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Citation: White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor*, 9(1), 38-43. Posted at www.williamwhitepapers.com

Toward a Philosophy of Choice: A New Era of Addiction Treatment

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Being given choices of institutions, levels of care, treatment goals/methods, service personnel, and service duration has historically not been part of the personal experience of addiction treatment in the United States. This article describes why addiction treatment professionals have been reticent to offer choices to their alcohol and drug dependent clients and why that philosophy is now undergoing reevaluation.

Dr. Jekyll and Mr. Hyde

Addiction treatment has for more than 150 years been more a process of professional diagnosis, direction, and indoctrination than a process of guided self-reflection and self-change. Since the advent of program accreditation standards in the 1970s, clients entering addiction treatment have been asked to sign a treatment plan. This ritual has conveyed the illusion of participation and choice, but anyone familiar with the process knows that the choices available to clients have, until recently, been narrowly prescribed by each program's treatment philosophy, available levels of

care, coercive dictates from referral sources, or by the external care managers who governed reimbursement decisions. Another factor concerning limited choice in addiction treatment is the perception that those entering addiction treatment have lost the power of choice—that the state of addiction is the very antithesis of choice (Michael Flaherty, personal communication).

Slogans heard within traditional treatment and recovery circles suggest that people addicted to alcohol and other drugs:

- Possess an elaborate cognitive defense structure (grandiosity, denial, minimization, rationalization, intellectualization, projection of blame, preoccupation with power and control) that seriously distorts reality and undermines decision-making (e.g., *Utilize, don't analyze, Identify, don't compare*).
- Are incapable of honest self-perception and complex choice-making (e.g., *When you think you're looking good, you're looking bad*;

Your best thinking got you here; Keep it simple, stupid; First thing's first).

- Cannot be relied upon to act in their own best interests (e.g., *An alcoholic is someone who finds something that works and then stops doing it; The three most dangerous words for the alcoholic—I've been thinking*).
- Best enter recovery through a process of submission and surrender (e.g., *Let go, Let God; Sit down, shut up, listen; When in doubt, act as if; Fake it 'til you make it*).

The problem with choice for the alcoholic/addict has often been framed as a problem of the split self. The question is, "Who's really choosing: Dr. Jekyll or Mr. Hyde?" How can we as professionals distinguish a client's authentic choice from what A.A. calls "stinkin' thinkin'", what Rational Recovery calls the addictive voice or "Beast," what Secular Organization for Sobriety refers to as the "lizard brain," what LifeRing Secular Recovery calls the "addict self" (versus the "sober self"), and what Christian recovery groups sometimes refer to as the "voice of the Devil"? If we offer each client enhanced choices, will it be the client or the disorder/devil making the decisions?

This treatment and recovery folklore has gained credence from recent scientific studies. In May 2007, Dr. Nora Volkov, Director of the National Institute on Drug Abuse, presented a historic lecture at the annual APA conference entitled the "The Neurobiology of Free Will" that signaled a turning point in the field's understanding of addiction as a brain disease. Dr. Volkov described the most complex picture to date of how drugs compromise multiple regions of the brain in ways that place continued AOD use as a priority over other best interests of the individual, family, and society (See also Nature Neuroscience, 2005). Based on the work of Volkov and other scientists, one could posit addiction as a disease of the will marked by a progressive loss of volitional control over AOD use and related decision-making. Unfortunately, work to date reveals very little about the neurobiology of recovery. There is much talk of hijacked brains (e.g.,

the erosion of executive function, the loss of inhibitory control, re-ordered motivational priorities), but the extent and timing of the reclamation of the will through the recovery process remains shrouded in mystery. Studies to date (e.g., Bartsch, Homola, Biller et al., 2007) show a good prognosis for brain recovery associated with abstinence, but questions abound regarding the pace and extent of such recovery.

The Context for Choice

The factors limiting client choice in addiction treatment now face countervailing forces. The options available to those with AOD problems have never been greater, as reflected in the number of specialized and competing addiction service organizations, the availability of brief interventions, numerous evidence-based treatments (including new pharmacotherapies), the growth and diversification of addiction recovery mutual aid groups (including explicitly religious and secular alternatives to Twelve Step Programs), the availability of peer-based recovery support services, and the growing availability of Internet-based services (Humphreys, 2004; White, 2004; White, in press). There is also growing scientific evidence that many people resolve AOD problems without professional or peer assistance (Cunningham, Sobell, Sobell, et al, 1995; Granfield & Cloud, 1995). Today, individuals and families seeking help have choices that vary widely in setting, philosophy, service elements, service personnel, and costs.

There is growing awareness of the legitimacy of multiple pathways and styles of long-term recovery (White & Kurtz, 2006b). A new recovery advocacy movement is calling upon individuals and families to take responsibility for their own long-term recovery processes and to promote pro-recovery social policies and recovery-oriented systems of care (White, 2006). The need for informed consumers of addiction treatment is underscored by historical and scientific findings that:

- “Harm done in the name of help” has a long tradition in the history of addiction treatment (White, 1998).
- Many current mainstream treatment practices lack scientific evidence of their effectiveness, and others have been shown to be potentially harmful (Miller, Wilbourne, & Hettema, 2003; White & Miller, 2007).
- Treatments utilizing different philosophical foundations and therapeutic techniques can generate comparable treatment outcomes for adults (Project MATCH Research Group, 1998) and adolescents (Dennis, Godley, Diamond et al., 2004), but individual treatment programs and individual counselors vary widely in their recovery outcomes (McLellan, Grissom, Brill et al., 1993; McLellan, Woody, Luborsky, & Goehl, 1988).
- Responses to all recovery mutual aid groups vary, including individuals who fully respond, partially respond, and fail to respond (Morgenstern, Kahler, Frey, & Labouvie, 1996)—a finding that reinforces the importance of person-program fit.
- Client motivation and transfer of learning from therapeutic to natural environments is enhanced by client choice in the treatment and recovery support process (Miller & Rollnick, 1991).
- When given a choice, individuals tend to choose the goal that is most appropriate for them (Larimer et al., 1998).

The movement to expand client choice-making in addiction treatment is also being fueled by the development of new service technologies (e.g., motivational interviewing, contingency management, recovery coaching) that provide frameworks for facilitating client choice and the use of special aids to enhance recovery-conducive decision making (e.g., from pharmacological adjuncts to sustained professional and social support). It is in this context of expanded

service options and new strategies for managing choice that calls are increasing to redefine the relationship between addiction professionals and those they serve from an expert relational model to a partnership-consultant model that provides stage-appropriate guidance and support (White, Boyle, & Loveland, 2002). And yet the question remains, “Would promoting expanded choices put clients in the driver’s seat when, according to some therapeutic philosophies, that is exactly the position they need to abandon?”

Choice and the Stages of Recovery

One way to partially reconcile the dilemma between the traditional and emerging views of choice is to first acknowledge that free will in addiction and recovery is not an all or none phenomena. The capacity for volitional control over AOD use and related decisions is variable across individuals (as a function of the interaction between problem severity/complexity and recovery capital) and is dynamic (shifts incrementally on a continual basis within the same individual through both addiction and recovery processes). Recovery can be viewed as progressive rehabilitation or reclamation of the will—the power to reclaim personal choice (Smith, 2005). There are times the recovery process may involve consciously not choosing—relying on resources and relationships outside the self, and times that the next recovery steps require an assertion of self. At a practical level, this means that the first hours of acute detoxification are not the best time to rely exclusively on client choice. And yet long-term recovery is not possible without choice. If there is no rehabilitation of the power to choose and encouragement of choice, we are left with, not sustainable recovery, but superficial treatment compliance.

To effectively apply a philosophy of choice requires great skill on the part of the addiction professional, particularly where a client’s immaturity, cellular craving, impulsivity, psychiatric symptoms, and impaired judgment severely limit choice generation, choice analysis, and the

capacity to stick with any personal resolution. In such cases, we must carefully plot a path between complete autonomy (total choice and clinical abandonment) and paternalism (no choice and intrusive control). Most clients have a sense of this need as well. Studies have shown that people with severe alcohol problems, perhaps recognizing their impaired decision-making capacities, prefer therapist-set goals in treatment, whereas those with less severe problems prefer self-set goals (Sobell, Sobell, Bogardis, Leo, & Skinner, 1992). I suspect mismatches in the degree of choice allowed in the treatment process (both ill-timed episodes of too much and too little choice) contribute to high rates of treatment non-completion via clients leaving against

staff advice and clients being administratively discharged.

Implementing a Choice Philosophy.

One of the most important arenas of choice within addiction treatment involves broad frameworks of recovery. The choice philosophy is based first on the recognition of multiple (secular, spiritual, and religious) pathways and styles of long-term recovery and the recognition of the right of each person to select a pathway and style of recovery that represents their personal and aspirational values. Steps that addiction treatment programs can take to actualize a philosophy of choice related to recovery pathways are illustrated in Table 1.

Table 1 Actualizing the Choice Philosophy Related to Recovery Pathways
<ul style="list-style-type: none"> • Addiction counselors, recovery coaches, and volunteers represent the diversity of pathways and styles of personal/family recovery. • Addiction counselors and recovery coaches are knowledgeable about the full spectrum of religious, spiritual, and secular recovery support groups and can fluently express the catalytic ideas used within each of these frameworks. • Addiction counselors and recovery coaches are aware of common patterns of co-attendance (concurrent or sequential participation in two or more recovery support structures). • Individuals and their families are educated about the variety of recovery experiences and the legitimacy of multiple pathways and styles of recovery. • Informational materials, lectures, and structured exercises that people receive represent the scope of recovery support options, e.g., posting all local recovery support meeting schedules on the treatment agency website and facility bulletin boards, giving each client a wallet card with the central contact numbers of local recovery support groups, profiling local recovery support groups in agency/alumni newsletters. • Individual choice is respected; individuals receiving services are not demeaned or disrespected for the recovery support strategies they choose; clinical strategies involve motivational interviewing principles and techniques rather than coercion and confrontation. • Addiction counselors and recovery coaches are encouraged to self-identify negative feelings they may have about a particular pathway of recovery chosen by a client and discuss such feelings in the context of clinical supervision. (Adapted from White & Kurtz, 2006a)

Creating Informed Consumers

A philosophy of choice is viable only with persons who have the neurological capacity for decision-making, who believe they have the right to make their own

choices, and who are aware of and can evaluate available service and support options. Creating informed, assertive consumers of addiction treatment and recovery support services can be enhanced by: 1) affirming the service consumer's right

to choose, 2) distributing and reviewing consumer guides on treatment and recovery support services published by local recovery advocacy organizations, 3) teaching service consumers how to recognize quality treatment services and healthy support groups, 4) informing consumers about the potential of harmful side effects of treatment and mutual aid group participation, 5) encouraging consumers to visit and sample service/support options, 6) defining the criteria by which the client and service specialist will know if participation in a particular activity is working or not working, and 7) monitoring each client's responses to treatment and support services (Bev Haberle, Personal Communication, 2007). Similar considerations need to be extended to educate the family members of those needing or seeking recovery.

Choice and Limited Resource Alternatives

A major obstacle to implementing a choice philosophy remains the limited recovery support options available today within many communities. Altering that situation requires moving from a clinical perspective to a recovery community development perspective. Recovery options are expanding, clients are using these options (either alone or in patterns of co-involvement with one or more support groups), and progressive treatment organizations are playing a role in nurturing the development of expanding recovery support resources (White, 2007). The internet is also bringing expanding treatment and recovery support services into many previously resource deficient communities. The choice philosophy only has meaning where legitimate alternatives exist for treatment and recovery support.

A Closing Reflection

A day is coming when each client seeking help for the resolution of AOD problems will be given a menu of service and support options. This menu will include the best scientific evidence drawn from national

and international studies on the degree of effectiveness of the respective menu options. When that day arrives, each client, family, and referral source will also have the right to review standardized, recovery-focused performance measures for each treatment institution, each method of treatment, and each addictions professional. Our struggles today with the question of choice may mark the dawn of that coming day.

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Acknowledgement: Portions of this article have been excerpted/adapted from White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: Institute for Research, Education and Training in Addictions. A free download or purchase of a hard copy of this monograph is available at <http://www.ireta.org/store/customer/home.php?siteversion=ireta>.

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