UNDERSTANDING DRUG AND ALCOHOL ISSUES: AN OVERVIEW

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Chapter 40
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I. Introduction
   Because of the huge number of alcohol and drug abusers in the United States, approximately
seventeen million, such people are more likely to become involved in divorce litigation, which often includes child custody and child visitation issues. Therefore, to effectively practice family law, particularly child custody cases, attorneys must have a basic understanding of the concepts of drug and alcohol abuse. This article will provide an overview of alcohol and drug abuse in general, the diagnosis process, and intervention and referral options and their application in the family law arena. When dealing with the combination of substance abuse, and child custody and visitation issues, the ideal solution is to encourage two parent families to work together to achieve the healthiest possible outcome. The goal should be answering “What is in the best interest of all involved?”

II. Terminology and Overview

Although this article uses the terms “alcoholism”, “alcoholic”, and “addict” when referring to substance abusers and substance abuse, I want to be clear that all other addictive activities, and processes such as gambling, work, sex, etc. are equally self and family destructive, but are not specifically addressed in this overview. This article deals primarily with alcohol abuse. However, the information is applicable to drug abuse cases as well; addiction is addiction!

A. Terminology

According to the National Council on Alcoholism’s Public Policy Committee, “alcoholism is a chronic, progressive, and potentially fatal disease. It is characterized by tolerance and physical dependency or pathologic organ changes, or both – all the direct or indirect consequence of the alcohol ingested.” Alcoholism, also known as alcohol dependence, includes the following elements:

- **Craving** – a strong need or compulsion to drink;
- **Loss of control** – the frequent inability to stop drinking once a person has begun;
- **Physical dependence** – the occurrence of withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety, when alcohol use is stopped after a period of heavy drinking. These symptoms are usually relieved by drinking alcohol or by taking another sedative drug.
- **Tolerance** – the need for increasing amounts of alcohol in order to get “high.”

When classifying alcoholism as a “disease”, the word disease means an “involuntary disability” with genetic, psychosocial, and environmental factors influencing its development and manifestations. The cravings that the alcoholic feels for alcohol can be as strong as the need for food or water and can last a lifetime – thus the label “chronic.”

Not all people who encounter problems with drinking alcohol are alcoholics, but are instead classified as alcohol abusers. Where the alcoholic will likely experience many of the same effects as the alcohol abuser, the reverse is not necessarily true. The alcohol abuser lacks the craving, the complete loss of control and the true physical dependence on alcohol. Also, the alcohol abuser is less likely to have the tolerance element of alcoholism. If left untreated, alcohol abuse can, however, lead to alcoholism. Alcohol abuse has been defined as a disease in which the person drinking refuses to stop even though their drinking causes neglect of important family and work obligations. Alcohol abuse is evident if the pattern of drinking is accompanied by one of the following situations within a twelve month period:

- Drinking when it is dangerous (e.g. while driving)
- Frequent, excessive drinking
- Interpersonal difficulties with family, friends, or coworkers caused by alcohol
- Legal problems related to drinking, such as being arrested for driving under the influence of alcohol, or for physically hurting someone while drunk

B. Overview of Alcoholism
Most people consider alcohol as a pleasant accompaniment to their social activities. One or two drinks per day, depending on the person, are not harmful for most adults. But, unfortunately for millions of adults, this is not the case because they are alcoholics.

There are many common misconceptions about what alcoholism really is and what it is not. For example, alcoholism is characterized by loss of control over the amount consumed but it is not about drinking all the time. Another interesting fact is that alcoholism is treatable, but it is not curable. An alcoholic can never resume “social” drinking without triggering the addiction. Also, alcoholism is an identifiable biochemical disease and is not caused by nagging spouses, guilt, debt, nerves or personality disorders.

Since Alcoholics Anonymous (AA) was originally founded in 1935, the AA “Big Book” has been published in four editions and is the foundation for recovery for millions of alcoholics. In the Big Book, the mindset of the active alcoholic is demonstrated by the following quote;

“The idea that somehow, someday he will control and enjoy his drinking is the great obsession of every abnormal drinker. The persistence of this illusion is astonishing. Many pursue it into the gates of insanity or death.”

This quote illustrates that alcoholism manifests itself as an obsession of the mind and a compulsion of the body. The links between the physical and the mental aspects of alcoholism are many and varied and include genetic, biological, environmental, psychological and socio-cultural factors.

1. Genetics
Many scientists now believe that genetics play a major role in the increased risks for alcoholism, including the craving and tolerance aspects of alcoholism. Although the specific gene has not yet been identified, a number of studies using twins and adopted children support the idea that genetics are involved in the disease. For example, in one particular study involving identical male twins who were raised separately, the subjects shared patterns of alcohol use, including dependence.

2. Biology
Biologically different populations tend to react to alcohol in substantially different ways. For example, Chinese, Japanese, and Koreans are deficient in the liver enzyme alcohol dehydrogenase, which breaks down the effects alcohol in the body. Because of this enzyme deficiency, members of these populations are more likely to experience vomiting, flushing, and increased heart rates and subsequently do not drink as often or to excess and are less prone to develop alcoholism. On the other hand, Native Americans suffer a much higher incidence of alcoholism. Some researchers attribute this to the fact that they do not become intoxicated as quickly as other races and so may tend to drink more.

In addition to these racially based studies, researchers are also studying the possible correlation between certain brain wave patterns and the increased risk for alcoholism.

3. Environment, Psychology and Culture
Environment, psychology and culture are difficult to separate in a discussion of substance abuse. Typically, gender, family history and parenting all play significant roles in influencing a person’s drinking patterns. Men tend to abuse alcohol at a rate of 5:1 more than women. In fact twenty five percent of sons of alcoholic fathers become alcoholics themselves. In recent years the ratio between men and
women seems to be decreasing with the increase in the number of women who drink and abuse alcohol.

A person’s expectations and beliefs about alcohol also influence their drinking patterns. Younger members in a family tend to mimic the conduct of their parents, older siblings and other family members. Peers also play an important role in influencing drinking behaviors. Children who grow up in environments with little parental monitoring and excessive family conflict tend to develop alcoholism, even when the family history of alcohol abuse is absent. Also, conduct disorders, poor coping skills and ineffective socialization patterns increase the potential for alcohol abuse.

There is a general misconception in the public that education and economic levels also play a role in the incidence of alcoholism. However, a 1996 study showed that lesser educated people and those on welfare have comparable rates of alcoholism to those of the general population.

The outward appearance of alcohol abuse can come in many forms. There are binge drinkers who drink heavily for days, weeks, or months then stop for a while. There are daily drinkers who drink steadily at a moderate or heavy level throughout the day. There are weekend drinkers who only allow themselves to let go on the weekends. As many different forms as there are for the pattern of drinking, there are just as many reasons that the alcoholic gives for drinking. Some believe that alcohol is necessary to get through their daily activities. Others drink in isolation to dull the pain of loneliness or alienation. No matter the form the alcoholism takes, the craving, the increased tolerance and the dependency are the same.

III. Addiction as a Disease

Before performing a diagnosis, it is important to first understand what we are in fact diagnosing. There is an ongoing debate on whether alcoholism is a disease or not. Most Americans believe that addiction is a medical problem but many are not yet ready to declare it a disease. Those arguing against disease follow the Choice Argument. The argument that alcoholism is a disease follows the Disease Model format.

A. Choice Argument

The Choice Argument draws a distinction between behaviors, which are choices, and disease. The argument is illustrated by the following scenario:

“a syringe of drugs is placed in front of an intravenous drug addict and the offer is made to “spike up!” When the addict picks up the needle and bares his arm, a gun is placed to his temple and the qualifier is added that if the addict injects the drug his brains will be blown out. Most addicts given this choice can summon the free will to choose not to use drugs.”

This ability to choose is the basis for the Choice Argument and is used to prove the theory that addiction is a choice not a disease. The argument continues that real diseases are not affected by behaviors or choices made. For example, if the same gun is pointed at the head of a person with diabetes, free will does not make the need for insulin any less vital.

The Choice Argument is such a powerful argument, but it is incorrect in that it is incomplete. Although addicts do make bad choices, that is not the end of the story. Is it just a matter of choice, or is there something driving the choice – a disease perhaps?

B. The Disease Model

The Disease Model theory has been in use for about 100 years. It originated from the Germ Theory
which was propounded by such medical research giants as Louis Pasteur and Robert Koch. In 1939, Dr. William D. Silkworth, MD wrote “that the body of the alcoholic is quite as abnormal as his mind.” He went on to state that the action of the chronic alcoholic is a manifestation of an allergy that causes a craving for alcohol. This description of the alcoholic’s bodily reaction to alcohol tracks the Disease Model theory precisely. Within the Disease Model, choice is not an issue. There is no place for social, psychological, or environmental arguments.

In layman’s terms, the Disease Model is as follows: an organ gets a physical, cellular defect, and as a result of this defect, you see symptoms. The same symptoms will be present every time this same defect occurs. The only differences will be in the severity of the symptoms and the stage of the illness. To illustrate this model, consider the case of the diabetic. The organ at issue is the pancreas. The defect is cell death which leads to a lack of insulin. The lack of insulin causes symptoms which manifest themselves in all diabetics. When insulin is replaced in the body, the symptoms go away.

C. The Disease Concept of Addiction

Addiction is a disease much like heart disease or diabetes; a chronic illness (meaning lifelong) that requires ongoing treatment. A one-time or occasional treatment for addiction would be as ineffective as a one-time treatment for diabetes. When the alcoholic takes the first drink, the ingestion of the alcohol triggers a compulsion of the body that demands more. This cycle is repeated over and over and results in an increased tolerance and a need for more alcohol to achieve the same results each time.

Using drugs or alcohol repeatedly over time changes brain structure and function in fundamental ways that can persist long after the individual stops using. See, Alan I. Leshner. These brain chemical changes are responsible for the distortions of cognitive and emotional functioning that characterize the inability of the alcoholic to perform as a parent, spouse, or just as an average person in society. It is as if the drugs have high-jacked the brain’s natural motivational control circuits, resulting in alcohol or drug use becoming the sole, or at least the top, motivational priority for the individual. Thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease: a condition caused by persistent changes in brain structure and function.

It is important to note that the addict is not a hapless victim. The addiction begins with the voluntary act of taking the first drink and so the addict must take responsibility for his or her own recovery. Just because this first drink resulted in addiction does not absolve them of responsibility, but it does help explain why they can not simply stop using.

1. The Science of Alcoholism

To use the Disease Model in discussing alcoholism, we first have to identify the affected organ. It is of course the brain, but until recently there was no way to scientifically prove there was a defect in the brain which caused the addiction. In the last few years brain imaging has progressed to the point that researchers have identified the precise area of the brain that is involved in addiction. There is concrete evidence showing what happens in the brain when it becomes addicted to drugs or alcohol. This research shows that there are brain chemistry reasons for the conduct of addicts – their “poor choices.”

The study of the brain, neuroscience, has resulted in the discovery of some very powerful data about addiction. Neuroscience has provided us with new information about the science of addiction and with this new information new tools are available to treat the disease. According to Dr. Charles A. Dackis, Chief of Psychiatry at the University of Pennsylvania Medical Center, “there has been a revolution in the way we view addiction. It’s being seen now as a disease of the reward centers of the brain, much like pneumonia is seen as a disease of the lungs.” Because of the great advances made in brain imaging, we
now “know the changes drugs cause in the brain at the molecular level that lead to addiction.\(^{31}\)

a. Drugs affect the midbrain which is the area that processes the amoral, limbic, reflexive, or unconscious survival. This is not the same area that processes conscious choice. That area is the cortex. In an unaffected brain, the cortex normally overcomes the libidinal reflexes of the mid-brain. However, in an addict, the defects occur at a level far earlier than cortical processing. This results in the midbrain becoming stronger than the cortex.\(^{32}\)

b. Stress is the primary cause of addiction. Although genetic factors play a major part, stress plays an even greater role. It is true that everyone experiences stress but it is also true that everyone does not experience it in the same way. This chronic stress that affects the midbrain is interpreted by the brain as a threat to survival.\(^{33}\)

c. Addiction is a stress induced defect in the midbrain which interferes with the brain’s ability to perceive pleasure. When the brain experiences persistent stress, it releases hormones such as Corticotripin Releasing Factor (CRF). CRF acts on genes for novelty-seeking and dopamine neurotransmission. When under severe stress, people will increase risk taking in an effort to find relief. Simultaneously, the brain’s ability to perceive pleasure and reward (mediated by dopamine) becomes unbalanced. This imbalance causes the inability to derive pleasure from things that would normally bring pleasure.\(^{34}\)

d. Drugs and alcohol cause a rapid release of dopamine in the midbrain. If the stressed and imbalanced person is exposed to this drug-induced surge of dopamine, the midbrain recognizes the relief and tags the drug as the means for survival. The midbrain now deems the drug as required for life.\(^{35}\)

e. Increased stress levels (and CRF) trigger cravings. In a non-addicted person, this is overcome by self-will. But to an addict, this craving is constant, involuntary, and persists until it is satisfied with the drug. Brain imaging allows researchers to see the difference in the mid-brain activity of the addict and the non-addict during craving and also shows that there is no difference in activity in the cortex.\(^{36}\)

Through the Disease Model, we can see that the science of addiction disproves the Choice Argument. The addict craves the drug. It is not a matter of choosing to crave. As a matter of fact, the addict does not have the choice not to crave. Even if the addict chooses not to ingest drugs or alcohol, the craving is still there and the suffering continues. The defect in the midbrain causes the changes in behavior. In attempting to separate behaviors from symptoms, the Choice Argument ignores the vital discoveries of neuroscience. Defects cause the brain processes to falter. Even though the addict has the free will to choose not to drink, the will is not the issue in addiction.

This information allows us to fit addiction to the Disease Model: the organ is the midbrain, the defect is a stress-induced hedonic (pleasure) dysregulation, and the symptoms of addictions are loss of control of drug use, craving and persistent use of the drug despite negative consequences.\(^{37}\)

2. The Consequences of Alcoholism

We have established that addiction, and alcoholism in particular, is the result of a defect in the midbrain. Acceptance of the results of this scientific research is more widespread every day, especially in the medical and research communities. But in the mainstream world, the science of alcoholism is sometimes less important than the consequences. The physical, psychological, and social manifestations of alcohol dependence trump the science for the general public.

a. Physical Consequences
When large amounts of drugs or alcohol are ingested, the body is limited by how much of the substance can be metabolized. The blood alcohol concentration increases and results in intoxication. In the early stages of intoxication, the drinker experiences reduced anxiety and sometimes a feeling of sedation. As the levels increase, some signs of further intoxication include confusion, impaired memory, poor judgment, slurred speech, lack of coordination, and short attention spans. Finally, at its highest levels, the alcohol causes the drinker to fall asleep or pass out and occasionally can lead to alcohol poisoning and death. In an addict, the tolerance factor is important. Those who drink large amounts of alcohol regularly require more alcohol to produce the same effects, such as the desire for reduced anxiety. The more they drink, the more they need to drink – a vicious cycle.

For the alcoholic, reducing the amount they drink, or stopping altogether is next to impossible without treatment. The craving is too strong and tends to take over their life. Their daily existence is governed by alcohol.

The physical or medical consequences of excessive drinking are many and severe. Chronic alcohol abuse and dependence can damage many organs in the body. For example, the alcoholic can suffer from blood disorders which cause anemia and easy bruising. Damage to the cardiovascular system is evidenced by heart disease and high blood pressure. The gastrointestinal system suffers massive damage including gastritis, liver damage, pancreatic cancer, ulcers, and esophageal inflammation or cancer. Neurological damage takes the form of short term memory loss, confusion, nerve damage and vision difficulties. For pregnant women, the damage also is communicated to the unborn child resulting in fetal alcohol syndrome (i.e. low birth weight, small head size, and mental retardation).

A diagram of how alcohol affects the body is attached hereto as Appendix “A”.

b. Psychological Consequences
The psychological effects of addiction are acute. For alcoholics who are already suffering from mental health disorders, the severity of the conditions is multiplied many times over. Studies show a strong association between alcoholism and depression. If an alcoholic tends to suffer from depression, the depression will be much more severe. It is estimated that twenty-five percent of suicides are the result of alcohol abuse.

c. Social Consequences
Spouses, children, friends, and co-workers are not as interested in why their loved one is an alcoholic. Their lives are affected daily on a more basic personal level. These people experience the consequences of alcoholism right along with the addict. Alcoholism causes horrific suffering in relationships with family, friends and co-workers. Missed work, low productivity and on-the-job accidents cost employers millions of dollars each year. Alcoholics tend to have a much higher rate of divorce and separation and of participating in domestic violence situations. If a person has cancer, all those around him will tend to feel sorry for him but no one will be angry with him for having cancer. The same is not true for the alcoholic. Alcoholism “engulfs all whose lives touch the sufferer’s. It brings misunderstanding, fierce resentment, financial insecurity, disgusted friends and employers, and warped lives of blameless children, sad wives and parents – anyone can increase the list.”

In purely economic terms, alcohol abuse problems cost approximately $100 billion each year, and in human terms the costs are incalculable.

d. “Death” Consequences
The most disturbing statistics of all concern the numbers of people who die because of alcohol. Alcohol abuse increases the risks of death from automobile crashes, recreational accidents, employment
accidents, as well as homicide and suicide rates.\textsuperscript{45} “According to the \textit{Diagnostic and Statistical Manual \textit{IV} (DSM-IV), more than one-half of all murderers and their victims are believed to have been intoxicated at the time of the murder.”\textsuperscript{46} In addition to these violent deaths, the National Highway Traffic Safety Administration estimates that over sixteen thousand fatalities from traffic accidents are attributed to drunk driving each year.\textsuperscript{47}

\textbf{IV. Denial and Diagnosis}

Friends and family members of the alcoholic are quite often the first to notice the problems and the first to seek professional help. Very often the alcoholic will deny that there is any problem at all, or at the very least in the early stages, will not acknowledge the severity of the problem. In fact, denial is a universal characteristic of alcoholism. The more dependent the person is on alcohol, the greater the level of denial. Denial has been defined as:

“an unconscious mental mechanism (unlike lying) by which an individual protects himself from recognizing his increasing need for alcohol and from being aware of the often devastating consequences of its use. Denial is a primitive defense mechanism that all people have and may regress to in order to safeguard themselves against the recognition of something which is threatening to their well-being. It is the ostrich syndrome: I don’t see it, therefore it is not there.\textsuperscript{48}

This constant tension between dependence and denial is what makes alcoholism so insidious. The alcoholic just cannot allow himself to recognize what is happening to him.\textsuperscript{49} Because of this denial, alcoholics rarely seek treatment on their own, unless they have truly “hit bottom.” Quite often, the “bottom” is the imminent loss of their family, the ultimate crisis that can break through the wall of denial.

In the diagnosis process, the differences between alcohol abuse and alcoholism become more acute. Often, abuse is diagnosed in people who have recently begun overusing alcohol. Over time, that abuse may progress to dependence – the true level for alcoholics.

Dependence is defined in the \textit{DSM-IV} as “[a] maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same twelve month period:”\textsuperscript{50}

\begin{enumerate}
  \item tolerance, as defined by either of the following:
    \begin{enumerate}
      \item a need for markedly increased amounts of the substance to achieve intoxication or desired effect
      \item markedly diminished effect with continued use of the same amount of the substance
    \end{enumerate}
  \item withdrawal, as manifested by either of the following:
    \begin{enumerate}
      \item the characteristic withdrawal syndrome for the substance
      \item the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
    \end{enumerate}
  \item the substance is often taken in larger amounts or over a longer period than was intended
  \item there is a persistent desire or unsuccessful efforts to cut down or control substance use
  \item a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects
  \item important social, occupational, or recreational activities are given up or reduced because of substance use
  \item the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking
\end{enumerate}
despite recognition that an ulcer was made worse by alcohol consumption

To determine abuse or dependence, the clinician relies on interviews and self-report questionnaires to assess the quantity and frequency of the drinking. The definition of moderate drinking is 4 -14 drinks per week for men and 3 – 7 drinks per week for women. The typical risk assessment questions include:

- How many days a week do you drink alcohol?
- On a typical day when you drink, how many drinks do you have?
- What is the maximum number of drinks you had on any given occasion during the last month?

Another method of assessment is the CAGE questionnaire:

C – Have you ever felt that you should Cut down on your drinking?
A – Have people Annoyed you by criticizing your drinking?
G – Have you ever felt bad or Guilty about your drinking?
E – Have you ever had an Eye opener – a drink first thing in the morning to steady your nerves or get rid of a hangover?

One “yes” answer indicates a risk for abuse or dependence. More than one “yes” indicates a high likelihood for dependence.

Additionally, for the non-clinician, Johns Hopkins Hospital developed a series of twenty questions (attached hereto as Appendix “B”) that can be asked to help the alcoholic break through the walls of denial and come to grips with the problem. The questions tend to focus on how alcohol use or abuse affects the life of the client, such as “Do you lose time from work due to alcohol?”, Is drinking making your home life unhappy?”, Is drinking jeopardizing your home or business?”, etc.

Examples of other methods and tests for diagnosing alcohol dependence including the Alcohol Use Disorders Identification Test (AUDIT), the Primary Care Evaluation of Mental Disorders (PRIME-MD), the SASSI-3 Adult Assessment, and the McAndrews Scale of the DSM-IV.

V. Treatment

Generally, treatment for basic intoxication is not warranted. Once the body has had time to metabolize the alcohol, the drinker will sober up. However, there are times when some intervention may be necessary, such as in college hazing rituals where young men drink huge amounts of alcohol as fast as they can. In these instances, the risks of alcohol poisoning which may lead to coma, cardiac arrest or even death are greatly increased and emergency medical care is required.

Most drinking alcoholics do not want to be helped. They are sick, unable to think rationally, and are incapable of giving up alcohol by themselves. In fact, most recovering alcoholics were forced into treatment against their will by friends or family. The self-motivation to recover usually occurs during and after treatment, not before.

In cases of alcohol abuse and dependence, treatment is vital. The severity of the dependence must be taken into account when determining the most effective type of treatment. Often, the extent of the treatment is based on the person’s physical condition, motivation, ability to remain abstinent, history of previous treatments, and the degree of disease progression. Treatment programs can vary from extended inpatient programs to less intensive outpatient programs, such as AA. But no matter what kind of treatment plan is followed, abstinence is necessary for successful recovery.
A. Inpatient

Inpatient treatment is provided by residential facilities and hospitals. In typical short-term in-patient scenarios, the patients admit themselves to these facilities and usually stay for about one month. The treatment includes alcohol education, psychotherapy (both individual and group), and sometimes family involvement. For alcoholics who lack a firm support system, who have failed previous outpatient treatments, and/or who have other physical or psychological conditions, the inpatient treatment is recommended.56

Some patients require more treatment than is available in the short-term programs and choose instead to admit themselves into long-term facilities. These programs can last anywhere from six to twelve months and are typically in non-hospital settings. The best known long-term residential treatment model is the Therapeutic Community (TC). The TCs focus on “resocializing” the individual and use the entire treatment community, including staff, other residents, and the social setting to accomplish its goals.57 Generally, the TC resident has co-occurring mental health problems in addition to their addiction issues.

B. Outpatient

Outpatient treatment programs provide alcohol education and counseling (both group and individual). Such treatment is less expensive than in-patient programs and is therefore, accessible to more people. Outpatient treatment options include both low-intensity programs and intensive day treatment plans.58 The low-intensity programs typically offer addiction education and admonition in regularly held meetings or sessions. These sessions are generally offered several times a week. For the alcoholic with a strong family or friend support group, and who has no other mental or physical conditions, this type of program can be successful. Also, for those who have participated in inpatient care, the regular sessions can help keep them focused on their recovery. Higher intensity outpatient programs are comparable to inpatient treatment programs in their services and effectiveness.59

C. Alcoholics Anonymous

One of the most commonly recognized outpatient programs is Alcoholics Anonymous (AA), a self-help organization which was founded by alcoholics. In January of 2002, AA reported that there were over 100,000 groups worldwide, and over 2 million members. In the United States alone there were over 1 million reported members. AA offers interactional group meetings which are facilitated by the members. “The framework of AA is a spiritual-based twelve step program through which attendees admit their dependence on alcohol and seek to modify their behavior.”60 The AA Preamble defines AA as:

“a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; we are self-supporting through our own contributions. AA is not allied with a sect denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes. Our primary purpose is to stay sober and to help other alcoholics to achieve sobriety.61

Regular attendance is required for successful treatment and, in fact, in the Ouimette study in 1998, it was determined that regular “attendance and involvement were more strongly related to positive outcomes than was outpatient treatment attendance.”62 Twelve-step programs are most effective if the following list of actions is followed:

Remain abstinent from alcohol and drugs
Attend meetings (90 meetings in 90 days at the start and then regular attendance- at least five per
week for two years after that)
Obtain a sponsor and call them every day
Participate in a Home Group
Working the Steps (with their sponsor)
Reading recovery literature
Prayer and Meditation
Service Work
· Working with others. 63

D. Pharmacotherapy
There are medications that have been proven effective in alcohol recovery, but they work when used in conjunction with a treatment plan. A physician must prescribe the medication. Two types of medication are used to treat alcohol dependence: aversive and anti-craving. 64

a. Disulfiram (Antabuse) – is an aversive medication that has been in use since 1940. It creates a chemical reaction with alcohol that causes vomiting, flushing and increased blood pressure and heart rate when taken within two weeks of alcohol ingestion. 65

b. Naltrexone (Revia) – is an anti-craving medication that has been shown to reduce the effects of alcohol and to reduce the amount consumed when used with behavioral therapies. Studies have shown that it can decrease the occurrence of relapse by half.66

For any treatment to be effective, the addict must refrain from alcohol or drugs. Abstinence is necessary for successful treatment. Many feel that they are the exception and that after treatment they will be able to resume “social” drinking. The DSM-IV reports that sixty-five percent of patients who abused or were dependent on alcohol abstained for at least a year following treatment.67 Abstinence is the key.

E. Referral
Psychiatrists have generally been regarded as the ultimate authorities on alcoholism. Unfortunately, they have in fact not had academic courses or field training in dealing with alcoholism.68 The general public, which includes referring attorneys, has tended to rely on the flawed premise that alcoholism is a primarily a psychological and social problem, as opposed to focusing on the true biological nature of the disease and so have usually referred the individual to a psychiatrist. But this is not necessarily the best road to recovery. Licensed addiction therapists are trained to help the alcoholic or drug dependent patient in their quest for recovery.

In connection with addiction recovery treatment, chemical imbalances may very well need to be addressed by a medical professional. Sometimes the addict may need to take an anti-depressant to correct the imbalance and relieve the depression before they are even able to address the more intensive treatment.69

Once the chemical issues have been addressed, the next thing alcoholics and addicts must do is get out of the victim role. Once in recovery, the alcoholic and addict must take responsibility for their actions and cannot blame their behavior on having a disease. They must do what is necessary to stay sober. Family, friends, and co-workers of the alcoholic are vital to this factor of recovery and must never feel they need walk on eggshells. Being open, honest, and understanding, without enabling, is what is needed most from all who are in support of the individual who is in recovery.70
If you suspect that your friend, family member, or colleague suffers from substance abuse, referral to a twelve step program, such as AA, can start the healing process and help get the addict on the road to recovery. Addiction is not of the type of problem that will just go away if ignored – it will only get worse. There are many resources available that offer help to substance abusers and in fact, nearly every community has a local AA group, or something similar. Hesitating to offer help or recommend treatment is not the answer.

If the problem is more severe and inpatient treatment looks to be the better solution, there are several tips to keep in mind when considering a referral to a treatment center;

Inquire about demographics, patient mix and “milieu”
Make finances and insurance a secondary issue
Consult with others about their rehab experiences
Always favor programs which encourage outside AA-type meetings
• Be wary of facilities that do not freely cross-refer.71

The alcoholic as client presents a unique twist to the question of treatment and referral. For the sake of the individual suffering from this disease, the best thing that could happen to them would be for the attorney to act as both legal advocate and counselor. This duel role can either be viewed as a conflict of interest, or as serving the client in the best way possible. It is the lucky client whose attorney falls into the latter group. In addressing the disease and referring the client to treatment, not only are the client’s short term legal needs addressed, but the long term health and happiness of the alcoholic client are also met.

VI. Conclusion
The guilt borne by alcoholics, as well as their friends and families, can seem insurmountable. This guilt is a product of the misconception that their addiction is a character flaw or moral failing. In essence, they are emotionally and psychologically overcome by the Choice Argument, even when they intellectually understand their addiction through the Disease Model. We can only hope that, over time, the weight of the truth of addiction as a disease will win out over the “choice” misconceptions.

With the advancements in brain imaging technology, science has proven the Disease Model theory. It is clear that the reward centers in the midbrain are adversely affected by the consumption of alcohol. The abusive ingestion of alcohol and drugs brings about discernable physiological changes in the activity of neuron receptors of the brain. These changes can last long after the alcohol abuse has stopped. The cravings and potential for relapse are always present.

There is no question that social and environmental factors also play a part in alcohol and drug addiction. But with the continuing advances in neuroscience and in addiction treatment, for addicts everywhere, there is hope. Although their addiction is not curable, it is definitely treatable. When friends, families, co-workers, and even attorneys insist that the alcoholic receive treatment, they are effectively saving a life.
APPENDIX A

APPENDIX B
Symptoms of Alcoholism
Are you an alcoholic? 20 questions developed by Johns Hopkins Hospital. Answer them as honestly as you can.

1. Do you lose time from work due to drinking?
2. Is drinking making your home life unhappy?
3. Do you drink because you are shy with other people?
4. Is drinking affecting your reputation?
5. Have you ever felt remorse after drinking?
6. Have you gotten into financial difficulties as a result of drinking?
7. Does your drinking make you care less of your family’s welfare?
8. Do you turn to lower companions and inferior environment when drinking?
9. Has your ambition decreased due to drinking?
10. Do you crave a drink at a definite time daily?
11. Do you want a drink the next morning?
12. Does drinking cause you to have difficulty in sleeping?
13. Has your efficiency decreased due to drinking?
14. Is drinking jeopardizing your job or business?
15. Do you drink to escape from worries or trouble?
16. Do you drink alone?
17. Have you ever had a complete loss of memory as a result of drinking?
18. Has your physician ever treated you for drinking?
19. Do you drink to build up your self-confidence?
20. Have you ever been to a hospital or institution on account of drinking?
If you have answered YES to any one of the questions, there is a definite warning that you may be an alcoholic.

If you have answered YES to any two, the chances increase that you are an alcoholic.

If you answered YES to three or more, you definitely need to seek help.