

The Psychology, Biology and Family Connection to Addiction: Searching For Effective
Treatments

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THE PSYCHOLOGY, BIOLOGY and FAMILY CONNECTION TO ADDICTION
SEARCHING FOR EFFECTIVE TREATMENT OPTIONS

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Abstract

The field of alcohol and substance abuse disorders and their treatment is a rapidly evolving field. The diagnostic and treatment options are becoming more geared toward matching treatment options with the client's treatment goals. The starting point however should be in assessing the history of the client and his/her genetic and family connection to alcohol. Determining the degree of addiction and the level of previous treatment received must also be factored into the designated treatment plan. Abstinence goals can be modified according to the background of the client and their dependency symptoms. Awareness of alternative moderation programs is an additional issue to be considered when outlining a patient's treatment plan. Knowing the features of these programs and their effectiveness will assist the counselor in offering them to the client who is struggling with alcohol issues. This paper examines the history of alcohol abuse and dependence, explores possible genetic links, compares and contrasts alcohol problems as disease or learned behavior and discusses family tendency toward alcohol abuse. It then offers sources of help and hope from Alcoholics Anonymous to Moderation Management, identifying and treating relapse, and the co-occurrence of mental illness and alcohol addiction. Finally the newest treatments from pharmacology to therapy are presented.

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CHAPTER I: INTRODUCTION

Statement of the Problem

Alcohol addiction is said to affect every member of society at some level. The person who is addicted to alcohol suffers tremendously as do the family members and friends who are part of the addict's social network. The rest of society is impacted also because of the heavy financial costs incurred by the addict. The addictive drinker also poses a threat to the safety of society. Drunken driving accidents, domestic crimes exacerbated by the use of alcohol and emergency room resources are but some of the ways the rest of society suffer (www.ncadd.org). The focus of this research will examine the varying degrees of alcohol abuse issues in individuals as well as the treatment options presently available. The biological, psychological and social roots of addiction will also be considered as addiction is a multi-factorial issue in its origin as well as in its treatment.

The first step to examine is the biological connection to alcoholism. The question that has been posited is whether or not there is a gene that runs in families that might predispose a person to an addiction to substances such as alcohol. Also questioned is whether alcoholism runs in families and what the family system does to contribute to the problem. What, for instance, causes one child but not others, to become addicted when they all were raised in similar circumstances? The chemical addiction research has looks closely at both biological and psychological roots. The review of the current literature will seek to understand the distinction between the alcoholic and the person who abuses alcohol. Understanding this difference will allow the counselor to more effectively counsel the client and assure better long term results.

Method of Approach

The research was conducted through the Karrmann Library on the campus of the University of Wisconsin–Platteville, using search engines such as EbscoHost and Academic Search Elite. There were internet searches for journal articles and research studies. Key topics were alcohol addiction, effective treatment and relapse prevention. The Milwaukee Public Library and lending libraries of dear friends will be used for books on history of addiction, 12 step programs, and relapse prevention

While the majority of this paper is related to alcohol addiction, the crossover findings are also applicable to other addictive behaviors regarding drugs. In today's society, the counselors of addicts are treating people who often use alcohol as well as a combination of other substances, both prescription and nonprescription. Likewise the addicted person today often has mental health issues such as depression and anxiety. Therefore effective addiction treatment and mental health treatment must often co-exist and be closely related. Clients with mental health problems also frequently have substance abuse problems and the skilled therapist needs to untangle the origin of one when treating both. Dual diagnosis is a more complex treatment issue because it addresses mental illness in connection with addiction. The myriad issues are finally being recognized and there are an increasing number of programs trying to address them. It is estimated that as many as 50 percent of the mentally ill population also has a substance abuse problem. The drug which the mentally ill use to self-medicate most commonly is alcohol, followed by marijuana and cocaine. Prescription drugs such as tranquilizers and sleeping medicines are also frequently abused. Because treatment facilities have come under hard

economic times in our healthcare crisis, the fine points of understanding the exact nature of the addict's problem is crucial and cannot be overlooked.

The final piece of the research examines the present treatment programs and their effectiveness in preventing relapse. It is vital in working with those who either abuse or are addicted to alcohol to offer them assistance which will help them move toward a life of sobriety and dignity.

CHAPTER II: REVIEW OF THE LITERATURE

Overview: History

Most alcoholics are not the stereotypical homeless person or the skid row bum. Alcoholics are doctors, nurses, security guards, rock stars, professional athletes and first ladies. Most likely they are members of most families in America. Alcoholism is a disorder of great destructive power. In the United States alcoholism is involved in a quarter of all admissions to hospitals and plays a major role in the four most common causes of death among young people in the United States: suicide, homicide, accidents and cirrhosis of the liver (Blendon & Young, 1998). Everyone, whether aware of it or not, knows an alcoholic or the wife or husband of an alcoholic and everyone's life has, in some capacity, been impacted by the behavior of the alcoholic:

Alcohol plays a well-documented and publicized role in accidents, homicides, and suicides. Almost 50% of all traffic fatalities are alcohol related. Intoxication is a factor in approximately 1/3 of homicides and deaths from boating and aviation accidents. Nearly half of persons in prison were intoxicated when they committed their crime. Becoming increasingly evident is the role of other substances, notably marijuana and cocaine, in plane crashes, and of course automobile accidents. (Stimmel, 2002)

Alcohol is a legal drug which is the center of much of society's entertainment, dining experiences, religious ceremonies and relaxation time. Millions of people however become addicted to alcohol and millions more routinely abuse alcohol (www.ncadd.org). Alcohol use can become alcohol abuse and then can become alcohol dependence. It is a slow process that

usually takes several years to develop into chronic alcoholism. So insidious is the disease of alcoholism that people can become addicted or dependent without realizing what is happening to them

Clinical depression, marital conflict, and parental interference become reasons for addiction as well as problems in their own right. Problems within the personality structure of the individual and with the basic values and beliefs also are exacerbated as the individual continues to engage in the addictive behavior. As the addictive behavior becomes a predominant presence and an overriding value in the life of the individual, other areas of life are undervalued, problems in those areas seem less significant, and effective problem solving is compromised (DiClemente, 2003). Thus, it can be difficult to distinguish cause from effect when examining the role of alcohol in the cycle of addiction. A variety of factors, such as genetic predisposition, family background, personality, and social environment, play a role in alcoholism

An alcoholic is an individual who compulsively uses alcohol even as it destroys his or her life and who displays symptoms such as withdrawal from family and friends and physical symptoms such as blackouts. (APA, 1994). “Addiction is a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving.” (Savage, Joranson & Covington, 2003, p. 655).

The ultimate consequences for the drinking alcoholic are grim and limited which is why intervention and treatment are so necessary. It is agreed that alcoholism is a biogenetic disease with a psychosocial background. To further complicate the issue, alcoholics often have

diagnosable depression anxiety or mental illnesses. Many drinkers find they are unable to stop on their own and the potential for serious consequences increases. The combination of these factors is an area the counseling fields understand and must accommodate. The absence of long term treatment means the drug and alcohol counselors must work harder to increase the effectiveness of the intervention process. The dramatic decrease in treatment centers highlights how important it is to be proactive in treatment.

According to the National Survey of Substance Abuse Treatment Services (N-SSATS) annual surveys, the number of treatment facilities in Wisconsin has decreased from 324 in 2002, to 290 in 2006 (SAMHSA, 2009). In years past most people with a diagnosis of alcohol addiction had insurance that paid for inpatient treatment for up to thirty days. Today too many people do not have insurance at all and the average length of stay in a hospital or treatment facility is three to seven days. The behavior of an alcoholic can often lead them into encounters with the legal system and they are often incarcerated. As a result, a lot of treatment today is being carried out in the corrections facilities. This approach is haphazard at best and does not replace the necessary long term care required to help the suffering alcoholic. Because of a lack of insurance for treatment, more individuals are getting deeper into their addictions. This often results in criminal behavior and/or physical hospital stays. As a society we may have taken on the price for addictions treatment as insurance companies have decreased benefits. Almost two thirds of the inmates in jail and minimum security detention are there for committing drug related crimes.

The cost of addictions to the society at large is unacceptably high (SAMHSA, 2009). Work problems, family problems, children needing foster care, as well as people incarcerated for drug related crimes are taxing society's fragile resources. As funding for treatment disappears

jails are being filled past capacity. Mandated treatment in lieu of incarceration might give addicted people a chance to change their lives as well as save society billions of dollars in human services and corrections. Treatment in lieu of incarceration could be the beginning of the solution rather than the present trend of punishing addicted people for their disease.

Genetic Predisposition: Adoption Studies

Even though researchers have not located the gene responsible for alcoholism there is an overwhelming amount of evidence that alcoholism is inherited. Much of this evidence has been gathered through decades of adoption and twin studies.

Scientists exploring a potential genetic basis of alcoholism have preferred to study adult alcoholics who had been adopted as children. That way, any inherited tendency can be isolated from the environmental influences of an alcoholic home. If a person is an alcoholic from a family which is predisposed to alcoholism the study is skewed toward that conclusion. There are however challenges to this approach. Studying adopted children often presents a problem determining parentage because of incomplete or absent records. In the United States many records of birth parents and their medical history were either closed or sealed. It has been only recently that people who were placed for adoption sought to obtain accurate medical information and they have faced many challenges. Even when ancestry is correctly determined and information about birth parents obtained, there is still the need to detect alcoholism in the family background. As a result of these formidable hurdles and challenges research has been difficult.

Luckily the Scandinavian countries have kept excellent birth and medical records and their studies have been enlightening. They have kept records regarding the rates of alcoholism in their

country. In tracking children who were adopted soon after birth, it was discovered that babies of an alcoholic father adopted by non-alcoholic parents are nearly four times more likely to become alcoholic than babies of non alcoholic parents (Goodwin, 1973). An additional finding is that babies who had normal parents, but were adopted by an alcoholic stepfather are at no greater risk of becoming alcoholic than the general population (Cloninger, 1988). The conclusion was clear that genetics does influence the tendency to become alcoholic.

One Swedish study tracked all babies born out of wedlock between 1930 and 1949 who were adopted by nonrelatives. These babies were separated from their parents at an average age of four months and were adopted by the median age of eight months. The rate of alcohol addiction for children of a known alcoholic parent was up to 3.5 times greater than normal (Cloninger, 1988).

A Danish study analyzed babies from similar backgrounds who had been separated by age six weeks and adopted into comparable homes. By age 29, those born to alcoholic parents had an addiction rate of 20% compared to 5% with nonalcoholic parents (Goodwin, 1973). That is four times greater than normal.

Because addiction often does not become apparent until drinkers reach their 30's, a much higher rate would be expected for both groups after age 29. True to form, when two student groups from Boston were tracked to ages 55-60, the lifetime rate of addiction for offspring of nonalcohol addicted relatives was 9-10% as compared to 26-34 % for students with several alcohol abusing relatives (Valliant, 1995).

Another way to determine genetic influence is to study people with the greatest similarity - twins. Fraternal twins are born from two eggs and share 50% of the same genes. They have no more similarity than normal brothers and sisters but are simply born at the same time. Identical twins however are born from a single egg and share 100% of their genes. If one twin is addicted to alcohol, does the rate of addiction for the other twin vary depending on whether they share 50 or 100% of the same genes? A Swedish study of 174 twin pairs showed a 28% addiction rate for fraternal twins, and a predictable doubling to 54% for identical twins. (Kaij,1960). After studying twins for decades, researchers find that differences exist between identical and fraternal twins. Identical twin pairs are much more likely to match each other in their predisposition for alcoholism than fraternal twins. Pairs of fraternal twins are more likely to differ in their tendency to be alcoholic - one twin being alcoholic while the other is not. This indicates that genes - not environment - determine alcoholism. This supports the belief that alcohol is inherited not learned (Jay & Jay, 2002). The gene research continues and the debates rage on as well. What is agreed on is that the counselor needs to consider several underlying causes as well as behaviors and counsel accordingly.

The Disease Model of Addiction

The disease model of addiction has a long history. For many health care and alcohol treatment specialists, even today it remains the preferred model for treating patients addicted to alcohol. This theory considers how alcoholics suffer a gradual and progressive addiction leading to loss of control over alcohol. Addiction is a process in which a person develops a dependence on a mood-altering substance. An addiction is accompanied by obsession, compulsion, and loss

of control. When not using the substance the person who suffers an addiction thinks about, plans, and looks forward to using again. It is that cycle that defines the behavior as an obsession (Gorski & Miller, 1986). Using alcohol interferes with healthy living yet there is a compulsion to use again in spite of immediate and long term painful consequences. Addiction is differentiated from earlier use by the lack of freedom of choice. Addiction, characterized by a compulsive use of a substance resulting in physical or psychological dependency, is usually accompanied by increased tolerance. The person is unable to restrict or control drug or alcohol use. As addiction develops, individuals lose control over intake and invest their energies in obtaining further access to alcohol (Stimmel, 2002). With a condition so misunderstood and stigmatized, the idea that a disease process is the cause of the problem of drinking or drugging is foreign to and even rejected by many people (Erickson, 2007).

While the disease model of alcoholism is generally accepted today, until the medical research in the 1960's of Dr. Jellinek it was believed to be a psychological weakness or a moral issue. In defining a progressive, addictive medical disease by stages, Jellinek dramatically altered conventional theoretic approaches to alcoholism. He described a downward spiral of identifiable symptoms and behavior distinguishing certain stages: The purely symptomatic stage, which includes, pre-alcoholic and pro-dromal phases. The addictive stages marked by physical dependency and loss of control. Jellinek worked within a medical framework, classifying alcoholism as a disease with more than 40 specific symptoms (Brown, 1985). Also he classified alcoholics as falling into five "species" although he believed there could be more. Jellinek serves well as a foundation on which future researchers build to continue to further understand

the origins of the addiction. It must also be noted that Jellinek was careful to caution that his theory was a working hypothesis in need of empirical testing and refinement (Lender, 1979; Miller, 1992).

For example, the work of Dr. E.M. Jellinek in the 1950's and 1960's led to the acceptance of alcoholism as a disease by the American Medical Association (AMA), the American Medical Society on Alcoholism (AMSA), the National Council on Alcoholism as well as The American Psychiatric Association, and the American Academy of Family Practice. It is also considered a disease by the American Psychological Association, American Public Health Association, American Hospital Association and the World Health Organization (Jellinek, 1960). Clearly, while the disease model has its skeptics, the medical community agrees that it is a mental health issue affecting millions of Americans and need to be further researched and studied. The work of Jellinek was invaluable to this belief.

Even among those who have accepted alcoholism as a disease there persisted a belief that its primary cause was psychological. Dr. James Milam (Milam & Ketcham, 1981) has made a major contribution to the recognition of alcoholism as a primary physical disease by building on the previous work of Jellinek. He challenged the notion that alcoholism is caused by psychological susceptibility and presented instead the evidence that the body of someone who becomes addicted to alcohol does not react in the same way as the body of someone who does not become addicted.

Dr. Robert Karp, program director for genetics at the National Institute on Alcohol Abuse and Alcoholism's Division of Basic Research, explains that alcoholism is one of the most

complex diseases we know and continues to be a great challenge for scientists. Although the research is making progress, science must develop new scientific methods to meet the demands of studying the disease. Dr. Karp further states, “Even though researchers have not located the genes responsible for alcoholism, there is an overwhelming amount of evidence that alcoholism is inherited.” This evidence has been gleaned through decades of adoption studies. (cited in Jay, 2000, p. 23) .

In spite of the on-going research and debate among alcohol theorists about the tenets of the disease model, there is agreement that alcoholism has genetic, psychological and environmental contributing factors. On those points there is complete consensus.

Family History

It is important to understand the environment and the family system in which the alcoholic lives. This is because we can see that alcoholism tends to run in families with a genetic predisposition and/or a higher chance factor of addiction. That would indicate that one or more parent was previously alcoholic. If a parent was an alcoholic, than he/she displayed typical alcoholic behaviors.

The term ‘alcoholic family’ refers to a family in which alcohol is the organizing principle. Family members develop the same behavioral and cognitive disorder as the alcoholic; they are controlled by the organizing principle of alcohol and yet deny it at the same time. What is most important in looking at the family as whole and individual members separately is to understand the degree to which alcohol was and is the main organizing principle. (Brown, 1985, p. 236)

The alcoholic tends to develop his own set of behaviors to facilitate his drinking episodes. As the disease progresses and the drinker begins to try to put time constraints and amount constraints on his spiraling-out-of-control drinking he frequently fails and begins to lie to himself and others about the problem. At the same time shame and embarrassment begin to surface. Hiding drinking and lying about the amount consumed begins to accelerate. After more inevitable problems the alcoholic begins to feel loss of self-respect and self-worth and loneliness develops. The alcoholic continues to drink. Denial of problems and compulsiveness to continue drinking contribute to the progression of the disease. Alcohol creates its own confusion and fog and those drinking too much cannot see clearly. If the alcoholic is a parent research indicates that his children develop a certain set of sick behaviors to cope with the out of control environment in which they live. Understanding the individual family environment is extremely important in dealing with individual patients. Through a clear understanding of what it is like in the family, the particular family dynamics can be understood, including the degree to which alcohol is indeed the major organizing principle in the family (Brown, 1985).

Lacking proper coping mechanisms to adjust to living in a difficult world and seeing excessive drinking behavior as a panacea for problems, one can see how the disease progresses in the alcoholic family. In the alcoholic family there can be considerable dissonance. What is most visible and most problematic, the alcoholism itself, is most vehemently denied. When the consequences of the alcoholism become more visible and difficult to resolve (job loss, drunken driving, and physical abuse), the need for secrecy grows and the family rapidly becomes a closed system. Children must join in this denial or risk betraying the family. They learn not to trust

their own perceptions of reality, not to say what they see, but rather to view the family experience through an alcoholic perspective modeled by both parents. In this atmosphere, the child's needs, feelings, and behavior are dictated by the state of the alcoholic at any unpredictable time in the drinking cycle (Black, 1981) .All family members struggle to find ways to control a system that is by nature out of control. In the alcoholic family children often take on awesome responsibilities, both real and imagined. They learn early what is expected of them in rapidly changing situations, switching from child to parent to peacemaker, always attempting to control the actions of others. There are so many similarities among alcoholics who came from an alcoholic home that this connection to that experience must be part of the therapy and his treatment.

Women and Alcohol: History, Different Problems, Different Needs

Historically women have had a very different relationship with alcohol because of the added stigma of being women. In Roman times, female drinking was not only illegal but punishable by death (Blume, 1986). Women in colonial America drank on social occasions and were the majority of tavern keepers. Excessive drinking in the nineteenth century was done by both men and women but was considered especially reprehensible for women. The punishment for public drunkenness for both sexes was imprisonment (Straussner & Attia, 2002).

Women became the driving force behind the temperance movement but it was not their own excessive drinking that concerned them. If a women was married to a drunk there was no divorce allowed and little help provided other than social mores that put forth the concept that wives stay in a situation that often involved physical, emotional and financial abuse. Prohibition

did not put an end to alcohol use and illegal use flourished. After prohibition was overturned and women won the hard earned right to vote, they gained additional freedoms and independence such as the right to work. Women became more socially and economically independent and they too began drinking more frequently and openly. After World War II more women were drinking, driving, smoking, attending college and using birth control than ever before.

Whether women smoke, drink, or use drugs is determined more by their environment than by their genetics. But whether this use will become dependence is determined more by genetic susceptibility (Califano, 2006). No formula exists for who will engage in substance use and whether or not that use will become abuse or dependence. In many cases common biological or genetic factors can account for the co-occurrence of substance abuse and psychiatric disorders. Certain mental health disorders in a biological parent relate to similar disorders in children, and these mental health disorders tend to co-occur with substance abuse and more frequently in women (Giancola & Mezzich, 2000).

Drinking is especially dangerous for women. They suffer heart, liver, and brain damage after drinking less, and for shorter times, than men. (Kirkpatrick, 1984) A woman's risk of liver cirrhosis becomes significant when she averages just two drinks per day. Women's bodies process alcohol differently than men's bodies. When a man and a woman are given the same amount to drink, we'd expect the women to be more intoxicated due to size differences. But we would never anticipate that her blood alcohol level would be significantly higher even after adjusting for weight (Frezza, 1990). As a result, a typical woman having two to four drinks is at least 50% more intoxicated than a man drinking the same amount. Most cultures, though, simply

used social taboos, rather than laws or punishment to curb the practice of women drinking. The image of women as the mother and caretaker was a pervasive picture in culture and added to the stigma and secretiveness under which women drank. This overly protective position and paternalistic mentality had some benefits. Because of the social stigma connected to women drinking the genetic time bomb carried by many women failed to explode and women with a family history of alcoholism did not engage in the years of heavy social drinking that can lead to dependence. As a result, addiction rates for women have always been significantly lower than men's rates. Today, though, the statistics are far more alarming:

- Six million women in the United States abuse or are dependent on alcohol.
- Approximately one-third of all girls had their first alcoholic drink before entering high-school.
- Nearly half of high-school girls drink alcohol and more than one in four binge drink.
- Teenage girls who are heavy drinkers are five times more likely to have sex, and a third less likely to use protection, than girls who don't drink.
- Frequent binge drinking in women's colleges increased by 124 percent between 1993 and 2003.
- Alcohol is involved in as many as 73 percent of all rapes and up to 70 percent of all incidents of domestic violence.
- Women who drink get drunk faster, become addicted more easily, and develop alcohol-related diseases more readily than men who drink (Califano, 2006).

Often women are unprepared to handle and face life's problems and difficulties so support and intervention is desperately needed. As mentioned earlier, with gains made in independence and entrance into the work force after World War II, women also joined the statistics of those becoming addicted to alcohol. Women have become even more accepted in the drinking culture after the sixties and seventies removed many social taboos.

If it is true that many women also carry the genetic propensity that will ignite with significant exposure to alcohol, permissive attitudes should lead to increases in alcohol addiction rates in women. Others too will become addicted through excessive years of use and will contribute to this increase. That is exactly what the statistics are showing.

Another dangerous impact of the female heritage is that women became more secretive in their drinking and suffer greater anxiety and depression as well as lower self esteem than men (Ashley, 1986). Men go out socially and drink and even over drink and it is socially acceptable. Women more frequently conduct their drinking in secret or underground because the stigma of alcoholism is still much greater for women. Most women alcoholics feel guilty about their drinking and this is even more profound if she is also a mother. Women alcoholics also tend to have pre-existing depression and histories of abuse, sexual and otherwise, in greater numbers than the general population.

Sources of Help

There have been enormous grass roots efforts to offer help to those, both male and female, attempting to recover from alcohol related issues. One of the better known and extensive in its outreach is the organization Alcoholics Anonymous (AA). Alcoholics Anonymous is an organization of men and women who have a common goal which is to stop drinking and to stay sober. (Alcoholics Anonymous, 2001). It was started in 1935 by two men, Dr Bob and Bill Wilson in Akron, Ohio. It was based on the concept of the power of sharing experiences in a confidential and informal setting. The common bond of membership and what brings the members together is their negative experiences with alcohol. Members help each other accept the fact that they cannot drink and offer support to meet the challenges of daily living without drinking. Alcoholics Anonymous is unstructured and has no rules, regulations, dues, affiliations, or membership cards. The philosophy behind Alcoholics Anonymous, which is intended to become a way of life, is called the program. This program consists of twelve steps or principles which, when applied, can change the quality of a member's life. Meetings are held daily and nightly all over the world. Open meetings are open to the public for anyone who has an interest in alcoholism. Alcoholics Anonymous also offers a non threatening way for family members of alcoholics to learn about support programs designed to help (Alateen and Alanon). The closed meetings are for alcoholics only. A particular topic or step is suggested and that becomes the focal point of the group's sharing. Although alcoholism is the common bond that weaves its way in and out of the member's stories, a meeting may be devoted to subjects like anger, procrastination, impatience, or keeping life simple (AA, 2003). The focus of the meetings is to

help members grow in life skills and to remind the member that he/she cannot drink. Most members do outside reading related to the psychological aspects of alcoholism. Learning new coping mechanisms to navigate a difficult world is a key element to sobriety. The program of AA is an important program to take under consideration when treating the alcoholic.

Treatment: Classic 12 Step Model

Since the adoption of the disease model for alcoholism in 1960, beginning treatment has consisted of a detoxification from alcohol followed by a length of stay in a treatment hospital specializing in alcohol. The treatment consists of a program generally based on the Alcoholics Anonymous model of the twelve steps and supplemented by family counseling, vocational counseling, skills training like anger management and other various therapies. The first step in treatment is detoxification which consists of removing the toxic substances from the body. Acute withdrawal symptoms that emerge when the chemical is removed can be very serious. Withdrawal is a medical problem and should be treated and monitored by a physician ideally in an inpatient treatment center or detoxification unit of a freestanding hospital.

In most instances a choice to stop using alcohol is not sufficient to bring about long-term sobriety and recovery unless the decision is accompanied by additional treatment of some type. Many well-intentioned, chemically dependent people have made honest attempts to quit using but without help they have not been successful.

Detoxification alone is not adequate treatment. Addiction affects all aspects of a person's life. Recovery requires long term physical, psychological, behavioral, social, and spiritual change.

Education is an important aspect of treatment. Individual and group counseling in a hospital inpatient or outpatient program or a nonhospital residential setting are vital components of treatment. The intent of counseling is to facilitate the development of skills that will support ongoing sobriety and long term recovery.

Often times the home situation is a place where family members are using mood-altering substances and it is very difficult to maintain abstinence around others who are using alcohol. There are also many times in the course of recovery that the recovering person will confront specialized problems. These may include financial difficulties, marital problems, emotional or psychological disorders, or behavioral problems that are the direct result of the addiction. While these can improve with a self- help program, it has been shown that professional counseling and therapy can provide assistance in resolving these problems also. Management of these symptoms, as well as understanding and accepting the ability to manage feelings and emotions, is vital to recovery. It also includes overcoming the guilt and shame associated with addiction and possibly related to family of origin issues. Stress management, developing coping skills, and balanced living are the goal of recovery. Maintaining abstinence requires resolution of family, work and social problems that were created by active addiction. It also involves the development of new and more meaningful social networks (Erikson, 2007).

Treatment in the 1960's through the 1990's consisted of a thirty day inpatient stay in a treatment facility. This treatment was generally paid for by insurance companies and the participant was generally working for a company that had insurance coverage for this care. The insurance companies decreased the length of inpatient stay in the early 1990's to a maximum of

seven days. The rest of what would have been the 30 days was performed on an outpatient basis in the days or evenings, which greatly reduced the cost to the insurance companies. Generally patients were only allowed one treatment per year. The loss of jobs with insurance in the mid 1990's until now has led many alcohol dependent people or their families to seek other long term extended care. Well known treatment centers like Hazeltown often have longer term recovery houses where clients live together for thirty to ninety days to continue a twelve step based program and offer mutual support and accountability to members. The goal of twelve step based treatment programs is lifelong abstinence, attending AA meetings, and continued counseling for other problems. The therapist may use cognitive behavior therapy to search for and change learned behaviors that have become problematic.

The Community Reinforcement Approach (CRA)

Another treatment method for helping people with alcohol problems is known as the community reinforcement approach or CRA (Cloninger, 1988). Developed in 1960 it is based on the philosophy that if a person is going to give up something they enjoy such as drinking, it needs to be replaced with something that is even more enjoyable. The program helps the recovering drinker build a life of positive interactions that do not depend on drinking. It is best practiced under the guidance of a trained counselor who has had special training in understanding the aspects of the program. The focus is to learn new coping skills, try new activities and find and keep employment which is enjoyable. The client and counselor focus on ways to change the addict's life to one of positive interactions and eliminate negative ones. Ideally, the recovering person develops a life without alcohol that is too positive and enjoyable to

jeopardize or give up. While the Community Reinforcement Approach does not maintain its own website, an internet search will provide history of the cognitive-behavioral approach for therapists or patients.

Moderation Management

There are those who have had trouble with alcohol and who are concerned about their drinking but who do not fit the description of the alcoholic. Groups such as Alcoholics Anonymous which emphasize complete abstinence from alcohol do not appeal to such drinkers because of their strict guidelines. For those people a program which offers way to control and limit their drinking and manage the negative effects of their drinking is appealing. Moderation Management is a self-help organization founded by Audrey Kishlin designed for people who want only to reduce their drinking. It is a program geared more toward the problem drinker and away from the true alcoholic (Gilliam,1998). Moderation Management makes a distinction between the alcoholic and the problem drinker. It says that the problem drinker is too quickly labeled an alcoholic and the heavy handedness of the abstinence only programs will not work for them. The program's founder believes that the problem drinker is far more prevalent than the alcoholic and is in need of different treatment. Moderation Management not only guides alcoholics toward abstinence-based programs but informs them of their options such as Alcoholics Anonymous, Rational Recovery and SMART (Self Management and Recovery Training). They try to help problem drinkers at the earliest stage at which drinking becomes harmful. The program consists of nine steps toward moderation and balance which encourage members to examine how drinking has affected their life and determine under what

circumstances they drink (Gilliam, 1998). It teaches members to learn the guidelines for moderate drinking, abstain from drinking for thirty days and make positive changes (www.moderation.org).

Rational Recovery

The Rational Recovery, RR, program was founded by Jack Trimpey, an Alcoholics Anonymous dropout. In response to his dissatisfaction with Alcoholics Anonymous, Trimpey wrote a book entitled *The Small Book* (Trimpey, 1995), a rebuttal to *The Big Book* of Alcoholics Anonymous. At the time it was published, *The Small Book* was very controversial and seen as AA bashing by many. However Trimpey's program has gone on to help thousands recover from the insidious pull of alcoholism. Rational Recovery does not depend on a higher power or any other spiritual component. For many people the spiritual component of AA is an area where they cannot reconcile their belief system. Trimpey places complete reliance in the power of one's own rational mind to overcome addiction. He uses a process called Addictive Voice Recognition Training to strengthen the rational mind and to help alcoholics identify and overcome the influence of the addictive mind (Trimpey, 1995).

In both *The Small Book* and his follow up work, *Rational Recovery*, Trimpey debunks many of the theories of Alcoholics Anonymous as being irrational. He writes in his book that, "The difficulty in getting stopped stems, in large part, from the extremely popular, irrational alcoholic belief that alcoholic people cannot choose to become non-addicted. The truth is that many do, and do so every day (Gilliam, 1998). Like the other maintenance programs, Rational Recovery

operates under the philosophy that the problem drinker is not addicted to alcohol but does abuse alcohol in their personal life (www.rational.org/).

SMART Recovery Program

SMART, an acronym for Self Management and Recovery Training is designed to help the individual gain independence from addictive behavior. Like other programs which address the destructive role alcohol can play in the life of an individual and a family, SMART helps by offering alternatives to destructive decision making. The program operates from the idea that the user responds to urges and behaviors without consciously learning how to cope with the cravings. It offers strategies for balancing short-term and long-term pleasures and satisfactions in life. If alcohol has assumed a negative role in the life of an individual, that person needs to be deliberate and thoughtful about how alcohol enters into their decisions toward coping with stress. Abstinence is the ultimate goal but more important is teaching someone to use strategies for making crucial life decisions. Not only does SMART encourage abstinence from alcohol but from all addictive behaviors. By examining what role a substance plays in covering up a deeper issue, a person can initiate long term change. The program is based on scientific knowledge and evolves as scientific knowledge progresses. (Fletcher 2001)

How an individual finds a program that best meets his/her needs depends on a skillful counselor understanding the nature of the client's abuse of alcohol. Literature exists which describes in detail the strengths and weakness of the several recovery programs. All of the recovery programs discussed, have web based information available as well as on-line support (www.smartrecovery.org/).

Relapse Prevention

Although addictive disease can be controlled it can never be cured. (Gorski & Miller, 1986) There is always the possibility of a relapse. Unless measures are taken on a long term basis to control the alcohol free or alcohol reduced lifestyle, relapse is likely. The first step is to recognize that problems have again develop related to alcohol use/abuse/dependence and the possible negative consequences. The next step is total abstinence from all mood altering chemicals. The third step is to recognize warning signs on a daily basis that preclude potential problems in living life with all of its issues and concerns. Recovery from an addictive disease requires a lifetime of changes. The first two to three years are considered stage one recovery. Studies indicate that it takes an average of eight to ten years for an alcoholic to fully return to preabusive state. (Desoto, Clinton, Alfred, & Lopes, 1985) Recovery from addiction must be an active program that will include and provide guidelines for productive and healthy living. The belief is that balanced living means living responsibly, having time for work, family, friends, spiritual growth, and growth in other areas of life. Issues in any of these areas may underlie the start of chemical use. A person must achieve a balance between meeting responsibilities to others as well as needs for self fulfillment. Change in life causes stress for the recovering persons who may be less able to handle stress because of faulty or undeveloped coping mechanisms. Stress may trigger denial - the faulty coping mechanism. Denial of a problem may increase stress and activate symptoms of post acute withdrawal. These include poor decision-making skills, not talking to others about the emerging problems, and losing control of emotions. When this happens the stage is set for a sometimes subtle behavior change. These changes may

undermine the consistent life patterns that have been carefully set in place to maintain stability. Loss of control of judgment precedes loss of control of behavior which is the last step before a full blown crisis may reactivate the drug or alcohol use problem.

Relapse prevention is a lifelong process for recovering people. Through education and sharing, individuals can regain control of their lives. Assessment of a problem situation, relapse sign warning identification, warning sign inventory, daily personal inventory, and a solid recovery program are the best insurance against reactivating a chronic, deadly disease.

Treating Dual Diagnosis

The term dual diagnosis is a common, broad term that indicates the simultaneous presence of two independent medical disorders. Within the fields of mental health, psychiatry, and addiction medicine, the term has been popularly used to describe the co-existence of a mental health disorder and Alcohol and Other Drug (AOD) problems. Common examples of dual disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, polydrug addiction with schizophrenia, and borderline personality disorder with episodic polydrug abuse (Ries, 1994). The combinations of alcohol and drug problems and psychiatric disorder vary along important dimensions such as severity, chronicity, disability, and degree of impairment of functioning. The two disorders may each be mild or severe, or one may be more severe than the other. Also the degree of the severity of either disorder may change over time.

Patients with mental disorders have an increased risk of AOD disorders and patients with AOD disorders have an increased risk of mental disorders (Ries, 1994). About one-third of

patients who have a psychiatric disorder also experience AOD use at some point, which is about twice the rate of people without a psychiatric disorder (Reiger, 1990). Also more than half of the people who use or abuse AOD's have experienced psychiatric symptoms significant enough to fulfill diagnostic criteria for a psychiatric disorder(Reiger,1990). Compared with patients who have a mental health disorder or an AOD disorder alone, patients with dual disorders often experience more severe and chronic medical, social, and emotional problems. Because they have two disorders, they are vulnerable to both AOD relapse and worsening of the psychiatric disorder. Addiction relapse often leads to psychiatric decomposition, and worsening of psychiatric problems often leads to addiction relapse. Relapse prevention must be specially designed for patients with dual disorders. Compared with patients with a single disorder, patients with dual disorders require longer treatment, have more crisis events, and progress more gradually in treatment.

New Medical and Drug Therapy Treatments

The American Medical Association recognized addiction as a disease in 1956. The work of E.M. Jellinek in his seminal work, *The Disease Concept of Alcoholism* was instrumental in getting alcoholism classified as a chronic, medical disease recognized by the American Medical Association. The Diagnostic and Statistical Manual 4th Edition also classifies alcohol dependence as a psychiatric diagnosis. This research supported the fact that alcoholics deserve compassion and care by the medical and psychiatric communities. This classification also binds the insurance companies whether private, state, or federal, to recognize that a disease exists and

measures to treat it should be compensated. New treatments with drug therapies and vaccines are addressing the physical and mental nature of this disease.

One of the earliest drugs to treat alcohol addictions was Antabuse. The drug, if combined with alcohol, causes rapid heart rate, nausea, vomiting and fainting. For some people who are abusers of alcohol the threat of getting sick is sufficient to keep them sober (Erickson, 2007). The drug is combined with behavior modification because the patient must take the drug in the morning when the craving for alcohol is at its lowest. Then as the day progresses it is the knowledge of how ill they will become that staves off taking a drink.

Another new drug currently in use for alcohol dependence is Naltrexone (Vivitrol). In April 2006 the FDA approved its use in therapeutic environments. The manufacturer's recommended dose is one time monthly IM of 380 mg of Naltrexone. The intramuscular route of this medication makes it difficult to skip. The drug blocks the effects of any alcohol taken orally so that alcohol provides no effect. Recommendations for this drug say it is to be part of a comprehensive management program which includes psychosocial support (Vivitrol prescribing information, 2006).

Several studies have indicated that when patients are undergoing treatment for alcoholism, the drug Naltrexone (ReVia, Vivitrol) has been effective. It is the first drug since Antabuse to be approved for treatment for those with alcohol dependence. It works by preventing the euphoric and rewarding effects of alcohol in the brain by blocking the endorphin rush. Medical studies have determined it to be about 50% effective because not all alcoholics get an endorphin rush from alcohol (Erickson, 2007). The research is young and most physicians are

not aware of the drug and are not comfortable writing a prescription for it. The effectiveness of the drug increases with the combination of anti-depressants and counseling. Early studies have shown few side effects and positive results (Erickson, 2007).

Drug therapy has been shown to be most effective when combined with the support of abstinent or management programs and ongoing counseling. There continues to be clinical trials and extensive research in this field but most counselors and health care professionals agree that it is still in its infancy. Scientific conclusions are always open to challenge and certainly more research is needed in these areas.

In summation, the study of the chemical of alcohol and the impact it has on the brain has been the focus of decades of research and documented studies. Many issues related to alcoholism and its treatment still need much more research. While there are a lot of empirical data and study findings, the studies which put into context real-life people and outcomes have the greatest insight into the real truth.

Genetic research elucidated the relevance of a family tolerance to alcohol. The findings point strongly in the direction that regardless of the strata of society in which a person is raised or the family system in which they flourish, the genetic strand is present and powerful. The research of twins separated at birth has been reproduced throughout the years and the findings remain consistent. New brain research conducted within the last ten years has confirmed the susceptibility of a predisposition to an addiction to alcohol. The twins study also considered the influence of environment and there too the findings were profound. The conclusion was that a

strong family system which intervenes early and is patient and loving can delay and even thwart the progression into full blown alcoholism, but the powerful genetic factor is still omnipresent.

The family environment is how most people form their attitudes and understanding about alcohol and drinking. The taboo of drinking and even drunkenness has been lifted in our society and children from an early age see how accepted its use is. Research has shown that children exposed to one or more drinking adult role models contributes greatly to their perceptions about alcohol. Even living in a home where alcoholism is present can become the norm for young family members who are not educated to the contrary. Without outside intervention or a strong support system, young family members will experience the long term and true life consequences of living in such an environment. Again, research supports that it is a training ground for the next generation to develop patterns of alcohol misuse or abuse. Family attitudes about alcohol, alcoholic adult role models, and unspoken messages have led to an environment that has had the effect of desensitizing alcoholism.

The role of genetics and the role of environment are huge issues but the concept of alcoholism as a disease is also important. The dependence syndrome has challenged the concept of addiction as they believe it differs significantly from other diseases. Some dispute that a “disease” which require the afflicted to consume voluntarily the substance that triggers the compulsion, is instead a behavior problem. The critics believe that classifying alcoholism as a disease, releases the abuser from their behavior. Chemical dependence is considered a brain disease and has gained popularity in the scientific differentiations considered by researchers. The debate as to whether it is a disease or a behavior has implications in the treatment of the patient.

The medical staff members who care for the alcoholic will be affected by whether they think they are treating a self induced condition or a medical disease, It remains a controversy if the addict is a sick person or not. While the research continues, the treatment options are adapting to the needs of the problem drinker.

CHAPTER III: CONCLUSIONS AND RECOMMENDATIONS

For people who struggle with a compulsion to abuse alcohol, there is a desire to find a solution to the suffering. The loneliness and shame caused by the overwhelming need to over consume is devastating. Recovery programs and self help groups are different from treatment and counseling but they are a significant piece of the recovery process. When a person enters treatment, the focus is on addressing the physical and psychological consequences of the drug abuse. Detoxification and medical management is crucial to the life of the patient. Medication to treat depression, anxiety or obsessive compulsive disorders is also often part of the treatment process. Advances in pharmacology and the treatment of brain disorders have been enormous in the last decade and counselors should be current on the efficacy of the medicines. Once that part of the process is complete, recovery groups as on-going process are recommended. While Alcoholic Anonymous is the most well known of the recovery programs, it is certainly not the only option available. Alternative group programs believe that not all alcohol abusers are alike. They believe they should seek a recovery program which addresses their particular behavioral needs. Programs such as Moderation Management and Smart Recovery, teach that each person should examine their state of mind and environment when deciding to drink. For instance, if one is drinking to ease anxiety in a social setting, they should ease the anxiety and avoid the dependence on an artificial solution. The belief is that in a case like that, the person actually suffers from an anxiety problem and that is what needs to be managed. Thus alcohol is a solution rather than a symptom. Secular groups have rejected the spiritual component of the Alcoholics Anonymous program and have splintered into alternative programs. Some stress managing thinking and behavior rather than completely abstaining from alcohol. While some of

the programs assume alcohol in moderation is manageable, others advocate only complete abstinence for the rest of their lives. The key to managing alcohol for the alcoholic is to find a program which respects their spiritual and life experience beliefs. Also necessary, is to address how alcohol affects family members, employers and society at large. Family members and those who are affected by the alcoholic also need support and counseling.

What all of the programs seem to share is the strength of the power of others sharing their experiences and giving the alcoholic hope for a future free of chemical dependence. For the professionals working with the chemically dependent and their families, knowledge of such programs is crucial. The tools for treating the alcoholic offer variety of options. The literature changes quickly, but the fundamental principles remain the same. It is that the alcoholic is suffering and the counselor is one of the key parts in leading them toward a future of hope and dignity.

When people become aware that alcohol is causing a problem in their life they face the task of deciding what to do about it. If their drinking problem is more dramatic, however, there are often intervention systems which are part of the decision making. Often accompanying the problem is the pressure placed on the client from others who are affected by his/her drinking. There are various stages to the user's drinking problem and a counselor must be aware of those stages. The research conducted broke down the background of the alcohol user's genetic history as well as family system and their relationship toward alcohol. The research focused only on

alcohol, as the companion addictions are so vast and far -reaching as to complicate the treatment course findings. Understanding that the background of a client must be considered in making any treatment recommendations was crucial in the exploration of this topic.

The next part of the research focused on the kinds of programs available and the effectiveness of those programs. Both complete abstinence and drinking modification programs were examined. Recommendations would be determined by the type of drinker the client is, as well as the social and support networks he/she is exposed to. Finally the recent finding in the area of drug treatment therapy was studied. It is in that area that there has been the least amount of progress. The role a therapist and counselor performs is helping the client or patient make an informed decision about the course of treatment and therapy. To do this most effectively, the counselor needs to be cognizant of the most up- to- date information available in the arsenal of fighting this pervasive social and chemical condition. The counselor's role is to provide practical support and suggestions for the individual who has trouble with alcohol and wants to change. The choices offered should be based on reliable data and recent information regarding scientific investigations. Skilled professionals who work with clients who have issues with alcoholism or problem drinking understand it is better to help them make a rational lifestyle choice before a negative life event occurs which forces the change

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www.ncadd.org National Association of Alcoholism and Drug Dependence Web Site

www.samsha.gov United States Department of Health and Human Service Substance Abuse
and Mental Health Services Administration Web Site

www.nami.org National Association of Mental Illness Web Site

www.moderation.org Moderation Management Website

www.rational.org/ Rational Recovery Website

www.smartrecovery.org Smart Recovery Website