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# Substance Use Disorders

**Nicholas R. Lessa, M.S.W., M.A.**

**Walter F. Scanlon, Ph.D., M.B.A.**

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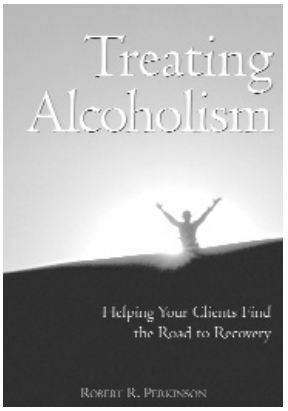


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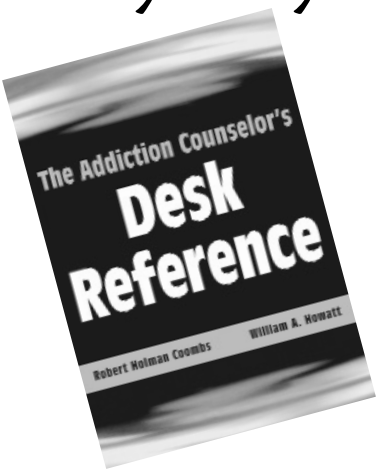


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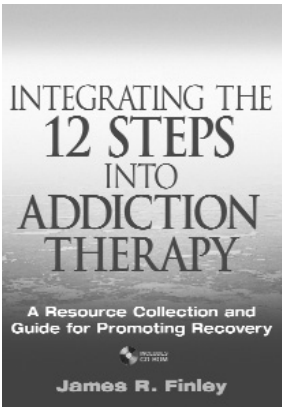


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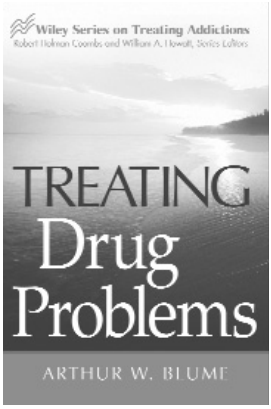


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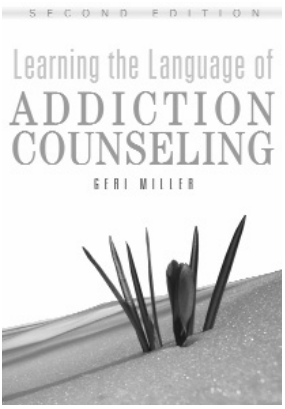


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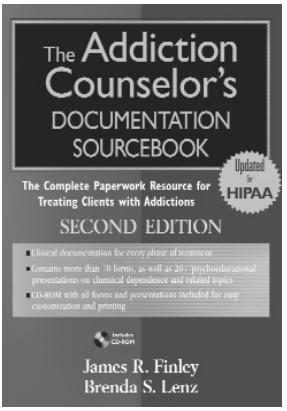


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To
Our respective families

We cannot control the direction of the wind, but maybe we can adjust our sails
–Emmerich Vogt

# CONTENTS

## Section Three: Treatment

# SERIES PREFACE

The *Wiley Concise Guides to Mental Health* are designed to provide mental health professionals with an easily accessible overview of what is currently known about the nature and treatment of psychological disorders. Each book in the series delineates the origins, manifestations, and course of a commonly occurring disorder and discusses effective procedures for its treatment. The authors of the *Concise Guides* draw on relevant research as well as their clinical expertise to ground their text both in empirical findings and in wisdom gleaned from practical experience. By achieving brevity without sacrificing comprehensive coverage, the *Concise Guides* should be useful to practitioners as an on-the-shelf source of answers to questions that arise in their daily work, and they should prove valuable as well to students and professionals as a condensed review of state-of-the-art knowledge concerning the psychopathology, diagnosis, and treatment of various psychological disorders.

*Irving B. Weiner*

# PREFACE

The world of substance dependency and abuse is multidimensional. With its global economic and political manifestations notwithstanding, it is a national concern that impacts every strata of society. No one is immune to its devastation. Alcohol-related vehicular deaths, drug-related crimes, domestic violence, and drug overdoses attest to its seriousness. And because of their attention-getting sensationalism, these consequences of Substance Use Disorders (SUDs) are the problems society becomes aware of. But they are the tip of the iceberg—we need to reach and treat those users who make the news—and we also need to reach and treat those who have not made the news—yet!

Early intervention based on proven treatment methods is the key to achieving that objective. While the past 100 years reveals a variety of clinical and administrative efforts to deal with alcohol and other drug problems in the United States, the dawn of the twenty-first century will, hopefully, become a period of clinical innovation and intervention. As the scientific community continues to study and better understand the biology and physiology of addiction, the behavioral treatment community works on etiologically sound treatment applications.

The *Wiley Concise Guide to Mental Health: Substance Use Disorders* is divided in 12 chapters that cover, to a greater or lesser degree, six related subgroups: users, family, society, suppliers, law enforcement, and helping professionals. The users, those individuals afflicted with Substance Use Disorders, are the driving force behind this book. Many of them will eventually find their way to treatment, while others will continue to attempt to meet life's challenges through mood-altering drugs. Still others will fail in recovery, not for a lack of motivation—it is *our* job to motivate them—but for lack of treatment options.

The need to continue to improve upon the existing treatment alternatives and provide more opportunities for recovery is the impetus for most works in the

field. In that way this book hopes to find itself in the good company of many excellent works that have brought us to where we are today in treatment. And as every author hopes to advance the cause of treatment in some meaningful way, we, too, humbly hope to achieve that objective. By offering a treatment guide that reduces often otherwise complex concepts to simple terms, we hope to play some part in providing more opportunities for recovery.

While mood-altering substances have been around for thousands of years, the concept of *drug addiction* did not emerge until the beginning of the nineteenth century. Up until that time, the world seemed to be in a state of mass denial. In Chapter 1, we discuss the importance of this revelation and how it relates to the challenges in treatment that still exist. With the focus on definitions, treatment, and misconceptions about mood-altering substances, the progression of Substance Use Disorders is examined in this chapter as well as the criteria that define *abuse* and *dependence*. Because Substance Use Disorders are viewed by most professionals as biological, psychological, social, and spiritual disorders, we thoroughly explore spirituality as a factor in addiction and recovery in Chapter 9. The disease controversy and treatment as a science are also discussed. Other controversies, including gender differences in treatment, outpatient treatment versus inpatient treatment, and the role of the professionally trained recovering person as a treatment provider are also reviewed.

The wise words of George Santayana, a Spanish-born American author, "Those who cannot remember the past are condemned to repeat it," prompted our starting Chapter 2 with a brief 100 year history of drug use in our society. While viewing drug use in its historical perspective may not be essential to becoming a good clinician, it allows the clinician to better understand why it remains a problem that is not likely to go away. The legal classification of psychoactive substances and laws to better control the availability of designer drugs were legal attempts to reinforce the war on drugs. The legal classification of drugs approaches the problem from a criminal-justice perspective while the general or pharmacological classification of drugs serves the medical and treatment communities. We also discuss in this chapter the mood-altering properties of specific drugs and drug classifications, together with their synergistic, tolerance, and withdrawal potential.

Everything we know today about the treatment of Substance Use Disorders comes out of our successes and failures of yesterday. The theme in Chapter 3 is that in order to treat any disorder, we must first know exactly what we're treating. Unlike yesterday's hit-and-miss program-model attempt to treat the person with a Substance Use Disorder, today's treatment is far more individualized and precise. Using *DSM-IV-TR* diagnostic criteria and American Society of Addiction Medicine levels of care, this chapter discusses assessment methods, tools, and applications in developing treatment plans. Case studies are used to test their application, emphasizing the importance of collateral information, mental status, employment history, and family impact on the client. As in the treatment of any

malady, the more information the clinician has, the better the chance of an accurate diagnosis and treatment plan.

In Chapter 4 we talk about levels of care and their importance in providing appropriate treatment services. Chapter 4 is a detailed description of those levels of care and the services provided for each of them. Outpatient and inpatient treatment facilities, including intensive outpatient programs, day-hospital facilities, methadone maintenance treatment, inpatient rehabilitation programs, extended-care facilities, halfway houses, and therapeutic communities are explained, and their historical relevance reviewed in this chapter. Because overtreating the patient may be as ineffective as undertreating the patient, knowing exactly what services are provided on each level of care is essential to good treatment planning and successful outcomes.

Physical tolerance and withdrawal symptomatology take us to the medical aspect of Substance Use Disorders. Chapter 5 deals with the importance of medical detoxification on the continuum of care. A biological understanding of intoxication and maintaining biological balance (homeostasis) are important to a safe detoxification. The goals of detoxification, treatment protocols, assessment tools for alcohol and other drug withdrawal, Breathalyzer readings, and opioid maintenance therapy are discussed in this chapter. The science of agonists and antagonists are also discussed. While medical detoxification can be managed on any level of care, this chapter provides the tools to determine the appropriateness of outpatient versus inpatient detoxification. The value of counseling at this acute phase of treatment is also talked about.

Medical conditions can often complicate treatment. Such conditions may have preceded the Substance Use Disorder or may be the consequence of substance use and abuse. While most Substance Use Disorders can be life-threatening at some point, untreated serious medical problems can be particularly dangerous. Chapter 6 reviews such risks, including cardiovascular diseases directly related to drug abuse; liver disease, including hepatitis C; other blood-borne diseases, such as HIV and AIDS; as well as pulmonary and respiratory diseases. Lung cancer is on the rise in addicts who smoke marijuana and crack cocaine, while more and more IV drug users are found to be developing liver cancers. This chapter will also discuss chronic pain and the addicted patient.

Coexisting mental disorders, if left untreated, are certain to inhibit recovery. In Chapter 7 the reader will learn how to assess and take appropriate action if other mental health problems are present. This includes understanding comorbidity and its treatment implications, assessing for Psychotic Disorders, Mood Disorders, Anxiety Disorders, and Personality Disorders. Substance treatment professionals need to assess and refer for consultation those patients that exhibit symptoms of mental health disorders. This calls for recognition of symptomatology and the ability to differentiate between Substance Use Disorder symptoms such as mild anxiety and depression from symptoms that may point to a concomitant mental health diagnosis.

A Substance Use Disorder affects not just the identified patient, but also family members and other loved ones. Conversely, the family environment often enables continued substance use, abuse, and dependence. The family will frequently undermine recovery. Chapter 8 will explore both the importance of family in treatment as well as the deliberate exclusion of family involvement. Family dynamics will be examined, including family mental health, family alcohol and drug use, family rules, and family resistance to recovery. An accurate family history is important to treatment planning and ongoing recovery. The difference between recovery and abstinence is also reviewed, as well as the role of the workplace in ongoing recovery, the social environment, and the culture of addiction from which the person with a Substance Use Disorder emerged. Moderation management, a controversial approach to recovery, will be discussed.

We refer to spirituality as the neglected dimension. While it is probably impossible to experience spirituality when in the throes of a Substance Use Disorder, it has become the fourth dimension when describing the components of a Substance Use Disorder: biological, psychological, sociological, and spiritual. Spirituality in some form may become an important dimension in recovery. Chapter 9 will discuss various aspects of spirituality: resistance to it, gravitation toward it, and surrender to it. Ego versus humility, irresponsibility versus discipline, and resentment versus forgiveness are some of the topics to be discussed. Under any other name, recovery is, in and of itself, a spiritual experience.

Chapter 10 is all about the use of structured intervention in getting the identified patient to accept the help he or she needs. The myth of *hitting bottom,* a belief that prevails in both the treatment community and in the general population, is explored in this chapter. We continue to hear, "They are not going to stop drinking or stop using drugs until they hit bottom." The identified patient often has already hit bottom but does not yet know it. The intervention is a pretreatment strategy that serves to present this reality to him or her in a receivable way.

The notion that significant others need to wait around as the person with a Substance Use Disorder spirals downward has served to foster denial among individuals, families, the medical community, and helping professions. Unlike most other illnesses, resistance to treatment is a feature of Substance Use Disorders; the simplest (but least helpful) response to resistance is denial: "We can't help them until they're ready for help." An intervention, however, dispels this myth and raises the bottom through a collaborative effort of support and loving leverage involving family, friends, and employers. Several intervention models are explored in this chapter.

In Chapter 11 we address what has been the essence of treatment for individuals with Substance use Disorders—behavioral change. This chapter is aimed at developing effective counseling skills and treatment strategies. Using motivational interviewing and motivational enhancement therapy as the foundation for this chapter, emphasis is placed on change rather than abstinence. While absti-

nence is the desirable goal in most Substance Use Disorder diagnoses, our contention is that skillfully moving the client to the next level of behavioral change will prove far more effective in most cases than demanding abstinence. Treatment readiness, stages-of-change strategies, resolving ambivalence, teaching coping skills, and preventing relapse are a few of the important concepts covered in this chapter.

Relapse prevention therapy is the core of effective treatment and relapse is as much a part of recovery as it is of the disorder. Chapter 12 is dedicated exclusively to relapse prevention both as a separate function as well as an integrated component of treatment. Many of Marlatt and Gordon's concepts associated with relapse and relapse prevention, including high-risk situations, self-efficacy, and the abstinence violation effect are explored in this chapter. Gorski's integration of the fundamental principals of Alcoholics Anonymous with the Minnesota treatment model is also explored. While both the Gorski and Marlatt and Gordon models have more similarities than differences, their differences are important to understand.

As a profession emerges, it develops technical language to facilitate communications. Medicine and psychiatry, for example, have professional reference resources such as the *Physician's Desk Reference* and the *Diagnostic and Statistical Manual,* respectively, that serve to standardize communications. The social work profession, in addition to using these resources, developed language that reflects not just the person and his or her malady, but also the *person-in-environment.*

The treatment of Substance Use Disorders, a relative newcomer to the helping professions, borrows from these disciplines and has also developed a substance-specific language. Because it is a relatively new profession, its vocabulary continues to emerge. Words like *dependency* and *abuse* have specific diagnostic criteria that standardize their use. *Chemical dependency,* however, is a vague nebulous term that does not differentiate abuse from dependence. In other words, as a technical term it lacks technical accuracy. In an effort to encourage the use of unambiguous language, we chose to use *Substance Use Disorder* in this book's title rather than *chemical dependency.*

*Alcoholism* is another word that fails the technical accuracy test. Is a person diagnosed with Alcohol Abuse afflicted with alcoholism? Or is that word reserved for those who are alcohol dependent? How about an *alcoholic*? Would either diagnosis of Alcohol Dependence or Alcohol Abuse qualify as alcoholic?

*Addict,* another word that defies definition, comes from the noun *addiction.* Is a marijuana smoker who meets the diagnostic criteria for Cannabis Abuse an addict? Or is that word reserved for Cannabis Dependence? The word *addiction,* in fact, does not necessarily indicate a Substance Use Disorder. A person who is medically dependent on a prescription opioid, for example, may not necessarily meet the criteria for a Substance Use Disorder, as defined in the *DSM-IV-TR.* The term *drug abuser* is also a generic description and does not separate dependence from abuse.

While the terms *chemical dependency, alcoholic, alcoholism, drug abuser,* and *addict* are likely to remain with us, we have used them only where they are appropriate, such as in a historical context. We have taken the liberty, however, to use certain words and terms interchangeably. *Patient, client,* and *identified patient* will all mean the same thing—a person who is in treatment, should be in treatment, or will soon be in treatment.

An SUD is an equal gender disorder. When considering all the different substances that one can abuse or become dependent on, it is difficult to assess with absolute certainty whether there are more women or more men with SUDs. Men, for example, abuse more alcohol, but women may abuse as much amphetamine and cocaine. It would follow then that pronouns used throughout this book would represent both genders; for example, "him and her," "he and she," or "his and hers." We use this form in many instances. But where doing so would detract from the continuity of a paragraph, section, or chapter, we chose to revert back to the "him," "he," and "his" pronouns representing both genders. We hope that in the name of clarity, you accept our apology.

The terms *substance abuse professional, counselor, therapist, social worker, psychologist,* and *health-care professional,* depending upon the nature of the text, might also be used interchangeably. *Addictions counselor* and *chemical-dependency counselor* might be used in a historical perspective.

While the words *sobriety* and *sober* were in the past associated with alcohol, it is not unusual to see them representing any person with a Substance Use Disorder who is drug- and alcohol-free. The diagnostic classifications that fall under Substance Abuse and Substance Dependence, such as Cannabis Dependence, Alcohol Abuse, Heroin Dependence, and so on, will not be represented in any form other than these *DSM-IV-TR* classifications.

We like to think of the founding of Alcoholics Anonymous (AA) on June 10, 1935 as the beginning of treatment as we know it today. But in reality, AA is not treatment—it is self-help. And there was a lot of treatment available before William Griffith Wilson (Bill W.) and Robert Holbrook Smith (Dr. Bob) founded the program that changed the way we think—not just about *alcoholics,* but about the power of the human spirit. It is just that most of the help that was available in those early days was whimsical and ineffective. Miracle tonics, magical formulas, aversive methods, geographical cures, and other radical measures gave lots of hope but offered little success in helping individuals who were struggling with alcohol and other drug problems. The twenty-first century, however, is promising. Twelve-step programs are as popular as ever, science is on the cutting edge of pharmacological innovation, and behavioral therapies continue to reshape themselves to meet the needs of the substance treatment community. While the dream of a magic pill to end all drug abuse and dependence is not likely, our optimism and understanding of behavioral and pharmacological treatment today is as exciting as those early days of Alcoholics Anonymous when Bill W. and Dr. Bob shook hands for the first time.

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This book could not have been written without the many lessons learned from the literally thousands of teachers I have had over the years—my patients. I wish to also acknowledge my mentor, Lee Kassan, for his assistance and encouragement, and my coauthor, Walter Scanlon, for without his collaboration, this book would have remained a dream.

My gratitude goes out to my family, friends, and business partners, Robert Smith and Vincent Casolaro, for their love and support during this endeavor. And finally, my dedication to my daughter, Samantha, and my wife, Laura, who remain my hope and strength.

Nicholas R. Lessa

While we authors assume credit for the final document, a book is really a collaborative effort involving many others. Taking an idea and turning it into a readable work is a process requiring the input of lots of people. This input comes in the form of hands-on assistance, personal support, and ongoing encouragement. Without the help and patience of family, friends, and colleagues, this book would probably not have been possible. I am especially grateful to Farida Parakh for her personal support, professional perspective, and experience on several levels of care. Her reviews and feedback on several drafts served to ensure that this book would reach its targeted audiences.

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Finally, I thank all the recovering, and yet to recover, men and women who, wittingly and unwittingly, made this book possible.

Walter F. Scanlon

# ABOUT THE AUTHORS

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Walter Scanlon is a program/workplace consultant with 25 years management and clinical experience in behavioral health care, including the treatment of Substance Use Disorders, employee assistance program (EAP) development, and structured intervention services. The principal of Walter Scanlon Management (WSM), Dr. Scanlon has taught, trained, and presented nationally; he is an adjunct professor at Marymount Manhattan College and City College of New York. Dr. Scanlon is widely published in the areas of substance abuse, employee assistance, criminal justice, and related areas, including two books, the latest titled *Alcoholism and Drug Abuse in the Workplace: Managing Care and Costs through Employee Assistance Programs* (1991). Dr. Scanlon has held clinical and EAP management positions at Beth Israel Hospital, the Port Authority of New York and New Jersey, and Freeport Hospital. As the principal of WSM he has provided EAP services for Alcoholics Anonymous World Services, Hazelden New York, Verizon Communications, and American Express. He currently serves as a consultant to the New York City Police Department. Dr. Scanlon holds a PhD in Psychology, a Master's of Business Administration (MBA), and is credentialed as a Certified Employee Assistance Professional (CEAP), a New York State Credentialed Alcoholism and Substance Abuse Counselor (CASAC), a national Substance Abuse Professional (SAP), and a Master's Addiction Counselor (MAC).

SECTION ONE

# Introduction

CHAPTER 1

# Substance Use Disorders: Definitions, Treatment, and Misconceptions

While the use and abuse of psychoactive substances predates the printed word, it was not until 1821 that the Western world was presented with an extraordinarily new concept: drug addiction. It was then that Thomas De Quincey created a minor sensation with his autobiographical *Confessions of an English Opium Eater* (Jonnes, 1999, p. 15). Describing in disturbing detail his "tortured love affair with laudanum"—a liquid form of opium dissolved in alcohol—De Quincey's work confronted, perhaps unwittingly, English men and women of that period with the consequences of drug use. Although opium usage was a common remedy for "sundry aches and pains," the Western world seemed to have been in a state of mass denial.

De Quincey's unsettling tale was the earliest documents to reveal the truth about drug use in a somewhat clinical manner. He invented the concept of recreational drug use, making it absolutely clear that opium's value in society is more than medicinal or spiritual (Boon, 2002, p. 37). In doing so, he got society to consider two additional facts: Drugs are fun, and drugs are addictive. While many probably dismissed De Quincey's *Confessions of an English Opium Eater* as "his problem," it begged the soul-searching questions—Am I using drugs for pain or for pleasure? Are the consequences of my drug use negative or positive? Can I stop anytime, or am I dependent?

Almost two centuries later, we are asking these same questions. But because the answers are as elusive as they are important, such questions now take the form of qualifying criteria. The criteria are as quantitative as they are qualitative, rendering not simply the answers to such questions but the type and severity of the

problem. While a diagnosis is just the first step in the treatment of a Substance Use Disorder (SUD), it is impossible to develop an effective treatment plan without first establishing what's being treated. A good start is to differentiate between recreational use and problematic use.

## The Progression of Substance Use

Progression is viewed as either an increase in consumption or an increase in problems. Often imperceptible to the user, the psychoactive substance assumes an ever-more important role, and problems mount. The word *psycho* relates to the mind, and *psychoactive substances* are drugs that alter the mind. Acting on the central nervous system (CNS), such drugs are often referred to as *mood-altering substances*.

While innocent experimentation may prove harmless for many, for others it serves as an introduction to recreational drug use. Although we have observed cases where individuals had established an almost instantaneous problematic relationship with alcohol or other mood-altering substances, the progression to an SUD is more likely to happen in three stages. As the sidebar shows, we have discovered that each stage is totally independent of its succeeding stage. What separates one stage from the next? For example, when does experimental use progress to recreational use? Does using a substance for the second time mean one is now a recreational user? Does missing 1 day from work constitute problematic use? How about 1 day per month? Or perhaps one DWI? Progression is not always predictable, yet when the user arrives at the next stage, it was almost as if it *were* predictable.

Initially, psychoactive substance use is begun either for *medical* or *experimental*

### SUD Progression

1. Stage one, *experimental use,* usually occurs in the preteen, teen, and adolescent years. The cocaine epidemic of the 1980s, however, challenged this notion. The 21 to 35-year-old age group accounted for countless new users throughout that decade. Not all who experiment progress to recreational drug use.
2. Stage two, *recreational drug use,* does not necessarily lead to problematic patterns of use. Ninety percent of the population, for example, enjoys alcoholic beverages without serious incident.
3. Stage three, *problematic substance use,* represents those who meet the criteria for an SUD.
   a. Substance Abuse
   b. Substance Dependence

(This is further discussed in the next section.)

### Experimental Substance Use

Mary was offered marijuana at a party when she was 22 years old. She had never tried marijuana before. In fact, she never tried any other illicit substance in her life. Her parents instilled in her a fear of drugs. She, however, was curious about the drug. Several of her friends smoked marijuana and did not seem negatively impacted by regular use of it. She told herself, "Why not?" She tried marijuana at the party and did not like the effects. Mary never smoked marijuana again.

reasons. A substance may be prescribed by a doctor for the treatment of a physical or psychological condition. It is then discontinued once the acute condition has improved. The prescribed substance may be taken for longer periods of time if the condition being treated is chronic in nature. This pattern of use may or may not be problematic, depending on the patient's ability to discontinue the medication once it is no longer medically warranted. Problematic use patterns of this type are known as *low-dose dependencies.* Some physicians, when prescribing psychoactive substances, underestimate the addictive qualities of the substances being prescribed. This can be especially problematic when the patient has a genetic predisposition to addiction. While trusting the training and experience of the medical professional is usually a good idea, we cannot always assume that the doctor knows best under these circumstances.

When the start of substance use is *experimental,* the substance is initially used out of curiosity for its mood-altering qualities. The person tries the substance to assess its effects. If the substance is not considered pleasing or beneficial in some way, the substance is likely to be discontinued. However, if the substance is considered to be rewarding, it may be continued. The determination on whether to continue using the substance is based upon a variety of psychological, social, physiological, and perhaps spiritual factors, such as prior beliefs or lack of understanding on the danger of the drug or past experiences with other substances. Experimental use is not considered problematic. One government study on adolescent drug use conducted many years ago showed that the vast majority of adolescents experiment with some form of mood-altering substance at some time during their adolescence. It considered experimental use of mood-altering substances to be a kind of rite of passage for adolescents. The study went on to say that the small minority of adolescents who did *not* experiment were found to display more psychopathology, as a whole, than did the experimenters. This is, obviously, a controversial finding that may have reflected a particular period in time.

If the person continues to use the substance

**Progression of an SUD**

| Stage | Dynamic | Control |
|---|---|---|
| Experimental | Curiosity | Full |
| Recreational | Fun | Choice |
| Abuse | Denial | Limited |
| Dependence | Addiction | Impaired |

## Recreational Substance Use

John is a 36-year-old accountant. He began drinking beer at age 17. He has now become an aficionado of wine. He has a collection of expensive wines in his custom-built wine cooler. John likes to have dinner parties with friends about once a month when he presents several wines from his cooler. John appears to drink responsibly. He seems to know when he has had enough to drink and can easily refuse offers for more alcohol. He has not displayed any negative consequences (e.g., physical, social, occupational, or financial) around his wine drinking.

beyond the stage of experimentation, he or she is considered to be in the *recreational* stage of use. Recreational use typically involves using in the company of others, for example, in social situations such as parties, to enhance pleasurable situations. (This is not to say that problem use cannot occur while attempting to enhance pleasurable situations.) Sometimes the substance may be used when alone, such as when a person enjoys an alcoholic beverage during a meal. Recreational substance use involves significant choice and control. For example, the person who uses alcohol recreationally may decide not to drink on a particular occasion and, as a result, abstains during that occasion. Or a person who recreationally uses marijuana at a party decides only to have two puffs on a joint and is okay with that choice. The recreational user does not display any negative consequences regarding the substance use—socially, legally, occupationally, or physically. Sometimes the person may not be aware of the consequences of use (e.g., an alcohol user damaging his or her liver) or may deny the consequences (e.g., how cocaine use is affecting the marriage). Under these circumstances, the use is not considered to be recreational—it has begun to become problematic.

## Substance Abuse

Peter is a 46-year-old building engineer. In our initial interview, he has been drinking alcoholic beverages since he was 15 years old. He began using cocaine when he was 18 years old. Peter is the first to admit he is a heavy drinker, but he would resist identifying himself as an alcoholic. He regularly drinks on the weekend and occasionally during the week. At least once weekly, usually on Friday nights, Peter uses cocaine along with his beer drinking and shots of tequila. Most Friday nights there are no problems related to his partying. Once in a while, though, Peter gets himself into trouble. He has been arrested twice for Driving While Intoxicated (DWI) and arrested once for assault after a bar fight. Additionally, Peter's girlfriend recently left him, complaining about his drinking and irresponsible behavior. Peter will admit that he has missed a few Mondays at work because of hangovers. He also began missing clinic appointments and dropped out of sight for 9 months. Peter remains ambivalent about stopping but is back in treatment.