What Works in Addiction Treatment and What Doesn't:

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Abstract

The current trend toward treating drug and alcohol (and other) addictions in disease oriented, 12-step programs has had less success than most people believe. Treatments that teach coping skills, mobilize community forces, and instill values toward prosocial behavior have had success rates far superior to therapies that instruct individuals that they take drugs or drink excessively because they have a disease or because drugs are inherently addictive. Successful treatments instead deal with addicts' interactions with their environments and help them develop beliefs in their self-efficacy. Nonetheless, even addiction treatments which have demonstrated success face limitations in their ability to confront individual intentions and values, community standards, and
environmental pressures and opportunities. At the same time, more individuals have quit addictions on their own than have been successfully treated by even the best therapies. Put simply, no therapy will ever be able in itself to make a substantial impact on our drug and alcohol or other addictive problems. In the meantime, addiction treatment is becoming more pervasive and coercive, and today holds out the possibility of corrupting our society and the self-conceptions of its members. [Translations are provided in the international Abstracts section of this issue.]

WHAT WORKS IN PREVENTING AND TREATING ADDICTION/SUBSTANCE ABUSE?

An expanding body of research has identified which therapies for addiction substance abuse succeed and which do not. Indeed, the American National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) have begun major programs to study the efficacy and outcomes of treatment and prevention programs for alcohol and drug abuse, while the National Academy of Sciences has received a mandate from the U.S. Congress to do like-wise. However, there is already a considerable body of data on these issues—data that show strong consistencies both within individual problem areas and across the range of addiction and substance abuse problems. Nonetheless, the United States government and professional treatment organizations and individual treatment facilities have shown no inclination to make use of the ample data that already exist on these topics, forcing us to wonder what good more such research or compilations of research will accomplish.

Exhaustively surveying the literature on comparative or controlled research on alcoholism treatment, Miller and Hester (1986) noted

Not only is the volume of research large, but it is gratifyingly consistent. The results of well-controlled studies in this area have seldom contradicted one another. ... Certain methods have a very good track record, working well across a wide range of populations and settings. Others seem to have little therapeutic value, and are rather consistently found to yield little impact on drinking behavior when subjected to controlled evaluation. ... As we constructed a list of treatment approaches most clearly supported as effective, based on current research, it was apparent they all had one thing in common...: they
were very rarely used in American treatment programs. The list of elements that are typically included in alcoholism treatment in the United States likewise evidenced a commonality: virtually all of them lacked adequate scientific evidence of effectiveness. (p.122)

Miller and Hester constructed a table summarizing effective and much-utilized therapies (which, as they point out, are mutually exclusive sets) in Table 1. The following elements characterize the successful therapies Miller and Hester list:

1. (+) They reduce the reward value of the addictive/substance involvement (aversion therapies, self-control training).

1. (+) They enhance clients' coping skills so as to reduce the anxiety involved in real-world coping and enhance success at achieving real-world rewards (community reinforcement approach, stress management, family therapy, social skills training).

2. (-) They do not characterize the alcoholic as having a disease or life-long malady, provide putative information about the Nature of alcoholism, or dwell on putative reasons for alcoholics' drinking (Alcoholics Anonymous, alcoholism education, group therapy, individual counseling).

3. (-) They do not assail clients' self-concepts (confrontation) or bypass clients conscious coping mechanisms (disulfiram).

Table 1a

Supported Versus Standard Alcoholism Treatment Methods

<table>
<thead>
<tr>
<th>Treatment methods</th>
<th>Current supported by controlled outcome research</th>
<th>Currently employed as standard practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aversion therapies</td>
<td>Alcoholics Anonymous</td>
<td></td>
</tr>
<tr>
<td>Behavioral self-control training</td>
<td>Alcoholism training</td>
<td></td>
</tr>
<tr>
<td>Community reinforcement approach</td>
<td>Marital and family therapy</td>
<td></td>
</tr>
<tr>
<td>Social skills training</td>
<td>Stress management</td>
<td></td>
</tr>
<tr>
<td>Stress management</td>
<td>Individual counseling</td>
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</tr>
</tbody>
</table>
a. Miller and Hester (1986)

b. The community reinforcement approach combines marital and family therapy, job interventions, and self-control training using a time-out procedure under conditions of high likelihood of relapse.

Compare Miller and Hester's list of effective alcoholism therapies with a summary of the therapeutic community (TC) concept. Dc Leon (1987) describes the addicted person and the aims of the therapeutic community (TC) as follows:

Rather than drug use patterns, individuals are distinguished along dimensions of psychological dysfunction and social deficits. Many clients have never established conventional lifestyle Vocational and educational problems are marked; middle-class mainstream values are either missing or unachievable. Usually these clients emerged from a socially disadvantaged sector, where drug abuse is more a social response than a psychological disturbance. Their TC experience is better termed habilitation, the development of a socially productive, conventional lifestyle for the first time in their lives.

Among clients from more advantaged backgrounds, drug abuse is more directly expressive of psychological disorder or existential malaise, and the word rehabilitation is more suitable...

In the TC's view of recovery, the aim of rehabilitation is global. The primary psychological goal is to change the negative patterns of behavior, thinking and feeling that predispose drug use. Healthy behavioral alternatives to drug use are reinforced by commitment to the values of abstinence; acquiring vocational or educational skills and social productivity is motivated by the values of achievement and self-reliance. Behavioral change is unstable without insight, and insight is insufficient without felt experience. (p.8)
Charles Winick, a pioneering addiction/drug use researcher, examined all of the therapeutic communities in operation for heroin addicts in New York City. He found therapeutic communities retrained their clients in fundamental living skills, including attaining a high school diploma, developing basic competencies (like managing a bank account), graded assignments to work, and even training in personal hygiene. The TCs Winick studied were geared toward success outside the TC-that is, toward allowing the client to function in the real world. For example, all the communities emphasized occupational training and job placement. TCs, such as Phoenix House, downplay the disease model of addiction/drug use. Instead of being recipients of a medical treatment, as the director of the London branch of Phoenix House makes clear, TCs place the responsibility for change with the addict:

We believe it is essential the addict be given ample opportunity to help himself in his own recovery and to assume responsibility for his life. Treatment of the ex-addict as helpless and incapable deprives him of this opportunity and panders to his manipulative and irresponsible behavior. (Warner-Holland, 1978)

Dc Leon's and Winick's evaluations offer solid evidence of success through TC programs. Winick's research examined clients before and after treatment, finding substantial improvement in terms of avoiding prison, working, and staying away from drugs. Dc Leon's research compared those who stay in TC treatment through graduation versus those who drop out, and found that graduates do far better. The problem with comparing dropouts with perseverers in the therapeutic community is that treatment failures become the comparison point for the treatment, an especially acute problem since this research reveals a high dropout rate in therapeutic communities.

One drawback to TCS is their often coercive nature, the worst example of which was Synanon, whose founder and director-Charles Dederich, an AA graduate-hired a goon squad to attack internal and external critics (Weppner, 1983). At least one student of TCs has noted that they all share this tendency toward totalitarianism: originally a great booster of TCs, Weppner (1983) eventually concluded that most Synanon techniques, including "immediate, harsh criticism for lapses in expected behavior or work performance, authoritarian rule by 'old-timers,'" and emotional growth by conforming to the unrelenting twenty-four-hour surveillance in the organization, have been adopted by most therapeutic communities in the United States. .....In retrospect.... I must emphasize my belief that therapeutic communities are not the panacea, the easy answer to drug-abuse treatment ..... - have seen them to be.... Abuses are so eminently possible
because of the inherently authoritarian nature of therapeutic communities” (pp.38, 213).

On the other hand, the successful aspects of TCs as revealed in Winick's and Dc Leon's work are:

1. They reject the disease model of drug use and do not consider addiction a life-time characteristic of the individual

2. They demand responsible behavior from the addict/user and require positive contributions to the community from residents.

3. They teach addict/users specific skills geared toward coping outside the community.

4. The goal of therapy is to graduate from the TC into the broader world

5. TCs explicitly inculcate values toward prosocial activity to replace the immature acting out that characterizes addict/user lifestyles.

An entirely different focus on drug abuse from that of the TC is provided by programs aimed at preventing (and to a lesser extent, treating) adolescent substance abuse. Newcomb and Bentler (1989), who have for some time studied the longitudinal development of drug use problems in the young, evaluated prevention programs in light of various risk populations. The authors in the first place identified the risk factors for drug abuse as the following:

1. Social-structural-factors:
Peer influences

Disadvantaged socioeconomic status

Disturbed families and adult models of drug abuse

2. Psychological factors:

Need for excitement

Psychopathologies such as depression and anxiety

3. Value factors:

Lack of religious commitment

Lower achievement orientation and poor school performance

Greater tolerance for deviance and a history of deviant behavior

Newcomb and Bentler divided prevention programs into the following groups:
1. Informational of knowledge programs, which provide so-called objective information about drugs and alcohol, including programs that rely heavily on scare tactics (as in the standard lecture by ex-addicts or David Toma; cf. Peele, 1989).

2. Peer programs that focus on social skills involved in rejecting negative peer influences. These programs follow the notion of "Just Say No," although the realistic ones build in behavioral and social skill training and strive to enhance self-esteem.

3. Affective programs aimed at psychological growth.

4. Alternatives programs that focus on community, leisure, and physical activities and on remedial training such as job skills or one-on-one tutoring.

5. Combined affective/informational programs.

Evaluating the success of these programs with reference to different groups, Newcomb and Bender (1989) noted that "Scare tactics ... have not been effective" and, more generally, "knowledge, affective, and knowledge/affective approaches had little effect ... (and sometimes increased drug use)." The authors found these approaches don't work because they ignore environmental factors. Peer programs, on the other hand, have often shown strong benefits, primarily for the "typical teenager," who finds it easier to resist invitations to drug and alcohol use. However, the authors noted, the effectiveness of this approach is limited primarily to those groups which already show the fewest risk factors for drug use.
The peer modality can help the teenager at a party, who is wavering about whether to try the marijuana joint being passed around, to decline the offer. (Such) peer approaches reduce the use of drugs but have less impact on abuse of drugs. The typical teenager who experiments with beer or shares a joint at a party is unlikely to be the one who will have severe problems with drugs later in life. Labeling this person as a "druggy," sick, screwed up, or in need of treatment is liable to be more destructive than the use of the drug itself. (Newcomb and Bender, p.246)

Looking beyond this group for whom treatment is contraindicated, Newcomb and Bender (1989) declared, "It is misleading to bask in the success of some peer programs that have reduced the number of youngsters who experiment with drugs (but would probably never become regular users, let alone abusers) and ignore the tougher problems of those youngsters who are at high risk for drug abuse as well as other serious difficulties." Newcomb and Bender concluded: "For those most vulnerable to abusing drugs, prevention aimed at promoting alternative activities, building confidence and social competence, and providing broadened experiences was most effective" (p.246).

To summarize the Newcomb and Bender meta-analysis of drug use prevention and treatment programs:

1. Most prevention and treatment programs for adolescents are ineffective and they may be counterproductive, particularly when treatment programs mislabel drug use as a pathology for ordinary children who are likely to achieve normal life resolutions on their own.

2. Help for the most susceptible groups of young people involves teaching children real skills and enabling them to broaden their horizons and to achieve wider opportunities.

WHAT SHOULD WE DO-ELIMINATE THERAPY?
All three of these surveys of effective treatments, so divergent in their methodologies and subject populations, point in the same crucial directions. All three make clear that:

1. Treatment along medical-model lines that identifies drug use or alcohol misuse or addiction as an internal, individual problem is misguided and doomed to failure.

2. Most treatment in the United States assumes such an individual-deficit, medical model. Although all data contraindicate this approach, it is actually growing and being applied to broader and younger populations than those for which it was designed, meaning that a failed system is expanding into areas where its failures will be even more costly.

The reasons for this persistence in the face of contravening data, of course, have to do with American social history, the economics of treatment, and successful proselytizing by ex-addict/users and alcoholics who have undergone conversion experiences along the lines of the AA model (which actually follows the format of the earlier, Temperance model) (Peele, 1989).

In a positive direction, what these summaries show about effective therapy is that:

It teaches people real skills for dealing with the world, dealing with other people, dealing with work, and dealing with themselves.

It confronts without apology the negative value system of the addict/users and their worlds.

It concentrates on broader social units—families, social groups, and communities—both as causes of and as resolutions for addiction.
But all of these things—skills, values, and community—are best approached in natural settings and not in the treatment setting. Teaching people prosocial values and how to work or to deal with their families is something that can only be approached in the most stop-gap and expensive manner outside of the contexts in which these things have traditionally been taught—in families, in schools, in religious and civic organizations, and in communities.

The word community occurs constantly in these summaries. By far the most effective program reviewed by Miller and Hester (1986) was the Community Reinforcement Approach (CRA). Hunt and Azrin (1973) found that with chronic addicted inpatient alcoholics, CRA patients drank on 14% of days (compared with 79% of those in a standard hospital program involving AA and lectures), were unemployed one-twelfth as much, and spent one-fifteenth the time in institutions. Obviously, therapeutic communities involve communities—both in terms of the therapy intervention and in terms of the stated goal of successful TCs of reintroducing the resident into the broader community.

What, then, about therapies that rely directly on the community as a therapeutic resource? Mulford (1988) described such a community program as it operated in Iowa. The Iowa program hired a community coordinator in each town to deal with alcoholics. The University of Iowa trained coordinators and monitored the results in each town, providing the coordinators with feedback to help them learn from and build on their own and others' experiences. Coordinators were not required to have any special background or training. It was simply expected that they would care about alcoholics, and draw upon their common sense, experience, intuition, and empathy to contact people with drinking problems and lend them a helping hand. Their coordinators' approach to clients varies depending upon the nature of the case. No two are treated alike.

[The coordinator] explains to alcoholics that there is no solution for their problem that anyone can give or sell them. They must get it the old-fashioned way—work for it. Any benefit they get from others' efforts to help them is in proportion to the effort they themselves put into the process. He does nothing to alcoholics, and he does nothing for them that he can get them to do for themselves. Nor is his office a place for the community to dump its responsibilities to alcoholics. To encourage widespread
community responsibility, he seeks to involve as many other citizens in the alcoholic’s recovery as possible.

Serving as a catalyst for natural rehabilitation forces, the coordinator helps alcoholics restore and strengthen social relationships—through job, family, Alcoholics Anonymous, church, and social activities. He also helps them use appropriate community services and resources to resolve their medical, legal, financial, religious, or other problems. (Mulford, 1988, cited in Peele, 1989, p.267)

In 1975, however, the Iowa program was centralized under a State Alcoholism Authority, funded by federal and state funds and directed through federal guidelines according to the orthodox medical model (before that, communities were responsible for paying the coordinator and whatever office rent and expenses he needed themselves). The immediate result was that costs rose at least twofold for each community, while the State Authority’s budget increased by a factor of ten. Yet, more alcoholics fell through the cracks, and in the first two years of operation, the new federally and state organized community programs served half as many new alcoholics as had the old community programs Mulford explains the cost differential:

The great cost-effectiveness advantage of the coordinator approach lies in the vastly greater number of persons served at minimal cost. The Washington County center [the one community coordinator program remaining in Iowa—this county declined to participate in the federally funded program] has annually been serving about 250 alcoholics on an annual budget of less than $45,000. That would treat only three or four cases in a nearby hospital-based center, and only one or two in an expensive private clinic. (Mulford, 1988, cited in Peele, 1989, p.268)

The alcoholism and addiction treatment movement always calls for more money to be spent on alcoholism—this is taken as a measure of America’s commitment to combating alcoholism and drug addiction, and of its own success. Mulford, in contrast, here
describes an actual program, growing out of real community re spouses, that costs a fraction of the typical medically-based programs and that would plow money directly into American communities. However, even under a Republican, Reagan-Bush Administration—one that gives lip service to returning power to communities and cost-effective government expenditure-America simply has continued to build up its costly and ineffective alcoholism and addiction bureaucracy.

In good part, this is due to American's delusion that great progress can be made—has already been made—through identifying the medical basis of alcoholic misbehavior. Mulford (1988) describes how this delusion actually works against us as communities and as a nation:

The alcoholism-disease way of thinking leads us to disown our responsibilities to keep each other reasonably sober as a part of the process of keeping each other human. Instead, it encourages us to relinquish our authority for informally constraining each other's drinking behavior to designated "experts" who are all too eager to assume the task—(Mulford, 1988, cited in Peele, 1989, pp.268-269)

CONCLUSION

There is more and more treatment in economically advanced nations, which costs more and more and becomes increasingly entrenched, while social outcomes spiral downward. The NIAAA epidemiology research center, the Berkeley Alcohol Research Group (ARG), studies community responses to drinking problems in societies round the world. Robin Room (1988), director of ARO, noted that, "we were struck with how much more responsibility,. . . [those in developing nations] gave to family and friends in dealing with alcohol problems, and how ready.....

[those in technological societies] were to cede responsibility for these human problems to official agencies or to professionals" (p.43). Yet, anthropologist Dwight Heath (1982) has noted that drinking problems—especially the isolated, compulsive drinking that is an integral definition of alcoholism—are "virtually unknown inmost of the world's cultures,"
particularly preindustrial cultures (p 436). The major exception to this, of course, is when indigenous communities are destroyed by outside forces, as has occurred with Native American and Eskimo societies in the United States.

Room (1988) summarized the Alcohol Research Group's cross-cultural findings:

Studying the period since 1950 in seven industrialized countries [including California in the US] .. we were struck by the concomitant growth of treatment provisions in all of these countries, The provision of treatment, we felt, became a societal alibi for the dismantling of long-standing structures of control of drinking behavior, both formal and informal. (p. 43)

It seems, then, that the institution of a modern medical and social services system for dealing with problems like alcoholism corresponds exactly with the removal of the forces most effective in curtailing these problems in the first place. The entire alcoholism and addiction/drug abuse treatment movement is a giant subterfuge for avoiding the realities, responsibilities, and means required to deal with addictive/substance misuse problems in industrial nations around the world, As the community resources in these nations are eroded, they may and all too often seek escape in an orgy of drug addiction/abuse treatment because they cannot conceive of how to reverse the process of community deterioration, This social process can reasonably be described and defined as "addictive."

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Stanton Peele, PM), a social psychologist, published his first book, *Love and Addiction* (written with Archie Brodsky), in 1975. More recently, Dr. Peele has pointed out the inherent contradiction between therapies that tell people they are born addicts and the encouragement of self-efficacy needed for people to cope effectively and permanently to overcome addiction. His most recent books are *Diseasing of America: Addiction Treatment Out of Control* (1989) and (with Archie Brocisky and Mary Arnold) *The Truth About Addiction and Recovery: The Life Process Program for Outgrowing Destructive Habits* (1991).