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PERSONAL PERSPECTIVE

Taboo Topics in Addiction Treatment

An Empirical Review of Clinical Folklore

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Abstract—*This article reviews 11 taboo topics, that is, research findings that question traditional assumptions and teachings of addiction treatment. These topics include: (1) the lack of empirical support for the Minnesota Model; (2) questions about the necessity of Alcoholics Anonymous for maintaining abstinence; (3) the existence of spontaneous remission; (4) the detrimental aspects of labeling; (5) the value of addicted individuals' self-reports; (6) the lack of empirical support for the addictive personality concept; (7) cue exposure as an underutilized intervention; (8) the interactional nature of motivation; (9) the value of smoking cessation in early recovery; (10) the overuse of the addiction concept; and (11) the lack of empirical support for the disease concept of codependency. Misconceptions arise due to the lack of communication between disciplines and the experiential bias of current addiction treatment modalities. Emphasis is placed on the importance of empiricism in order to advance the addiction field beyond faith and supposition.*

Keywords—addictions; relapse; nicotine addiction; expectancy; motivation; spontaneous remission.

WITHIN THE HEALTH CARE FIELD, addiction treatment is an anomaly. Perhaps more than any other discipline, the treatment of addicted people frequently relies more on faith than science, more on personal experience than empirical findings. Even the notion of disease, which lends scientific credibility to treatment of addictions, is applied too broadly and with much subjectivity (Shaffer, 1987). At the same time, there is a strong gravitational pull toward conformity within the field. This tendency likely arises out of the belief that the rejection of traditional ideas of recovery (by the patient *or* professional) constitutes denial. This anti-intellectual and antiresearch bias is compounded by the fact that most substance abuse counselors are in recovery themselves and are probably untrained in research methodology. However, behavioral scientists and medical practitioners share the blame because they have historically underestimated the benefits of self-help groups. Their rejection of groups like Alcoholics Anonymous and Narcotics Anonymous paved the way for an independent and sometimes contradictory approach to addiction treatment.

As the addiction treatment field has grown, there has been an integration of self-help philosophy with psychotherapy techniques. Some of this philosophy qualifies as folklore or supposition, but is readily accepted and transmitted to newly recovering alcoholics and drug-addicted people (thereby perpetuating potentially inaccurate ideas). Despite an infusion of research literature questioning the validity of these teachings, there has been little change. It is unfortunate that the professional disciplines within the addiction field do so little sharing of formal knowledge. When sharing does take place (as in the controlled drinking controversy surrounding the Sobells), the arguments become more emotional and political than objective.

Unfortunately, the addicted person is likely to suffer when the field does not advance itself. Significant relapse rates have been documented in all addictions, including alcoholism (Miller & Hester, 1986; Vaillant, 1983), cocaine addiction (Wallace, 1989), heroin addiction (Hubbard et al., 1989), nicotine addiction (Brandon, Tiffany, & Baker, 1986), and obesity (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). Because re-

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lapse has been considered a knowledge deficit (Monti, Abrams, Kadden, & Cooney, 1989), the transmission of accurate information to patients may actually improve outcome.

Such openness would counter three tendencies in addiction treatment professionals that are often noted in patients. First, patients are frequently considered rigid and in denial, which prevents the addicted person from generating healthy solutions to problems. As the treatment of addicted people begins to reduce dogma and increases open discussion, patients are more likely to be open and flexible in their problem-solving. Second, professionals in the field would act less like an alcoholic family, that is, would begin to speak more openly, even if doing so disputed an accepted idea. Third, professionals would counter the self-help notion of insanity, that is, expecting a different outcome when applying a previously unsuccessful solution. Questioning these ideas forces professionals to develop *new* treatment techniques, not repeat old ones.

The goal of this article is to review some of the common teachings of addictions treatment and compare them to available empirical findings. Any viewpoint or finding that disputes these teachings qualifies as a taboo topic because it questions an accepted belief. When currently accepted beliefs *are* questioned, there is a tendency for the believer to be seen as insensitive, naive, or even heretical. This review does not strive to dismiss the potential utility of current addiction treatment or the experiences of those in recovery, but simply to stress the importance of scientific discourse.

WHERE DO TABOOS WITHIN THE ADDICTION FIELD ORIGINATE?

The Concise Columbia Encyclopedia (1983) defines *taboo* as "the prohibition of an act or the use of an object or word under pain of severe punishment" (p. 827). This concept applies to objects that are sacred, dangerous, or unclean. The disease concept of addiction enjoys such wide acceptance in American society that anyone who questions it may be regarded as a heretic, misguided, or misinformed (Miller, 1986). Despite the fact that few people outside of the alcoholism field can state the entire theory (Caetano, 1987), the disease concept (e.g., loss of control, progression, the need for abstinence) and its implications (e.g., the necessity of AA, the acceptance of the alcoholic label) are generally unchallenged. In fact, there is a tendency for the general public to label just about any disorder or -ism as a disease (Shaffer, 1987). It is interesting to note that the American fixation with the disease concept (biological emphasis) differs from other more flexible psychosocial approaches utilized in other countries (Miller, 1986; Smart, Murray, & Arif, 1988). Treatment inflexibility is an inadequate response to the changing (and increasingly diverse) needs of alcoholics and has been noted in other countries, for example, Japan (Higuchi, Muramatsu, Yamada, Muraoka, Kono, & Eboshida, 1991).

Given the near-religious acceptance of the disease concept, it is not surprising that those who raise questions about it experience intense and sometimes emotional reactions from the addiction treatment establishment. What is important here is not which theory is correct, but why there is an uneven flow of empirical information. The controversies over controlled drinking (Cook, 1985; Maltzman, 1989; Miller, 1983; Sobell & Sobell, 1989) and the necessity of AA (Dorsman, 1991; Trimpey, 1989) are two examples. Peele (1989) notes that biochemical or genetic discoveries are initially given massive coverage in the press, but that refutations or disagreements are often minimized.

As with most taboos, such tendencies have a stabilizing function—they maintain the vested interests of various groups, namely the recovering community, the medical profession, and the treatment industry (Miller, 1986). Except for a massive proliferation of meetings, Alcoholics Anonymous has changed little since its inception. Due to the importance of anonymity, AA does not welcome research, which prevents the infusion of new information. As Galanter (1990) states about self-help groups (including AA), ". . . members should have access to objective scientific observations on the problems they address, thereby avoiding cultic seclusiveness." This concern applies to *any* self-help group devoted to a medical or psychological problem. How effective would self-help groups for patients suffering from cancer, anxiety, or sexual abuse be if they ignored the latest research?

As a result, many of those who staked their recovery in AA are able to avoid the cognitive dissonance of anomalous information and transmit traditional (often inaccurate) notions of addiction to newly recovering individuals. The cycle is then expanded to the treatment industry because the medical community and treatment industry employ and gain referrals from the recovering community. The medical community can claim addiction as its turf as long as it is viewed primarily as a disease (Heather & Robertson, 1989). Economic, political, and theoretical interests and biases become intertwined and interfere with scientific discourse (Fingarette, 1988) and may actually impede important social and political reforms (Heather & Robertson, 1989). A research-oriented professional who questions these vested interests may be treated as an outsider who hasn't been there. However, there is room for both experiential and empirical approaches, because *all* medical and psychological treatment specialties involve both clinicians and researchers.

As Kuhn (1970) has noted, science advances when anomalous findings accumulate. When these anomalies become persistent and cannot be ignored, a crisis

develops within the field of study and new explanations are generated. The present review is based on discussion of some of these anomalies and how they differ from generally accepted practice in the field of addiction. Some of these anomalies speak directly to the disease concept (e.g., the negative effects of labeling), some involve discussion of underutilized interventions (e.g., cue exposure and smoking cessation), and others point out the pitfalls of unquestioned adherence to the disease concept (e.g., the overuse of the concept of addiction and the lack of support for the concept of codependency).

TABOO TOPICS

The Lack of Empirical Support for the Minnesota Model

The uniformity of addiction treatment is no doubt due to the popularity of the Minnesota Model. This model has several major components: (1) the importance of psychoeducational approaches to build an awareness of the consequences of addiction; (2) the use of recovering personnel who can share their experience in recovery; (3) the acceptance of the disease model; (4) the importance of self-help groups such as Alcoholics Anonymous; and (5) the reliance of group counseling to confront denial and build awareness of the effects of addiction. Despite the widespread application of this model on an inpatient and outpatient basis, empirical support for its effectiveness is lacking.

Miller and Hester (1986) found little empirical support for common treatment components such as confrontation, alcoholism education, group therapy, individual counseling, and Alcoholics Anonymous. They did find support for some treatment modalities which frequently are not included in standard treatment. Aversion therapies (Rimmele, Miller, & Dougher, 1989), behavioral self-control training (Miller & Baca, 1983), the community reinforcement approach (Sisson & Azrin, 1989), marital and family therapy (O'Farrell & Cowles, 1989; McCrady, 1989), social skills training (Monti, Abrams, Binkoff, & Zwick, 1986), and stress management techniques (Stockwell & Town, 1989) have all received empirical support in recent years.

Even without a broad base of empirical evidence, personal experiences and the widespread use of traditional chemical dependence modalities suggest that this type of treatment may be effective – for some people. In a review of inpatient alcoholism treatment, Miller and Hester (1986) found that the effective components of treatment vary from patient to patient. They conclude that "more severe and less socially stable alcoholics seem to fare better in inpatient (i.e., more intensive) treatment, whereas among less severe and more socially stable (married, employed) alcoholics, outpatient (i.e., less intensive) treatment yields more favorable outcomes than inpatient treatment" (p. 801).

Recent advances in psychotherapy have emphasized a shift away from the cookie-cutter approach, that is, applying the same treatment interventions to all patients. The concept of treatment matching (Hester & Miller, 1988; Miller & Hester, 1986; Prochaska & DiClemente, 1986) is gradually taking on greater importance. Treatment matching entails a thorough assessment of the individual and the systematic application of pragmatic and empirically supported treatments. Despite treatment success rates that dip below 50% (Hunt, Barnett, & Branch, 1971; Miller & Hester, 1980; Wallace, 1989), alcoholism treatment programs continue to provide essentially the same treatment plans to all addicted people. Individualizing treatment may actually lead to greater support for inpatient addiction treatment programs, which have experienced increasingly shorter patient stays due to insurance industry assessments that uniform treatments are ineffective.

Questions about the Necessity of Alcoholics Anonymous for Maintaining Abstinence

Recent U.S. census figures indicate that worldwide membership in Alcoholics Anonymous is fast approaching the 2 million mark, with half of this number in this country alone (Robertson, 1988). The increase in its popularity and decrease in its stigma have helped publicize AA and further expand its influence in contemporary addiction treatment. Whether one believes in the 12 steps of recovery or simply in the opportunity for support and skill-building provided by AA meetings, frequent attendance is often prescribed by even behavioral, empirically oriented clinicians (McCrady & Irvine, 1989).

Peele (1989) questions the assumption that AA is more effective than other treatments or even the lack of treatment, because random assignment to these conditions yields no significant differences in outcome. This argument sets up a straw man because AA is not billed as a treatment, but as a self-help program. Its greatest strength, anonymity, is also its greatest weakness, because no formal research can be applied to its membership. Despite this lack of empirical evidence (Emrick & Hansen, 1985), it is evident that Alcoholics Anonymous has had a major positive impact on many addicted individuals and their families.

However, it may be erroneous to regard AA as an *essential* element of recovery. While the enthusiastic testimonials of ardent members of AA are moving and convincing, they fail to resolve an important chicken-and-egg dilemma. Hoffman and Harrison (1989), in their review of studies which associate posttreatment AA attendance and abstinence (Hoffman, Harrison, & Belille, 1983; Hoffman & Harrison, 1986; Harrison & Hoffman, 1987), state, "One major limitation to

these naturalistic studies of AA is that they cannot resolve the question of whether involvement in AA contributes to recovery or whether those individuals with the greater commitment to recovery are more likely to attend AA" (pp. 42–43). Commitment to recovery may precede attendance at meetings, thus yielding a sample of motivated, but unrepresentative, alcoholics.

In their study of the personality differences between AA members and nonmembers, Hurlburt, Gade, and Fuqua (1984) found that members tended to be psychologically more healthy than nonmembers. They pointed out, however, that "no clear conclusion can be made as to whether AA members become more psychologically healthy as a result of their membership or whether AA attracts people with these personality traits in the first place" (p. 171). These studies suggest that the AA movement may be a *result* of health and commitment, rather than a means by which people recover.

Although little is known about AA members, even less is known about those who have *not* chosen a 12-step method of recovery. Nationwide estimates of alcoholics and problem drinkers far exceed the number of AA members. This suggests that for many who have abstained independently and for others who continue to drink abusively despite attendance at meetings, Alcoholics Anonymous has not been the answer. Rather than simply wait for these people to hit bottom, investigation of ways to encourage AA attendance and alternatives to AA may attract addicted people to develop social support.

Clinicians are beginning to be more selective in the inclusion or exclusion of AA as a part of an individual's treatment plan because certain subgroups, for example, those with psychiatric or emotional problems may not benefit from AA. Weiss and Mirin (1989) observed that some "persistently depressed" alcoholics may find AA discouraging because they fail to experience the dramatic improvements described by fellow AA members. In addition, AA members' traditional blanket distrust of potentially helpful psychotropic medication, as well as potentially demeaning jargon (e.g., sitting on the pity pot) may serve to further demoralize such individuals.

Finally, most clinicians have been confronted with patients who hold strong, negative feelings about 12-step programs. Central AA concepts such as higher power and spirituality may alienate those who want help, but simply do not believe in these concepts (Dorsman, 1991). Despite the insistence of AA members that the higher power need not represent God, it should be noted that God is mentioned in four of the steps and 132 times in the *Big Book* (Blau, 1991). With the availability of other potentially effective treatment methods and the formation of alternative groups such as Rational Recovery, addicted individuals who adamantly oppose the spiritual nature of AA have other viable options.

The Existence of Spontaneous Remission

The recognition of spontaneous remission (also known as *natural recovery*), is trapped in a tautological argument advanced by disease model advocates. Their reasoning is based on the post-hoc assessment that an ability to cease addictive behavior on one's own suggests that the individual was not addicted in the first place. If one is *not* able to stop independently, then an addiction is present. This has led to an assumption that addicted people are unable to determine effective methods of recovery without formal treatment or self-help groups. If they are somehow able to stop addictive behavior without such intervention, they are often considered to have a dry-drunk recovery.

However, addiction researchers have documented natural recovery in alcoholics (Smart, 1976), cocaine-addicted people (Shaffer & Jones, 1989), heroin-addicted people (Waldorf, 1983), marijuana abusers (Kandel & Raveis, 1989), obese individuals (Schachter, 1982), and cigarette smokers (Fiore et al., 1990). Nicotine addiction is considered by *most addicted people* to be the most difficult drug to stop using (reported by Lynn Kozlowski in *Drug Addicts*, 1990). However, 95% of those who stop do it on their own (Peele, 1989). In fact, Schachter (1982) found that untreated smokers who stopped smoking and obese clients who lost weight did so for longer periods than those receiving formal intervention.

Avoiding the reality of natural recovery deprives treatment professionals and addicted patients of a valuable source of information. Studies indicate that untreated and treated addicted patients progress toward abstinence through similar stages and with similar methods (Prochaska & DiClemente, 1986). For example, many cocaine-addicted individuals and alcoholics who attain natural recovery change daily routines, develop social support, achieve a sense of spirituality, and avoid cues that can trigger relapse (Shaffer & Jones, 1989; Vaillant, 1983). Waldorf (1983) found that processes such as the drift from deviant to conventional behavior, conversion to religious, spiritual, or ideological groups, and environmental change enhanced recovery in both treated and untreated heroin-addicted people.

Those who achieve stable abstinence from addicting drugs without treatment may have valuable lessons for those who do seek treatment. Shaffer and Jones (1989) point out several clinical implications of research in natural recovery: (1) treatment should be prescriptive and individualized; (2) treatment should be directed at building structure in the addicted person's life; (3) secondary drug use and abuse should be as-

sessed; (4) the addicted person's ability to tolerate painful feelings is critical to maintaining abstinence; and (5) awareness of risk periods in long-term maintenance is important in preventing unhealthy substitutions in recovery.

Many disease-oriented advocates allow that natural recovery is possible, but that natural recovery is not as complete or meaningful as recovery with treatment or self-help. While it is clear that many cocaine-addicted people who attain natural recovery do so with unhealthy substitutions such as excessive exercise, use of caffeine, and compulsive sex, there are many who utilize religion, volunteer work, formal education, and re-commitment to friends as relapse prevention techniques (Shaffer & Jones, 1988). Vaillant (1983) found that some spontaneously remitted alcoholics utilized chain smoking, compulsive work, or benzodiazepines as their major methods, but that others develop a new love relationship or devote themselves to spirituality. As a result, it is apparent that untreated addicted people develop unhealthy *and* healthy substitutes, not unlike those who are treated. Attendance at AA or involvement in treatment is no guarantee of nor the only way of developing a healthy recovery—these involvements may only help one's chances for recovery.

A final point should be made here. An unquestioned, and disturbing, trend in the chemical dependence field concerns the assumption that most young people who are using drugs or alcohol will develop or maintain addictions in adulthood. Although a survey by the National Institute of Drug Abuse found that prior to graduation from high school 92% of students had tried alcohol and 57% had tried an illicit drug (Johnston, O'Malley, & Bachman, 1988), drinking and drug-taking activities tend to peak in adolescence and early adulthood (Cahalan & Room, 1974; Kandel & Raveis, 1989). Adolescent drinking has been found to be uncorrelated with adult drinking (Donovan, Jessor, & Jessor, 1983; Temple & Fillmore, 1986). More simply stated, many adolescents outgrow their addictions and develop natural recoveries.

In a significant longitudinal study, Shedler and Block (1990) examined the relationship between adolescent drug use and psychological adjustment and health. Their results strongly suggested that personality, family, and parenting factors were the key predictors of drug use and general adjustment. Experimentation with drugs *did not* predict frequent use or abuse, nor did it necessarily render the experimenter less psychologically healthy than abstainers. In fact, the authors conclude that "it is difficult to escape the inference that experimenters (with drugs) are the psychologically healthiest subjects, healthier than either abstainers or frequent users" (p. 625). Those that had experimented with drugs evidenced better adjustment than those who abused drugs or who abstained, based on measures of parenting and personality functioning. This finding should not be construed as evidence that the use of drugs *leads* to psychological health, but that many psychologically healthy young people actively experiment with their world. This experimentation may occasionally lead the young person into unhealthy activities, but psychologically healthy people eventually develop responsible patterns and find healthy alternatives. This maturing-out hypothesis has been supported by a recent study that found a significant decrease in drinking among young people who developed stable marriages (Miller-Tutzauer, Leonard, & Windle, 1991). Clinicians should therefore evaluate the drug and alcohol histories of their clients within the context of initiation and progression through developmental stages, because age at first use (prior to age 15) may be associated with increased potential for later problems (Robins & Przybeck, 1985).

The Limitations of the Alcoholic or Addict Label

The acceptance of the label of alcoholic or addict is considered half the battle in the traditional treatment of chemical dependence. The first step of Alcoholics Anonymous states, "We admitted we were powerless over alcohol—that our lives had become unmanageable" (*Twelve Steps*, 1952). Support group meetings of many of these organizations begin with a stated acceptance of this label ("Hi, my name is John and I'm an alcoholic"). A person's unwillingness to accept such a label is frequently the first issue to be addressed in treatment, because further intervention may be fruitless without such acceptance. Confrontation may be used to achieve acceptance and decrease denial, but can lead to the ultimate indicators of resistance—treatment drop-out or relapse.

A growing body of literature suggests that the acceptance of such a label is not an essential first step. Some would even consider the use of such labels as counterproductive, doing more damage than good (Fingarette, 1988). Such acceptance is associated with the belief in addiction as an incurable disease and a lifelong condition (Wesson, Havassy, & Smith, 1986; Hall & Havassy, 1986). The implications of such a belief are potentially problematic in terms of self-image, expectancies, and attributions (Seligman, 1975; Peterson & Seligman, 1987; Bush & Ianotti, 1985). Research indicates that the negative effects of the acceptance of such a label, or the struggle with treaters to accept this label, might be especially acute with adolescents (Bush & Ianotti, 1985).

The belief that one must accept the label of addict or alcoholic in order to make gains places great and unnecessary limitations on clinicians. Because change is considered an internal process, others can exert only limited influence over an addicted person. Personal

change then becomes independent of outside forces. However, studies on motivation, specifically regarding alcoholism and alcohol use, have suggested that individual choices to drink or not to drink are far more complex than previously thought (Miller, 1985; Miller, 1987; Cox & Klinger, 1988). Environmental cues, the expectancies of others, and past reinforcements all affect the motivation to drink and subsequent behavior.

Therapeutic work with addicted populations can begin without the initial acceptance of the alcoholic or addict labels. Cox and Klinger (1987) focus on individual perceptions, memories, and conditioning histories to alter the expectancies and motivation toward drinking. Ellis, McInerney, DiGuiseppe, and Yeager (1988) apply the philosophy and techniques of Rational-Emotive Therapy to alcoholics and substance abusers. Their initial emphasis is on the discussion of the *specific* pains, hassles, and evils of drinking and substance abuse for that *individual*, as well as the advantages of giving up alcohol and drugs. Hester and Miller (1988) focus on the importance of flexibility, for example, the use of treatment matching and working with individual alcoholics at their level of commitment and motivation, employing external motivators when necessary. Their primary emphasis is on keeping the patient in treatment long enough to provide the opportunity for progress, not on the acceptance of the label alcoholic. Once addicted people understand what an alcoholic or addict is, they will be more likely to convince *themselves* that they should accept these descriptions of their behavior.

The Usefulness of Addicted Individuals' Self-Reports

The dishonesty and denial among addicted people is a common expectation of treatment professionals. This expectation results from an assumption that dishonesty is an inevitable trait within the addictive character. The role of the therapist, therefore, is to break through this deceit and denial, looking for inconsistencies in an effort to encourage the alcoholic to get honest with himself and others. This may set up a bias in which any views or information which differ from the therapist's opinions will be met with skepticism. When denial and dishonesty are assumed, the patient is guilty until proven innocent or engaged in attempts by the therapist to catch him in a lie. Given findings that the accuracy of lie detection among individuals trained to detect lies (including law enforcement personnel and psychiatrists) rarely exceeds 60% (Ekman & O'Sullivan, 1991), such cat-and-mouse games will rarely make clinical sense. The therapeutic relationship may then become adversarial rather than cooperative, resulting in treatment resistance (Miller, 1985).

Despite the skepticism with which they are viewed, there is evidence that alcoholics' self-reports are more reliable than usually thought. A review by Sobell and Sobell (1986) suggested that alcoholics' self-reports generally agree with official records (hospital admissions, arrests, previous treatments) and collateral (e.g., family) reports. The use of various data-gathering methods (e.g., questionnaires or computer-assisted interview), type of setting (e.g., group or individual), or type of questions (e.g., alcohol vs. nonalcohol) did not appreciably affect the reliability or validity of self-reports. A later study found that alcoholics generally: (1) retain memories about distant life events; and (2) tend to answer inconsistently due to misplacement of events temporally or misunderstanding of questions rather than lying (Sobell et al., 1988).

Distorted histories may also be the product of impaired cognitive functioning. A significant body of research findings suggests that there are deficits in the cognitive functioning of substance abusers when compared to nondrinkers or social drinkers (Parsons, 1987). Such deficits may take the form of language, attention, abstraction, memory, or problem-solving impairments (McCrady, 1987; Miller & Saucedo, 1983; Parsons, 1987). Cognitive deficits may result from or precede the use of drugs or alcohol and are time-limited in most addicted people (Miller & Saucedo, 1983). Given the psychoeducational focus of traditional addiction treatment, it is not surprising that most patients have difficulty recalling recently presented information in the first 2 or 3 weeks of treatment (Becker & Jaffe, 1984).

Abstinence generally enhances recent memory functioning over the first few months of recovery (Miller & Saucedo, 1983; McCrady, 1987), which may lead to more accurate self-reports. Inconsistencies in these self-reports may actually represent a clearing in the patient's thinking rather than an attempt to deceive. Treatment professionals *should* expect variations in self-report, with more accurate reports given over time. For instance, alcoholics have difficulty discriminating internal emotional cues, which may contribute to a minimization of emotional life events (Tarter, Alterman, & Edwards, 1984). A highly confrontational approach would likely further confuse the emotional state of a patient who is struggling to regain lost cognitive skills (and may actually punish honesty). Cooperation, mutual goal-setting, empathy, provision of alternative solutions, and flexibility by therapists are likely to lead to more clinically useful self-reports.

Finally, it is important to consider whether denial or dishonest self-reports inevitably represent maladaptive defensiveness. Some addicted people may minimize or not even acknowledge significant emotional events due to their extreme nature, for example, natural disasters, combat experiences, physical abuse, or sexual abuse. For instance, the relationship between a history of incest and alcoholism, especially in women, is well-documented (Herman, 1981; Hurley, 1991).

Many of these women feel stigmatized and branded by their incest experiences (particularly within family and intimate relationships) and may utilize a variety of defensive maneuvers as emotional self-protection. Inaccurate self-reports or minimization by incest survivors may therefore suggest self-protective motives rather than irresponsibility. The defensive structure of an addicted incest survivor should be respected rather than eliminated in early recovery.

The Lack of Empirical Support for the Addictive Personality Concept

The quest for uniformity among addicted people is nowhere more evident than in the notion of addictive personality. Countless dollars have been spent on research attempting to discover a trait or set of traits that characterize *all* people addicted to alcohol or drugs. Unfortunately, the results can be summed up in Mark Keller's statement that "the investigation of any trait in alcoholics will show that they either had more or less of it" (cited in Goodwin, 1988). Despite the acceptance among researchers that there is no singular alcoholic personality (Graham & Strenger, 1988), there is little reflection of this awareness among front-line treatment providers.

Behavior is probably a better predictor of alcoholism and drug addiction than trait descriptions. Nathan (1988) states that antisocial behavior better predicts alcoholism than antisocial personality disorder. Tarter (1988) reports that an excessive activity level, antisocial behavior, and emotionality predispose children to alcoholism. People addicted to opiates may engage in antisocial behavior or experience chronic emotional distress prior to their addiction (Maddux & Desmond, 1986). As a result of specifying a behavior rather than a whole personality, intervention is more likely to target significant behaviors that could lead to relapse. This approach individualizes treatment and allows for treatment-matching strategies (Miller, 1989). Assuming that the addicted person has an addictive personality encourages a lack of creativity in intervention and can worsen outcome.

The Usefulness of Cue Exposure in Treatment Settings

Exposing patients to relapse cues is generally considered taboo in most treatment environments. These cues include ashtrays for smokers, white powders for those addicted to cocaine, drug-related songs for marijuana smokers, and liquor advertisements for alcoholics. This overprotective practice is unfortunate, because many patients retain cue reactivity, that is, powerful physiological reactions to drug-related stimuli, even after significant treatment. Opioid-addicted people who become abstinent persist in their physiological arousal to drug cues even after 30 days of residential treatment (Childress, McLellan, Ehrman, & O'Brien, 1988). The powerful cue reactivity effects of cocaine are well-known (Washton, 1989). When exposed to smoking cues, smokers show more heart rate increases than nonsmokers or successful abstainers (Abrams et al., 1987). Given the finding that cue reactivity is related to relapse potential (Niaura et al., 1988), treatment can become an exercise in futility when the addicted person is re-exposed to relapse cues in his natural environment. This has been documented back to Wikler (1948), who discovered that many opiate-addicted people who returned to an urban environment after treatment (in this case New York City) became nauseous or vomited when exposed to the sights and sounds of the city. Many people addicted to other drugs are equally unprepared for the reflexive nature of cue reactivity.

Monti, Abrams, Kadden, and Cooney (1989) report that exposure to drug-related cues has several advantages: (1) cue exposure in the absence of drug-taking can reduce the reward value of the cue; (2) cue exposure provides an opportunity to practice coping responses such as relaxation or cognitive restructuring in a realistic situation; and (3) cue exposure can increase self-efficacy, which will increase the likelihood that the response will be utilized in future real-life cue exposures. Rational and careful cue exposure recognizes the reality that it is impossible to avoid drug-related cues, even with the most conservative lifestyle. Patients become better prepared and do not assume that the safety net of treatment will support them outside of treatment.

Cue exposure as a treatment technique has been surprisingly underutilized (Heather & Bradley, 1990), but there are several studies that offer promising results. Using slides, videotapes, and paraphernalia, researchers have found decreased reactivity among those addicted to heroin, cocaine, and alcohol (Laberg, 1990; O'Brien, Childress, McLellan, & Ehrman, 1990; Powell, et al., 1990). Exposure to food has also been shown to decrease binge eating in two single case reports (Wardle, 1990). Future clinical work that combines cue exposure with coping skills training (e.g., drink refusal) offers the best usage of this technique (Marlatt, 1990).

The Limited Usefulness of Current Models of Motivation

Contrary to popular belief, motivation is not a force or characteristic that singularly resides within the addicted person. Motivation is usually subjectively determined by the treatment professional. It is more likely to reflect compliance and agreement with the therapist than an internal compulsion to seek change. As Miller (1985) states in his review of motivation in

alcoholics, "A client tends to be judged as motivated if he or she accepts the therapist's view of the problem (including the need for help and the diagnosis), is distressed, and complies with treatment prescriptions" (pp. 87–88).

In fact, patient characteristics account for no more than 5–10% of the variance in outcome (Rounsaville, 1986). *Therapist* behaviors are probably equally important in building motivation. Imhof (1991) contends that countertransference (defined as "the total emotional reaction of the treatment provider to the patient") is an obstacle to objective diagnosis and treatment. He traces current pessimistic attitudes about drug treatment to well-respected clinicians who promulgated negative expectancies about addicted people. In a review of motivation in alcoholics, Miller (1985) concluded that therapist hostility, making a poor prognosis, and a lack of empathy all effectively reduce compliance. Valle (1981) found that higher levels of interpersonal functioning in counselors were associated with fewer relapses, fewer relapse days, and less alcohol use among alcoholics during two years following treatment. Meichenbaum and Turk (1987), in a review of patient adherence in general medical treatment, found that patients who experienced a lack of collaboration, negative interactions with practitioners, or impatience with the progress of treatment were less likely to follow treatment recommendations. Organizational factors relating to therapist behavior also affect motivation. Craig and Rogalski (1982) reported four variables that were related to dropping out of opiate detoxification treatment: (1) staff absenteeism during treatment; (2) number of admissions during treatment; (3) prescription of methadone; and (4) absenteeism of the primary therapist. Given the trend for treatment centers to stretch their resources during these difficult economic times, it is inappropriate to blame patients for the professional lack of attention to their problems. To claim that the patient was not ready or had not hit bottom relieves therapist and organizations of their responsibility in preparing a patient for treatment.

The dynamic and evolving nature of motivation is also underestimated. There is often an assumption that patients possess a particular, unchanging level of motivation that carries them through recovery. However, Prochaska and DiClemente (1984) suggest four stages in therapeutic change, all involving different levels of motivation and therapeutic needs: (1) precontemplation (lack of recognition of a problem); (2) contemplation (recognition of a problem); (3) action (completion of tasks to solve the problem); and (4) maintenance (development of lifestyle changes that support change). A patient who is motivated at one stage may not necessarily be motivated at a later stage, for example, an alcoholic may admit his alcoholism (stage 2), but not be willing to attend AA (stage 3). When these stages are taken into account, it is not surprising that research shows no significant difference in outcome between coerced and noncoerced patients (Westermeyer, 1989). Some people forced into treatment gain insight and make behavioral changes, while some who make an independent decision to seek treatment become unwilling to follow treatment prescriptions.

The Importance of Smoking Cessation in Early Recovery

Ninety percent of alcoholics smoke (Istvan & Matarazzo, 1984), compared to 30% of those in the general population (Pierce, Fiore, Novotny, Hatziandreu, & Davis, 1989). Those who drink heavily are less likely to attempt to stop smoking (Zimmerman, Warheit, Ulbrich, & Auth, 1990). When the first author once asked a group of addicted people about their plans to stop smoking, many reacted with incredulity. They regarded smoking as so difficult to stop that they did not even consider the possibility. This notion is supported by the addiction treatment establishment in this country. Many treatment professionals (including physicians) assume that smoking cessation detracts needed attention away from treatment of alcohol and other drug addictions. Patients often state, "I'm not here (in treatment) to stop smoking. I'm here to stop using drugs."

Even if one accepts the assumption that addicted individuals should work on their primary addictions first (which is questionable, given the severe health consequences of nicotine addiction), smoking is not just smoking. There is ample evidence that smoking is related to a number of undesirable behaviors and health practices. Smokers have more antisocial behavior, questionable health habits, and addictive tendencies than nonsmokers (Coambs, Kozlowski, & Ferrence, 1989). Heavy smokers are less physically active and sleep less than nonsmokers ("Smokers' Problems," 1988). This latter article also describes the increased tendencies of these smokers to engage in high-risk behavior (such as visiting high-crime areas and carrying guns), get into arguments, and use medications. Because addiction treatment has evolved into a holistic approach stressing both physical and psychological aspects of recovery, the quasi-support for maintaining smoking as a tool in relapse prevention is dubious.

What are the outcomes for treatments that *do* include smoking cessation as an intervention? Recent findings suggest that alcoholics who stop smoking are more likely to develop long-term abstinence from alcohol (Bobo, 1989). Smoking cessation did not appear to increase relapse potential. Hurt and Slade (1990), writing about a survey conducted by the Society of Addiction Medicine, found that no-smoking policies do *not* tend to lower occupancy rates, increase discharges against medical advice, or require more physical restraints. A review of smoking cessation among psychiatric patients found that even those with severe disorders were able to stop. These authors also report

that half of the surveyed treatment center directors did not believe that smoking cessation among addicted individuals in treatment would interfere with their alcohol or drug cessation. Even adolescents, who might be expected to be particularly resistant, seem to accept inpatient smoking bans, as they tend not to complain of withdrawal, request nicotine gum, or seek out illicit cigarettes (Kaplan, Busner, Rogers, & Wasserman, 1990). Staff members who are still smoking themselves or underestimate smoking as an addictive activity represent one of the major obstacles to smoking cessation among addicted patients (Sees, 1990; Wallace, 1986).

The Overuse of the Concept of Addiction

Peele (1989) refers to this country's current passion with addictions as an addiction splurge. The notion that everybody has an addiction is accepted as a truism by many practitioners in the addiction field. With all of the newspaper articles, television talk shows, and self-help groups touting the discovery of new addictions, it is no surprise that those who deny having an addiction are viewed as naive or lacking in insight. Unfortunately, the multitude of addictive labels does little to explain compulsive behavior and may actually say more about the labeler than the labelee. These labels reflect social constructions more than scientific determinations (Shaffer, 1987). The leap from compulsive behavior to addiction to disease is hazardous and usually not well-conceptualized. The tendency to reduce complex problems to syndromes, diseases, and addictions detracts needed attention from societal and political factors that shape unhealthy behavior. Indeed, society itself has been labeled an addict (Shaef, 1987).

Apart from the social implications of labeling everyone (if everyone fits this label, maybe we are just describing the human condition!), the numbers simply do not add up. Estimates of alcoholism are about 13 million people (Wisotsky, 1986), cocaine addiction at least 1 million (Gold, 1990), heroin addiction about one-half million (Trebach, 1982), nicotine addiction about 50 million (U.S. Public Health Service, 1989), and compulsive gambling about 1 million (Custer & Milt, 1985). Even if other drugs such as marijuana and new disorders such as sexual addiction (estimated at 3–6% of the population by Carnes, 1991) are included, the numbers do not approach the U.S. population of 250 million. Also, it should be noted that many of the people in these figures are multiple drug users, so simple addition of addiction statistics will yield an inflated estimate of addiction in this country. As stated earlier, 90% of alcoholics smoke cigarettes, so there may be particular individual characteristics, rather than societal tendencies, relating to addiction.

One byproduct of the search for addictive behavior is the emphasis on biological factors such as genetic predisposition, biochemical markers, and high-risk physiological characteristics in children of addicted people. The most widely cited evidence for the biological component of addiction is the finding that alcoholism runs in families. Research suggests that children of addicted people are more likely to become addicted to drugs or alcohol themselves (Goodwin, 1988; Maddux & Desmond, 1986). These findings are supported by twin (Hrubec & Omenn, 1981; Pickens & Svikis, 1988), adoption (Bohman, Sigvardsson, & Cloninger, 1981; Goodwin et al., 1974; Cloninger, 1988), and half-sibling (Schuckit, Goodwin, & Winokur, 1972) studies. These studies, along with animal studies (Deitrich & Spuhler, 1984), provide evidence for a genetic factor in alcoholism. Furthermore, this biological predisposition may be independent of parenting and environmental factors (Goodwin, 1988).

A possible (and common) misinterpretation of these findings can lead to the belief that all alcoholics are equally predisposed to alcoholism, and that this predisposition is overwhelming. There is evidence that male children of alcoholic parents are more likely to develop alcoholism than sons of biological parents who were not alcoholic (Goodwin, 1985; Schuckit, 1987). Estimates suggest that 20–25% of sons of alcoholics become alcohol dependent (Goodwin, 1988). Because even fewer females with familial alcoholism become alcoholics (Goodwin, 1988), it is apparent that most individuals in alcoholic families do *not* become alcoholics. In contrast, there are many people without familial alcoholism who become alcoholic.

In his review of genetic research, Searles (1988) concludes that "environmental influences may have been underestimated as significant factors in the etiology of alcoholism" (p. 163). Indeed, even those who ascribe to the disease model of alcoholism acknowledge the complex interplay of biological, psychological, and social factors (Goodwin, 1988; Schuckit, 1984; Cloninger, Bohman, & Sigvardsson, 1981), as well as the limitations of current neurobiological findings (Wallace, 1988). This acknowledgement has led to the postulation of a biopsychosocial approach to the treatment of addictions (Donovan, 1988; Chiauzzi, 1991; Zucker & Gomberg, 1986). The biopsychosocial model emphasizes assessment of all three domains, the possibility of individual differences in the representation of these domains within each addiction, and the commonalities in these domains across addictions (Chiauzzi, 1991). Careful biopsychosocial assessment of addiction not only individualizes treatment, but prevents careless labeling of syndromes and diseases.

The Lack of Support for the Disease Model of Codependency

The rapid rise and acceptance of codependency within the addictions treatment field has overshadowed scientific debate about the validity of the term and whether it is a condition qualifying as a disease. Cermak (1986) describes a set of criteria (combining features from de-

pendent, borderline, and histrionic personality disorders and posttraumatic stress disorder) that form the basis for placement in *DSM-III-R*, suggesting that codependency is a psychiatric problem. Schaef (1986) regards codependency as a disease that *precedes* alcoholism in the spouse and states that "it is their (the codependent's) disease they are sliding into, not the disease of the alcoholic." She also states, ". . . everyone who works with, lives with, or is around an alcoholic (or a person actively in an addictive process) is by definition a co-dependent and a practicing co-dependent." It is assumed that children growing up in alcoholic homes inevitably become affected by the alcoholic parent(s) and become dysfunctional themselves (Black, 1979; Woititz, 1983), thus continuing the codependent chain. The widespread and uncritical acceptance of the codependency concept has led to the development of treatment programs that help the patient recognize the child within (Whitfield, 1987) and the dysfunctional nature of their families (Wegscheider, 1981).

Aside from the contention that codependency has been medicalized to enhance insurance reimbursement (van Wormer, 1990), there are serious deficiencies about some of the major assertions that codependency is a disease. First, there is no general agreement regarding the symptoms of codependency. As the term is used now, its defining characteristics can be applied to virtually any behavior (Ashley & Brissett, 1988; Gomberg, 1989; Haaken, 1990). Codependency generally refers to an identity based on caretaking and taking excessive responsibility (Haaken, 1990), which encompasses a broad range of behavior. It is therefore possible for help-giving to become pathological, even when given to those who are not addicted.

Second, there is no research that supports a disease process in codependency. Instead, current information is based on "intuition, assertion, and anecdotes" (Gomberg, 1989). The evidence for the disease process is based on steps, stages, roles, irrational beliefs, and labels. One set of criteria was drawn from surveys of spouses of chemically dependent people (van Wormer, 1989). Other findings are based on self-reports of readers of chemical dependence publications or the experience of addicted patients in treatment (Burk & Sher, 1988). In fact, in the first author's perusal of 34 well-known codependency books at a local bookstore, there was little indication that writers even attempted to make a empirical case for codependency as a disease! These books presented relatively few research citations (generally citing each other), reflecting a bias toward personal experience and the appeal of these books to the general reading public.

Third, the label of codependent may lead to a self-fulfilling prophesy. There has been much concern over quasi-medical labeling of people, particularly in terms of potential stigma that it may produce (Burk & Sher, 1988). There is evidence for negative stereotyping of teenagers labeled as COA's by both mental health professionals and peers (Burk & Sher, 1990). This is especially unfortunate because studies show that most children of alcoholics function within the normal range (e.g., achievement, communication, intelligence) despite growing up in unstable homes (Burk & Sher, 1988; Werner, 1986; West & Prinz, 1987). Rather than focusing on psychopathology, there needs to be more attention paid to childhood resilience (Rutter, 1987), which stresses competence and problem-solving. With the broad application of such psychopathology to virtually anyone in the general population (Kaminer, 1990), it would seem difficult to escape labeling or at least a claim that one is in denial. It is noteworthy that Hazelden, a nationally recognized treatment center, discontinued usage of the term codependency after finding evidence of a variety of coping skills in alcoholic families (cited in Gomberg, 1989).

Fourth, there is a distinct blaming the victim tone in the literature, particularly against women. Asher and Brissett (1988) note that this affliction by association makes women appear more deviant. Rather than trying to correct unjust conditions or circumstances that render women powerless, their difficulties are blamed on codependency. There is much overlap between sex-role socialization (help-seeking, loyalty to a partner, dependency, maternal sensitivity) and the label of codependency (van Wormer, 1989). The result is that complex problems (poverty, discrimination, economic disparities, physical and sexual abuse) are explained away with labels and generalizations. Even organizations and countries can be considered codependent (Kaminer, 1990). Such reductionistic thinking only obscures or minimizes the individualized assessment needed to effectively institute meaningful change in addicted individuals.

CONCLUSION

This article reviewed empirical findings that dispute 11 traditional assumptions within contemporary addiction treatment. These notions are seldom questioned by patients, recovering people, and even treatment personnel, but may actually interfere with the development of effective interventions. Open discourse will move the field from the realm of experience and faith into empiricism, which is a natural progression in the development of a science (Shaffer & Jones, 1989). Empirical questioning will encourage a multidisciplinary perspective, because addictions cannot be understood by any single approach (Donovan, 1988). Most important, increased flexibility within the addiction field may encourage the development of creative interventions that enhance outcome. As Mark Twain stated, "Its name is public opinion. It is held in reverence. It settles everything. Some think it is the voice of God. Loyalty to petrified opinion never yet broke a chain or freed a human soul."

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