ADDICTION TREATMENT: WHAT ON EARTH ARE WE DOING?

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The field of Clinical Psychology has advanced considerably in the last several decades. From a field dominated in the early part of the century by nebulous and unsubstantiated theories of human behavior and psychotherapeutic techniques of questionable efficacy, clinical psychology has evolved into a discipline dominated by sound, empirically driven interventions. At last psychology can join the table of other sciences, having demonstrated that its constructs can be operationalized, investigated and validated and that there are some therapy treatments that actually work! To mention but a few recent advances; intricate scientifically based models of emotion which explain maladaptive mood disorders, treatments for depression and anxiety that focus primarily on peoples distorted thinking, behavioral parent training methods for impulsive children and extremely precise near-psychological assessment tools that can map out specific areas of brain damage.

One area which has experienced a great deal of research attention recently is substance abuse. Over the last two decades our understanding of addiction has advanced tremendously. Some recent advancements include: assessment instruments which can help measure severity of substance abuse, individual antecedents for relapse and even level of motivation for change. Other advances include new models of addictive behavior which take into consideration social learning, beliefs and memory as contributing to the vulnerability to addiction problems. Further, research has provided evidence as to which treatments appear to be most effective for various levels of substance abuse severity.

Unfortunately (and quite curiously) most of the advancements in this area have not made it out of the Ivory tower. There are volumes of research in this area, most of which are not applied in clinical settings. This inequity has always ailed the field of psychology and in many ways appears to be singular to it. Research and clinical practice are often on opposite sides of the fence.

A medical analogy should drive home the significance of my point. Imagine a proven advancement in the treatment of Rheumatoid

arthritis being published in the December issue of The Journal of the American Medical Association (JAMA). Suppose that this article suggested that, based on a number of clinical trials, the new pharmacological treatment is considerably more effective than an existing treatment. How long do you think that this new treatment would take to become a standard in care? My guess would be, if not the month of the issue, several months before! It would be quite unacceptable for a physician to continue using a method that has been proven to be less effective than another, given the symptom picture. In fact many would deem the behavior unethical and perhaps evidence of malpractice.

In the field of psychology things are much different. There has always been a vast separation of research and practical application. If the practice of psychotherapy mirrored its own scientific knowledge base, things would be much different. For example, therapists would no longer administer silly inkblot tests (given that there is no conclusive proof of their ability to detect anything), non-directive "play" as a model of therapy for children would not predominate and large hospitals would not be reimbursed by insurance companies for placing individuals with non-severe alcohol problems in intensive and expensive inpatient and "partial hospitalization" programs.

Thankfully, things are changing in some realms of psychology. for example, to not administer cognitive therapy to a depressed person, in lieu of another technique like long term non-directive psychodynamic therapy, would raise many eyebrows in the mental health field. Without a doubt this technique has been supported by research to be the most effective psychotherapeutic intervention for unipolar non-psychotic depression.

However, the field of substance abuse treatment is lagging significantly. The field of addiction has been dominated by a model that has not changed much since its beginning. I am referring to the disease model and the 12-step model of recovery. It has withstood the test of time, and for some unsettling reasons. First a brief history of American Drinking:

Alcohol has been a part of American culture since its beginning. The meaning of drinking, however has undergone changes in the course

of American history. As Stanton Peele points out (Peele, 1989) in his sobering book, The Diseasing of America, Americans were not particularly concerned about alcohol problems in colonial times. Rather, drinking alcohol was very much woven into people¹s lifestyles. It was considered a part of normal life and was therefore considered healthy. Most social gatherings included alcohol, even when children were present. This is not to say that drunkenness, with all of it's inappropriate behavioral referents did not occur., but it was conceptualized differently:

"Drunkenness was not so much seen as the cause of deviant social behavior--in particular crime and violence-as it was looked at as a sign that someone was willing to engage in such behavior." (p.36).

From the turn of the 18th century and into the third decade of the 19th century, there was a tremendous increase in the population and in industry. The tight knit community and the tight knit family virtually disappeared. Taverns were no longer a place for family gathering; rather, the saloon was the place where the overworked American male went to get drunk and to gamble. Violence was not uncommon. It was under these conditions that Americans became acutely aware of the effects of alcohol abuse. But rather than focusing on the social problems and inequities of the time, drink was blamed.

From the turn of the 18th and into the first half of the 19th century America¹s population increased tremendously as did industry and lifestyle. The tavern lost its place as the family gathering place, and the saloon replaced it. It became a place where primarily men went to get drunk after a tremendously dissatisfying day. The American Temperance Movement was established around this time. This movement Promulgated the idea that alcohol was the root of all evils and pushed abstinence as the only cure. The movement was quite effective, about 1 million drinkers quit.

Benjamin Rush, a physician (who incidentally signed the Declaration of Independence), advocated the temperance movement and was the first to take a stance on the idea that chronic drinking was a disease. It should be added that his stance was based on a personal conviction as opposed to scientific evidence.

The temperance ideology was not the same as today's disease model. Temperance mentality suggested that everyone should abstain from alcohol because the substance is inherently poisonous. Everyone, according to this doctrine, could develop the disease of alcoholism.

As Peele points out, the key element was the same as current ideology however, "loss of control", that the alcoholic, in the throes of the disease is helpless and incapable of making rational decisions. The only cure was a religious conversion that led the drinker to swear that he would never drink again.

Following the Civil war, the temperance movement became tremendously invested in the prohibition of alcoholic beverages. Prohibition went into effect in 1920. During these thirteen years, cirrhosis deaths and all alcohol-related fatalities dropped for the nation.

The negative effects of prohibition, in addition to all of the opportunistic crime it created, were that distilled spirits replaced beer and wine as most popular drinks because they were more concentrated and easier to smuggle. Families didn't drink together, and food was not served with alcohol. The whole point of going out to drink was to get drunk. (See J.P. Morgan, M.D for a chilling account of the ill effects of prohibition, past and present). Needless to say, Prohibition failed to clean up America and was repealed in 1933.

Two years later, AA was created by Bill Wilson, a stockbroker and Robert Smith, a physician. The proposition was that the alcoholic is unable to control his or her drinking and that only through the support and help of other alcoholics could he keep from spiraling into the insidious disease which would inevitably lead to death if allowed to continue "untreated". What made AA philosophy different from Temperance philosophy is that it claimed that alcoholics were a special group who had an inherited allergy and that alcoholism was a lifetime condition (this explains why those in AA consider themselves "recovering" even with 10 or 25 years of sobriety!

Elvin Jellinek M.D., using pseudo-scientific methodology, endorsed the disease model, and by the 1940's alcohol as a sickness was the

law of the land.

The idea of abstinence as the only cure for the insidious disease of alcoholism has stuck. I am not suggesting that it is "bad" to have AA. The model has been a life saver to many. It just isn¹t for everyone. Further, the extrapolations of AA into other areas has created an insidious marketing of twelve step groups for every known maladaptive behavior to mankind. Peele states:

"The United States is singular in its sense of the desperateness of the alcoholics condition and the irreversibility of alcoholism. Today, no other country in the world has as active an alcoholism establishment as the United states, treats as many people for alcoholism, commands as much media attention for the problem or has gained such wide acceptance for the conception that alcoholism is a disease. Moreover, no other nation has taken the implications of disease theories of behavior as far as the United States or applied the disease model to as many new areas of behavior." (sexual addiction, codependency etc.) (Peele,1989, P.54)

Things haven't changed much in the public mind since the promotion of AA and the disease model in the 1930s. Without conclusive evidence to support the disease model proper, anyone having problems with alcohol must submit to the disease model and abstinence as a goal or be denied services. Disease model approaches to alcohol abuse predominate in this country. In fact you would be hard pressed to find more than one or two major treatment facilities in the nation that advocate a non-disease model approach to alcohol abuse--They are there however, few and far between, mostly in university settings and largely unmarketed.

This simply is not the case abroad. In the Netherlands, for example, treatment approaches are scientifically based, largely outpatient, individualized and AA is actually only one of many types of interventions depending on the person's individual needs and goals. The key element that differentiates treatment models in other industrialized countries from ours is that treatment is "broad spectrum and individualized". Treatment is catered to the individual's needs, goals and personal ideologies, rather than the railroading that goes on in this country. The whole idea is "Harm reduction", not

indoctrination!

Many people, even professionals, believe that disease model treatments have a great deal of empirical support. William Miller and his colleagues (1986) recently Conducted a thorough review of the alcohol abuse literature. After evaluating over 600 studies, they discovered, much to their surprise that there ARE dozens of treatment approaches to alcohol abuse, internationally. They were shocked to discover that though there are some that have been demonstrated to be more effective than others, these approaches are rarely used in treatment programs in the United States.

In fact, the list of elements that are typically included in alcoholism treatment in the US evidenced a commonality: virtually all of them lacked adequate scientific evidence of effectiveness. These techniques include: confrontation, non-directive group therapy, intensive inpatient rehabilitation and A.A. Techniques which have demonstrated effectiveness include: cognitive behavioral interventions, social skills training, behavioral marital therapy and brief motivationally oriented interventions which tap into existing skills and prepare people to change on their own. Also receiving a great deal of empirical support are moderation training interventions which help people whose alcohol problems are non-severe learn how to cut down their alcohol consumption. This technique in particular has angered so many people in the mental health field that it may be a decade or more before moderation training becomes acceptable in the US.

So why the inequity? Why do treatment programs continue to emphasize methods which are not empirically substantiated?

1. Separation of research and clinical application. Researchers are typically not clinicians and clinicians are not typically researchers. The scientist practitioner in the addiction field is a rarity indeed. Researchers in the area of addiction are more interested in publications, tenure etc. and not in marketing their results in an applied setting. Therefore, results of scientific studies stay in the ivory tower and don't make it to the street.

2. Strength of disease, medical model of alcoholism. Finagrette

(1987) suggests that many institutions are quite invested in the disease model continuing to rule the land.

a. Hospitals rely on it for income (a disease is worth more money than a bad habit).

b. The Alcohol business is invested in it (only a small group of Americans have the disease--the rest of you can drink to high heaven! Buy Seagrams!).

c. The model fits into 20th century approach to psychotherapy. (Don't take responsibility, find someone to blame, e.g. toilet training, victimization, disease-- think about how many addiction analogies have been made in recent years: sexual addiction, codependency, workaholism). I recommend E. Fuller Torrey, M.D., "Freudian Fraud" or Sykes "A Nation of Victims" for elaboration on this issue. Never has victimhood ever been stronger.

d. Lastly, Addiction treatment professionals are typically M.D.s , social workers and paraprofessional recovering addicts and alcoholics. (It is appalling how few Ph.Ds specialize in addictive behavior--even among those who deem themselves behaviorists or cognitive behaviorists. In fact, only 1% of member s of the prestigious Association for the Advancement of Behavior Therapy (AABT) consider addictive behavior a primary specialty. The figure is less for the American Psychological Association!

Though I have painted a dismal picture, I must say that I have a tremendous amount of faith that change is on the horizon. Certainly few are missing the fact that we are in the midst of massive health care reform. I predict a paradigm shift, in which the discrepancy between research and application will become clear to those who are footing the bill. It will become impossible to continue offering the spectrum of individuals with alcohol related difficulties one intensive, expensive and scientifically unsubstantiated mode of treatment.

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