



PERSPECTIVES

Re-envisioning Addiction Treatment: A Six-Point Plan

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This article is focused on improving the quality of addiction treatment. Based on observations that patients are leaving treatment too early and/or are continuing to use substances during their care, the authors propose six actions that could help reorient and revitalize this kind of clinical work: (1) conceptualize and treat addictive disorders within a psychiatric/mental health framework; (2) make the creation of a strong therapeutic alliance a core part of the healing process; (3) understand patients' addictions and other problems using models based on multiple internal parts, voices, or modes; (4) make contingency management and the use of positive reinforcement systems a standard and central practice in all treatment settings; (5) envision long-term change and healing through the lens of identity theory; and (6) integrate the growing developments in recovery culture with formal treatment.

KEYWORDS *Addiction treatment, dual-diagnosis, psychotherapy, harm reduction*

Tragically, the addiction treatment system is failing to help many who are struggling with drug and alcohol problems, despite the serious efforts and

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best intentions of those who work in the field. The purpose of this article is to present six core treatment paradigms and techniques that could be used as a way of reforming and improving the care of those with substance abuse difficulties.

A SYSTEM IN CRISIS

In terms of what is required for effective treatment within the current system, Gerstein (2004), in a review of outcome studies, specified that 6 months of care was the threshold at which treatment in outpatient settings starts to become effective. Hubbard (2005), in a similar review, found that at 3 months, patients will begin to experience the impact of treatment, but that it will take one year for them to demonstrate major changes in behavior. The National Institute on Drug Abuse (NIDA, 2009b) stated that methadone maintenance treatment requires 12 months of participation to be effective. Using these findings as a guideline for retention, 6 months would appear to be the minimal amount of time that a patient should spend in nonresidential treatment and one year should be the norm. A number of studies, large and small, that have included treatment-as-usual conditions as a control have uncovered various combinations of low levels of retention and high levels of substance use (Ball et al., 2007; Peirce et al., 2006; Petry, Alessi, Marx, Austin, & Tardif, 2005; Petry, Martin, Cooney, & Kranzler, 2000; Petry, Peirce, et al., 2005; Silverman et al., 1996).

Although the addiction treatment field has, in general, neither acknowledged the depth of the problem nor begun an all-out search for new solutions, there have been some responses to this challenge. For example, NIDA has been running the Clinical Trials Network for over a decade (Wells, Saxon, Calsyn, Jackson, & Donovan, 2010), the Robert Wood Johnson Foundation sponsored the Network for the Improvement of Addiction Treatment or NIATx Project (Uzoigwe, 2007), and the Center for Substance Abuse Treatment (CSAT) has been supporting the Addiction Technology Transfer Centers (ATTC; 2011c). In turn, Carroll and colleagues (2008) began creating effective computer-based treatment programs, and O'Brien and McLellan (1996) argued that addictions are, in fact, a chronic, relapsing condition and that treatment needs to move from an acute-care model to a chronic-care model. From a more grassroots perspective, the rise of the Recovery Movement (White, 2009; White & Kurtz, 2006) might be seen as a response to the crisis as well.

All of these efforts may be understood as forms of progress that, for the most part, will not conflict with what is being proposed here. However, to more deeply and powerfully transform addiction treatment, six pragmatic and conceptual changes are being proposed for exploration and adoption:

1. Formally and comprehensively define and treat addictions as a psychiatric/mental health disorder.
2. Give central importance to the therapeutic alliance.
3. Conceptualize and treat patients using models based on multiplicity of self.
4. Make contingency management a standard practice in all treatment settings.
5. Understand change and healing through the lens of identity theory.
6. Integrate formal treatment with recovery culture.

It is our belief that retention and effectiveness rates will increase dramatically as these six ideas become accepted and implemented.

ADDICTION AS A PSYCHIATRIC/MENTAL HEALTH DISORDER

In 1950, Dr. Bob, the cofounder of Alcoholics Anonymous (AA), advised AA members,

But there are two or three things that flashed into my mind on which it would be fitting to lay a little emphasis; one is the simplicity of our Program. Let's not louse it up with Freudian complexes and things that are interesting to the scientific mind, but have very little to do with our actual AA work. (Dr. Bob, 2004, para. 3)

Since then, the world has changed, and what may have been advisable and successful in a self-help group 60 years ago may not be appropriate in a formal treatment setting today. Given our deeper understanding of the addiction experience and the diverse problems confronting so many drug-using individuals, it may be more than fitting to say that "Complex problems require complex solutions" (Tatarsky, 2002, p. 136).

What, then, is the nature of this new understanding of addiction? The former head of NIDA, Dr. Alan Leshner, used to say that "They should be called patients, not clients" (personal communication, January 21, 2008). By this he meant that given the growing understanding of addiction as a brain disease, it is more appropriate to conceive of addicted individuals as suffering from a true medical illness. Strikingly, though the addiction treatment field has long referred to addictive disorders as a "disease," this was, in fact, more of a metaphor than an actual biological condition. The long-standing opposition to methadone maintenance and, in some cases, psychiatric medication, would not have occurred if the field had embraced a

“true” disease model. If addictions were actually understood to be illnesses, then the use of medication would have been an essential part of treatment.¹

Why is this important? In a sense, all addiction treatment functions on two axes: one of health and illness and the other of good and evil (Kellogg & Triffleman, 1998). This means that a fundamental question that confronts all who wish to work with those who have drug problems is: Are these sick people who need treatment or bad people who need punishment? In the world at large, punishment has often been a favored approach (Jacobs, 2010; Mydans, 2010). Given this, the widespread adoption of the term *patient* and the championing of a “true” disease concept will go a long way toward humanizing treatment and improving its quality.

This “new” disease model is currently being championed by many forces in the field. For example, NIDA (2008) said that addiction is a “brain disease” and a “chronic disease” (NIDA, 2011). The ATTC (2011a) also agreed with NIDA’s (2011a) perspective by affirming that it is a “brain disease,” that it involves a “changed brain,” and that is a “chronic disorder” (ATTC, 2011b). The National Institute on Alcoholism and Alcohol Abuse (2007) said that alcoholism is a “chronic disease” while not saying that it is a brain disease. Last, CSAT (2005) described it as a “medical condition,” as an illness, and as a “chronic, relapsing disorder” (CSAT, 1994).

If an addiction is a disease, the next question is: What kind? We believe that understanding it as a psychiatric/mental health disorder is the most accurate and most useful way of conceptualizing this problem. In a sense it already is one as the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association, 2000) classifies addictive and problematic substance use as substance dependence and substance abuse disorders. In addition, NIDA (2009a, b) labeled it a mental illness. Given that the disorder (1) has a strong behavioral component, (2) utilizes the brain as its primary organ of action, (3) benefits from the development of new medications that target or involve the brain, (4) occurs in the context of many other psychiatric disorders, and (5) requires the same treatment skills that are needed in other forms of psychotherapy, it clearly seems the most appropriate paradigm to use. Last, studies have shown that 60% to 80% of patients with an addiction have another mental health disorder, and 40% to 60% of those with a mental illness also have a substance abuse disorder (Sciacca, 2009). Above and beyond this, the rest of those who use substances do so for reasons that may also need specific attention. Centering addiction treatment in psychiatry and mental health also has certain treatment advantages. First, it provides a strong foundation for the judicious use of addiction-related medications (i.e., methadone, naltrexone, suboxone,

¹It is interesting to note, in this context, that Bill W., the other cofounder of Alcoholics Anonymous, went to Dr. Vincent Dole, the creator of methadone maintenance treatment and an AA board member, and asked him to formulate a methadone equivalent for alcoholics (Green, Kellogg, & Kreek, 2004).

topiramate, acamprosate, and disulfiram) and psychiatric medications, while also providing the medical base necessary for the use of such harm reduction and public health interventions as naloxone distribution. Second, it supports the purposeful and creative use of the cognitive, behavioral, psychodynamic, and experiential therapies not only in the treatment of the addiction but also in work with the underlying causes and the co-occurring disorders.

To further advance this new understanding of addictive disorders, there are three specific steps to consider. The first is to take action to ensure that all who work with addictive disorders have formal training in psychotherapy and a discipline-specific credential in addiction treatment. The second is to merge the addiction and mental health agencies and treatment programs so that this artificial separation, which does not serve patients, finally comes to an end. The third is to find, create, or develop effective and deeper ways of treating patients based on this new paradigm and understanding.

THE THERAPEUTIC ALLIANCE

As findings in the psychotherapy outcome literature (Safran & Muran, 2000) and the drug addiction treatment literature have found (Meier, Donmall, McElduff, Barrowclough, & Heller, 2006), the connection between the patient and the clinician is of vital importance. In addition, a range of studies have revealed that a strong and positive alliance can play a significant role in improving retention rates, increasing levels of treatment completion, and facilitating positive treatment outcomes across a variety of substances (Bethea, Acosta, & Haller, 2008). Two of the key components for the effective creation and maintenance of a therapeutic alliance are (1) that patients should be treated with respect and empathy and (2) that the alliance should be a central concern throughout the healing process (Tatarsky, 2002; Tatarsky & Kellogg, 2010).

More specifically, a strong, positive therapeutic alliance can be healing because (1) it provides a space or experience of safety that allows the patient to relax and engage in a process of self-reflection, (2) it encourages “the integration of self-regulation or self-management skills as the therapist both models and teaches these skills and gives the patient permission to use them” (Tatarsky & Kellogg, 2010, p. 125), and (3) because the pain that underlies much substance use has interpersonal roots and these issues are likely to come up in treatment, a strong alliance provides an opportunity for resolving these productively.

The second part of the alliance is the therapeutic contract. What the goals of treatment are, however, may be decided by the patient, the patient and the therapist together, or by institutional forces—depending on the therapeutic setting. For example, in harm reduction and harm reduction psychotherapy settings, therapists may strive to simultaneously “meet the

patient where they are at” and be of help in any way they can (Majoor & Rivera, 2003; Tatarsky, 2003; Tatarsky & Kellogg, 2010). Gradualists, in turn, believe that abstinence, “true” moderation, or nonaddictive use should be the ultimate, if not immediate, goals of treatment (Kellogg, 2003; Kellogg & Kreek, 2005).

In more institutional settings, treatment goals other than abstinence have typically been unacceptable, although in some dual-diagnosis programs, there may be a greater tolerance for ongoing substance use (Bellack, Bennett, Gearson, Brown, & Yang, 2006; Sciacca, 2009). In general, the therapeutic alliance will be strengthened by the use of individualized treatment plans that reflect an understanding that people entering treatment have different histories, biological constitutions, problems, and goals.

MULTIPLICITY OF SELF

Before discussing multiplicity itself, it is useful to understand that the pragmatics of addiction treatment can be conceptualized in terms of horizontal and vertical interventions (Kellogg & Tatarsky, 2009). Horizontal interventions are those that are specifically focused on controlling and/or discontinuing drug use whereas vertical interventions are used to address underlying pathology, meaning, and suffering.

The horizontal interventions typically take two forms. The first of these is substance use management (Bigg, 2001). Using the term broadly, it refers to the range of harm reduction techniques that help people use drugs in ways that are safer. In addition to such interventions as needle exchange, this includes working with patients to change the amount of drugs that they consume, the method in which they take them, the duration of time that they are involved with them, the context in which the use takes place (alone or with others), and, in some cases, the specific substances they favor. The goal here is to help patients who continue to use substances make changes so that they can reduce their immediate and longer term risk of death or serious impairment. This is especially appropriate for patients who are not willing to stop, for those who are having difficulty in their attempts to do so, and for those who need to do depth work first (Denning, 2000).

The second horizontal intervention is relapse prevention (Marlatt & Gordon, 1985). Although these interventions can also be adapted for harm reduction purposes (Marlatt, 2004), they were historically associated with efforts at abstinence. This approach involves working with patients to (1) understand how triggers and cues work, (2) identify their specific high-risk situations and triggers—emotional and interpersonal, and (3) teach them to manage these difficult situations using such skills as assertiveness, relaxation therapy, distraction, and accessing social support (Marlatt & Gordon, 1985).

In turn, multiplicity of self, the understanding or perspective that people have a number of internal parts, schemas, voices, modes, objects, forces, or archetypes, is playing an increasingly important role in psychotherapy and can be very helpful in addiction treatment (Rowan, 2010). Schema mode therapy, an integrative psychotherapy that utilizes concepts of multiple modes, emphasizes the ultimate goal of creating a strong healthy adult mode (Kellogg & Young, 2006; Rafaeli, Bernstein, & Young, 2010; Young, Klosko, & Weishaar, 2003). This is a part of the self that can (1) regulate other internal parts (including those connected to avoidance, impulsivity, and self-criticism); (2) interact successfully with other people; and (3) take assertive, meaningful, and effective action in the world. Therapeutically, this means that when using a mode model, two important goals of treatment will include (1) giving voice to the different parts and (2) creating a strong and responsive internal leader.

Addicted individuals frequently use the concept of multiplicity as can be seen in the ubiquitous references to Dr. Jekyll and Mr. Hyde (Stevenson, 1967; White & Kurtz, 2006). “Once she had a drink she became unrecognizable. She was like two people, like Jekyll and Hyde” (Rhind, 2008). In some commonly used treatment approaches, the issue of multiplicity can be seen as implied, if not formally explicated. With motivational interviewing (Miller, 2000) and the decisional balance (Marlatt & Gordon, 1985), it is easy to posit that there is a part of the person that wants to use/does not want to change and a part that does not want to continue to use/does want positive change. Motivational interviewing, though not using this formulation, does seek to create an encounter between these two parts of the self that will lead to tension and conflict, and, hopefully, a change in behavior.

Rothschild (2010) believed that people have a variety of internal parts and that these may form complex relationships with one another. In situations in which there has been trauma, these parts may become more disengaged from each other as patients may increasingly rely on dissociation as a coping mechanism. As she put it, “one of the hallmarks of trauma is dissociation, defined as a discontinuity between various aspects of self or an inability to hold conflicting views of self at the same time” (p. 141).

This means that though one part of the person may be concerned about the negative consequences of his or her drug use, another part may be deeply invested in it; in fact, to this latter part it may seem to be a matter of life and death. To work with this kind of patient, both parts, voices, or modes need to be invited and welcomed into the session; in addition, their views and desires need to be respected and appreciated. One complication here is that in cases of dissociation, it is already difficult for patients to tolerate the conscious awareness of internal ambiguity, and they will sometimes “flip” back and forth between the two polarities (Young et al., 2003). This means that the part that wants to stop (1) attends the session, (2) learns the cognitive-behavioral techniques for managing urges, and/or (3) agrees to go

to a meeting over the weekend. After leaving the session, the other part, which was not welcomed into the therapy hour, takes over and problematic drug and alcohol use ensues (Rothschild, 2010). In a clinical situation in which drug use is condemned a priori, this situation may be exacerbated as only one part will be allowed to speak.

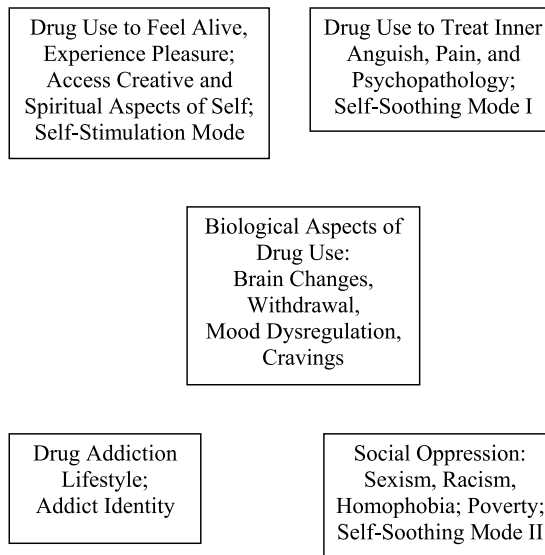
Again, the therapeutic answer is to create a situation in which all of the parts are welcomed into the room; one in which it is safe for them to speak and perhaps encounter each other. “It is the therapist’s job to hear and hold both, to be in a nonadversarial position from which she can recognize and empathize with the multiple aspects of the patient’s self, helping to unite them into a coherent whole” (Rothschild, 2010, p. 142).

In a similar vein, Tatarsky (2002, 2003) developed a complex vision of why people use substances, and he believed that each of these factors needs to be identified, understood, and, in some cases, treated directly.

Along these lines, substances may be used to: quell the pain of anxiety or depression, help block intrusive traumatic memories, increase the ability of those with attention-deficit/hyperactivity disorder to focus, and reduce the symptoms of psychosis. Wurmser (1978) has explored the role of the “inner critic” or the harsh, punitive superego in the use of substances. For many, alcohol or drugs serve as a kind of revolt against or escape from this experience of internal tyranny. (Tatarsky & Kellogg, 2011, p. 42)

Some patients seek to overcome a sense of inner deadness through their use. They want to have a greater sensitivity to life, be able to experience states of happiness and euthymia that they are not able to achieve in their normal state of consciousness, and/or gain access to aspects of themselves that have been dissociated or blocked off. Building on this, it is clear that there may be a number of parts or “persons” inside the patient who are using substances (see Figure 1). For example, Denning (2000) wrote about a patient with borderline personality disorder who snorted cocaine when she went out dancing and injected cocaine at home by herself when she was feeling suicidal. Here the same drug is being used in different settings and with different methods—each of which gave the use a different meaning. Clearly, the therapist would want to engage and work with both the “Party Girl” and the “Suicide Girl.” This is the kind of complex and sophisticated understanding of drug use and its treatment that is necessary to move the field to the next level. All of this also points to the fact that there is no substitute for individual psychotherapy! In this new vision of healing, the individual encounter, not the group, is the primary vehicle for change and transformation.

The process of integrating the issues raised in the multiplicity discussion with those connected to vertical interventions can perhaps best be illustrated through a case example. Table 1 contains a patient’s decisional balance, a



Note. This image shows five mode groups that may play a role in ongoing drug use. These include pleasure, self-medication, biological necessity, social oppression, and addict lifestyle and identity. Depending on the internal constellation of the patient, some or all of them may need to be specifically addressed before the patient will be prepared to cease or change their use of drugs.

FIGURE 1 Drug user internal mode system.

two-by-two matrix that includes the patient's perceptions of the positive and negative aspects of his or her drug use and the positive and negative aspects of positive change.

Why does this patient use? First, he uses because he experiences strong feelings of pleasure from the substances. The power of this experience, which may, in some respects, be beyond words, is profoundly meaningful and compelling and likely to call him back. Second, he feels some kind of basic disconnection from life; for example, some patients report that they feel as if there is a wall or clear screen between themselves and the world. For this patient, drugs help him break through in some way and connect to the world and others. Third, connecting with others is not easy. He appears to be signaling that he is socially anxious and that substances help him feel more comfortable when in gatherings with others. In a related vein, he also feels that his inhibitions prevent him from revealing himself in a positive way, and that using chemicals helps to facilitate self-expression; he feels more truly "known" by others when he is using them. Fourth, like many patients with addictions and other psychiatric or mental health problems, he is plagued by voices of inner criticism—most likely driving feelings of anxiety, depression, and self-hatred. Here, the substances serve even more directly as a form of

TABLE 1 Drug Use Decisional Balance

Decisional balance	
Positives of drug use	Positives of change
Immediate physical pleasure (10)	Feel a greater sense self-discipline (9)
Feeling more “there” (10)	Would be more productive (10)
Feels more emotion (10)	Help him be more comfortable with self (8)
Reduces social anxiety (6)	Greater confidence (6)
Shuts out inner critic voice (7)	
People will know “real” self (7)	
Mean score = 8.33	Mean score = 8.25
Negatives of drug use	Negatives of change
Feels guilty (7)	Would not enjoy life as much (9)
Others are concerned (6)	Would be ignoring a part of himself (10)
Not as productive (10)	Breaking up with something he loves—a hard breakup (9)
Feels like it is a crutch (10)	
Feels bad (7)	
Health problems (7)	
Mean score = 7.83	Mean score = 9.33

Note. The Decisional Balance first involves asking the patient to identify the positives and negatives of drug use and the positives and negatives of stopping or changing their use. After these forces are identified, the patient is asked to rate the power of each one, positive or negative, on a scale of 1 to 10. Only those items that achieve a score of 6 or higher are kept. To create a metaphorical calculus of the patient’s motivation, means are formulated for each of the four boxes. The force for continued use is the Positives of Drug Use Mean plus the Negatives of Change Mean; the force for recovery or change is the Negatives of Drug Use Mean plus the Positives of Change Mean. In this example, when the ratio of forces is computed, the result is 17.66 : 16.08—which helps to illuminate the “stuck” position of this patient.

self-medication—they block out these painful attacks on the self. Fifth, an examination of the negatives of recovery shows an anticipated experience of deep grief and loss. He fears that the hedonic qualities of his life will be greatly diminished and that he will have to ignore an inner part or mode that has played a significant role in his life.

If different modes are involved in the use of substances, various modes may also be involved in their cessation. Again, using the decisional balance, it appears that there are, respectively, a moral part, an ambitious part, a relational part, and a healthy part. Each of these could be given a voice and allowed to express hopes and fears. In fact, a complex dialogue could be set up in which the patient embodies and expresses the five parts that are connected to the use and the four parts that are concerned about it (Kellogg, 2004; Tatarsky, 2003). After several rounds of back-and-forth encounter, the balance of power could be reassessed, and possible shifts in motivation could be considered. With other patients, the therapist might want to add a brain/biology mode. Integrating insights from neuroscience, it is important to acknowledge the reality that parts of the brain may be seeking drug-

based experiences and that biology may have imperatives beyond those of psychology and the reasoning mind.²

CONTINGENCY MANAGEMENT

Contingency management, particularly the use of positive reinforcement systems, has proven to be one of the most powerful psychosocial mechanisms for behavior change available (Higgins & Silverman, 2008). Forty years of research have shown that when using reinforcements of significant magnitude, clinicians can dramatically improve retention, decrease substance use, and increase group attendance (Kellogg, Stitzer, Petry, & Kreek, 2006; Kirby, Amass, & McLellan, 1999; Petry, 2000). It can also be helpful with other issues such as medication compliance (Elk, 1999). Given the central concern with retention and drug use in treatment, it is clearly time to make the adoption of positive reinforcement systems a foundational and standard part of care in every treatment facility.

IDENTITY THEORY

Three central and perennial questions in the treatment of addictions are (1) Why do people change? (2) How do people change? and (3) How do people maintain long-term abstinence, sobriety, or moderation? Although there may be many hypotheses, identity theory stands out as a particular useful one as it can not only help us to better understand the recovery process, but also guide us in the strengthening of our current practices and in the creation of new ones.

Identity theory developed out the symbolic interactionist tradition (Stryker & Serpé, 1982). It, too, is a theory of multiplicity and, from this perspective, individuals are understood to have several and sometimes many identities. Christiansen (1999) identified three core components of identity. The first is that of self-definition. For example, people may think of themselves as farmers, athletes, mothers, and Episcopalians. Moving beyond the level of self-definition, they are also likely to evaluate how well they are performing these roles or fulfilling these identities.

The second is that identities have a relational and interpersonal component. In general, identities come into being, are further elaborated, and undergo transformation within social contexts. Last, identities, to be of value and importance, must have an agentic quality. That is, identities are expressed through action and created by it.

²For specific thoughts on the treatment of this patient, please go to www.gradualismandaddiction.org/articles/.

In general, the creation of identities occurs in a social context. This is a creative and dialectical process in which the group influences the individual and the individual influences the group. Typically beginning in adolescence but throughout the life span as well, individuals can engage in “identity projects” (Harré, 1983) or “identity work” (Deaux, 1991), a process by which they consciously and purposefully make claim to an identity. Whether they will be successful depends on whether their performance meets the standards of the appropriate reference group (Shibutani, 1968).

Because individuals belong to more than one social group, they have more than one identity, and these are organized into a hierarchy of salience or importance. The more important the identity, the more it will guide and direct behavior (Stryker & Serpé, 1982).

The process of addiction interacts with identity in several ways. In terms of initiation, Anderson (1998) wrote that people want roles and identities and that young people, when they have difficulty accomplishing this, may seek out “alternative social groups” such as “drug subcultural groups” (p. 253).

An ongoing and significant involvement with drugs or alcohol typically leads to the creation of a drug user or addict identity. As substance use becomes an increasingly important activity, it takes up more and more time, and the addict identity comes to dominate the hierarchy; as this happens, it often seriously damages or destroys other identities that may have existed (i.e., worker, son, father, or wife) (Biernacki, 1986).

Two processes play a role in moving the individual toward treatment and recovery. With role stress (Goode, 1960), drug users find that the process of maintaining their drug addiction is getting more difficult and that their levels of internal and external pain are becoming intolerable. Another way of framing this is to see that the individual is failing to fulfill the requirements of the addict identity. This may lead to temporary solutions such as taking methadone or another opiate substitution medication so that they can lower their tolerance and eventually return to heroin use at a more affordable level. It may also lead to more permanent solutions such as entering a program, joining a 12-Step Fellowship group, or finding and engaging in other social institutions that provide meaning and identity (such as family, churches, political movements, or schools). In his study of heroin-addicted individuals, Stephens (1991) concluded that role strain was a major motivation for entering treatment.

Role conflict, in turn, occurs when the drug use is threatening the viability of other cherished identities. Stereotypically, the man seeks out treatment because he will lose his job, and the woman seeks out treatment because she is afraid that she will hurt or lose her children.

It should be noted that identity transformation processes are often initiated through a relationship with a member of a different social group. This new connection may serve as a bridge that carries the individual from the old group to a new one that will provide a new identity. In this regard, it is worth

noting that in the 2007 AA Membership Survey, 33% reported that another AA member was one of the most important forces leading to their coming to AA (Alcoholics Anonymous, 2010). In turn, the 2007 Narcotics Anonymous Membership Survey found that 58% said that an NA member was influential in their decision to attend their first meeting (Narcotics Anonymous, 2008).

What all forms of treatment and recovery are attempting to do—directly or indirectly—is create or reestablish viable, meaningful, and reinforcing identities that can compete with and ultimately replace those that are based on drug use (Biernacki, 1986; Kellogg, 1993; Kellogg & Kreek, 2005). For middle-class and working-class patients, there may be remnants of other identities that can be accessed to help build a new life; that is, they may have some recovery capital available (Granfield & Cloud, 2001). However, for those who grew up in cultures of poverty or in the underclass, the addict identity may be the most viable one they have ever had. Here, the work will frequently involve identity creation *de novo*—which may help explain why this healing journey may be more difficult to complete.

The direct creation of a recovery identity is the central focus of the 12-Step Fellowship Programs, the therapeutic communities, and many traditional treatment programs (Biernacki, 1986; Greil & Rudy, 1984; Maxwell, 1984). The transformation of the drug-using self and/or the creation or empowering of competing identities is frequently a project in individual psychotherapy. Many, if not most people, with addictions who recover on their own do so by finding social settings or identity niches that will support other identities (Biernacki, 1986; Granfield & Cloud, 1996, 2001; Kellogg, 1994). Last, harm reduction settings also have the potential to provide new identity possibilities that can lead to dramatic decreases in drug use (Zibbell, 2005) and, perhaps, initiate a journey of change and healing.

Given that identity processes are at work in all treatment and recovery settings—even if they are not recognized and acknowledged—the first step toward claiming the power of this paradigm would be for the treatment field to acknowledge the role of identity in healing. The second would be to consciously use identity theory in their treatment programs and aftercare efforts (Kellogg & Tatarsky, 2010).

RECOVERY CULTURE

The Addiction Recovery Movement is, in a number of ways, a reinvocation of some of the deepest traditions of the American and Native American self-help and mutual aid traditions (White & Kurtz, 2006). It is also emerging in the context of two important events in the addiction treatment field. The first of these is the above-mentioned realization that the system has been based on an acute-care model of treatment and that a chronic-care model is a much more appropriate way to work with a “chronic, relapsing disease” (O’Brien

& McLellan, 1996). The second is the emergence of groups such as Faces and Voices of Recovery who are seeking to give a public face to recovery and show that people do attain freedom from their addictions (White & Kurtz, 2006).

The Recovery Movement seeks to create a broader culture of recovery—a culture that would supplant that based on drug use and addiction (White, 2009). In this new vision, the primacy of recovering people as agents of change would be championed, and formal treatment settings would be seen as adjunctive and supportive of a much larger network of institutions, social settings, self-help groups, dedicated individuals, and real and virtual relationship networks that are each working to connect, affirm, and guide the newly-abstinent individual on the path to recovery. This would also place a central primacy on the experience and wisdom of those who have recovered using many different paths.

Although these are compelling developments, it is with excitement and trepidation that the Recovery Movement is included on this list of recommended steps and practices. A fundamental issue is whether addicted individuals are best served (1) through intrapsychic/psychological treatment, (2) the judicious use of medications, or (3) by social/group transformation. In our formulation of treatment, there is a deep need for all three. Looking first at its weaknesses and dangers, it is clear that a recapitulation of many of the negative dynamics of the current system is at work in the Recovery Movement. For example, White (2009) wrote, “Where addiction treatment has drawn heavily from the disciplines of psychiatry, psychology, and social work; recovery community building draws upon knowledge drawn from public health, sociology, social movements, community development, and community organizing” (p. 154).

The first part of this quote is in direct contradiction to one of the primary points of this paper—that the addiction treatment field has opposed or been resistant to the use of the insights, techniques, and visions of psychiatry and psychology for decades. Instead, it has championed and based its treatment on the beliefs and practices of self-help groups. In this regard, Wurmser (1978) observed that many addicted individuals suffered from what he called “psychophobia” or a deep fear of looking at their internal life experiences. In a striking parallel, the addiction treatment field itself has been very reluctant to engage with the inner world of the patient, to wrestle with, and treat the addict’s fears, wounds, dreams, darkness, and suffering in a direct and psychotherapeutic way, using appropriately trained and highly skilled practitioners. Sadly, almost every mainstream treatment either avoids these inner realities or engages with them in a shaming or punitive manner.

Recovery Movement advocates have, in essence, argued that these approaches have not worked very well and that it is time to emphasize social and community healing. In this regard, White (2009) wrote, “Treatment is best thought of as an adjunct of the community rather than the community

being viewed as an adjunct of treatment” (p. 152). The reality is that the field is just on the cusp of actually engaging with a true psychiatric/mental health/medical model of addiction treatment. Again, for the work to become much more effective, the field will need to embrace the central importance of a profound clinical and psychotherapeutic engagement with each patient. Again, this means that there is no substitute for individual psychotherapy.

Moving beyond this, there are obviously great benefits for addicted individuals in the Recovery Movement and in the creation of Recovery Culture. Certainly these kinds of networks can provide identity materials (Biernacki, 1986) and identity niches (Kellogg, 1994) that would help them to successfully claim a recovery identity and hopefully many others as well.

One very powerful metaphor for this movement is The Healing Forest image that is part of the Native American Wellbriety Movement (Coyhis & Simonelli, 2006; White 2009).

In this metaphor, a forest is filled with malnourished trees that are slowly dying. . . . A single tree is removed from the forest, cared for, and nursed back to health in nutrient-rich soil with plenty of sunlight. . . . Once the tree is well, it is brought back to its forest and replanted. At first, the tree stands firmly. . . . Yet slowly it begins to wither once again—the other trees . . . are, after all, contaminated with illness. . . . What is needed then is an environment conducive to recovery that will allow *all* the trees to thrive—what Coyhis refers to as a “Healing Forest.” (Gryczynski, Johnson, & Coyhis, 2007, pp. 475–476)

In short, the healing of the addicted individual and the healing of the drug- and alcohol-ravaged community are intertwined (Coyhis & Simonelli, 2006). Looking at this more broadly, a national social movement that creates a vibrant recovery culture and that successfully advocates for the moderate use of substances as a social norm would only be for the good.

CONCLUSION

The motivation for this article was a deep concern that the addictions treatment field is failing to heal its patients. Of the six points presented, one is paradigmatic (addiction is a psychiatric disorder), three combine the clinical and the conceptual (multiplicity of self, identity theory, and recovery culture), and two involve the conscious use of mechanisms of change (therapeutic alliance and contingency management). The identification and championing of these perspectives and techniques will not, necessarily, be easy to implement; we do believe, however, that they will serve as a rich source of clinical creativity and power. It is our hope that they will be not only be adopted and implemented quickly, but also they will serve to inspire others to take dramatic and effective action to improve our system of care. In the end, the

essence of psychiatry, clinical psychology, and psychotherapy is a mixture of science, art, and love, and this is best realized in the “sacred space” of the individual therapeutic encounter. This is what addicted patients want, it is what they need, and it is what they deserve.

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