According to the National Association of Social Workers (2006), just 3 percent of licensed social workers in the United States call addictions their primary practice area, but nearly three-quarters of NASW members report having helped a client with an alcohol or drug problem in the last year (O’Neill, 2001). Social workers play vital roles in assisting individuals, families, schools, workplaces, and communities to address addictions. Addictions affect people from all walks of life, and social workers in virtually all practice areas see people with these problems. This chapter discusses addictions, broadly defined, and methods that social workers use to address these problems. It also considers policies that social workers may wish to promote to better address addictions. You may decide to specialize in addictions practice, but even if you don’t, you will be a more confident practitioner if you know how to screen for addictions and intervene, no matter where you work.

Alcohol and drug problems are not the only problems commonly called addictions. Though helping professionals argue about what constitutes an addiction, the public uses the term to describe impulse-control disorders or compulsive (repeated) behaviors that can cause psychological, social, and sometimes physical harm, such as gambling, overeating, sex, Internet use, and shopping. Some strongly object to calling all these problems addictions. Despite common features that these behaviors share, such as escalation of the behavior in order to get the same high, or relief, and the life problems that result, these individuals see substance use (alcohol and drug) disorders as distinctly different from these behavioral disorders.

Addictive disorders, broadly defined, often co-occur. For example, many pathological gamblers have alcohol use disorders (Center for Substance Abuse Treatment, 2005). In addition, a person trying to control one addictive disorder may develop another in its place. Addictive or impulse-control disorders also often co-occur with depression or other mental disorders.

Social workers see individuals with addictions or impulse-control disorders in many settings. For example, social workers help parents with alcohol and drug problems in the child welfare system, and they often treat individuals who gamble pathologically as a condition of deferred adjudication for
writing bad checks. Social workers employed as supervisors or agency administrators are also responsible for employees who come to work intoxicated or have other addictive disorders that interfere with their work. Social workers may also see colleagues impaired by these problems. In all these situations, social workers need to be able to identify problems and intervene.

HISTORY OF SOCIAL WORK IN ADDICTIONS

Social workers in the United States have assisted individuals with addictions and their families since the earliest days of the Charity Organization Societies and the settlement house movement in the late 1800s (Straussner & Senreich, 2002). The public generally considered alcoholism a sin or moral problem. Mary Richmond, a notable Charity Organization Societies leader, had a more enlightened view. She referred to “inebriety” as a disease, encouraged early identification and treatment, and developed an alcoholism assessment instrument that contains items that social workers today continue to use. In these early days of the profession, social workers often addressed alcohol problems through the temperance movement and their work in public welfare, child welfare, and the workplace, but few alcoholics received direct help. Many died early or were confined in mental institutions, jails, or prisons because professionals knew little about how to treat them or had little interest in helping them.

During social work's early years, pathological gambling was also considered a moral failing rather than a treatable mental illness. Compulsive overeating was not the problem it is today. The processed food and fast food industries had not blossomed, and the Great Depression limited many individuals’ access to food. In fact, many Americans were poorly nourished and were encouraged to eat more (see DiNitto, 2007).

Though the mutual-help group Alcoholics Anonymous was founded in 1935, there was little focus on specialty alcoholism treatment programs until the mid-1950s. Among social workers’ most notable accomplishments during the mid-1900s was the work of Gladys Price, Margaret Cork, and Margaret Bailey, particularly in helping families of alcoholics (Straussner & Senreich, 2002).

Developments in the 1970s led more helping professionals to enter the field of addictions. The federal government established the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the agency now known as the Substance Abuse and Mental Health Services Administration (SAMHSA). These agencies lent legitimacy to work on alcohol and drug problems, and federal financial aid became available to students to prepare for careers in the field. The number of hospital- and community-based alcohol and drug treatment programs grew rapidly.

Mental health professionals also began recognizing impulse-control disorders. In 1980 pathological gambling earned a place in the American
Psychological Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

Eating disorders like anorexia nervosa and bulimia nervosa are considered mental disorders that social workers also treat, but they are beyond the scope of this chapter. Rather than a mental disorder, obesity is considered a general medical condition. Social workers often address compulsive overeating as well as nicotine dependence in their work with clients who are dealing with depression, stressful events, or other problems.

Today's social workers have a growing interest in addictions. In 1995, NASW established a specialty practice section for its members in the alcohol, tobacco, and other drug field and now offers a specialty clinical credential in this field. The first social work journal on addictions, the *Journal of Social Work Practice in the Addictions*, was established in 2001. Social workers hold some of the top positions in government agencies like SAMHSA. With initiatives like the National Institute on Drug Abuse–funded social work research development programs begun in 1999, social workers have become increasingly involved in conducting alcohol and drug research, especially on preventing and treating these problems.

**THE MANY PROBLEMS CALLED ADDICTIONS**

Conceivably, an individual could become addicted or habituated to almost anything that seems to make him or her feel better or assuage pain. We now consider some behaviors commonly referred to as addictions.

**Substance Use Disorders**

The American Psychiatric Association (2000) does not use the term *addiction*; instead, it refers to alcohol and drug problems as *substance use disorders*, and more specifically, *substance abuse* or *dependence*. These diagnoses are determined by the effects alcohol and drug use have on an individual’s functioning, *not* how much alcohol or drugs one uses or how often. Individuals diagnosed with substance abuse have experienced one or more of four symptoms related to their alcohol or drug use within the past year: (1) failure to meet obligations at work, school, or home; (2) use of alcohol or drugs in hazardous situations, such as driving; (3) legal problems, like arrests for public intoxication; and (4) interpersonal problems, like fights. In order to be diagnosed with substance dependence, one must have three or more of seven symptoms: (1) use of more of the substance to get the same effect, (2) withdrawal symptoms when one is not using the substance (e.g., shakes, delirium tremors), (3) use of more of the substance than one intended, (4) unsuccessful efforts to cut down, (5) increasing amounts of time spent using and recovering, (6) decrease in usual activities, and (7) continued use despite persistent physical or psychological problems. Substance
abuse may seem like a lesser problem than dependence, but abuse can result in serious problems like disabling or lethal motor vehicle accidents. You probably know someone who has met the criteria for abuse or dependence and suffered consequences like the loss of his or her family or job, serious health problems, or incarceration. Even misuse of alcohol (sometimes called risk drinking) or drugs that does not meet diagnostic criteria can result in life-threatening problems like overdoses or accidents. Social workers are also concerned about alcohol and drug misuse.

Alcohol problems are far more common than problems with illicit drugs. Commonly used illicit drugs that can result in abuse or dependence are marijuana; stimulants, or uppers (e.g., cocaine, including crack cocaine; amphetamines; and methamphetamines); depressants (e.g., heroin and quaaludes); opioids (e.g., heroin, morphine, and codeine); and hallucinogens (e.g., LSD and psilocybin, or magic mushrooms). Many prescription drugs and over-the-counter drugs can also lead to misuse, abuse, or dependence. Young people are more likely than older people to experience problems from using inhalants, so-called designer drugs such as Ecstasy, or anabolic steroids. Older adults are especially susceptible to problems associated with prescription drug use because they take more prescribed medications than other seg-

Social workers intervene to prevent drug problems and help clean up neighborhoods such the one where this shooting gallery is located.

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ments of the population, and as people age, they generally do not metabo-
lize medications as efficiently as they once did. Medications may have neg-
ative interactions with each other, and alcohol can exacerbate this problem.
A recent trend is for young people to abuse prescription drugs that are usu-
ally obtained illegally, a practice known as “pharming.” They mistakenly
believe that this is safer than using illicit substances.
Approximately 9–10 percent of the U.S. population currently meets the
criteria for substance abuse or dependence; about 15 million have an alco-
hol use disorder, about 4 million have a drug use disorder, and about 3
million have both alcohol and drug disorders (Office of Applied Studies,
2005). Most do not receive treatment because they cannot afford it or do
not recognize that they have a problem (Office of Applied Studies, 2005).
A majority of parents in the child welfare system and incarcerated indi-
viduals have alcohol or drug problems, as do about half of individuals with
a mental illness and those involved in domestic violence, and nearly a
third of those with disabilities (see Straussner & Senreich, 2002). It is no
wonder that social workers assist so many people affected by alcohol and
drug problems.
The Betty Ford Clinic in California, perhaps the most famous alcohol and
drug rehabilitation program, was named after President Gerald Ford’s wife.
This First Lady was addicted to alcohol and prescription drugs. Her courage
in going public—and that of many others—has encouraged others to get
professional help. Social workers work in inpatient rehabilitation programs,
residential programs like therapeutic communities and halfway houses,
outpatient treatment programs, and addiction programs located in many
jails and prisons.
Dependence on nicotine—cigarettes and other tobacco products that
are smoked, chewed, placed between the cheek and gum, or sniffed—
generally does not cause legal problems, but it causes great human suffer-
ing. The Centers for Disease Control and Prevention (2007) cite tobacco
use as the nation’s leading preventable cause of death, close to a half mil-
lion per year. Few social workers are employed in smoking cessation pro-
grams, but all social workers should help their clients quit using tobacco
products.

Pathological Gambling

The American Psychiatric Association (2000) criteria for pathological gam-
bling include a preoccupation resulting in illegal acts to obtain money for
gambling (embezzlement, forgery); loss of family, friends, and jobs; increas-
ing amounts of time spent gambling; lying about gambling; having to gam-
ble more money to achieve excitement; and failed efforts to control gam-
bling, and irritability when trying to do so. The increase in gambling
venues—casinos, state and multistate lotteries, and the Internet—has made gambling easier and has also increased social workers’ need to be aware of problem gambling and to intervene when necessary. An estimated 1.5 percent of adults in the United States (0.9% in the past year) have met the criteria for pathological gambling. More adolescents than adults gamble pathologically (National Research Council, 1999).

Compulsive Eating

Needless to say, Americans have easy access to fattening foods that many do not eat in moderation. Approximately 61 percent of adults in the United States are overweight or obese, and 13 percent of children and 14 percent of adolescents are overweight (the number of overweight adolescents has tripled in the last two decades) (U.S. Department of Health and Human Services, 2001). Excessive weight may result in increased risk for type 2 diabetes and coronary heart disease and may exacerbate conditions such as hypertension (high blood pressure).

Compulsive Shopping or Spending

Compulsive shopping and spending are not listed in the DSM, but some criteria for substance use disorders and pathological gambling can be applied to these problems. Individuals may experience excitement or euphoria from purchasing items even if they do not need or even want them. They may promise to stop buying but fail to do so, incur large debts, and try to cover them with illegal activities (Engs, 2004). Excessive spending can result in financial ruin and break up families. Social workers may see clients specifically for compulsive shopping, but such problems often come to light during marital therapy or through court-mandated education and treatment following legal proceedings for writing bad checks, stealing from an employer, or other charges.

Compulsive Sexual Behavior

The DSM describes disorders such as pedophilia, but not compulsive sexual behavior or sex addiction. The Society for the Advancement of Sexual Health (2007) says that sexual addiction is difficult to define and takes many forms but involves loss of control over some form or forms of sexual behavior, negative consequences, and constant involuntary preoccupation with the behavior. Sexual Compulsives Anonymous (n.d.) has devised twenty questions to help people determine if they are sexually compulsive; these criteria include feeling guilt or shame over sexual behavior and having sex with prostitutes, others one has just met, or people with whom one would
not otherwise associate. Individuals who have sex compulsively may engage in abusive or painful sexual activities and practice unsafe sex, putting themselves and their sexual partners at risk for sexually transmitted diseases. Others may restrict sexual activity to masturbation or other solitary sexual behavior. The construct of sexual compulsivity or sexual addiction needs more study, but many social workers see clients whose behavior indicates that they have some form of this problem.

Excessive Internet Use and Other Excessive Behaviors

Some people use the Internet to engage in illegal activities such as viewing child pornography or soliciting sex from minors. Internet use may also lead to extramarital relationships that may be confined to emotional infidelity or result in sexual infidelity. Excessive Internet use itself can become a problem. People may spend inordinate amounts of time online searching for news, sports, or other harmless information. Internet use becomes problematic when it interferes with relationships, work, and other aspects of everyday life. The same can occur with watching TV or engaging in sports or other activities.

What Causes Addictions and Other Compulsive Behaviors?

The causes of addiction or impulse-control disorders are widely debated (McNeece & DiNitto, 2005). Many people have strongly held views about what causes these problems. Social workers should carefully examine their personal views of these problems before proceeding to help clients.

Some people see addictions as moral problems that result from a lack of willpower or the wanton acts of individuals unwilling to change and become responsible citizens. Others see them as a lifestyle or conscious choice and believe that if individuals choose to engage in these behaviors, they can choose to stop.

Many individuals with alcohol or drug disorders have a family history of these problems, suggesting a genetic predisposition. Growing evidence indicates that genetics and abnormal neurotransmitter systems (brain chemistry) play a part in substance use disorders (National Institute on Alcohol Abuse and Alcoholism, 2000). Many report that using alcohol and drugs makes them feel “normal.” Alcohol and drug consumption in sufficient quantities and over a period of time can alter brain chemistry and promote continued use. Abnormal brain chemistry has also been identified in some pathological gamblers (American Psychiatric Association, 2000). Social workers need information about brain chemistry and medication use in treating these problems.
Having parents, grandparents, or other relatives who have had alcohol or drug disorders may suggest a biological predisposition to these problems. It may also mean that using alcohol or drugs to deal with life is a learned behavior. In addition to learning theory, personality theories have been used to explain substance use and other impulse-control disorders. Some people are thrill seekers, behave impulsively or antisocially, or have unresolved insecurities or immature personalities. Such psychological conditions have all been used to explain why some people develop substance use disorders, gamble pathologically, overeat, or shop compulsively, though proof is lacking.

Culture may also play a role in people’s development of or protection from addictive behaviors. Alcohol and drug problems vary across countries and among cultural groups. For example, the French and Irish reportedly have higher rates of alcohol problems than Italians and Jews (Levin, 1989). Though members of some American Indian tribes do not drink, other tribes have high rates of alcohol dependence and fetal alcohol spectrum disorders (physical abnormalities and/or mental retardation in newborns) (National Institute on Alcohol Abuse and Alcoholism, 2000). SAMHSA (2006) reports that Puerto Ricans are more likely to be treated for opiate (heroin) problems than other ethnic groups in the United States. Since genetics or other biological factors do not seem to account for these differences, culture may be an explanation.

Gender and sexual orientation may also be factors. Women are reportedly less likely to have substance use disorders. This may be due to the ways problems are identified or measured (e.g., women are less likely to get into fistfights after drinking). Pathological gambling is also more common among men. Research suggests that lesbians have higher rates of alcohol problems than straight women (Crisp & DiNitto, 2005).

Poverty may play a role in alcohol and drug problems. Residents of poor communities have greater exposure to alcohol advertising, bars and liquor stores, and illicit drugs; this, combined with feelings of hopelessness about the future, might promote substance use. Culture may also affect gambling and eating habits. Social workers take into account gender, ethnicity, culture, and class in order to make more accurate diagnoses and better referrals and to improve treatment.

Social workers view many problems of the human condition as having a biopsychosocial basis. Thus, social workers consider whether and how biological, sociological, and psychological factors may contribute to an individual’s addictive or impulse-control disorders. Social workers generally reject simple moral explanations for these problems. They believe that human beings prefer to act morally, but due to biopsychosocial risk factors, they may need help in doing what they believe is right. Social workers also generally believe that people should be held responsible for poor judgment
or illegal acts, but they are compassionate toward those struggling with addictions or other problem behaviors. Social workers understand that overcoming addictive behaviors is usually a difficult task and often requires professional help. Just think of a behavior you have tried to change and how difficult it was.

Social workers typically take detailed social histories to learn more about factors that may cause, contribute to, or exacerbate a problem. But without proof that biological, psychological, or socioenvironmental factors cause addictive behaviors, social workers utilize what seems to work best for helping people with these problems.

**EVIDENCE-BASED ADDICTIONS PRACTICE**

There is a growing number of evidence-based approaches for preventing and treating addictive behaviors. Most are behavioral or cognitive-behavioral interventions designed to change the addictive or compulsive behaviors and cognitions (thoughts and feelings) that precede these behaviors. Social workers try to discern which may be most useful in their practices.

**Prevention**

Many social workers enjoy working with children. Children are the focus of many efforts to prevent addictive behaviors, and school social workers are often involved in delivering prevention programs. For example, SAMHSA offers information on evidence-based prevention programs targeted to children of different ages and ethnic backgrounds.

Adults also need prevention or health promotion programs. Social workers in public health practice and other medical and social service settings help adults recognize early indicators of alcohol and drug problems or overeating before they develop into full-blown problems, encourage them to adopt healthier habits, and instruct them on how to do so. Social workers have become increasingly involved in developing adult prevention programming that is culturally relevant and age appropriate.

**Screening and Diagnosis**

Social workers in nearly all practice areas need skills to screen for the problems discussed in this chapter and refer to treatment providers. Screening tools are generally short questionnaires administered by the social worker or completed by the client. There are many alcohol- and drug-problem screening tools. For example, the CAGE is a four-item screening device for alcohol problems that social workers can administer in less than a minute (Ewing, 1984). But helping requires more than ask-
ing clients questions about whether they have tried to reduce their drinking or have felt guilty about their drinking. Developing rapport, asking questions in a nonjudgmental way, and ensuring confidentiality (to the extent possible) are also important. Social workers also use questionnaires or inventories based on DSM criteria, such as the South Oaks Gambling Screen, to help screen clients for gambling problems (Lesieur & Blume, 1987).

Social workers assess the validity and reliability of screening and diagnostic tools and select those appropriate for their clientele based on age, gender, ethnicity, and whether the client has a disability. For example, the South Oaks Gambling Screen has adult and adolescent versions. The Problem Oriented Screening Inventory for Teenagers screens for alcohol and drug problems as well as social, behavioral, and learning problems (Winters, 1999). The Alcohol Use Disorders Identification Test is available in several languages and can be adjusted for drinking norms in different cultures (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). You can search the Internet to learn about tools for helping people consider whether they are overeaters, sexually compulsive, or have other problems, but they may not have been subjected to reliability and validity testing.

Screening may suggest an individual has a particular problem, but the social worker needs additional knowledge and skills to support or confirm a diagnosis. Social workers must usually have a master's degree and credentials such as a clinical license to make diagnoses. A clinical license may also be required to obtain payment for making diagnoses and providing treatment.

**Brief Interventions**

Brief interventions can take many forms, such as having clients attend one or several short counseling sessions, asking clients to read educational materials and keep logs to monitor their behavior (e.g., number of drinks consumed; cigarettes smoked; amount of time or money spent gambling, shopping, or using the Internet), and providing cards to remind clients what to do should alcohol or drug cravings or urges to gamble, eat, or engage in compulsive sexual behavior occur. Research indicates that brief interventions are often, but not always, effective in reducing risk drinking (National Institute on Alcohol Abuse and Alcoholism, 2000). It may be a sign of the times and current insurance policies that brief interventions are now used to address many problems discussed in this chapter, particularly those that have not reached very serious proportions.

One framework for brief interventions is the FRAMES approach, which stands for giving feedback to the client on his or her problem behavior
(such as exceeding safe drinking limits or screening positively on the South Oaks Gambling Screen), recognizing the individual's personal responsibility to change, providing clear advice about how to alter the behavior of concern, offering a menu of choices about how to change, counseling in a warm and empathic way, and emphasizing self-efficacy—that the client can do it (Miller & Sanchez, 1994). Social workers delivering brief interventions also help clients establish goals for behavior change, follow up to assess progress, and provide ongoing encouragement. Of course, some clients need interventions that are more intense or of longer duration.

**Effective Treatment**

The National Institute on Drug Abuse (2000) has identified “principles of effective drug addiction treatment” that overlap with social work principles, like individualizing treatment to clients’ needs and addressing multiple problems. Social workers may need to help clients do more than stop using drugs or gambling. They may provide marital and family counseling or help clients obtain legal aid and find a job, child care, or other assistance to rebuild their lives due to the destruction that addictions or compulsive behaviors have caused. Social workers also monitor progress. They might check urine screen results for those with drug problems, review clients’ logs of problem behaviors and healthy behaviors, and with the client’s permission, contact “collaterals” such as family members, teachers, or probation officers to ask how the client is doing. Social workers also monitor attendance at counseling sessions. They want to ensure that clients follow through with referrals and remain in treatment long enough to see positive results, and they follow up when clients have missed sessions. Monitoring is often the job of social workers employed as case managers. Social workers also discuss clients’ feelings about their progress, difficulties they are having, and gains they have made.

**Motivational Enhancement Therapy**

Approaches more consonant with social work practice have replaced the heavy confrontation once used in alcohol and drug treatment programs. Research suggests that alcohol and drug therapists’ interpersonal skills are key factors in treatment effectiveness (Najavits & Weiss, 1994). Among the approaches that stress a supportive, empathic counseling style are motivational interviewing and motivational enhancement therapy (Miller & Rollnick, 2002). Motivational enhancement therapy is usually short term and can be applied to a variety of problem behaviors (Center for Substance Abuse Treatment, 2005). The therapist helps the client weigh the advantages
and disadvantages of changing (decisional balance) in order to resolve the client's ambivalence about changing.

Motivational approaches can help move clients along the stages of change, from precontemplation, where they may not recognize a problem (“I drink like everyone else,” “I can control my gambling”) or its cause (“I wouldn’t drink like this if my work weren’t so stressful”), to contemplation, where they recognize the problem and consider changing, to preparation, where they make plans to change, to action, where they make behavioral changes, and maintenance, where they continue to change and prevent relapse (Prochaska, DiClemente, & Norcross, 1992). Depending on the stage of the intervention and the individual client, social workers may use education, consciousness-raising, role-playing, positive reinforcement (e.g., rewards), community involvement, and many other techniques to help clients move on in the process of change.

**Treating Adults with Substance Use Disorders**

It takes skilled and dedicated social workers to keep up with the increasing numbers of evidence-based treatments for addictions. One such method for treating adults with substance use disorders is the community reinforcement approach, which seeks to alter the client’s environment in order to reduce substance use and increase well-being (Meyers & Miller, 2001). Social workers may find it appealing because of its comprehensiveness. The community reinforcement approach involves the client’s spouse or partner and provides assistance finding employment, social skills training, social and recreational counseling, relaxation training, and help complying with medication regimens. Network therapy is another multimodal cognitive-behavioral approach (Galanter, 1997). A network usually consists of two or three family members or friends who provide support and work with the client and therapist to help the client reach his or her goals. Clients participate in individual sessions with the social worker (or other therapist) as well as sessions with other network members. Some clients either have alienated family and friends or have none available locally. Social workers may need to be creative in finding others who can be incorporated into the treatment, such as clergy members or other service providers assisting the client. Behavioral marital or behavioral couples therapy may also appeal to social workers because it involves the client’s significant other (Fahls-Stewart, O’Farrell, Feehan, Birchler, Tiller, & McFarlin, 2000).

Social workers may work in shelters and missions, like those operated by the Salvation Army, where they provide many services to clients who have lost everything as a result of addictive behaviors. They may help clients locate more permanent shelter in a halfway house or other residential program, find a job, apply for food stamps, and get health care from a
Treating Adolescents with Substance Use Disorders

Behavioral therapy seems effective with adolescents who have substance use disorders (National Institute on Drug Abuse, 2000). In this approach, social workers utilize techniques like assignments, rehearsals, logs, progress reviews, urine screens, and rewards as the client moves toward goal achievement (Azrin, Donohue, Besalel, Kogan, & Acierno, 1994). Adolescents learn to avoid risky situations; increase the amount of time they spend engaging in healthy activities; and recognize and redirect thoughts, feelings, and plans that lead to drug use. Family members and others are included in the treatment. Also promising is multidimensional family therapy, which involves individual and family sessions (Schmidt, Liddle, & Dakof, 1996). The adolescent gets help with life skills, and the parents with parenting skills. Consistent with social workers’ systems perspective, this approach sees drug use in terms of individual, family, peer, and community influences and requires intervention in each system.

Treating Pathological Gambling and Other Compulsive Behaviors

There have been few randomized clinical trials of pathological gambling treatments. Some evidence indicates that behavioral or cognitive-behavioral interventions can be useful (Oakley-Browne, Adams, & Mobberley, 2004). These approaches help clients address irrational beliefs, for example, that they are able to increase their odds of winning (see Center for Substance Abuse Treatment, 2005). Psychodynamic treatment may also be used in combination with cognitive-behavioral therapy to help clients understand the negative emotions, conflicts, or defenses that may underlie the need to engage in pathological gambling (Center for Substance Abuse Treatment, 2005) or other compulsive behaviors. Box 8.1 describes a social worker helping a client cease pathological gambling.

The most common approaches to addressing overeating and obesity are helping the client to eat a healthier diet and engage in more physical activity. For severely obese adults, gastrointestinal surgery may also be an option when traditional approaches are not effective or there are serious obesity-related health problems (National Institute of Diabetes and Digestive and Kidney Diseases, 2004). The advantages and disadvantages of the different types of surgeries must be weighed. Social workers can provide emotional support to clients as they consider these choices with their physicians and help ensure the client’s questions are answered. Overeating and obesity in children are generally addressed through diet, physical activity, and parental involvement (Steinbeck, 2005).
Relapse Prevention

Individuals usually make more than one serious attempt before they successfully abstain from alcohol or drugs, quit smoking, stop gambling, or reduce other behaviors to nonproblem levels. Those in recovery from alco-

Box 8.1 Helping a Pathological Gambler

A social worker at a community mental health center was assigned the case of Michael B. Screening with the South Oaks Gambling Scale and an interview based on the DSM criteria for pathological gambling made it clear that Michael had a gambling problem. During the first few sessions, Michael was reluctant to express his feelings. The social worker focused on using an empathic counseling style and motivational interviewing skills, and eventually, Michael began to realize that she was truly interested in helping him. As Michael began to talk more about his gambling, he described how he relished the competitiveness of card playing and had developed a reputation as a tough player and a winner early in his gambling career. His gambling gradually got out of control, and he was unable to stop until he lost all his money. However, when he attempted to stop gambling, he would feel depressed. In treatment, he acknowledged that he felt increasing anxiety when he was winning and felt relief only when he lost everything.

The social worker learned that Michael’s father had been a successful business executive who had been very demanding and critical of Michael throughout his life. Michael had been determined to “beat my father at his own game” and become even more successful. Michael had developed many businesses, but they always collapsed after an initial success, a pattern that mimicked his gambling. In therapy, the social worker saw that Michael felt guilty about his thoughts of “beating” his father, which contributed to the destructive pattern of his gambling and his unsuccessful business ventures.

The social worker helped Michael weigh the pros and cons of continuing to gamble. Eventually the balance was tipped, and Michael stated that he wanted to stop gambling entirely. The social worker also helped Michael let go of his guilt-producing fantasy of spectacular success and focus on how he could enjoy life without feeling a need to compete with his father. At the social worker’s suggestion, Michael identified hobbies he was willing to pursue, including activities with his wife. Michael was able to set more realistic goals to achieve a sense of accomplishment without gambling. After several sessions in which Michael’s progress was evident, he and the social worker developed a relapse prevention plan. Michael identified triggers he feared would continue to prompt his gambling, like coming into extra money or feeling particularly lucky. He pursued his newly found hobbies and agreed to call the social worker if he needed booster sessions.

Michael B had two relapses within a six-month period. He did recontact the social worker. Eventually, Michael was able to abstain from gambling for longer periods without feeling depressed and inadequate. Today, he holds a job he enjoys, continues to engage in hobbies, and has not gambled in three years.

hol dependence often say, “It is easier to get sober than to stay sober.” People who have lost weight know how easy it is to regain weight. Lifelong work is often needed to remain free of an addictive or compulsive behavior. Lifestyle changes are generally needed. Many individuals do not sustain the desired change indefinitely, but social workers continue to help them achieve progressively longer periods of abstinence or other desired behaviors.

Some professionals may be dissuaded from specializing in addictions practice because they perceive clients’ resistance to be strong and relapse rates to be high. Treatment compliance and relapse in clients with alcohol disorders are similar to treatment compliance in individuals with other chronic illnesses like type 2 diabetes, hypertension, and asthma (McLellan, Lewis, O’Brien, & Kleber, 2000). Helping clients prevent relapse is an important task. Social workers use relapse prevention approaches to help clients identify triggers, or high-risk situations, for problem behavior and ways to avoid or defuse these situations and adopt healthier lifestyles (Marlatt & Gordon, 1985). For example, socializing with old buddies may be a trigger for drinking for one client, or failed relationships with men may be a trigger for shopping sprees for another. Social workers help clients avoid triggers and make plans to adopt other behaviors in their place—counting to ten and going for a walk, exercising, talking with friends, or engaging in other healthy and rewarding behaviors.

**Medications**

Social workers cannot prescribe medications, but they can listen to clients’ concerns about medication use and help them discuss these treatment options with psychiatrists or other physicians. The Federal Drug Administration has approved a few medications for the treatment of alcohol and drug dependence, but they seem to lack acceptance (i.e., few use them) (McNeece & DiNitto, 2005). Disulfiram, or Antabuse, has been used to help alcoholics refrain from drinking for several decades, but it may be unappealing because individuals know that they will become violently ill if they drink while taking it. Naltrexone prevents the drinker from experiencing the euphoria produced by opiate drugs; it may also inhibit the euphoria produced by alcohol and may help reduce gambling cravings and behavior (Center for Substance Abuse Treatment, 2005). The use of methadone to treat heroin dependence remains controversial. Although it helps individuals lead more productive lives because it reduces drug cravings and this results in less illegal activity to obtain heroin, patients become addicted to methadone. Patients generally obtain methadone from an approved clinic, where social workers may provide counseling and other social services. More recently, buprenorphine has been approved for treating heroin and other opioid dependence. It differs from methadone, as it seems to create a milder dependence, is taken less frequently than methadone, and can be
obtained from approved physicians in private practice, which may make it more attractive to clients than methadone (see Center for Substance Abuse Treatment, n.d.). Many individuals who have substance use disorders or gamble pathologically suffer from depression, and antidepressants may help them (Center for Substance Abuse Treatment, 2005).

Social workers are obligated to discuss the range of treatment options with clients to help them make informed choices. To do so, social workers need to stay abreast of information on psychopharmacological agents (medications). The services that social workers provide remain the mainstays of addiction treatment, because medications to treat addictions are recommended only in conjunction with psychosocial services.

Social Workers and Mutual-Help Groups

Some individuals recovering from addictive disorders utilize professional assistance; others utilize mutual-help groups; some use both. In 1935, a stockbroker and a doctor both struggling with alcoholism founded Alcoholics Anonymous. The number of AA groups has grown tremendously. Narcotics Anonymous, Cocaine Anonymous, Marijuana Anonymous, Gamblers Anonymous, Overeaters Anonymous, Sexual Compulsives Anonymous, and Debtors Anonymous are all patterned after AA. These are all twelve-step programs that have a spiritual orientation and make reference to God. The Lord’s Prayer is generally recited at meetings. Atheists, agnostics, and those of non-Christian religious persuasions have recovered through twelve-step programs, perhaps due to the camaraderie and support. Those who do not want a spiritually based program may prefer programs like Secular Organizations for Sobriety or Rational Recovery.

The loose organization and emphasis on voluntary participation and anonymity make studying mutual-help groups’ effectiveness difficult, but many individuals attribute their recovery to these programs. Some clients need a relatively short course of professional treatment and use one or more of the many mutual-help groups for longer-term assistance. Others report that they do not find these groups useful. While many social workers embrace these groups, others have a more reserved view of them and for whom they may be most helpful. Since little hard research is available, social workers need to learn about mutual-help groups and attend meetings before they make their own judgments. Many groups have open meetings where professionals and other visitors are welcome.

Social workers generally educate clients about mutual-help groups; suggest they attend; and consider which, if any, they might find useful. Social workers also keep group literature and Internet addresses handy for clients. Mutual-help group members may offer help that professionals do not pro-
vide and may be available at times when professionals are not. Some AA groups operate clubs that are open twenty-four hours a day, seven days a week. Many mutual-help groups have twenty-four-hour phone lines or answering services. Continued attendance at meetings may help avert relapse.

**Impaired Employees and Colleagues**

Social workers may supervise an employee who is not performing adequately at work. The reason may be an addictive disorder. In these cases, the supervisor does not screen or diagnose but may make a referral to an employee assistance program, where social workers are often employed to identify the problem and provide necessary services. In other cases, a social worker may recognize a colleague is impaired (cannot perform adequately at work) because of an addictive disorder. The social worker may be responsible for discussing the concern with the colleague or reporting to a superior, licensing board, or group designated to intervene by a professional organization.

**ADDICTION POLITICS**

The Office of National Drug Control Policy reports that the federal government’s annual drug control budget is about $12 billion. For the fiscal year 2006, about 39 percent went to demand-side efforts (treatment, prevention, and related research), and 61 percent to supply-side efforts (law enforcement and interdiction). However, there is really no evidence that supply-side efforts reduce drug abuse and dependence (McNece & DiNitto, 2005). No matter how many drugs are confiscated, drug trafficking continues and drug supplies continue to flow. Since there is evidence that one dollar spent on treatment results in twelve dollars saved in money spent on criminal justice, health care, and other services (National Institute on Drug Abuse, 2000), social workers will continue to make a case for allocating more funds to treatment.

Social workers support efforts like community drug courts and Proposition 36 in California, which divert drug possession offenders to treatment rather than incarceration (see box 8.2). Other aspects of decriminalization also warrant social workers’ consideration, such as reduced penalties for possession of small amounts of drugs and permitting the use of marijuana for medical purposes. Crack cocaine offenses are treated much more harshly than powdered cocaine offenses, which discriminates against poor people and African Americans, who are more often arrested for offenses involving crack cocaine (see U.S. Sentencing Commission, 2002).
Action may also be needed in public benefit programs (DiNitto, 2002). Alcohol and drug problems are the only disabilities that can keep otherwise-qualified individuals from receiving publicly supported disability benefits. Felony drug convictions can keep parents from receiving public assistance and food stamps. Public housing tenants may be evicted if any household member is using drugs. A college student with a drug conviction as an adult is ineligible for federal financial aid for a designated period of time. In addition, the Americans with Disabilities Act does not provide employees who currently use illegal drugs or whose job performance is impaired by alcohol use with the same employment protections as individuals with other disabilities. Children may be removed from homes where a parent is using drugs even if there is no evidence of child abuse or neglect. Women have been arrested and incarcerated for using drugs while pregnant even though a fetus has no legal standing as a person. Such practices and policies may violate the Constitution’s equal protection and due process clauses and require social workers’ vigilance to prevent civil rights infringements and promote social justice.

Work is also needed on health insurance parity. Insurance coverage for alcohol and drug treatment lags behind coverage for mental health treatment, and both lag behind physical health coverage. Managed care has taken a toll by limiting access to the type and amount of alcohol and drug treatment (Hay Group, 2001). Even worse, millions of Americans have no health insurance coverage at all. These situations affect individuals’ access to treatment and social workers’ and other providers’ opportunities to treat...
them and to be paid for their work. Social workers will continue to press for ways to ensure that all Americans have health insurance, including full parity for addictions treatment.

Many alcohol and drug treatment programs espouse a goal of abstinence for clients. Harm reduction approaches make no such demands, focusing instead on reducing the harm that may come from drug use. Harm reduction is consistent with the social work principles of starting where the client is and respecting the dignity and worth of the individual. Some harm reduction strategies (e.g., heroin replacement therapy) are too radical for the U.S. government to consider. More moderate approaches have also been ignored. For example, the federal government has refused to fund needle-exchange programs despite its acknowledgment that they can reduce HIV transmission and do not promote injection drug use (U.S. Department of Health and Human Services, 1998). To save more lives, social workers who support needle exchange or other harm reduction approaches are seeking to make them more palatable to elected officials and the public.

**FUTURE OF ADDICTIONS PRACTICE AND SOCIAL WORK**

Social workers specialize in addictions practice for many reasons, including the challenge of the work (DiNitto, 2007). The field needs social workers’ systems and strengths perspectives to develop new and improved approaches that will prevent people from developing addictions, motivate those with addictions to enter treatment, and produce better treatment results. Social workers are also needed to press for policy changes that will increase treatment access and promote more rational and effective approaches to drug offenders and others with impulse-control disorders and compulsive behaviors.

The expanding definition of addictive disorders provides new employment opportunities for social workers. Addictions practice is also growing because professionals in child welfare, criminal justice, and other fields recognize that many clients have addictive disorders and need simultaneous (integrated) treatment for their problems. Many insurance plans cover treatment for addictive disorders, and the public has come to understand that these problems are treatable, resulting in increased demand for social work services. Increased treatment demand, also resulting from measures like Proposition 36, may overload the system, especially if more social workers are not prepared for addictions practice (McNeece, 2003).

Demographic trends are also increasing addiction practice opportunities (DiNitto, 2007). There has been a general population growth due to factors such as increased life spans, and baby boomers are the first generation with
wide exposure to illicit drugs. Thus, a growing portion of the older population may need services for illicit drug use as well as alcohol use disorders and prescription drug misuse. Younger people can obtain drugs with increased ease, meaning that more youths are being referred to services for drug offenses and drug treatment. More youths are overweight due to lifelong habits of drinking too much soda and eating too much high-calorie processed and fast foods. Youths’ familiarity with the Internet fuels gambling and shopping habits.

Another demographic consideration is the many immigrants who were victims of war, genocide, extreme poverty, and other horrific conditions before coming to the United States (Amodeo, Robb, Peou, & Tran, 1996). They may turn to alcohol and drugs, including substances indigenous to their homelands, to assuage the pain from these ordeals. Social work’s attention to culturally relevant definitions of addictions and models of practice can be useful in identifying and treating these problems.

The addictions workforce of the future may go to the lowest bidder—those willing to do the work at the lowest cost—as often seems to be the case today (DiNitto, 2007). On the other hand, highly skilled professionals commanding larger salaries may be needed to address the complex problems of individuals with addictive disorders and those with co-occurring mental disorders and health problems. Though there are no data indicating that any particular profession is best suited to treat clients with addictions, social workers, with their person-in-environment and biopsychosocial perspectives, may be ideal professionals for addictions practice (Straussner & Senreich, 2002).

Since the number of specialty addictions programs will not be sufficient to meet treatment demands, professionals in many settings must be able to incorporate addictions treatment in their work (Miller & Weisner, 2002). To do so, social work students should take courses on addictions, even if they are not required by their degree program. As members of the various helping professions vie for jobs and prominence, social workers can help secure their place in addictions prevention and treatment by demonstrating that they can help clients successfully address addictive behaviors.

**SUMMARY**

Social workers play important roles in addressing addictions. Some do this by specializing in addictions prevention or treatment. Others work in settings like probation, corrections, child welfare, emergency rooms, and college campuses, where alcohol and drug problems are prominent and interventions must be conducted or service referrals made. Others are employed
in medical settings where patients present with conditions like diabetes related to being overweight and with lung cancer, emphysema, and other health problems caused by smoking. Many of them need social work services as well as health care. In addition to developing skills in screening, intervention, and treatment, social workers can work to ensure that everyone with an addictive disorder, broadly defined, has access to affordable and effective treatment. More social workers are needed to address the growing problem of addictions.

**SUGGESTED READING**


Straussner, S. L. A. (Ed.). (2004). *Clinical work with substance-abusing clients* (2nd ed.). New York: Guilford Press. This book discusses many models of intervention and approaches to treatment to help clinicians choose those best suited to the client. There are chapters on adolescents; older adults; women; homeless individuals; individuals with borderline personality disorder; people who are HIV positive; and gays, lesbians, and bisexuals. The book contains many clinical case examples.

THE WORLD WIDE WEB OF SOCIAL WORK

Join Together http://www.jointogether.org/home/

This is a national resource center for communities working to reduce substance abuse through policy, prevention, and treatment. The organization provides timely information in condensed form through newsletters and alerts on topics of interest to social workers and those they assist.

National Addiction Technology Transfer Center http://www.nattc.org/

The NATTC, a project of the federal government’s Substance Abuse and Mental Health Services Administration, is dedicated to rapidly translating scientific information on addictions prevention and treatment for practitioners’ use. Its Web site offers links to the regional addiction technology transfer centers.

National Institute on Alcohol Abuse and Alcoholism http://www.niaaa.nih.gov

The NIAAA is a federal agency dedicated to promoting research on alcohol problems. The Web site contains a wealth of information on alcohol disorders of interest to social workers.


The NIDA is a federal agency dedicated to promoting research on drug problems. The Web site contains a wealth of information on drug disorders of interest to social workers.

Substance Abuse and Mental Health Services Administration http://www.samhsa.gov/

This federal agency includes the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, and the Center for Mental Health Services. SAMHSA provides an abundance of practice-relevant information on mental and substance use disorders, including its Treatment Improvement Protocol Series manuals (compilations of practice information and tools to help serve clients).