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Social Work, Social Science and the Disease Concept: New Directions for Addiction Treatment

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The perception of alcoholism and other substance abuse disorders as disease entities is a view ardently defended not only among chemical dependency professionals but, increasingly, by the general public as well. Over the past two decades, this perspective has also become so ensconced within the addiction treatment industry that alternative interventions are almost nonexistent even though evidence of their effectiveness is available (Miller & Hester, 1989). And yet, "no leading research authorities accept the classic disease concept" (Fingarette, 1988, p. 3). Competing views are generally characterized as irresponsible, and their sponsors summarily dismissed as dangerously uninformed by disease view proponents or accused of being in "denial" themselves (Kasl, 1992, Peele, 1989; Trimpey, 1989). In addition, public polls have revealed that Americans have increasingly subscribed to the addictive disease theory over the years. In the 1946–1955 Gallup polls, 20% indicated that alcoholism was a disease. By 1982, that response had risen to 80% (Gallup, 1987).

The professions have also been influenced by disease notions. In research conducted by the author, 520 social workers were surveyed in regard to their views about alcoholism and its treatment. In response to the query "Do you believe that alcoholism is a disease?" 74.2% of the respondents answered in the affirmative, 6.7% answered in the negative and 14% were unsure. Of the respondents 58.5% said that they believe alcoholism is a primary disorder, while 25% believe that it is symptomatic of an underlying disorder. When asked the choice of the most appropriate intervention for sufferers of alcoholism, 50% of the sample deferred to Alcoholics Anonymous (AA), with the remaining half mentioning a range of other interventions.

While this may mean the respondents are relatively unfamiliar with other approaches, the findings may also suggest that social workers embrace the disease view at both the theoretical and the operational level as indicated by the preference for AA, an intervention rooted in the disease model.

Public policy is also heavily influenced by disease notions. Most public efforts at remediation of substance abuse problems, aside from drug interdiction, are directed towards treatment and prevention (disease concepts) rather than toward broader macro or systemic approaches. This "medicalization" of social ills is consistent with the national tendency toward "reductionistic" approaches to social problems. Unfortunately, the transformation of complex issues into typifications and simplified causal models is at the root of many of our most ambiguous social policies.

While social workers in some quarters verbalize support for more enlightened policy, current social work practice seems to be converging with the methodology derived from the disease model, which has dominated the treatment scene for a number of years. According to Miller (1987), there have been virtually no substantive changes in American residential treatment in over twenty years despite the advances made during the same time period in the refinement of newer interventions. Once the disease model and its accompanying medical treatments took root in the treatment community, conflicting empirical research generated within the social sciences was disregarded (Peele, 1989).

Social Work and the Disease Model

If social workers are incorporating the disease viewpoint wholesale into their theory base, some troubling paradoxes emerge. For instance, how does a profession which has historically assessed individuals from a contextual point of view reconcile the disease notion that behavior is "determined" by unalterable biogenetic forces beyond the sufferers' control. Furthermore, how do clinicians account for differential manifestations of chemical dependency problems if the disease notion explicitly defines the malady as a unitary syndrome (Vaillant, 1983)? And finally, what unique social work perspective is

brought to bear on addictive disorders if its practitioners only mimic the efforts of paraprofessional counselors?

Possibly, social workers' changing view of substance abuse parallels the development of the profession (Cocozzelli & Hudson, 1989). In the early years of social work, alcoholism, along with other social maladies, was seen as a somewhat natural consequence of conditions created by immigration and urbanization, the exploitation of workers, and inner city squalor. For many years, social workers seemed to accept the fact that drug and alcohol abuse were a product of set and setting and that intervention necessarily involved addressing a range of issues, especially family functioning (NASW, 1965). The shift in thinking, however, is evident even as recently as two decades ago. A social work authority on alcoholism states "my basic premise is that alcoholism is primarily a *social problem* with medical complications rather than primarily a *medical problem*" (Krimmel, 1971, p. 7). Krimmel, however, makes this assertion in the introduction to his text, published by the Council on Social Work Education, and then goes on to describe micro-level, disease-disease-oriented treatments in detail. Quite possibly, social work rhetoric and practice have become disjointed.

In the pre-professional period of social work, during the Charity Organization Societies era, social work "visitors" frequently assumed a judgmental attitude toward drug and alcohol addiction, a condition considered to be symptomatic of the larger social pathology that was the plight of the poor (Pumphrey and Pumphrey, 1961). As the development and adoption of scientific principles propelled the advancement of professionalism, this view gave way to a perspective more consonant with theories of social disorganization (Abbott, 1931). Other enlightened perspectives were forwarded through the settlement houses, particularly in the cross fertilization of the ideas of Jane Addams of Hull House and of the University of Chicago sociologists (Deegan, 1988). Social reform was influenced by perspectives flourishing in the Chicago School, such as symbolic interactionism and critical pragmatism, debates over which Addams had varying degrees of influence.

In these contexts, the problematic drinking and drug taking behaviors displayed by clients were considered important, but

so were the broader mezzo and macro environmental conditions that impacted specific sufferers and wider target groups of sufferers. Social workers in those years were concerned not only with providing services to "inebriates," but also with changing the conditions that gave rise to the identified "social problem" of intemperance and inebriety (Kane, 1979). But, as independent clinical practice and proprietary hospital-based program settings have become the practice standard for addressing substance abuse problems, with their attendant need for patient classification, a treatable disease entity appears to serve those interests more than does a social problem. The opportunism of many social workers aspiring to private practice also helps to reinforce notions of "diseases" that respond to paid professional service rather than to structural changes in the economic and political life of the nation. Additionally, medical perspectives appeal to the general public at a time when coping with intractable social ills appears all but hopeless.

Social workers must be wary of incorporating purist applications of the disease concept. As in other fields of practice, the profession is relinquishing its own traditions in favor of accepting a methodology and knowledge-base that may challenge the very core beliefs on which social work is founded.

Addiction as a Disease

Interestingly, as the problems of addiction grow more complex and troubling, public and private views move toward the more simplistic. Unfortunately, reliance on disease interpretations and remedies leaves little room for a broadened understanding of addictive behavior. While the tenets of the disease theory seem to fit the gamma alcoholic or the hard core addict (loss of control, craving) there are many other situational, or problem, drinkers and drug users who do not fit that mold. Medical views of addiction frequently ignore ecological or anthropological considerations of behavior. Unfortunately, when an ecological perspective is absent, the causes of addiction are limited to a single element that ignores the varied range of human experience; furthermore, ignoring anthropological considerations discounts the meanings with which people endow their

experiences and life choices, particularly in regard to chemicals. Not only are such narrow approaches anathema to social work's knowledge base and values, they lack the empirical support which would justify the extensive treatment network in place in the United States.

Disease concepts are derived from a set of normative assumptions about human behavior, which see addiction as a biopsychosocial deviation which manifests in a unitary fashion, (that either one has the disease or does not), which is predictable in its progression and prognosis, and which has only one cure—abstinence through the principles of the 12 steps of AA. This set of assumptions is frequently linked to the belief in medical treatment for chemical addiction based on the cookie-cutter approach of the Minnesota model of 28 days of inpatient treatment. This model, developed at the Hazelden Corporation in the 1960s, consists primarily of detoxification, addictive disease indoctrination and AA immersion.

Nevertheless, the disease model continues to make important contributions to the treatment of addictive disease. These contributions include the de-stigmatization of substance abuse for sufferers and their families, the provision of solace and hope to those who may have felt condemned by a society prone to moralize against what it does not understand, and the establishment of a common language which has facilitated communication among those interested in addressing the problem of chemical dependency. The less desirable outgrowths of the disease perspective are what is at issue here. These secondary consequences include separatism attributable to the white mainstream value approach of most treatment facilities, the prescription of universal solutions that are effective only with certain individuals (treatment matching based on availability rather than the most appropriate treatment), and the "individualization" of a social problem. These manifestations would appear to be in conflict with traditional social work values.

While interventions promulgated under the disease model have helped a number of individuals, there is little evidence that when applied across a treatment population, these approaches are any more effective than natural remission (Fingarette, 1988; Peele, 1989). The most rigorous studies of treatment outcome

indicate that long-term drug and alcohol abstinence rates obtained through current medical model treatments rarely exceed 10% at follow-up (For reviews see Emrick and Hansen, 1983; Peele, 1989; Vaillant, 1983). Program representatives, however, often make "success" claims far in excess of these figures in marketing approaches. In addition, social science poses challenges to other elements of disease model treatments. There is clinical research demonstrating the efficacy of techniques aimed at moderating problem drinking among specific groups and documenting controlled drug use that suggests that addicts' usage patterns may deviate from the "loss of control" model. (For a review see Peele, 1989). Additionally, studies of the natural course of alcoholism and addiction indicate that alcohol and drug abusers will self-moderate their chemical use at a natural remission rate that often exceeds current treatment outcomes. (Vaillant, 1983; Fingarette 1988; Peele, 1989). These studies seem to contradict main tenets of the disease theory, which is less a "theory" than a loosely connected set of precepts derived mainly from poorly conducted research and speculation.

The articulation of the disease concept originated with Dr. Benjamin Rush late in the colonial period (Ray, 1983). Rush believed that alcohol itself was the culprit in the formation of the undesirable symptoms of addiction. The modern disease concept encompasses a shift in emphasis from the substance to individual vulnerability. Whereas the 19th-century version of the disease theory suggested that anyone who drank regularly or immoderately would become afflicted, the modern version emphasizes that only a small group of habitual inebriates actually have the "disease" of alcoholism. This group is characterized by an allergy to alcohol (and now drugs) that cause craving and loss of control once drinking commences. Jellinek's (1960) typological classification of alcoholism in the 1950s, though based on a very small sample, appeared to lend empirical support to this hypothesis. When the disease view was endorsed by the American Medical Association in 1956, it was given biomedical legitimacy and began its unchallenged reign as a guiding theory for most treatment and prevention efforts in the United States.

The "labeling" and "medicalization" of social problems has become a fairly widespread practice in the United States. From crime to mental illness, a host of social maladies have been redefined in light of medical "science" and have been relegated to psychiatry instead of to more traditional social control mechanisms. Conrad (1981) believes the medicalization of deviant behavior produces some positive outcomes but that its destructive impacts are formidable, including the problems of expert control, medical social control, the individualization of social problems, and the "depoliticization" of deviant behavior.

Expert control and medical social control are a particularly insidious threat not only to professional social work practice, but to our individual liberties as well. The elevation of medical "science" and its treatments from an entrepreneurial activity to a "religion" driving public policy has relegated many lifestyle choices and personal decisions to the realm of "medicine." Only a few years ago, the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association still listed homosexuality as a mental disorder, a condition many consider a status independent of choice. Substance abuse is still considered "pathology" from a psychiatric standpoint, however, it is unlikely to be removed from the DSM in the near future.

Medical social control ultimately manifests itself in a range of treatments (both chemical and behavioral) that put the "addict" in a secondary status. The promotional efforts of the anti-drug forces have left drug users without advocacy and at the mercy of the proliferation of laws, treatments, and restrictions that would "remake" them in a socially acceptable image or would lose them altogether. Individualization of social problems orients the focus on the intrapsychic functioning of the individual. This "blaming the victim" approach articulated by Ryan (1971) removes culpability for social inequities and institutionalized oppression, and affixes the remedy at the level of individual intervention. Once the mandate for social change has been sidestepped, the issue has been depoliticized.

Szaz (1985) has commented extensively on the medicalization of mental illness and drug abuse. He views drug abusers as classic scapegoats, employing the analogy that scapegoaters

view the drug offender much the same way that the Nazis viewed Jews during the second World War—i.e., as the source of most national ills. Hence, the best way to purge the nation is to identify the offenders (label them) and then control them (or kill them in the case of the Third Reich). Szasz charges that this view ignores the reality that substance use fulfills a crucial function in the user's life and is not destructive to society in and of itself. Only when "addiction" gets labeled and substances prohibited does society experience social and personal upheaval to the degree now present in the United States.

A further elaboration by Becker (1963) observes that the drug user (marijuana users in Becker's study) moves away from social controls in order to assume a drug-using lifestyle. The subgroup of which he becomes a part is at odds with the larger society, and the individual user takes solace in subgroup status. Typically, forces within the larger social system attack the deviant subculture and behavior through a "moral crusade." In Becker's formulation, these "moral entrepreneurs" redefine drug abuse as a medical and health issue, thereby placing it in the province of psychiatry and the helping professions. Becker stops short of analyzing the entrepreneurial motive, but, in carrying his analytical scheme further, one is forced to consider the possibility that moral entrepreneurship is reinforced by proprietary interests. Once the vested opposition group places addiction in the medical realm and disease proponents assume positions as professionals and managers in the sector charged with administering "help," then a powerful self-interest keeps the moral entrepreneur from ever questioning his or her own assumptions. The addiction treatment industry has developed in much that fashion in the United States.

Other social scientists see the development of drug prohibition and medicalization as an imposition of morality by those who have the power and will to impose it on the larger society. Gusfield (1963), working from the value-conflict perspective, analyzed the American temperance movement as a clash of lifestyles between "wets" and "drys" that saw a policy swing between the two positions in a relatively short period of time. During that span, "deviance" shifted from being associated with drinking to becoming synonymous with abstinence. Using

Gusfield's analysis to understand current events, one cannot avoid the conclusion that the rules and controls imposed on drug users derive from a moral stance that is neither superior to nor qualitatively different from that of the drug users, but, nevertheless, is supported by the power of law. The use of moral symbolism, and vilification of the opposition, serves to galvanize the public in support of prohibitive social controls.

Also consistent with the value-conflict perspective are views of the disease model and 12-step approaches derived from the feminist critique. Much of this literature considers addiction and codependency, at least among women and minorities, as a result of power differentials and value clashes between traditionally dominant white males and their perceived inferiors within the American class structure. Some commentators see the resultant manifestations, particularly codependency, as a social reconstruction mythologizing women's experience and recasting it in light of pathology (Krestan and Bepko, 1991). Kasl (1992) views addictive diseases as artifacts of internalized oppression generated by inequities in American social structures; accordingly, "patriarchy, hierarchy, and capitalism create, encourage, maintain, and perpetuate addiction and dependency" (p. 53). Schaef (1987) takes this view even further in her conceptualization of the United States as an "addictive society" which is not only oppressive to women and minorities, but to men as well. Kasl, while no separatist herself, reacts to traditional addiction treatment by rewriting the 12 steps from an "empowerment" perspective and removing any references to powerlessness, surrender, and a patriarchal God.

While impugning disease notions and their accompanying treatments cause reactionary sentiment among adherents to these approaches, it is imperative that social workers begin to think more critically about this issue as they attempt to provide what will truly offer the best help available for their clients. The challenge of the helping professions, and society at large, is to begin formulating solutions to substance abuse that can render significant change in the way society experiences its consequences. On this point, the collective failures are well documented. Policymakers and professionals must move beyond current guiding theories if meaningful progress is to be made.

Solutions

Social workers hopefully can begin moving toward a more enlightened view of addiction, a perspective that can incorporate the various elements which contribute to an integrated and proscriptive model of prevention and remediation. Much progress has been made in identifying the range of factors that influence the development and maintenance of addiction. However, to address this continuum, strategies and solutions will have to be multidimensional. A more ecologically oriented model of interventions could address a fuller spectrum of the important etiological and cultural factors that drive substance abuse problems.

At the macro level, a policy approach of a much wider scope is needed. The policy agenda envisioned here would include a perspective that views structural issues as key components in the development of the social program that is labeled as addiction. This shift entails attention to poverty and opportunity access, issues which have been neatly sidestepped in contemporary views. In recent history, a very narrow view of the problem focusing solely on the supply reduction of illicit drugs has come into vogue. This view must give way to a focus on demand reduction, a concept barely articulated at the national level and not implemented in any meaningful way. Concerned social workers should enter the policy debate over drug strategy at the local and national level. The National Association of Social Workers should formulate a coherent and integrated social welfare policy agenda for Congress and the administration which includes attention to institutional supports for addiction and impediments to recovery. Under President Clinton's leadership, much of this agenda is already well under way.

At the level of the individual, treatment and prevention approaches must take a view broader than that constrained by the disease model. Most clients are currently served within an extremely narrow range of options, with the same treatment often prescribed for all those seeking services rather than making available different modalities for clients with different needs. Similarly, the same level of intensity of care is often prescribed rather than determining the most appropriate level

for individual sufferers. Treatment technologies implemented and evaluated outside the disease model community are frequently dismissed out of hand by treatment specialists. A number of methods tested extensively in Veteran's Administration and other public settings show tremendous promise, but remain virtually unknown, even though the data is readily available (Miller, 1987). By the same token, a continuum of care matching approach is not available in most communities even though excellent models for matching currently exist (Gottheil et al., 1981).

If scientific practice is once again to become the hallmark of the profession, then social workers should begin to embrace interventions and treatment approaches that have been empirically justified as being the most efficacious available. Optimizing treatment outcome is the primary goal of an effective matching scheme, as it should be the goal of professional social work practice. Leading researchers in the substance abuse field have been urging treatment networks to adopt strategies based on the matching hypothesis (Annis, 1988; Gottheil et al., 1981). The centerpiece of the hypothesis is that while one treatment is not preferable over another for all patients, the documentation of selective improvement for certain clients under certain conditions is well on its way (Miller & Hester, 1989).

The development and implementation of a matching approach should be consistent with experimentally derived indicators that suggest the most efficacious modalities for special populations or for clients with a particular profile. This approach is compatible with an ecological view of chemical dependency that incorporates consideration of a range of factors, both individual and environmental, in making intervention decisions. Annis (1988) suggests that client variables, treatment variables, and substance abuse variables are all factors that may differentiate clients for purposes of treatment matching. Thus, the offerings of treatment regimens should more closely match individual deficits and needs rather than attempt to view institutional structure as a flexible response (i.e., extending length of stay), although these factors need to be considered.

The current impediment to this model in many areas is the lack of differentiation among treatment settings. While many

urbanized or traditionally well funded states can boast a comprehensive treatment network serving diverse populations, many large catchment areas are fortunate if they have one publicly funded chemical dependency treatment center. Multiple treatment setting types, such as methadone maintenance, drug-free outpatient, short-term detoxification, and therapeutic communities, may simply not be available. Another problem pointed out by Miller and Hester (1989) is that program staff tend to recommend the particular service they provide without regard to differential diagnostic characteristics of the client. Hence, under this shortsightedness, establishing treatment matching reliant on outside settings becomes more problematic. It will likely be necessary for social workers to network among existing providers as well as implement multi-modality approaches within existing programs in order to establish a range of treatment options sufficient for the establishment of credible matching schemes.

Moos and his Stanford group have made substantial contributions to the understanding of the benefits of patient-treatment matching (Finney & Moos, 1979). In their extensive studies, up to 33% of variance in treatment outcome is due to unique program-treatment effect, but up to 40% is explained through patient-treatment interactions. Additionally, 28% to 72% of the patient variable effects are shared in interaction with treatment variables. While these indicators suggest a need to make appropriate treatment assignments if outcomes are to be maximized, it is important that the particular treatment options in the model are shown to be efficacious for addressing specific client issues.

Miller and Hester (1989), in a comprehensive comparison of evaluated alcohol abuse treatment approaches, find evidence that social skills training, outpatient psychotherapy, and community reinforcement approaches are promising alternatives to the traditional methods producing enhanced outcomes in major client life-functioning areas. These three approaches share an emphasis on effecting positive client adaptations for functioning in the larger community, but they represent a mix of conceptually different treatment orientations including both intrapsychic approaches and environmental manipulation (Luborsky, 1984; Miller & Hester, 1989; Mallams et al. 1982). With the exception

of community reinforcement, these approaches have also been utilized with drug abusers (Hawkins et al. 1986; Marlatt and Gordon, 1985).

Psychotherapy should be employed in substance abuse treatment as a method to ferret out the individual emotional, cognitive, or behavioral blocks to recovery. Studies have indicated that psychotherapy – either supportive expressive psychoanalytically oriented (Luborsky, 1984) or cognitive-behavioral (Beck, et al. 1979) when added to drug counseling can produce significantly better outcomes than drug counseling alone. In a treatment outcome review of programs using psychotherapy with opiate addicts, Rousanville and Kleber (1985) found that the approach beneficial to certain individuals across programs. Litt (1992) compared psychotherapy with skills training and found that personality-disordered alcoholics benefitted more from psychotherapy while other alcoholic types benefitted more from skills training.

While the use of psychotherapy in various settings may be suggestive of the view that treatment is individualized, its use in many public drug treatment facilities is solely for the purpose of addressing diagnosed psychiatric problems. Psychotherapy is frequently assigned based more on therapist availability, cost considerations, and clients' willingness to cooperate, than on a comprehensive strategy of meeting assessed client need. The gains derived from psychotherapy as an adjunct to drug counseling appear to derive less from the theoretical orientation of the therapist than on the strength of the therapeutic relationship (O'Brien, Woody, and McLellan, 1984). Psychotherapeutic interventions in drug and alcohol treatment may be an area where social workers could bring considerable skill and experience to the task of implementing this component in existing programs.

Social skills training and community reinforcement are premised on the assumption that functional life skills and supports can be modified and positively enhanced through the application of interventions specific to each (For a review see Miller & Hester, 1989). While the theoretical premise of social skills and community reinforcement are similar, they are dissimilar in the way they are operationalized. Social skills attempts to provide concrete skills for the client to more successfully

respond to specific life stressors, an individual change approach, while community reinforcement relies more on providing a means for client alteration of certain stressors in the family and on the job and on providing positive lifestyle environmental supports. Interestingly, both of these modalities operate on a premise similar to case management, an ecosystems perspective that emphasizes the multidimensionality of significant life problems.

Social skills training is the teaching of adaptive coping skills and substance refusal responses to individuals who typically exhibit maladaptive responses to events that are high stress, anxiety-provoking, or substance abuse triggers. Marlatt & Gordon's (1985) studies of relapse found that at least a third of relapsers do so in response to anger and frustration. Consequently, the authors see social skills training as essential for those lacking adequate coping skills. Research on skills training provides evidence that clients assigned to skills training groups showed greater improvement in handling difficult tasks and drank less during follow-up than the alternate treatment and control group subjects (Chaney, 1978; Intagliata, 1978). Social skills training interventions were also found to be better predictors of improvement than drinking history or any other demographic variable. Studies of drug abusers showed improved social skill acquisition among subjects following systematic skills training as well as reduced drug-taking among certain classes of drugs (Callner & Ross, 1978; Hawkins, 1989).

The community reinforcement approach (CRA) has been studied almost exclusively within the alcoholism treatment field. CRA relies on the components of job skills training, family behavior therapy, community social supports and social/recreational counseling as essentials in the intervention package. A study comparing outpatient clients assigned to either CRA or to the regular treatment regimen found that those in the experimental group drank significantly less, frequented drinking environments less, and showed less behavioral impairment than the controls (Mallams et al., 1982). The strongest evidence for the efficacy of community reinforcement comes from studies conducted in the Veterans Administration system in which there are multiple treatment components available (For a review

see Miller & Hester, 1989). These results bode well for those localities that are restricted in the number of treatment options available.

More traditional modalities should be reconsidered as well. For instance, therapeutic communities (TCS), whose early evaluations appeared discouraging, were sometimes dismissed as ineffectual based on the logic that aggregate outcomes should be more encouraging if these programs were worthwhile. Instead, one should ask, which client groups are helped by these programs. A recent study found that half of a TC program's graduates were abstinent at the 10-year follow-up, but, the percent of graduates that could be located and interviewed constituted only a fraction of the total group (Charvuvastara, 1989). One study of an innovative TC that uses a shorter program and intensive reentry programming found that successful outcomes were achieved in 60% of cases at one-year follow-up (Winick, 1990). Another study found that outcomes were improved where continued systematic aftercare was a part of the TC program approach (De Leon, 1991). While these findings are mixed, they suggest that TCs probably serve as a vital link in the treatment network. It may be that for cocaine addicts, who seem to benefit from longer, more intense treatment stays, that TCs will become the modality of choice (Rawson, Obert, and McCann, 1991). Social workers can be of immense help in identifying client groups that can benefit most from the TC approach.

Other program approaches speak to the needs of special populations and should be a part of any comprehensive approach to meeting individualized needs. For instance, social workers have generally recognized that female addicts and alcoholics have special needs, although the treatment community has only recently begun to make meaningful changes in the way women are served. Several communities now offer programs that serve women only and include options for pregnant women and facilities for small children (Kasl, 1992). Many of these programs work from an empowerment model sorely lacking in traditional treatment. Other programs and models are incorporating ethnic-sensitivity in their approach, and specialized programs for Hispanics and Native Americans are starting to appear (Lawson and Lawson, 1989; Kasl, 1992). Although these

programs are too recent to have generated research on their relative merits, anecdotal data and common sense alone suggest that using them will yield results as favorable as those achieved in traditional programs (Bepko, 1991; Kasl, 1992).

A number of self-help alternatives to AA have been developed, of which social workers and others in the helping professions should be aware. Each of these were started by people who left AA and discovered that there were others like themselves who, for a variety of reasons, could not benefit from that program. Jean Kirkpatrick started Women for Sobriety when she felt alienated by sexist language and remarks in AA and by the patriarchal approach that was not sensitive to the needs of women (Kirkpatrick, 1976). Secular Organizations for Sobriety was begun by people who couldn't tolerate the religious/spiritual notions of AA (Christopher, 1988). Rational Recovery was developed by Jack Trimpey, based on the rational-emotive therapy of Albert Ellis, who was put off by the ideas of powerlessness and the notion that one should experience "ego deflation at depth" as is suggested to newcomers at AA (Trimpey, 1989). While each of these organizations uses a somewhat different programmatic format, they collectively adhere to the central theme of abstinence as a priority in recovery. Although these organizations appear to be attracting a following, unfortunately there is no research comparing the approaches to AA or each other in terms of their relative effectiveness in helping people achieve abstinence.

A caveat is in order following this discussion of treatments and effectiveness research. Social workers should be cautious in their choice and interpretation of outcome measures. In traditional disease model treatments, outcome measures have been customarily restricted to focus only on abstinence, but researchers suggest that a broader range of dimensions should be examined as a better descriptor of progress in recovery (Wells et al., 1988). Additionally, working from a competency perspective, it is appropriate that social workers in particular look at indicators which provide feedback related to the value base of the profession, such as empowerment, in addition to more discrete indicators of post-treatment performance (Frans, 1993).

The tenets of the disease view should be continually challenged and reevaluated, being especially mindful of current research and social work's unique mission. It is this author's view that an ecological approach may be social work's unique contribution to addressing drug and alcohol abuse. Such an approach actually fits well with the emergent "new paradigm" in social work that, according to one theorist, is returning the profession to a holistically oriented enterprise (Orcutt, 1990). Those social workers ascribing to such a notion should eschew simplistic and reductionistic notions, and, while possibly focusing their efforts at one particular level of intervention, they should continue to recognize their role within a broader multidisciplinary and multidimensional solution. Rather than totally reject the disease model, social workers should begin to develop a new ecological paradigm which can incorporate it appropriately in a broader vision for the future.

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