CHAPTER 1

Why Treat Addiction?

Treating addiction is not a matter for specialists alone but should be of vital concern for all professionals who work in health care, behavioral health, and social services (Office of the Surgeon General, 2016). The sheer worldwide prevalence of addiction problems and the suffering that they cause would be reason enough (Gowing et al., 2015; Whiteford et al., 2015). Alcohol use disorders alone afflict 14% of the U.S. population in any given year (Grant et al., 2015), with an overlapping 20% of the population addicted to nicotine (Chou et al., 2016) and 4% with other diagnosable drug use disorders (Grant et al., 2016). Lifetime prevalence rates from these same studies are higher still, of course: 29% for alcohol, 28% for nicotine, and 10% for other drug use disorders. These are the most common disorders encountered in behavioral health care, even more prevalent than depression. Other addictive behaviors such as pathological gambling and compulsive buying do not involve a drug, but each afflicts up to 5% of the population (Maraz, Griffiths, & Demetrovics, 2016; Petry & Armentano, 1999). Furthermore, substance use disorders (SUDs)—particularly use of tobacco and alcohol—are by far the leading preventable cause of death in the Western world. Treating addictions is quite literally a matter of life and death. Yet these very common, disabling, and high-mortality conditions often go unnoticed and untreated, a potentially life-threatening clinical error (Degenhardt et al., 2014; Gossop, 2015; Liese & Reis, 2016; Roerecke & Rehm, 2013).

A second reason is that addictions are closely intertwined with the problems that bring people into the offices of medical, mental health, social service, and correctional workers. In most populations seen by such professionals the prevalence of SUDs is even higher than in the general

population. In fact, people with addiction problems are far more likely to be seen in health care and mental health services than in specialist treatment programs (Edlund, Booth, & Han, 2012). Thus, aware of it or not, most health and social service professionals are already treating the sequelae of addictions without directly addressing a significant source of the problems.

Why not just refer people with addictions to specialist programs? There is a role, of course, for specialist care, particularly when treatment is closely integrated with other needed services. Yet there is a downside to regarding these disorders as separable, to be treated by unique specialists (Office of the Surgeon General, 2016). Patients are often reluctant to seek care from isolated and stigmatized addiction treatment programs, and may encounter other obstacles such as waiting lists, given the limited supply of specialist treatment. In the United States, only about one in five people with SUDs ever receives *any* help for this condition during their lifetime (Chou et al., 2016; Grant et al., 2015, 2016). Many people with SUDs also have concomitant mental and/or medical disorders that need attention. The presence of concomitant disorders complicates the treatment of addictions, and vice versa. The normal management of chronic medical conditions is not limited to episodes of specialist consultation, but is an ongoing process within a primary care medical home model. For all these reasons, there is movement toward integrating the treatment of addictions within a larger spectrum of health and social services (Compton, Blanco, & Wargo, 2015). In 2010, the U.S. Congress made addiction treatment an expected and fully reimbursable service within U.S. health care, which had already been the norm in Canada and Europe (Humphreys & Frank, 2014).

By the time people are willing to accept specialist addiction treatment or are compelled to do so, their problems have often reached a severe level. Typically they have already been seen repeatedly in health care, mental health, social service, and/or legal and correctional systems for conditions directly or indirectly related to their substance use. Yet their addiction problems were either unrecognized or not effectively addressed. It is clearly possible to identify and treat addiction problems in more general practice settings, and it may even be easier to do so because people tend to turn up in health care and social services at earlier stages of problem development, long before they may accept referral to specialist addiction treatment.

Perhaps the most persuasive reason for addressing addictions, however, is the one that attracted and has held the three of us in this field over the decades: *addictions are highly treatable,* and a range of effective methods are available. When people with addictions recover they *really* get better! You don't need subtle psychological measures to see the change. They look better. They feel better. Their family and social functioning tend to improve. They are healthier and

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happier. They fare better at work, school, and play. And, contrary to public impressions, most people *do* recover. The mistaken impression that addictions are untreatable has been a source of the shunning, negative attitudes toward, and discrimination against, people with SUDs (McGinty, Goldman, Pescosolido, & Barry, 2015). We have quipped that if you must have a chronic illness, addiction would be a good choice because it is so treatable! With the menu of effective methods now available it is rewarding indeed to treat addictions in practice.

Why *Not* Treat Addictions?

So why, then, have so many professionals chosen not to address this very common, life-threatening, and highly treatable class of disorders that are so intertwined with other problems? The answer lies, in part, in several misconceptions.

First, some practitioners believe treating addictions requires a mysterious and highly specialized expertise that is entirely separate from their own. In fact, as will become clear in the chapters that follow, the psychosocial

BOX 1.1. Personal Reflection: Why Addictions?

What draws people into the field of addiction treatment? Often it is firsthand experience, and that was certainly the case for me. I departed for college at the same time my younger sister entered an inpatient substance abuse treatment program. The anxious feeling of being on my own for the first time was compounded by the heartache of knowing that my sister was also living away from home and struggling to overcome addiction. When I visited her a few months into treatment, I saw in her a profoundly changed life: her values had shifted and she had found peace with herself.

But *how* did she change, I wondered? When I asked my sister this question, she shrugged and responded that it was hard to explain—something just happened. No one, including my sister, seemed overly concerned with exploring this question, with understanding why. They were content to simply appreciate the results of this change. But I remained curious: What had caused this significant and sudden change that allowed her to overcome addiction?

In my clinical work now, as I hear each client's story and watch changes occur throughout our work together, I continue to wonder how it is that people change. How can I work with people most effectively to help them enact and maintain change? Why is it that some clients like my sister do change profoundly, while others do not, at least during the time in which our lives intersect? It's a privilege to be a companion and witness to such important life changes, and fascinating to continue pondering questions like these along the way.

—A. A. F.

treatment methods with strongest evidence of efficacy are often familiar to behavioral health professionals who treat other disorders, and are commonly part of the ordinary training and practice of many professionals: person-centered listening skills, behavior therapies, relationship counseling, good case management, and motivational interviewing. Effective medications are now available to aid in treatment and long-term management of these chronic conditions. The major professional health disciplines have already contributed and will continue to add much in understanding and treating addiction. To be sure, there are some facts and particular skills that you need to know when addressing SUDs. Providing that background is a primary purpose of this book.

A second challenge is time. Counselors and psychotherapists may have 50-minute hours, but health care appointments are often much briefer, with many other tasks to be accomplished. Those who work in contexts like primary health care, family medicine, and dentistry may understandably see SUDs as "not my job"—falling outside the realm of possibility within time constraints. Yet many other complex chronic conditions are followed and treated within the scope of routine care, and it's possible to do what you can within the time that you have available. Medical professionals may have only a few minutes to address substance use concerns, but it is clear that even this amount of time when used well can make a difference (see Chapter 9). Similarly, those who work in mental health or probation services have other issues to address and may view addictions as beyond their professional responsibility or expertise, but alcohol/drug problems are closely intertwined with mental health and correctional concerns.

A third possible obstacle is the misconception that in order to be effective in treating addictions, one must be in recovery oneself. This is not an expectation in any other area of health care. Although a substantial minority of professionals who treat addictions are themselves in recovery, ample evidence indicates that therapeutic effectiveness is simply unrelated to one's own history of addiction. Those who are in recovery are neither more nor less effective than other professionals in treating addictions, even when delivering 12-step-related treatments (Project MATCH Research Group, 1998e). Rather, effectiveness is related to aspects of counseling style (see Chapter 4).

Then there is, for some, a social stigma associated with addictive disorders, sometimes linked to pessimism about the possibility of change (Schomerus, Corrigan, et al., 2011; Schomerus, Lucht, et al., 2011). This stigma was exacerbated by pejorative writings in the mid-20th century suggesting that people with addictions are pathological liars, sociopaths, "in denial," and highly defended by chronic immature defense mechanisms. One could judge that these disorders are self-inflicted by behavior, but that is also true of many other health problems. In truth, people with SUDs represent a full spectrum of personality, socioeconomic status, intelligence,

and character. Research provides no support for the belief that these individuals differ from others in overusing certain defenses, and they surely have no corner on dishonesty. One reason we, the authors, have remained in this field is that we have genuinely enjoyed working with people who are struggling with addictions, and also working with their loved ones. It is rewarding, lifesaving work.

A Continuum of Care

No disease is overcome merely by treating those already suffering from it. Yet care for SUDs has often been limited to identifying and treating those who are the most severely affected. A reservation that we share regarding a "brain disease" model of addiction is that it tends to focus on diseased individuals rather than on the environmental and social influences that can have such large impact on addiction problems (Gartner, Carter, & Partridge, 2012; Heather et al., 2018). Health care for other chronic life-threatening conditions like diabetes, hypertension, and heart disease normally includes universal and selective prevention as well as acute care, addressing the full spectrum of severity. Selective prevention moves upstream a bit to work with people who are particularly at risk of developing problems. A health care example is the identification of "prediabetes" metabolic syndrome, finding people who are likely to develop diabetes within a few years to help them make life changes early before the disease emerges fully or results in organ damage. Universal prevention addresses a whole population in hopes of reducing prevalence.

SUDs are widespread but they are not randomly distributed. Some people are at much higher risk than others. It is abundantly clear, for example, that biological relatives of people with SUDs are at higher risk themselves. This is true even when children are adopted at birth and did not know their biological parents. No one or two genes explain hereditary transmission; instead a range of genes contribute to risk and protective factors (Dick & Foroud, 2003). One well-established heritable risk factor for alcohol dependence is tolerance: a relative insensitivity to alcohol, the ability to "hold your liquor" without feeling or appearing to be as affected as others are (Joslyn, Ravindranathan, Busch, Schuckit, & White, 2010; Schuckit & Smith, 2010). There are also particular populations at high risk. A good example is offenders with a history of SUDs who are being released from prison. Release is a key transition point where suddenly restored freedom invites a return to substance use, with increased risk of drug-related death (Merrall et al., 2010), in part due to reduced tolerance and inadvertent overdose.

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As with diabetes and other chronic illnesses, different treatment goals and methods are effective for people at different points along the severity continuum (Kiefer, Jimenez-Arriero, Klein, Diehl, & Rubio, 2007). Educational strategies that can be effective in universal prevention of tobacco and alcohol use may be ineffective once nicotine or alcohol dependence is established. One universal prevention strategy has been developmental: to delay the onset of alcohol, tobacco, and other drug use. People who do not begin drinking, smoking, or using illicit drugs before the age of 18 are much less likely to develop disorders related to these drugs. As an example of selective prevention, consider that about 20% of men and 10% of women in the United States drink more than the National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommended limits, placing them at risk for adverse health or other consequences. Helping heavy drinkers to moderate their alcohol use is now recommended as standard practice in health care (National Institute on Alcohol Abuse and Alcoholism, 2005).

To encourage a continuum of care we will describe science and practices appropriate at various levels of problem development. Because SUDs occur all along a continuum of severity it would be ideal to find and intervene with people who are toward the lower end of the spectrum. An important reason for early intervention is to prevent the tragic consequences of heavy drinking or other drug use that require only a single occasion of intoxication, well before dependence sets in (Hingson, Heeren, Winter, & Wechsler, 2005). Even very low blood alcohol levels increase the risk of severe and fatal vehicle crashes (Phillips & Brewer, 2011). SUDs are involved in a substantial proportion if not a majority of deaths from drowning, falls, fire, hypothermia, firearms, cancer, stroke, traumatic injury, suicide, vehicular crashes, pedestrian fatalities, and of course overdose (Laslett, Dietze, Matthews, & Clemens, 2004; Stinson & DeBakey, 1992). Alcohol and other drug-related incidents constitute the leading cause of death before the age of 40. Beyond mortality, intoxication increases incidents of poor judgment that can have lifelong consequences, including injury-related disability, sexually transmitted infections such as HIV, illicit drug use, marital infidelity, child abuse, sexual assault and other violence, felonies, and fetal alcohol effects. Early intervention can shorten the window of vulnerability to such tragedies.

Alcohol and other drug-related incidents are the leading cause of death before the age of 40.

An Integrative Approach

The approach we describe in this book is integrative in at least four ways. As the chapters to follow reveal, this approach is (1) comprehensive and evidence-based, (2) multidisciplinary, (3) holistic, and (4) collaborative.

Comprehensive and Evidence-Based

Our integrated approach is first of all grounded in clinical science. Professional and public opinions abound regarding addictions. Such opinions, including our own, have often proved inaccurate when carefully examined in well-designed scientific research. In this book we have sought as much as possible to differentiate opinion from science and have given primary emphasis to the substantial base of scientific evidence that is now available to guide practice.

The approach we describe is also comprehensive in that it places treatment within a larger context of scientific knowledge about the nature of addictions, motivation for change, assessment and diagnosis, mutual help groups, case management, and prevention (Miller & Carroll, 2006). We address the full spectrum of addiction treatment, from crucial aspects of the first contact to long-term maintenance, as befits the management of a complex and often chronic condition.

Multidisciplinary

Second, we draw upon a range of professional perspectives including those from counseling and family therapy, medicine and nursing, pastoral care, psychology, and social work. In an ideal world, treatment might be delivered by a collaborative team of professionals representing these differing areas of professional expertise. In reality, treatment often relies upon a single or primary therapist whose role includes providing or serving as liaison with this range of services.

Holistic

Third, we seek in our integrated approach to consider the whole person: biological, psychological, social, and spiritual. Some think that going to a specialist for treatment of addiction is like going to a dentist for care of one's teeth. Yet addictions involve and affect the whole person and those around him or her. They are biological *and* psychological *and* social *and* spiritual. By nature of disciplinary training you may be prepared to deal best with one of these dimensions. Those who treat addictions, however, will meet all of these aspects of the person.

Collaborative

Finally, we advocate the integration and coordination of addiction care with the broader range of health and social services, a trend that has already begun. Sequestering addiction treatment in isolated programs has tended to sustain stigma and discourage treatment. As previously mentioned, we

favor involving a broad range of professionals in direct care for people with SUDs. In truth, most health and social service professionals are already seeing people with addiction problems, though they may be unaware of it or regard such problems as someone else's concern. In complex disorders like addictions, where attention is needed in so many spheres, care can begin in almost any area.

Taken together, the chapters of this book represent pieces of a puzzle, the building blocks of an integrative approach to addiction treatment. They describe a system of care that is comprehensive, evidence-based, multidisciplinary, holistic, and collaborative. That's a tall order for us in writing this book, and also for you in practice. Taking the attitude of "My way or the highway" and offering only one brand of treatment is a lot simpler but does a disservice to clients in failing to use the vast amount that has been learned about how to help people with addictions. An integrative approach is a challenging goal, a direction in which you can keep growing throughout your professional career. That has certainly been our ongoing experience, and we are grateful for this opportunity to pass on, for your consideration, what we have learned along the way.

KEY POINTS

- SUDs are prevalent in the general population, and even more so among people seen in health care, social service, and correctional settings.
- Early intervention is possible in the context of ongoing care and can prevent the development of more severe problems and consequences.
- SUDs are highly treatable. A majority of affected people do recover.
- An encouraging menu of effective evidence-based treatment methods is available, no one of which is best for everyone with addiction problems.
- People with SUDs commonly have other significant psychological, medical, and social problems, and coordinated treatment of these problems is best.
- Treating addictions should be a normal part of general health care and social service systems and not be limited to specialist programs.

Reflection Questions

- Of the people you normally serve (or anticipate serving), what percentage would you estimate have alcohol, tobacco, or other SUDs?
- What most encourages or motivates you to work with people whose lives are affected by addiction and with their family members?
- In your community, where are people with alcohol/drug problems most likely to turn up seeking help or services? (Hint: It's not in addiction treatment programs.)

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