoing (Walters, 2006). Today, in real life as in drama, the source of personal tragedy is often some sort of human flaw in the form of a harmful compulsion or obsession. The "fatal attraction" may involve a person, an activity, or a substance.

Thus, when we hear of the compulsive gambler who leads his or her family down the path of financial ruin, of the Internet whiz who, like the workaholic, sacrifices family life for an "affair" with Cyberspace, the kid who can't get off of Facebook, or of the drug addict who deals drugs or prostitutes herself to support her habit, we may find in us a sense of pity and awe, the essence of all great tragedy.

The effects of addiction are everywhere and nowhere—everywhere because they are in every family and workplace, nowhere because so much of the behavior is hidden from public view. Sometimes, as with Internet gambling or pill addiction, even family members are unaware of the problem until a major crisis ensues.

In contrast to the tales of classic literature, in real life there may be a way out of the pain, a way for the individual to get beyond the tragic flaw. The way out is called *recovery*. "I'm in recovery," says the proud member of Alcoholics Anonymous (AA). Similarly, the heavy drinker and marijuana smoker who has gotten some personal counseling in reducing the harm announces that now his or her own life has gotten under control.

In our jails, hospitals, women's shelters, and child welfare departments, all places where professional counselors and social workers are employed, the impact of substance misuse and addiction is a given. Where there is assault, incest, rape, child neglect, or attempted suicide, more often than not some form of substance misuse is involved. The effects may be immediate—for example, the neglectful parent so strung out on methamphetamines (meth) that he or she has lost all sense of time and all sense of responsibility. The effects may be lifelong—for example, the woman who suffered sexual abuse by a male predator early in childhood and who has taken to using prescription drugs and alcohol for self-medication to dull a pain the cause of which may or may not be remembered.

The misuse of alcohol, nicotine, and illicit and prescription drugs costs Americans more than $700 billion a year in increased health care costs, crime, and lost productivity (National Institute on Drug Abuse [NIDA], 2014). Every year, illicit and prescription drugs and alcohol contribute to the deaths of more than 90,000 Americans, while tobacco is linked to an estimated 480,000 deaths per year. High-risk behavior among the young are linked to their death rates, whether or not the individuals are addicted to the drug, alcohol. The tobacco deaths, in contrast, take place among people later in life who became addicted to cigarettes.

Members of the legal as well as mental health professions encounter the negative impact of addictive and other drug-related behavior as well. A police officer (personal communication, May 2010), for example, describes his daily experience in small town Iowa:

> Professionally, I see addicts every day. Whether it is the alcoholic who wanders the streets collecting cans to buy his bottle of wine, or the thief who steals the Texas fifth of vodka from the grocery store, I deal with meth addicts that cannot quit using even though they no longer work, lost their home, friends die of an overdose, yet the same day they shoot up, knowing they may be next. . . . It is these same addicted individuals who cause a good portion of the crime in society. It is this crime that I am left cleaning up after.

The criminal justice system is swelling, and the recidivism rate of released prisoners is extremely high. More than one million inmates incarcerated today are serving time for drug-related crimes. Accordingly, substance abuse agencies and their staff are far more involved than in previous years in providing services to incarcerated men and women and to persons on probation and parole. The treatment needs of this population both within prison walls and upon re-entry to the society are vast.

Another major national concern are the treatment needs of returning soldiers who have fought in the Gulf Wars. War-related trauma is closely correlated with substance use and addiction. How to meet the mental health needs of these former soldiers is a continuing concern of the government (through Veterans Affairs [VA]) and of mental health professionals and substance abuse counselors.

The impact of addiction, we should note, is seen in the suites as well as on the streets. This chapter explores the nature of addiction and contemporary trends in its treatment. Each section covers a different facet of drug and alcohol addiction, including definitional

issues; an overview of the biological, psychological, and social aspects; various treatment approaches and trends; and a look at the politics of addiction treatment. Two concepts that form a theme of this book—the biopsychosocial-spiritual model and the strengths perspective—are introduced in this chapter. Subsequent sections of the chapter present an introduction to the art and science of addiction treatment and contemporary trends in treatment. (The intimate experience of substance misuse is shared by the addicts themselves, their children, and professionals in the field.)

WHAT IS ADDICTION?

Addiction is seen in the man in the detox unit of a hospital who is cringing from the pain of pancreatitis. He has no plans to quit drinking, his wife says. Addiction is evidenced in the two-pack-a-day smoker who coughs steadily from emphysema. Addiction is implicated in the actions of the trusted employee who was imprisoned for embezzlement; she needed more money to gamble, and when she won, she'd slip the money back.

The economic cost of addiction is incalculable. Certainly, billions of dollars are involved. There is the health toll of alcohol and drug misuse, the astronomical expenditures in running the war on drugs and in incarcerating the over one million persons whose crime was related to alcohol or some other drug. Catering to people's addictions is big business that ranges from marketing tobacco to special populations, to setting up state lotteries, to organized crime. So, what is addiction? According to the *Dictionary of Word Origins* (Ayto, 1990), the roots of the word addiction are in the Latin past participle *addictus,* meaning "having given over or awarded to someone or being attached to a person or cause." The original connotations were highly positive. Originally used as an adjective in English, its meaning has become increasingly negative over time.

The way in which substance misuse is perceived has important practical implications for how individuals with drinking and drug problems are treated—by their families, by medical and mental health professionals, and by the state. In the substance misuse literature, addiction is variously defined as a "moral and spiritual condition" (Dalrymple, 2006, p. 6); "poverty of the spirit" (Alexander, 2010, book title); "a sense of helplessness" (Dodes & Dodes, 2014, p. 136); "excessive appetite" (Orford, 2001, p. 2); "a bad habit" (Peele, 2004); and "the search for emotional satisfaction" (Peele & Thompson, 2015, p. 91); "a stigmatizing label" (Szasz, 2003, p. 7); "a disorder of choice" (Heyman, 2009, book title); and, more compassionately, as "a chronic relapsing brain disease" (Volkow, 2010, p. 5). From a systems perspective, Pycroft (2015a) defines addiction as "a complex adaptive system" (p. 57). And to Miller and Rollnick (2012), addiction is fundamentally a problem of motivation.

For an official definition, we first turn to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association [APA], 2013). The significance of the *DSM* cannot be exaggerated; the diagnoses that are finally agreed upon by the panel of experts are used almost universally by mental health professionals to diagnose and receive insurance reimbursement for treatment for behavioral disorders.

The starting point for conceptualizing and treating substance use disorders is terminology. The *DSM-IV-TR* avoided use of the term *addiction* in favor of the seemingly more scientific term *dependence*. We disagreed with this terminology, as shown in our choice of *Addiction Treatment* as the title for our book in its earlier editions. Now the members of the *DSM-5* substance-related work group have come around to the same conclusion. The term **drug dependence** will now be reserved for physiological dependence on a drug, for example, withdrawal symptoms. Along these lines, the decision was made to include cannabis withdrawal in the fifth edition.

"Substance-Related and Addictive Disorders" is the heading to be used for this section of the manual. The *DSM-IV* differentiated substance use disorders into substance dependence and substance abuse. As denoted by the APA (2000), the major difference between them was the presence of tolerance and withdrawal problems. We, in previous editions of this text, disagreed with this dichotomization and conceptualized addiction as occurring along a continuum of severity. There is some concern, however, as Straussner (2014) indicates that the expanded definition of addiction might result in pinning the "addict" label on persons who deliberately drink to get drunk, for example, or take other drugs to get high, but who are not on the road to addiction. Moreover, the changed diagnostic criteria may limit the provision of insurance coverage to only those whose symptoms are deemed to be severe.

In their extensive national survey of over 36,000 Americans, researchers from the National Institute on Alcoholism and Alcohol Abuse looked at drinking problems based on the new DSM-5 criteria (Grant, Goldstein, et al., 2015). They found that 14% of Americans have an alcohol use disorder, only 20% of whom had sought treatment. This compares with the previous estimates using the DSM-IV criteria 7% with alcohol use disorder. Although the researchers are optimistic that more people are now included as in need of treatment, the risk is in having too expansive a definition of alcoholism.

Addiction, according to our understanding of the term, denotes loss of control over a substance or behavior. Although intervention may be required for reckless and potentially harmful behavior, the diagnosis of addiction disorder may not be helpful or accurate for many acting-out youths. How practitioners handle this diagnostic change in the *DSM* remains to be seen. In any case, substance use disorder now joins the abuse and dependence criteria into one unitary diagnosis. Substance use disorder now is dimensional, in the sense that the larger the number of criteria met, the more severe is the disorder and the associated dysfunction. For all *DSM-5* disorders there is a range denoting severity that extends from: mild (two criteria), moderate (four criteria) to severe (six or more criteria). As provided by the APA (2013), these criteria are:

Substance Use Disorder

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by two (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. 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)
   4. 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 (*Note: Tolerance is not counted for those taking medications under medical supervision such as analgesics, antidepressants, anti-anxiety medications, or beta-blockers.*)

5. withdrawal, as manifested by either of the following:
   a. the characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria sets for withdrawal from the specific substances)
   b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms (*Note: Withdrawal is not counted for those taking medications under medical supervision such as analgesics, antidepressants, anti-anxiety medications, or beta-blockers.*)
6. the substance is often taken in larger amounts or over a longer period than was intended
7. there is a persistent desire or unsuccessful efforts to cut down or control substance use
8. a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
9. important social, occupational, or recreational activities are given up or reduced because of substance use
10. 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
11. craving or a strong desire or urge to use a specific substance

The DSM-5 also includes the addition of diagnostic criteria for conditions not previously included in the *DSM*, such as cannabis withdrawal and caffeine withdrawal. And the concept of "polysubstance dependence" is removed as a separate disorder. In recognition of the similarity of gambling addictive behavior to substance use disorders, according to the APA (2013), gambling disorder now has been reclassified and placed under the category, Substance-Related and Addictive Disorders as a behavioral disorder. Internet addiction and sex addiction are not included, however, but are placed in the Appendix as in need of further study. Previously, pathological gambling was listed as an Impulse Control Disorder and not considered as a form of dependence. Nevertheless, the diagnostic criteria for gambling disorder are relatively similar in the earlier and later versions of the *DSM* with a focus on preoccupation with gambling, sense of euphoria when anticipating a win, increasing signs of loss of control over this habit, and cover-up and deceit to hide one's destructive behavior.

The significance of the inclusion of gambling addiction in the DSM-5 should not be overlooked. As Peele and Thompson (2015) indicate, this is a recognition that addiction can occur with something other than psychoactive chemicals. And as neuropsychologist Marc Lewis (2015) argues, brain changes do take place with all forms of addiction, but the way it changes has to do with learning and development, not only a response to the chemicals consumed.

Before we progress any further into the maze of classification and word usage, let us consider just how far into the depths of madness the addictive urge can lead us. In *A Common Struggle: A Personal Journey through the Past and Future of Mental Illness and Addiction*, Patrick J. Kennedy (2015), the son of the late Senator Edward (Ted) Kennedy writes in moving terms of the grip that alcoholism had on his whole family and opiate use and drinking had on himself:

> Amid this daily grind of self-medicating, I would intermittently go out for a planned "lost night" to blow off all the stress. I went out with friends, had five Glenlivets right away, almost blacked out, and just kept drinking; it wasn't uncommon for me to have fifteen to twenty drinks in an evening. . . . I remember after one of these nights I had to wake up and give a speech to a group of drug and alcohol counselors. (p. 220)

In his book on lifestyle theory, Glenn Walters (2006) strenuously objects to the use of such criteria that relate to a loss of control over a substance; to the disease model of Alcoholics Anonymous, which he finds disempowering; and to the word *addiction* itself. He proposes an alternative concept—the lifestyle concept—that allows for an emphasis on personal choice. The lifestyle concept, however, in our opinion, has problems of its own, chiefly in its rejection of the biological component in behavior that impedes the ability of many individuals to make healthy choices. A too-heavy emphasis on individual responsibility in the use of mood-altering substances can play into the punitive response so much in evidence regarding drug use in U.S. society. (We delve into this matter more in a later section, Treatment Trends.)

To define addictive behavior in terms of a lack of responsibility is fraught with political and treatment difficulties, as Joranby, Pineda, and Gold (2005) and Lewis (2015) suggest. If eating disorders, for example, are viewed as stemming from a lack of self-control, treatment resources will be hard to come by. And there is every indication of a close similarity between dependence on drugs and dependence on food. That food is a powerful mood-altering substance is borne out in scientific findings about brain reward systems and neurotransmitter aberrations, as, for example, among bulimics. Classification of eating disorders as an addiction, as these authors further argue, would help in our prevention and educational efforts. Many of the addictive chronic disorders, such as compulsive overeating and pathological gambling, are characterized by loss of control, relapse, compulsiveness, and continuation despite negative consequences. The *DSM-5* (APA, 2013) now does include binge eating disorder under the category, "Feeding and Eating Disorders" and although not as an addiction, its characteristics of marked distress, and feelings of lack of control closely resemble the characteristics of substance use disorders. Since food is a substance with addictive qualities, it could be classified as a substance use disorder. At least now, people who are endangering their health and relationships due to severe overeating can obtain the medical or psychological treatment they need thanks to the inclusion of this condition in the diagnostic manual.

The addiction concept, as stated previously, perceives addiction as occurring along a continuum. Severe life-threatening dependence may be placed at one end, the misuse of substances somewhere in the center, and a use of substances without problems at the other end. Individuals or their behaviors can be placed along a continuum according to levels of misuse or addiction at various points in their lives. The revised version of the *DSM* thankfully has discarded the overly simplified the either–or categories of substance use that existed in the previous edition to now help us appreciate the individual dimensions of human behavior. From this perspective there are no rigid boundaries between normal and pathological populations or between common diagnostic categories.

From a contemporary perspective, in marked contrast to the earlier view of alcohol dependence as a progressive and irreversible disease, most problem drinkers move in and out of periods of excessive drinking. And we know that the majority of people who meet the criteria for addiction in their teens and 20s have become moderate drinkers or drug users by their 30s, as Harvard psychologist Gene Heyman (2009) informs us. And most of them will never set foot in a treatment center. We need to keep in mind, of course, that people who present themselves at specialist treatment agencies (often by court order, as is typical in the United States) are apt to have severe problems including a history of legal violations and to represent the extreme end of the continuum. For this reason, we should refrain from generalizing about addiction and recovery to the general population based on the biased sample from the treatment population when more than three-fourths of all persons with addiction problems, as Heyman estimates, never enter treatment and recover on their own.

We can take issue with the *DSM,* even in its improved format, for one other reason as well: the incompatibility of such labeling and diagnosis with the tenets of the strengths perspective. As the name would indicate, **the strengths perspective** is an approach geared to look for strengths rather than liabilities, not because they are "truer" but because an approach geared toward a person's possibilities is more effective than an approach focusing on a person's problems. The entire mental health field, as strengths-based theorists Rapp and Goscha (2012) indicate, is "dominated by assessment protocols and devices that seek to identify all that is wrong, problematic, deficient, or pathological in the client" (p. 93). Still, in the United States, mental health practitioners, rehabilitation counselors, and social workers in many fields use APA criteria for substance use disorders as a means of obtaining insurance reimbursement and vocational rehabilitation services for their clients (Heyman, 2009; Lewis, 2015). The physical, psychological, and social aspects of addiction disorders, as spelled out in this diagnostic manual, can be helpful in assessment and communication among professionals and in giving testimony before the court.

A welcome change to the *DSM* is the use of the term *substance use* in place of *substance abuse*. A semantic problem with the term *substance abuse* is that the substance is not being abused. The individual may be committing self-abuse, but the substance is merely consumed or otherwise ingested; it is hard to abuse an inanimate object, after all. The terms *substance use* and *substance misuse* are more accurate and even more sensible, and they are used in this text to refer more specifically to general and harmful drug use, respectively. The terms *substance abuse treatment* and *substance abuse counseling* are used because of their familiarity rather than due to any descriptive accuracy. *Addiction treatment,* however, is our preferred term.

The concept of addiction offers us the flexibility to cover various forms of problematic behavior. It is also highly compatible with the biopsychosocial model, which attends to the *subjective* as well as objective factors in human behavior. **Addiction** can be defined as a pattern of compulsive substance use or behavior. *The Social Work Dictionary* (Barker, 2014) defines addiction as follows:

> ADDICTION: Physiological and psychological dependence on a behavior or substance. Behavioral addictions (sex, gambling, spending, obsessive Internet use) and consumptive addictions (alcohol, drugs, food) often have similar etiologies, prognoses, and treatment procedures. (p. 6)

Although the tendency is to equate addiction with loss of control, the extent to which the individual is truly beyond self-control cannot be proven but can be inferred only from external behavior or from an individual's self-reporting of this phenomenon. To what extent addiction is an involuntary disease is open to question. Heyman (2009), for example, argues that addiction is not an illness; the individual's decision to continue to use a harmful drug or to abstain depends on what the stakes are. People who have incentives to remain drug free, such as a good job, are more likely to do so than are people who have less to lose. Most addictions experts would agree with this supposition; what they would disagree with is the presupposition stated in the title of Heyman's book, *Addiction: A Disorder of Choice*. Few people, in fact, would choose to have any disorder, much less to be addicted to a substance or behavior. What's missing but needed in scientific research is a way to determine the point at which self-control over a craving for an addictive substance has gone beyond the level that it can be controlled. Without getting inside the mind of a drug user, compulsive gambler, or chain smoker, we do not know how hard it is to resist temptation. We will never be able to read people's minds, but we can gain a great deal of insight into this dimension from the recent advances in brain research. Through newer technologies such as magnetic resonance imaging (MRI), neurologists can now