

RESEARCH AND PRACTICE: The Great Divide in Substance Abuse Treatment

The substance abuse treatment community and empirically oriented academics concerned with substance abuse treatment share the common goal of reducing the harm caused by substance abuse. Yet, these two communities are deeply divided. They tend to see the causes of the problem and its possible solutions in dramatically different ways. This narrative describes my experiences in the terrain between the two communities, first while working for an insurance company as a substance abuse utilization reviewer, and later as a professor teaching substance abuse treatment to graduate students.

By David A. Patterson

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"If you shut your door to all errors truth will be shut out."
Rabindranath Tagore, *Stray Birds*, 1916, (Davis & Mesner, 1994, p. 163)



While completing my doctoral studies in social work, I worked for a nation-wide insurance corporation as a psychiatric and substance abuse utilization reviewer. In this capacity, I spoke with treatment professionals in substance abuse treatment facilities across the country in order to review the medical appropriateness of admissions and the necessity of continuing stay. This was in the late 80's when there was a dramatic nation-wide rise in demand for substance abuse treatment and an equally dramatic increase in non-profit and for-profit inpatient substance abuse treatment facilities.

In response to the soaring cost of inpatient substance abuse treatment, managed care companies, acting on behalf of insurers, were beginning to constrain admissions to, and lengths of stay in, substance abuse treatment facilities in an effort to control costs.

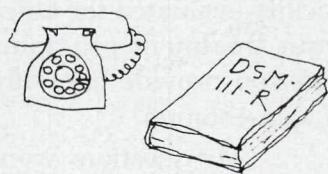
Concurrently, evidence of the lack of efficacy of substance abuse treatment and the findings that inpatient treatment was no more effective than partial hospitalization was beginning to appear in the literature (Annis, 1986; Longabaugh, McCrady, Fink, Stout, McAuley,

Dolye, & McNeill, 1983; Vaillant, 1983).

The goal of the company I worked for was to reduce medical costs by preventing unnecessary admissions and reducing the length of stay by transferring care to less restrictive (and less costly) settings when medically appropriate. As a utilization reviewer, I sat in a work-cubicle all day in front of a computer and spoke to representatives of treatment facilities across the country. Essentially, my job was to ask questions such as; "Why does this person need inpatient care as opposed to outpatient care at this time?" "Have there been previous attempts at outpatient treatment?" "What types of assessments have you done with this person and what are the findings that support your request for inpatient care?" "What are the goals of treatment that have been individualized for this person based on your assessments?" and finally, "Has your facility evaluated the efficacy of your treatment programs and can you provide me with such documentation?"

My questions were generally not well received. Even in those early days of managed care, calls from a utilization

review worker was not a welcome event. At least once, a physician referred to my colleagues and myself as minions of the insurance company devil. Second, because the questions I asked were shaped by my doctoral training with its emphasis on empirical research of clinical outcomes, they flew in the face of a treatment community that saw itself hard at the task of fighting a deadly disease. In answer to my questions, and almost always regardless of circumstance, I was provided the following answers: "The patient needs inpatient hospitalization because he/she was in denial about his/her disease." Outpatient treatment was inappropriate because the patient needs 28 days of inpatient treatment to break down their denial." "The patient meets DSM-III-R criteria for a substance abuse related disorder and therefore he/she needs inpatient care." "The goal of treatment is for the patient to work the first four steps of AA's 12-steps." and finally, "Our facility has not evaluated our program but we know it works because those patients who continue in aftercare tell our staff it has worked for them."



As my experience grew in reviewing cases with counselors, utilization review nurses, program managers, and physicians in drug treatment facilities across the country, it became apparent that we were not seeing the same information in the same light. Despite attempts on both sides to maintain respectful and cooperative relationships, the interaction would at times become adversarial. In most cases, I was told that what was required for this life-threatening condition was inpatient detoxification and an inpatient stay in which the patient would be educated about the "disease," would receive individual and group therapy, and would begin work on the 12-step program. The inpatient stay followed by weekly aftercare groups and attendance at 90 AA meetings in 90 days. I was familiar, however, with the emerging literature on substance abuse treatment failure rates. Consequently, I had little faith in the treatment plans, time frames, and interventions being proposed. Moreover, reviewing the case by phone and by express-mailed case records from the safety of a work-cubical hundreds or thousands of miles from the actual patient, I was insulated from both the context and the reality of the patient's life and the attendant anxiety it provoked in the treatment staff. One patient, one problem, seen from two worlds apart.

I was continually struck by the indifference expressed by treatment personnel at all levels to both the evaluation of the treatment efficacy of their

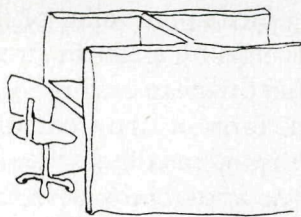
particular program and to the research literature in general. In a year and a half of daily admission reviews, only one facility was able to provide me with any outcome data on treatment efficacy. This high-cost facility in the western United States had done a single study on the effectiveness of an inpatient cocaine addiction unit in which, not surprisingly, their program appeared to be successful.

My most frequent discussions were with the nurse or social worker responsible for utilization review at the treatment facility. I would often ask, "Why should we pay for a program when you cannot demonstrate it works?" This question usually brought an initial stunned silence and then a shift of subject to the urgency of the case at hand. If pressed on the issue, there was usually an acknowledgment of the need to evaluate the program and the excuse that staff trained in evaluation, nor was there time, or money to carry out such program evaluation. All of which I am sure were true. On a number of occasions, I heard from representatives of treatment facilities that many of the treatment staff were graduates of the treatment program and the success in recovery was clear evidence that the program worked. At the time, I recognized the obvious selection bias in this "evaluation" measure. It was not until some years later that I began to see how such a bias constructs a perception of treatment efficacy dramatically divergent from the

one that emerges in the research literature.

My view of substance abuse treatment during this time was molded by the all too often accounts of repeated treatment failures. When reviewing cases at the time of admission, it was routine to ask about prior treatment. Frequently, the representative of the treatment facility reluctantly acknowledged that the patient had previously been treated one or more times in this program or elsewhere. I read case records with recurrent examples of patients who had been pressured into treatment and then upon discharge, 28 days and thousands of dollars later, resumed their substance abuse. Here, too, was a selection bias. I did not hear, or read, the case histories of those whose lives were dramatically changed by their treatment experience.

My perception of substance abuse treatment was further colored by research literature emerging in the late 80's. One stream of research was beginning to suggest that partial hospitalization programs in substance abuse treatment were at least as effective and more cost efficient than inpatient programs (Alterman, Hayashida, O'Brien, 1988; Annis, 1986; Longabaugh, McCrady, Fink, Stout, McAuley, Dolye, & McNeill, 1983). Despite this growing body of literature supporting the use of partial hospitalization in lieu of inpatient treatment, I encountered no instances in which partial hospitalization was proposed as the first treatment option.



During the same time period, numerous studies were published on the treatment efficacy, across treatment settings, of teaching patients behavioral skills such as social skills training, stress management, and behavioral self-control (Chaney, 1989; Miller & Hester, 1980; Hester, & Miller, 1989; Miller, Taylor, & West, 1980; Prochaska & Diclemente, 1984). In questioning representatives of treatment facilities about what treatment modalities were to be provided to a patient, I never heard that behavioral skills were to be taught. Psychodynamic group psychotherapy, individual counseling, educational groups, and AA 12-step work were the most commonly reported treatment modalities, despite the fact that none of them had empirically demonstrated clinical efficacy (Hester, 1994).

In social work, it has long been known that practitioners seldom read or utilize research literature in guiding their clinical practice (Rosenblatt, 1968; Kirk, Osmalov, & Fischer, 1976; Rosen, 1994). On a number of occasions, I pointed out to physicians and clinical staff that the therapeutic offerings of their programs were at variance with the treatment modalities shown to be effective in the research literature. Invariably, the research literature, (except, interestingly,

for the psychopharmacology literature), was dismissed as being out of touch with the realities of hospital practice. Moreover, research findings were discounted as not relevant to the treatment facility's particular treatment population, based on excessively controlled conditions, and treatment methods too complex for the level of training of the facility's counselors. From my own clinical experience in a variety of mental health settings, it appeared that there was an element of truth to all of these reasons. However, in recent years I have begun to believe that this disparity between the worlds of research and practice is formed by the more complex experiential factors that have shaped who we are, how we see that which is before us, and from where we draw our sources of truth.

TEACHING SUBSTANCE ABUSE TREATMENT

For the last four years, I have taught a graduate class in substance abuse treatment.

Despite my lack of direct practice in a substance abuse treatment facility, I was asked to teach the course because the (then) associate dean of the College of Social Work saw in my resume that I had some experience with substance abusers in psychiatric settings and had worked as a utilization reviewer of substance abuse treatment. As is often the case, while not profoundly qualified to teach the subject, I was the most experienced faculty

member available. The job came to me.

The course I developed emphasizes an empirically oriented, biopsychosocial approach to practice. In my class, I focus on trying to have students understand substance abuse as a heterogeneous phenomenon with multiple etiological sources, diverse and changing manifestations, and multiple possible outcomes. Treatment is presented as a collaborative process, individualized for each patient, based on objective and subjective assessment findings, and employing a variety of empirically validated intervention methods.

The course was formed from three streams of information: syllabi from peers at other universities who teach an empirically oriented approach to substance abuse treatment, the research literature, and my utilization review and clinical experience. Initially, two books, Stanton Peele's *The Diseaseing of America* (1989) and Herbert Fingarette's *Heavy Drinking* (1988), were critical in shaping the focus of my class. Both books provide strong empirically based critiques of the AA /disease model and the limitations of its assumptions about the etiology, course, and proper treatment of substance abuse. So armed with the "truth" of science on my side, I launched into teaching others the "truth" about substance abuse treatment. All the while, I expected that after hearing my "truth," they would embrace it as their "truth."

Over the last four years, the three informational streams of my course, formed on the

slopes of the research front, have been joined in the valley of class discussions by a fourth stream. The headwaters of this fourth stream form on the treatment/recovery side of the divide. The first year I taught the class, there was a student, in recovery, who discussed in class how upset he was by the readings that critiqued the AA/disease model. The student said, "I got so mad reading that stuff, I had to put the book down. It's the complete opposite of everything I was told in treatment, everything I believe."

Initially, I was frightened by the response of my student. I was concerned that, somehow, his sobriety would be undermined if the beliefs on which it rested were eroded by new information. I imagined him relapsing and me, the "heretical" junior faculty member, being blamed for the adverse impact of the "lies" I was spreading. Fortunately, my wife, who is a clinical social worker, was able to offer helpful supervision. She pointed out that he had to base his recovery on what worked for him and he needed to defend those beliefs on which his sobriety was based. So when the opportunity presented itself in class, I made the point of stating that, clearly, the AA 12-step approach does work for many people despite its failure in a number of controlled studies (Brandsma, Maultsby, & Welsh, 1980; Ditman, Crawford, Forgy, Moskowitz, & MacAndrew, 1967; Powell, Penick, Read, & Ludwig, 1985; Stimmel, Cohen, Sturiano, Hanbury, Korts, & Jackson, 1983).

Over the last few years, a number of students, who were in recovery themselves and now work in substance abuse facilities, have taken my class and have challenged and felt challenged by the content of the course, much like the previously described student. "Look," they tell me, "I know AA works because it worked for me and saved my life." "Of course, alcoholism is a disease. It was only when I accepted the fact I had a disease that I could finally stop drinking." "Don't tell me the AA/disease model of treatment doesn't work. I see it work all the time for patients who complete our treatment program." "What do you mean that in the natural history of alcoholism many problem drinkers stop or reduce their drinking without treatment. Alcoholism is a progressive disease and the only three outcomes are death, prison, or insanity."

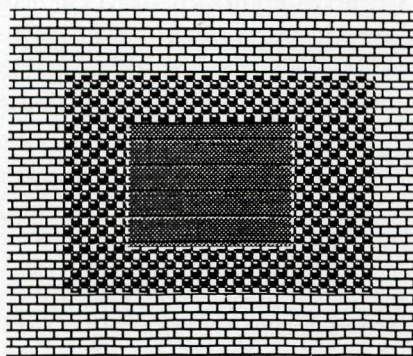
What has continually surprised and baffled me was how these students could read the findings reported in multiple, well-designed studies and yet remain so resistant to changing their beliefs about the causes, outcomes, and treatment of substance abuse. Stated less objectively, "Why couldn't they understand that what they learned while in treatment was simply wrong, that it did not match the world of substance abuse treatment known to and through empirical research?"

The issue finally came to a head for me this year. Our college which has three locations: Memphis, Nashville, and Knoxville. When we recently

began offering courses using interactive television, I volunteered to teach substance abuse treatment utilizing this method. While previously having taught the course to about 15 students each year, I found myself with over 40 students across three locations. Teaching on interactive tele-vision was both challenging and anxiety provoking. Not only was I trying to keep students, in three locations, engaged in the lecture and discussion, but now I had a much larger cohort of students who were in recovery. Many of these students felt personally threatened by the content of the course that challenged the AA./disease model. To make matters worse, I was anxious about responding to these challenges across this new teaching medium.

About three weeks into the course, the class was required to read, as part of their assignment for the week, an article by Miller (1992) in which he first reviews the evidence on treatment approaches, with little or no clinical effectiveness, before going on to report on interventions that suggest cause for optimism in substance abuse treatment. During class I was discussing the lack of empirical evidence supporting the use of AA in the treatment of substance abuse. At that point a student, with considerable treatment experience in one of the remote classrooms, broke in, saying in a tone that was far from deferential, "What do you mean AA does not work? Of course it works. I know lots of people it has worked for, including myself. Sure it works."

I rose to this challenge by quickly pointing out that four articles supporting my position were cited by Miller, which, I was quick to add, was part of this week's readings! I went on to cite possible contraindications for referring patients to AA. At that point, the student did something that truly shocked me. Perhaps not remembering he



was on camera, he mimed being slapped across the face. Students in all three locations saw his response and he made no further comment. I did not pursue the issue of his gesture, partly to avoid embarrassing him, partly because interactive TV did not, at the time, seem conducive to that level of personal inquiry, and partly because I knew that the intensity of my response was indeed a slap in the face. I also knew that during my answer to his challenge, I was angry. My anger was not only toward this student for not reading the assignment, or for his abrupt tone, but also with the fact that so many students in recovery seemed unable to reconsider their beliefs about substance abuse once they were presented with new information. My anger was born from the frustration of not being able to reach, or change, these students and, pos-

sibly, from a reservoir of frustration that had accumulated in my days of doing utilization review.

Later that week I had a conversation with a colleague, who is in recovery, about what happened in class. I explained my frustration with the recovering students who seemed unwilling and unable to re-examine their attitudes and beliefs about substance abuse treatment. I told her that it seemed as though these students had come to school only to have their pre-existing world views confirmed. My colleague reminded me of a quote whose origin is unknown to us about four common tasks of all spiritual practices and which are, perhaps, applicable to both the helping and teaching professions. These four common tasks are (a) show up, (b) pay attention, (c) tell the truth, and (d) don't be attached to the results. My colleague suggested that perhaps I was only accomplishing three of the four tasks because I appeared to be attached to both having the students change and to being right. Wanting others to change, and wanting to be right, were themes I had certainly struggled with, both professionally and personally. Upon reflection, it was no surprise that they found their way into my course.

My colleague went on to say that in one of her classes she had observed the same phenomenon of recovering students being very emotionally attached to what they had learned in treatment and practiced in their recovery. She explained that as a person in recovery herself, and

as a scholar of cognitive-behavioral therapy, she thought that she could glimpse both sides of the divide. She went on to say that for many people in recovery, their attachment to the AA/disease model went well beyond a set of beliefs that could be changed by new information. She said the attachment for individuals in recovery was at a deep emotional level, and for many at a spiritual level. She said further that their lives had been transformed, and often saved, by their experiences of receiving hope, support, guidance, and grace as their recovery progressed. She reminded me that many people in recovery have had profound spiritual experiences and that just as one's spiritual beliefs are often immutable to the logic of prevailing science, so too may be one's understanding of the factors that made recovery possible.

Fortunately, the student with whom I had the confrontation, proved to not only be resilient, but also open to learning. Over the semester he asked challenging questions and offered numerous examples from his own clinical experience in

support of the class material. One night, toward the end of the course, he shared his own experience in trying to reconcile research and treatment. "Look," he said, "I am starting to appreciate what you have been saying about why people abuse substances, that the reasons are complex and possibly have multiple causes, that treatment should be individualized and include behavioral skills training. But I am working with courtordered, resistant patients in our program. It is a hell of a lot simpler to tell them they have a disease, it won't go away, and they have got to quit drinking."

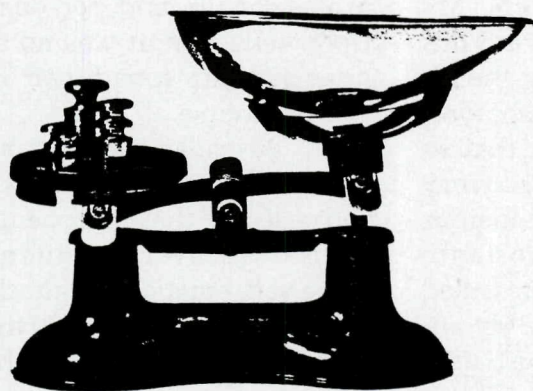
Like this student who is beginning to value the potential contribution of empirical research to his clinical work, I am slowly beginning hear, acknowledge, and appreciate the reports of students and friends whose lives have been made better by traditional treatment methods. The voices of recovering students, raised in class in objection to research findings, also tell other stories. These voices tell of lives nearly lost to addiction, of relationships ruined, careers left

in shambles, and the redemption they found in their recovery. In the telling of their stories, these students bring to the class and give to their classmates a perspective on the reality of addiction not realizable, in reading the outcome reports of treatment experi-

ments.

Just as quantitative research is enriched when it is augmented by the subjective voice of qualitative findings, so too has my class been enhanced by the contributions of recovering students and their peers who are currently working in treatment facilities. My goal for my students and myself is that we hear and honor the wisdom we each bring to our class. It seems that it is the abandonment of our attachments to right and wrong that enables us to move into the place of being most able to learn.

The image of a great divide that separates substance abuse treatment into two camps loses its metaphorical power if one expands his/her vision to see the common valley that unites the two sides. It is in this common valley that the resolution of the opposing sides of the divide occurs. It is my wish that my students and I may inhabit this common ground and draw upon the knowledge and wisdom accumulated on both sides of the divide. I suspect that we will not be alone. Increasingly, I am hearing from experienced substance abuse clinicians of their use of research findings to develop treatment programs in what were formerly very traditional treatment settings. As an academic, I believe that my colleagues and I must move to enrich our work by listening to the many voices that can inform our teaching. In essence, this may be the rent we all must pay to inhabit this common ground.



REFERENCES

- Alterman, A. I., Hayashida, M., & O'Brien, C. P. (1988). Treatment response and safety of ambulatory medical detoxification. *Journal of Studies of Alcoholism*, 49, 160-166.
- Annis, H. M. (1986). Is inpatient rehabilitation of the alcoholic cost effective? Con position. *Advances in Alcohol and Substance Abuse*, 5, 175-190.
- Brandsma, J. M., Maultsby, M. C., & Welsh, R. J. (1980). *The outpatient treatment of alcoholism: A review and comparative study*. Baltimore, MD: University Park Press.
- Chaney, E. F. (1989). Social skills training. In M. G. Galanter & Miller, W. R. (Eds.), *Handbook of alcoholism treatment*. (206-221). Elmsford, NY: Pergamon.
- Davis, R. & Mesner, S. (1994). *The treasury of religious & spiritual quotations: Words to live by*. Pleasantville, NY: Reader's Digest.
- Ditman, K. S., Crawford, G. G., Forgy, E. W., Moskowitz, H., & MacAndrew, C. (1967). A controlled experiment on the use of court probation for drunk arrests. *American Journal of Psychiatry*, 114, 160-163.
- Hester, R. K. (1994). Outcome research, alcoholism, Hester, R. & H. D. Kleber (Eds.), *Textbook of substance abuse Treatment*. (35-44). Washington, DC: American Psychiatric Press, Inc.
- Hester, R. K. & Miller, W. R. (1989). Self-control training. In Hester, R. & Miller, W. R. (Eds.), *Handbook of Alcoholism Treatment*. (141-150). Elmsford, NY: Pergamon.
- Kirk, S. A., Osmalov, M. J., & Fischer, J. (1976). Social worker's involvement in research. *Social Work*, 21 (2), 121-124.
- Longabaugh, R., McCrady, B., Fink, E., Stout, R., McAuley, T., Dolye, C., & McNeill, D. (1983). Cost effectiveness of alcoholism treatment in partial vs. inpatient settings: Six-month outcomes. *Journal of Studies of Alcohol*, 44(6), 1049-1071.
- Miller, W. R. (1992). The effectiveness of treatment for substance abuse: New reasons for optimism. *Journal of Substance Abuse Treatment*, 9, 93-102.
- Miller, W. R., & Hester, R. K. (1980). Treating the problem drinker: Modern approaches. In W. R. Miller (Ed.), *The addictive behaviors: Treatment of alcoholism, drug abuse, smoking and obesity* (11-141). Oxford: Pergamon Press.
- Miller, W. R., Taylor, C. A., & West, J. C. (1980). Focused versus broadspectrum behavior therapy for problem drinkers. *Journal of Consulting and Clinical Psychology*, 48, 590-601.
- Peele, S. (1989). *Diseasing of America*. Lexington, MA: Lexington Books.
- Powell, B. J., Penick, E. C., Read, M. R., & Ludwig, A. M. (1985). Comparison of three outpatient treatment interventions: A twelve-month follow-up of men alcoholics. *Journal of Studies on Alcohol*, 46, 309-312.
- Prochaska, J. O., & Diclemente, C. C. (1984). Toward a comprehensive model of change. In W. R. Miller & N. Heather (Eds.), *Treating Addictive Behaviors: Processes of Change*. New York: Plenum Press.
- Rosen, A. (1994). Knowledge use in direct practice. *Social Service Review*, 68, 561-578.
- Rosenblatt, A. (1968). The practitioner's use and evaluation of research. *Social Work*, 13 (1), 53-59.
- Stimmel, B., Cohen, M., Sturiano, V., Hanbury, R., Korts, D., & Jackson, G. (1983). Is treatment of alcoholism effective in persons on methadone maintenance? *American Journal of Psychiatry*, 140, 862-866.
- Vaillant, G. M. (1983). *The natural History of Alcoholism: Causes, Patterns, and Paths to Recovery*. Cambridge, MA: Harvard University Press.

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