CHAPTER 1

Why Treat Alcohol and Drug Problems in Psychotherapy Practice?

A basic premise of this book is that all mental health practitioners, regardless of professional discipline or specialty area, should have the knowledge and skills to competently address alcohol and drug problems in office-based psychotherapy practice. This premise is based on many compelling reasons, not the least of which is how common substance use disorders (SUDs) are among people with other mental health problems and how much preventable human suffering can be attributed to unrecognized and untreated SUDs. Why, then, have so many psychotherapists overlooked or deliberately chosen not to address these highly treatable problems in their clinical practices? The answer lies in a myriad of obstacles, past and present, that discourage mental health therapists from including SUDs among the behavioral disorders they routinely treat in private practice.

One such obstacle stems from a lack of formal training in this area. A majority of mental health professionals in practice today (ourselves included) received little if any formal training in the diagnosis and treatment of SUDs during graduate school, internship, or beyond. Despite the widespread prevalence of SUDs in all clinical populations, graduate and postgraduate training in the mental health professions (psychology, psychiatry, social work, mental health counseling, etc.) have historically failed to provide students with specific coursework, clinical supervision, research opportunities, and specialization tracks in this area. These training deficits perpetuate the mistaken belief that SUDs represent an entirely different type of behavioral disorder from those that psychotherapists should be prepared to treat and that the clinical skills needed to treat these disorders lies outside the realm of what mental health clinicians should know how to do. Accordingly, some therapists summarily decline to treat SUDs in

their practices based on the mistaken belief that they are best treated by specialist programs. This is quite unfortunate, considering that clients with SUDs are likely to respond well to intervention by therapists with whom they have already established good rapport and at least the beginnings of a good working alliance. The fact is, therapists are in an *excellent* position to help clients come to grips with substance use problems and develop the motivation to address it. Even in cases in which an individual's substance use problem is more severe than a therapist feels adequately prepared to deal with, it is a critically important task to help that individual to develop a more realistic view of the problem and possible goals and strategies for change and, if needed, to accept referral for further assessment and/or specialty treatment.

Another obstacle is a stigmatized view held by many psychotherapists (and other health care professionals) of individuals with serious alcohol or drug problems. Historically, substance users have been stereotyped as resistant, noncompliant, impulsive, unmotivated, and unresponsive to psychotherapy. In addition, they are presumed to be pathological liars and sociopaths who are difficult and frustrating to treat. These negative stereotypes generate self-fulfilling prophecies. Clinicians not having the confidence, interest, or skills to properly address SUDs are not likely to do well with these clients, and they may feel frustrated or "out of their league" when attempting to help them. These experiences serve only to confirm negative stereotyping and reduce the therapist's motivation to treat clients with addiction or substance use problems. Regrettably, many practitioners have not had a chance to see that many of the behavioral problems associated with chronic substance use often subside or cease after a period of sustained abstinence or markedly reduced use—suggesting that in many cases these problems are secondary to substance use and not necessarily indicative of a personality disorder. Antisocial, narcissistic, and other serious personality traits certainly do exist among people with SUDs, but only in a small minority of the clinical population. There is little, if any, empirical support for the notion that a predisposing "addictive personality" is common to all or most people who develop SUDs. To the contrary, it appears more likely that chronic use of psychoactive substances itself *induces* stereotypic distortions in behavior and personality as a result of profound biochemical changes in the brain caused by substance use itself, combined with the extraordinary behavioral demands of maintaining an active addiction—a socially stigmatized problem—while concealing it from others.

Another reason why therapists avoid treating SUDs is concern about the inherent risks of taking clinical responsibility for people engaged in dangerous behaviors that may cause severe crises and ominous consequences. There is no doubt that the risk of suicide, automobile injuries or fatalities, serious medical conditions, and other adverse consequences is higher among people with SUDs. It is understandable, therefore, that practitioners

unaccustomed to treating SUDs would avoid dealing with these patients—yet another reason why improving the training and education of mental health professionals in this area is so important.

Despite these obstacles, there are many compelling reasons why psychotherapists *should* treat SUDs routinely in their practices.

- ***Unmet demand for treatment.*** The demand for treatment of SUDs is greater than what specialty addiction treatment programs and practitioners alone can provide. The negative impact of untreated SUDs has been made glaringly obvious by the current opioid crisis. Although it is neither necessary nor practical for all therapists to become addiction specialists, there are certain facts and specific skills that mental health clinicians need to know to attain the confidence and competence they need to address alcohol and drug problems in their practices. Providing that information is one of the primary purposes of this book.

- ***SUDs are highly prevalent and destructive.*** SUDs are among the most prevalent, destructive, and costly health care problems in the United States today. As highlighted by the recent opioid crisis (Wilkerson, Kim, Windsor, & Mareiniss, 2016), SUDs are major contributors to a wide range of adverse consequences, including overdose deaths, drownings, suicides, domestic violence, automobile accidents, sexual abuse, HIV-risky sexual behaviors, psychiatric disorders, adverse interactions with medications prescribed for other medical conditions, and a wide variety of serious medical problems directly caused or exacerbated by substance use (Schulden, Thomas, & Compton, 2009). The sheer prevalence of these problems and the avoidable suffering they cause are reason enough why therapists should attend to them.

- ***SUDs are frequently intertwined with other behavioral health problems.*** SUDs are especially common among people seeking help for mental health problems whether or not substance use is a presenting complaint or the primary reason for seeking professional help (Hasin & Kilcoyne, 2012; Substance Abuse and Mental Health Services Administration, 2019). Whether they are aware of it or not, most therapists are already treating the problems caused or exacerbated by alcohol and drug use without directly addressing the source of these problems.

Undiagnosed and untreated SUDs frequently diminish or completely nullify the effectiveness of both behavioral and pharmacological treatments for other MH problems. The interaction between SUDs and other MH problems is complex, multifaceted, and not adequately understood. Chronic use of psychoactive substances can induce psychiatric symptoms that mimic almost any type of mental health disorder, including anxiety, depression, and bipolar disorders, personality disorders, and psychoses. It

is equally true that MH problems contribute to the misuse of psychoactive substances. Many people with MH problems use psychoactive substances to "self-medicate" negative moods and dysregulated emotions. In view of the extraordinarily high rates of comorbidity between MH and substance abuse problems, it is advantageous for SUDs to be treated by clinicians with advanced mental health training who can provide integrated care for both disorders.

• ***Increased need for medication-assisted treatments.*** The increased availability of more effective medications for treating SUDs (e.g., buprenorphine, naltrexone) has been accompanied by increased recognition that pharmacotherapy alone, no matter how effective, is often not sufficient to produce positive treatment outcomes and lasting change. No medication can teach coping skills or address co-occurring psychological, social, and behavioral problems associated with SUDs (Avery & Barnhill, 2018). Studies indicate that the combination of psychosocial and pharmacological interventions (known as medication-assisted treatment [MAT]) generally works better than either one alone (Dugosh et al., 2016). Working in collaboration with prescribing physicians, psychotherapists can do a great deal to increase the willingness of clients to try potentially helpful medications, adhere to prescribed medication regimens, and tolerate undesirable side effects. Furthermore, because SUDs do not develop in a vacuum but rather in the context of an individual's life, treatment must address the whole person, including complex psychological issues that go beyond the addiction itself.

• ***Well-trained psychotherapists are well suited for treating SUDs.*** It can be argued that well-trained mental health clinicians already possess many of the essential therapeutic skills needed to treat people with alcohol or drug problems and that the challenge for nonspecialists is to adapt, expand, and refine their clinical skills to work more effectively with these patients. First and foremost is therapists' well-honed ability to forge a positive therapeutic relationship with every client, one of the most crucial determinants of treatment effectiveness (Gerstley et al., 1989; McLellan, Woody, Luborsky, & Goehl, 1988). Moreover, studies show that the therapist's attitude and clinical stance toward patients matter a great deal in treating SUDs (Miller, 1983; Miller & Rollnick, 2013). In particular, Rogerian qualities of therapist warmth, friendliness, nonjudgmental acceptance, and empathy are seen as more important predictors of treatment retention and favorable outcomes than the therapist's theoretical orientation, treatment philosophy, or personal addiction history. Psychotherapists are trained to be highly sensitive and responsive to individual differences. The diversity of people with SUDs necessitates flexibility and sophistication to accommodate wide-ranging differences. Psychotherapists are generally well

prepared to make important diagnostic distinctions and to individualize treatment according to differing patient needs—essential ingredients for delivering effective treatment.

Harm reduction approaches to treating SUDs (Denning & Little, 2012; Tatarsky, 2002), rooted in the principles and practices of client-centered therapy, underscore the value of therapists' clinical skills and sensibilities in treating SUDs. These include good listening skills, nonjudgmental acceptance, meeting patients "where they are," and a keen appreciation for the importance of tailoring treatment to individual needs. Emphasizing the centrality of the therapeutic relationship, harm reduction empowers behavioral health clinicians from diverse theoretical backgrounds and professional disciplines to treat SUDs routinely in clinical practice.

- ***Opportunities for early intervention.*** Another reason why psychotherapists should treat SUDs is that office practitioners are in an excellent position to intervene with people in the early stages of developing an alcohol or drug problem before it becomes more severe. Therapists have a front-row seat for identifying emerging SUDs. Mental health practitioners probably come in contact with more people with these problems than other health care practitioners with the possible exception of primary care physicians. Typically, by the time people seek help at an addiction treatment program, their alcohol or drug problems have already resulted in serious consequences that earlier intervention may have helped to truncate or avoid altogether. Many people with substance use problems seek professional consultation and advice from psychotherapists as a first step in trying to decide whether their alcohol or drug use is really a problem and what course of action, if any, to take. Individuals who do not want or need an intensive treatment program are often good candidates for office-based treatment, including those already in recovery who want individual psychotherapy to help them consolidate gains and work through unresolved issues. All in all, office practitioners are well positioned to provide attractive low-threshold treatment for individuals who are not attracted to traditional treatment programs or have not done well in these programs.

Psychotherapists familiar with the dynamics of addiction, as compared with those who lack this familiarity, are likely to view the behavior of patients who use substances in ways that allow them to respond more empathetically and effectively. The patient will likely be seen not as character disordered or resistant but rather as highly ambivalent about giving up substance use and acting out this internal struggle by giving in to strong urges and cravings to use. The experienced therapist will acknowledge that cravings and urges are common features of the disorder, especially in the early stages of abstinence, and offer helpful suggestions on how to deal with these situations. For example, the therapist may offer suggestions about how the patient can avoid "high-risk" situations that stimulate the

desire to use and will also teach the patient ways to "surf" or ride out the cravings without resuming use. Lapses back to substance use are less likely to be seen as evidence of resistance, willful noncompliance, or lack of motivation but rather as emanating from ambivalence and lingering attachment to substances that are emblematic of SUDs. The inherent difficulties in counteracting what often are physiological and psychological compulsions to use alcohol or drugs even in the face of serious negative consequences will also be acknowledged. Thus therapists familiar with the phenomenology and clinical course of SUDs are able to join patients in acknowledging the struggle involved in breaking free of habitual use and to utilize behavioral and motivational techniques to facilitate change. This stance fosters development of a strong working alliance that is more empathic and supportive than standard confrontational approaches and more likely to engage and retain patients in treatment, especially during the initial phase when dropout rates are notoriously high.

• ***Availability of evidence-based approaches.*** Another reason why therapists should address SUDs is the recognition that these disorders respond to many of the same behavioral interventions that are effective in addressing other mental health problems. Psychosocial treatments with the strongest evidence of effectiveness are familiar to most therapists, including client-centered motivational strategies (Miller & Rollnick, 2013) and cognitive-behavioral interventions (Marlatt & Donovan, 2005; Washton & Zweben, 2008).

• ***Private practice opportunities.*** Office practitioners well prepared to treat SUDs are in an excellent position to expand the range of clients they can service in an increasingly competitive marketplace. Many people seeking help for an alcohol or drug problem reject the idea of going to an inpatient rehab or intensive outpatient program but more readily accept individualized treatment in a private office. The trend in recent years toward treating SUDs in less restrictive environments (i.e., outpatient rather than inpatient settings) has contributed to increased demand for office-based treatment. Some managed care plans routinely refer patients with SUDs to private therapists instead of routing these patients to specialized addiction treatment programs. This reflects an increasing recognition that office-based practitioners skilled in treating SUDs can provide clinically effective and cost-effective treatment alternatives for people who do not require intensive inpatient or outpatient treatment. Similarly, there is a growing demand for practitioners who can not only focus on the patient's addiction problem but also competently address co-occurring mental health problems. Many patients are inadequately treated by clinicians able to address mental health problems but not SUDs and by addiction counselors who can deal with SUDs but not mental health disorders. Relatively few therapists

have the professional competence to provide integrated treatment for both types of disorders.

• ***Personal and professional gratification.*** Last, but certainly not least, among the reasons why psychotherapists should address SUDs is that working with these patients is extremely gratifying. It is very rewarding to assist patients in liberating themselves from compulsive substance use and its consequences. Contrary to popular stereotypes, people with alcohol or drug problems often are not difficult to treat, and many show rapid, observable, and rather dramatic improvement in a relatively short time. There is no way of knowing just how profoundly substance use is affecting a person's functioning until the use is substantially reduced or completely stopped. Positive changes often become evident almost immediately in the days and weeks after the cycle of harmful alcohol or drug use is broken. These changes include improvements in physical health and fitness, family and other interpersonal relationships, work productivity and satisfaction, self-esteem, and overall quality of life.

Both of us have chosen to work as specialists in this field, but it is probably more accurate to say that this field chose us. Like most other mental health professionals, neither of us was formally trained in this area and did not go into clinical practice with the intention of becoming addiction specialists. It is the exhilarating experience of participating in the personal transformation of our patients and the profound sense of both professional and personal gratification we derive from doing so that originally motivated us to enter in this field over four decades ago and continues to motivate us today.

Unique Benefits of Office-Based Treatment

As compared with other modalities of treatment, such as inpatient rehab or intensive outpatient programs, office-based treatment offers several unique advantages.

• ***Lower entry threshold.*** Office-based treatment eliminates some of the entry barriers that discourage many people from considering or accepting treatment. It is up to the practitioner, of course, to skillfully seize the moment by making maximum use of an opportunity to intervene proactively. As stated earlier, as compared with outpatient treatment programs, office-based treatment attracts many individuals who do not need or want what conventional programs typically offer. This includes people in the early stages of developing a problem, as well as those in the early stages of acknowledging that the problem is serious enough to warrant clinical attention. It stands to reason that people who do not acknowledge the true

nature or extent of a substance use problem are not likely to seek help for it. Countless patients in therapy for other behavioral health problems could be spared much pain and suffering by therapists who have the clinical skills to intervene appropriately. Many people with alcohol or drug problems seek professional evaluation and guidance from psychotherapists to find out whether their alcohol or drug use is really a problem and what type of treatment, if any, might be best.

• ***Access to flexible, individualized care.*** Office-based therapy adds flexibility and choice to the menu of treatment options for people with alcohol and drug problems. Accordingly, treatment can be more precisely matched to address the specific needs of each individual. Private practitioners are not constrained by agency policies and procedures or by institutional control over treatment philosophy and approach. There are no rules dictating which patients are admitted into treatment and how treatment should be done. Practitioners have the freedom and flexibility to offer treatment that meets patients where they are instead of requiring them to comply with a preformulated treatment program.

• ***Provides an alternative, supplement, or sequel to addiction treatment programs.*** Psychotherapists who treat SUDs are in a unique position to offer effective alternatives to mainstream addiction treatment programs for people who do not want or need what these programs typically offer. Some traditional treatment programs based on the 12-step program of Alcoholics Anonymous (AA) may alienate people in the early stages of addressing an alcohol or drug problem with a dogmatic approach that advocates total abstinence from all substances and frequent attendance at AA meetings. Clients who do not accept this approach without challenge are often told that they are "in denial." Some patients readily accept the 12-step approach and make good use of it (which we wholly support), but others are turned off by the dogma and refuse to embrace the idea that there is only one effective path to recovery for everyone. One of the most important functions of office-based treatment is to offer an alternative path. Office practitioners have a unique opportunity and a clinical responsibility to offer flexible individualized treatment that opens the doors for people who do not want or need to be treated in traditional programs. The critical importance of working through, joining, or temporarily sidestepping client resistance is something that every psychotherapist appreciates.

Office-based therapy can serve not only as an alternative but also as a supplement to other forms of treatment. For example, many people involved in AA or other self-help programs seek help from psychotherapists when they encounter psychological or emotional problems that these programs cannot adequately address. Similarly, many involved in addiction treatment programs may benefit from concurrent individual therapy that supports,

amplifies, and extends the therapeutic work being done in an outpatient recovery group and increases treatment retention. Office-based therapy is often an important component of aftercare treatment for patients who have completed a structured inpatient or outpatient program and want the help of a professional psychotherapist who knows how to deal with psychological and emotional issues often intertwined with SUDs.

Final Comment

There are many compelling reasons why all psychotherapists should become proficient in addressing SUDs, regardless of patients' presenting complaints. Considering the extraordinarily high rates of comorbidity between SUDs and other mental health problems and the serious consequences that can ensue if both problems are not adequately addressed, all practitioners should know how to assess, treat, and properly refer patients with alcohol and drug problems and should do so routinely in their practices. Office-based treatment fills important gaps in the continuum of care for SUDs and provides treatment options not currently available in the existing treatment system. Treating patients with SUDs in office practice can be extremely rewarding, both personally and professionally.

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