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The Pain of Loneliness and Substance Use Disorders

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Check Us Out!

A recent article in the New York Times, entitled, *If Loneliness is an Epidemic, How Do We Treat It?* (Cummins & Zaleski, 2023) indicates that more than 1/5 of Americans over age 18 report that they often or always feel lonely or socially isolated. In Great Britain, a Minister of Loneliness cabinet position was recently created in order to address record numbers of self-reported loneliness among Brits. Certainly, the COVID-19 epidemic contributed to feelings of loneliness and isolation, however, difficulties related to loneliness surely exist prior to COVID right? Also, as counselors we're well aware that loneliness can be the result of grieving a loss of a loved one, mood disorders or social anxiety along with a myriad of other possible causes. Social media also plays a role in exacerbating loneliness as people often compare themselves to other social media users who appear to be having wonderful, exciting lifestyles.

However, the aforementioned news article says nothing about substance use disorders either as a correlate or cause of loneliness. Yet, those of us who have worked in the SUD treatment profession, know that loneliness is often highly correlated with SUDs. Paradoxically, both alcohol and substance use are often thought to enhance social interaction, (hence the term, "social drinker"). Cannabis, cocaine and MDMA are often associated with particular music events such as concerts or raves and for many, it seems that alcohol or substance use can be part of their social milieu. Even during COVID it was common for friends to get together at the end of the day, on Zoom, for "happy hour," or for many couples to report that they enjoy drinking or getting high together. However, generally what counselors witness as their clients progress deeper into an SUD is that they become more socially isolated.

Some recent research in the area of loneliness indicates that there may be a neurological component along with the emotional cluster of loneliness (including feelings such as anger, resentment, shame, guilt, jealousy and self-pity) (Alberti, 2019). Dr. Stephanie Cacioppo (2022), a behavioral neuroscientist, claims that loneliness transforms the brain by causing the neurotransmitters that allow for connection and bonding to go haywire. The lonely brain tends to be in a state of agitation or fight or flight mode in which the social world is perceived as being a dangerous, threatening or unwelcoming place. And unfortunately, the more one isolates, the more they become less inclined to want to venture out in order to try to connect with others. As counselors, we see this quite often with depression, whereby negative cognitive perceptions reinforce the view, "why bother to go out, I won't have a good time anyway," which often becomes part of anhedonia (inability to experience pleasure) that is so much a part of depression.

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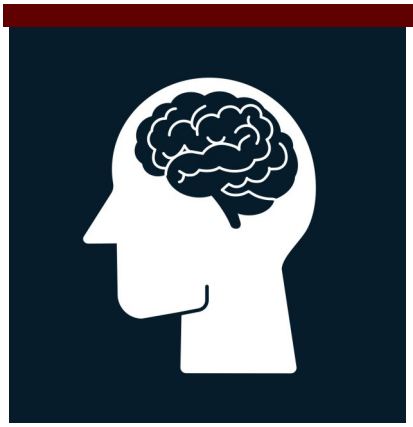

Now let's consider how all this plays out in neurochemistry of the brain of someone who has a substance use disorder. We're all well-aware of how most substances of abuse will cause disruptions and depletions in dopamine and serotonin. And we're also well-aware of how these disruptions cause emotions to be accentuated or numbed depending on the timing of recent use. No wonder individuals become more isolated as their use progresses (with the possible exception of high sensation-seekers). Not coincidentally, the types of remedies presented by Cummins and Zaleski are very similar to the types of recommendations we, as counselors make to newly recovering clients (e.g. go to AA/NA meetings, get a sponsor, even if a temporary sponsor, go to the diner after the meeting, have a list of phone numbers to call, talk about your relapse triggers with others, attend IOP etc etc etc.) If active SUD is about isolation, then it stands to reason that recovery is about connection. This concept is emphasized in Johann Hari's writings as well as Philip Flores (2004) who conceptualizes SUDs as attachment disorders. The first step towards forming a health connection is often with one's counselor, sponsor or group. For our students, it's important to impress on them that as counselors, we're trying to create a safe space for our clients. For many of clients, connection is scary, therefore if we can make connection with others less scary, we've accomplished a great deal.

References can be found on page 14

Educating Students on Client Survival Strategies and Their Impact on Treatment

Joseph Rosenfeld, Psy.D., CRADC, HS-BCP

People bring to treatment, whether inpatient or outpatient, several "survival strategies." These strategies have also been referred to as "hustles" (Lex, 1990; White, 1996), and "manipulations" (Jurgensen. 2009). They cause conflict in treatment settings and have been viewed as a means to resist recovery. Because of these conflicts, it's often recommended that services be discontinued until, "the client is ready," resulting in unnecessary and unwise terminations. However, survival strategies serve a larger purpose, described below, and are best addressed as a clinical issue. Emerging professionals can learn to successfully manage these behaviors and increase the likelihood of their client's successful recovery.

White, et al (2005) stated that the mismanagement of survival strategies resulted in the administrative discharge of 18% of all clients admitted to treatment. In 2005 that was approximately 228,000 people. To paraphrase the authors, we are the only healthcare field that discharges people for being symptomatic of their disease. Granted there are times when clients need to be administratively discharged. However, these should be reserved only for the most severe infractions. Passing notes, not making one's bed, arguing with other clients or staff, avoiding group therapy, causing turmoil, etc. are not examples of severe infractions. Yet these are reasons clients are administratively discharged.

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Unfortunately, for the sake of accurate attribution, this author does not know where he first heard the term "survival strategies." As remembered, these strategies are developed as a means for people to survive their families of origin, their general environment, and/or their careers as people with substance use disorders. As a person begins to develop a substance use disorder their survival strategy becomes integrated with behaviors stemming from their emerging lifestyle. For example, one client learned to lie to his parents at a very early age to avoid physical and psychological punishments. He became even better at lying when he developed a substance use disorder. Even as he entered recovery he would lie when there was little or no harm in the truth. He lied while in treatment; when he continued his recovery in the community; when working; and when he sought to establish a positive relationship with his partner. He found honesty hard to maintain even as he became aware of its importance in "keeping his side of the street clean." The urge to lie to avoid conflict, to smooth out a conversation, or just to keep people off balance was hard to resist. It took him many years to become a consistently honest person. Now he is doggedly so, although he admits the urge is still there.

Survival strategies, as implied by their name, are not behaviors people will give up easily. This is often the core of conflicts with staff. Staff believe that people in recovery should leave their hustles, manipulations, and other "bad" behavior at the door of the treatment program. However, when entering an unknown environment; looking at a recovering lifestyle that is also unknown and about which they are likely ambivalent; and interacting with staff and clients they have no reason to trust, people entering treatment are more likely to double down on their survival strategies than to leave them at the door.

The idea that people utilize various strategies to cope with hardship and trauma is not new. The examples of survival strategies provided below have their roots in the work of Eric Berne (1964), Claude Steiner (1971), Claudia Black (1981), and Wiliam White (1996). People in recovery are not necessarily conscious that they are using survival strategies. They likely don't come to treatment with that level of insight. Further as stated, it is highly unlikely that these strategies will be given up during an initial treatment episode. Therefore, clinicians must be aware of them and develop effective management and remediation strategies.

Below are some examples of survival strategies. People may demonstrate only one of these, present with an array, or have hybrids of the types presented:

Creating conflict: Also known as "Let's you and him fight", or triangulation. In this case the client pits staff against staff, client against client, and client against staff. This is done primarily through carrying tales, spreading rumors and words spoken (often slightly distorted) between people.

Creative chaos: This is the client who keeps everyone off balance by creating chaos of one kind or another in the unit or at the agency. This can include spilling large containers (accidentally), bumping into a fire alarm, bouncing from crisis to crisis, etc.

Distraction: Like creative chaos, this survival skill depends on distracting the therapy staff from any issues that may make the person uncomfortable. This person will bring up a lot of issues, but in fact, they are just distractions.

Exploding, or as one student described her own behavior "hulking out." This is a person with a hair-triggered temper who will explode at the slightest provocation. This protects its user by keeping people at arms length. The above-mentioned student became aware of this behavior in herself during classes and in her first practicum when it occurred in both settings. She worked very hard to reduce her reactivity and was still working on it at graduation.

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Lying: This was described earlier and is used as a method to avoid meaningful interaction, as well as avoiding any accountability or conflict.

Passivity: This as also known, as a "yes, but," "doing treatment (like doing time)," or being passive-aggressive. This person accepts all treatment recommendations but is "just" unable to accomplish any of them for an ever-evolving list of reasons. The goal is to get the staff to give up out of sheer frustration.

Playing bad: (aka "flight into health") Playing bad is an attempt to convince everyone involved in treatment, including parents and partners, that no amount of therapy in any guise will do any good.

Playing good: Playing good on the other hand, has the client straighten up their behavior immediately, and often being even better than remembered. Within just a few weeks they are urging their parents, partner, or therapist to allow them to stop therapy because they are all better now. Unaware parents and partners often fall for this. This person will appear to staff as easy to manage, and therefore ignore. The person will then skate through the treatment program unscathed.

Seduction: This is not only sexual seduction, but also flattery, or intense respect and interest in the therapist. When the therapist is successfully seduced, it gets them to back off due to the nature of their relationship. This can also be a form of "chaos" combined with "creative conflict," when the person seduces other clients and sets people against each other.

Shutting Down: Also called "withdrawing." This individual does not participate or participates at a level just above being discharged. Like a turtle in a shell, the client doesn't cause much trouble and so staff just leave them alone.

Therapist Helper: Also called" junior counselor." This individual bonds with the clinical staff to begin analyzing and providing services to other clients. It is a form of seduction.

This is likely not an exhaustive list. These behaviors, when they are survival skills, are deeply engrained in the individuals and will be present through any short (less than a year) treatment experience. They can cause deep chasms between the person in early recovery and the treatment staff, and as stated above can be the grounds for an administrative discharge. It should also be noted, that when these survival strategies are successful, and treatment avoided, there is a very high likelihood of a return to using behaviors.

Survival behaviors will be present along with Post-Acute Withdrawal Syndrome (PAWS) (Rosenfeld, 2021), and other behaviors that may stem from their lifestyle as a person with a substance use disorder. Both PAWS and behaviors formed by adaptation to the substance use disorder lifestyle will generally dissipate more quickly than survival strategies.

To ensure that we are not terminating people for deeply engrained behaviors that have helped them survive physically or psychologically, treatment staff need to be aware of the existence of these behaviors and commit to providing awareness and healing rather than punishment.

Clinical staff want to be aware of the types of survival strategies they may encounter. It is important not to attribute this behavior to "addict" behavior, to bad habits, or to treatment resistance. These misattributions lead staff to develop hostile countertransference toward the person in early recovery thus denying them care either through termination or emotional withdrawal. Properly, when staff witness these behaviors, they point them out, discuss their previous utility in the person's life, and introduce the possibility of more adaptive alternatives. A transformational process begins with awareness on the part of staff, moving to awareness in the client. Healing will take as long as it takes (probably years), can only occur in a psychologically and physically safe environment, and will require a great deal of practice.

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One role model for managing these survival strategies are the mutual aid groups (Alcoholics Anonymous, Narcotics Anonymous, etc.). The mutual aid groups are patient and accepting, with meetings providing a safe space and almost unconditional support. Next is the sponsor, a person who is chosen by the person in recovery when the person is new to the program. This contrasts with a person being assigned a counselor at a treatment program. Steps Four and Five initiate a process of self-examination (Alcoholics Anonymous, 1981). Steps Six and Seven set in motion a process of change. Step Ten activates a process of continual self-examination and personal reconstruction. There is no time limit for this process. Membership is open-ended with no barrier to entrance or return. Meetings provide ample opportunity for people in recovery to learn from the transformational journey others have taken.

As treatment programs are not structured like mutual aid groups, what can we teach our students to do in the time they have with people entering recovery? First, as stated earlier, when survival strategies are identified, use this as an opportunity to open dialogue with the client. Motivational Interviewing can be very helpful in these conversations (Miller and Rollnick, 2012), as it provides an avenue for the person in recovery to reflect on their behavior and its consequences versus engaging in a power struggle. Second, discuss alternatives to the survival strategy even though people in early recovery are unlikely to immediately adopt them. Third, reinforce the idea that full recovery will take many years and different treatment modalities. Here, this author agrees with David Mee Lee (2023), that the term graduation should never be used as people in recovery transition from one level of care to another. Fourth, reserve administrative discharge only for the most egregious acts that threaten the physical or psychological safety of others. Otherwise, figure out a way to work with the person in recovery in order to maintain them in therapy.

Fifth, all people in recovery should have an individual therapist and sufficient time to meet with that therapist on a regular basis. Then, when a conversation regarding a survival strategy needs to occur some level of relationship and trust has already been established. Sixth, integrate education about survival strategies into your program so that people are familiar with the concept and the ways that these behaviors, that were once adaptive, can become mal-adaptive in the larger world. Finally, utilize mutual aid groups as a means of providing people with both an ongoing support system and a time-tested method of personal transformation. Not all people in recovery will be amenable to mutual aid groups, and in those cases, work to identify groups with which people can affiliate that will serve a similar purpose. For some people in recovery that may be the treatment system itself, with which they may maintain a relationship for many years. Staff in short-term treatment programs should have a list of community-based practitioners who can work with people over many years.

Emerging professionals can be modest, realistic, and informed as to what is able to be accomplished in a short-term treatment program. If a person entering recovery begins to gain clarity on how their substance use disorder has impacted their life; starts to see a path to recovery; agrees to continue care beyond their first facility; and locates indigenous mutual support/communities of healing with which they will interact, then treatment has been successful. Emerging professionals set themselves up to feel frustration, aggravation and failure if they expect people entering recovery to completely transform themselves within short periods of time that are currently allotted in most treatment programs. In addition to providing education as to the strategies and techniques listed above, when we provide students with realistic expectations about the process of recovery then we have been successful.

References can be found on pages 14-15

Civil Commitment for Persons with Substance Use Disorders: Advantages and Disadvantages

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Several weeks ago, an email circulated on our INCASE list serve that contained a reference to an article written by David Sheff, best-selling author of *Beautiful Boy* (2009) and *Clean* (2013) both of which chronicle the author's attempts to get his son into substance use disorder treatment. The article made reference to Sheff's advocacy for civil commitment laws for individuals experiencing substance use disorders. Sheff feels that in some instances civil commitment may be a family or significant other's only recourse for saving their loved one's lives by obtaining a court order to have them admitted into residential treatment. Similar to mental health civil commitment laws, if one is determined to be a danger to themselves or others by the courts, they can be remanded or "committed" involuntarily to a treatment facility. While few would question the need and efficacy of mental health commitment laws, when it comes to substance use disorders there are many potential pitfalls and controversies. Let's be clear, voluntary admission is always considered to be the gold standard when it comes to both mental health and substance use disorder treatment, however, as many of you know, voluntary admission is not always feasible or possible.

One of the dilemmas inherent in the treatment of substance use disorders is that addiction counselors are often trying to motivate individuals towards change and towards entering treatment voluntarily. As is often said in the rooms of AA, "alcoholism is a disease, that tells you, you don't have a disease." And for decades, voluntary treatment was the only option available by which persons with substance use disorders could enter treatment. While voluntary treatment is preferable on several levels (e.g. lack of coercion or pressure, allowing for client autonomy, and self-determination), research indicates that mandated treatment can also be an effective approach to treating substance use disorders. As stated by Kelly, Finney and Moos (2005) "Contrary to popular belief, when offenders mandated to SUD treatment are compared with individuals who are self-referred to treatment, mandated patients show substance use outcomes and crime reductions similar to or sometimes better than, those achieved by voluntary patients" (pg.213). While treatment outcomes vary, it appears that some treatment is better than no treatment applies (see Anglin et al., 1989; Beane & Beck, 1991; Brecht, et al., 1993; Chankin, 1992; Dunham & Maurs, 1982; and Farabee et al., 1998).

Drug courts are a prime example of extrinsically motivating adjudicated individuals (i.e. someone who had been charged and convicted of criminal offense), to enter SUD treatment as an alternative to incarceration. Drug courts were designed to take non-violent persons who committed substance-related offenses and to divert them from the criminal justice system (i.e. jails, prisons) and into substance use disorder treatment. Unfortunately, however, this type of extrinsically-motivated treatment applies only to those who have been charged with drug-related offenses (e.g., drug possession) or those who have been granted entry into pre-trial intervention programs (Hora, 2002). Also, keep in mind that treating mandated clients has often been an integral part of substance use disorder treatment programs and often includes not only drug court clients, but also DUI offenders (Cavaiola & Wuth, 2001); probation/ parole referred clients, and parents/caregivers referred through child protective services.

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In the absence of court-mandated treatment, the dilemma faced by parents and significant others is essentially how to motivate their loved one to enter treatment voluntarily? Many parents report experiencing constant fear worrying they will get the call they have been dreading, i.e., that their son or daughter is in jail, an ICU or has died of an overdose. For those families, the powerlessness they experience as they wait for their loved one to "hit bottom" is fraught with constant dread, leaving them to question whether there are any reasonable and viable alternatives to help their loved ones who are refusing treatment. In response to these concerns approximately 37 states have adopted civil commitment laws whereby family members and significant others can petition to the courts to have loved ones committed to substance use disorders treatment facilities. On a practical level, involuntary treatment also becomes a means of diverting individuals with substance use disorders from jails and prisons and into treatment settings. Also, involuntary treatment may provide an alternative to homelessness that is especially common among persons with SUDs.

One example of civil commitment law referred to as the Marchman Act was passed into legislation in 1993 by the Florida legislature. This was one of the first of such civil commitment laws written specifically to address those with substance use disorders. The law provides for brief civil commitment (up to seven days) for individuals experiencing a substance use disorder and longer term treatment if proven necessary. Named for Reverend Hal S. Marchman, a dedicated and tenacious addiction treatment advocate, the Marchman Act specifies funding for mandatory commitment treatment programs whereby individuals with substance use disorders can be assessed and stabilized (i.e., detoxification or initiation of medication-assisted treatment; medical stabilization) with the goal of encouraging the individual to enter longer-term, mainstream treatment programs voluntarily. The rationale behind the Marchman Act is that it provides time for individuals who lack decisional competence (i.e., the capablity of making a rational, informed decision regarding entering treatment as well as engaging in ongoing substance use treatment) to regain clarity and lucidity. Also, the rationale inherent in many of the civil commitment laws is that if an individual with a substance use disorder has impaired insight and compromised capacity to make rational, informed decisions by virtue of continuous substance use, it therefore seems unreasonable to expect these individuals to provide informed consent to enter treatment voluntarily. The criteria utilized for civil commitment under the Marchman Act is as follows: "Lost power of self-control with respect to substance use and either: 1) has inflicted to threatened to inflict or unless admitted is likely to inflict physical harm or him or herself or another OR 2) is in need of substance abuse services and by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regards theretofore; however mere refusal to receive such services does not constitute evidence of a lack of judgment with respect to his or her need for such services" (pg. 11) (Marchman Act Handbook, 2003).

Florida's Marchman Act is just one example of a SUD civil commitment law, and there is wide variation in civil commitment SUD laws from state-to-state both in terms of the length of confinement; as well as whether the law can mandates outpatient as well as inpatient treatment in the criteria used for commitment (Brauser, 2011). For example, concerning the duration of confinement, state civil commitment laws for emergency commitment or emergency hold may range from 24 hours to 15 days from 1 to 3 months for involuntary inpatient assessment and stabilization and up to 12 months for inpatient involuntary commitment.

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With regards to the criteria utilized to determine commitment, there is also variation on whether states utilize criteria such as danger to self or others, grave disability, lack of decisional capacity, incapacitation, failure to manage personal affairs and addiction/loss of control (Brauser, 2011). Involuntary commitment can be initiated not only by family members and significant others petitioning the court but also by police intervention or at the time of an emergency department treatment by physicians. Under the Marchman Act there are five types of involuntary commitment. 1) being taken into protective custody (by the police) 2) emergency department admission 3) alternative involuntary assessment for minors (e.g. Levitt & Pinals, 2012). (It should be noted that none of the aforementioned forms of commitment require prior judicial review, however, judicial review would be required if a person were held for more than 72 hours. The other two forms 4) involuntary assessment and stabilization and 5) involuntary ongoing treatment, do require judicial review. The person who is committed has a right to a court hearing within five days of admission to a licensed addiction treatment facility (Brauser, 2011). In the instance of protective custody, the police officer must take the person to a "safe environment" whether that be a hospital, detoxification facility or other licensed addiction treatment facility. Also, the police must notify a licensed addiction treatment facility within 8 hours of taking the person into custody and arrange transportation to that facility. Similarly, in instances of emergency admission, a person may be admitted to a hospital, a detoxification facility or other licensed addiction treatment facility with certification from a physician, however, that individual must be evaluated by a *qualified addictions professional* within five days in order to determine if further involuntary inpatient commitment is warranted. If not, that individual must be released with appropriate referral for outpatient follow-up care. If further assessment and treatment is deemed necessary, (by virtue of that individual still meeting the criteria for involuntary commitment then a petition can be filled with the court and the individual will be retained in treatment (Brauser, 2011).

In instances where family members or significant others petition the court for involuntary commitment, a court hearing must take place within ten days of the petition of being filed with the court. The respondent has a right to legal counsel at that hearing. If the court determines that involuntary admission is warranted then the respondent is admitted to an "addiction receiving" treatment facility

where an assessment commences upon admission. The treatment provider has five days to report their findings to the court, at which time, the judge may vacate the order for further involuntary treatment or may extend the length of involuntary commitment for up to 60 days. However, such as assessment performed by the addiction-receiving agency may be construed as self-serving if the program then recommends longer-term treatment.

The impairment of decisional capacity (Jeste & Sacks, 2006), in individuals with SUD's is one of the cornerstones of most effective civil commitment laws. For example, one of the DSM-5 criteria for SUD is the *continued use of the substance despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or worsened by the substance.* (American Psychiatric Association, 2013). Therefore, individuals with SUD may lack the ability to delay gratification and often make decisions with short term gains and long-term losses, and treatment is often viewed by the individual to hinder their immediately gratifying use of the substances. Other research has examined whether individuals with opioid use disorders have the ability to provide voluntary informed consent (i.e. decisional capacity) to treatment. There are, times, when individuals with an SUD are unable to make rational decisions about substance use and the necessity of treatment, especially when the disorder has progressed to such a severe level that loss of control is evident (Charland, 2002).

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Civil commitment for individuals diagnosed with substance use disorders does provide a viable option for mandating individuals with severe substance use disorders into treatment, however, there are those who oppose such legislation on the basis that it interferes with one's civil liberties guaranteed under the 14th Amendment of the Constitution. Civil commitment could be construed as depriving individuals with substance use disorders of their freedom or constitutional rights. However, the same argument could be made of a mentally ill individual who threatens to harm self or others and is involuntarily committed (Rosenthal, 1988). Few would question the necessity of commitment in instances where imminent harm to self or others is threatened. However, there are those who may object to civil commitment on the basis that it is essentially coercive, paternalistic and takes away one's right to consent to treatment (Rustad, Junquera, Chaves & Eth, 2012). There are concerns that civil commitment for persons with SUDs may be a step backwards to the abuses of the Lexington Narcotic Farm of the 1930's.

Others might object citing the shortages of state-funded treatment beds, that are often limited and subject to lengthy waiting lists (e.g., there are several counties in Ohio that demand that family members pay 50% of the costs of involuntary hospitalization up front (Ohio, 2012). Civil commitment laws would most likely add to these already burgeoning waiting lists. There are also costs incurred to state budgets when providing involuntary commitment.

Another objection to civil commitment involves concerns the potential abuses of involuntary commitment. Hypothetically, a parent or spouse could petition the court to confine a family member who does not meet the criteria for involuntary commitment or who may not meet the DSM-5 criteria for a substance use disorder (for example, would civil commitment laws apply to someone with a Nicotine Use Disorder, especially considering that smoking results in more deaths than nearly all other substances combined). In those instances, assessment and judicial review would hopefully, reduce the likelihood of potential abuses of commitment laws.

Others object to SUD civil commitment as it may represent a form of social control. There may also be a potential that unscrupulous treatment providers may petition the court for an increased length of stay for someone involuntarily committed to their facility, in order to fill beds. Again, judicial review may help to reduce the likelihood of these types of abuse.

Also, some question the degree to which police, emergency department physicians or judges are sufficiently trained and knowledgeable about addictions in order to make a determination regarding whether a person truly requires involuntary commitment. (Absensur, 2012). This is where it becomes essential that evaluations be performed by independent, licensed alcohol/drug counselors. Although the potential for these types of abuses of the involuntary commitment statutes exists, they may be mitigated by the criteria for commitment (e.g., danger to self and others, and/or decisional incapacity) that are included in most statutes. Most state statutes have checks and balances built into their laws whereby involuntary commitment decisions are not made by one individual but rather by several professionals including addiction trained professionals who are required to perform thorough assessments.

One study in particular examines the outcome of 100 Florida residents involuntarily committed under the Marchman Act (Sweeney, 2013). This study found that the treatment completion rate, (i.e. those who completed treatment successfully as opposed to those who left against medical advice once the criteria for involuntary commitment was no longer met, was 69%. When compared to a group of individuals admitted to the same treatment facility voluntarily, the rates of completion was 70%. Given the overdose rates which appear to be increasing annually, civil commitment laws may provide a lifesaving alternative.

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A Final Note

In several of my addiction counseling classes, I would often include a lecture on "Motivating the Unmotivated or How to Manage Treatment Ambivalence". Included in these class discussions we would obviously talk about Motivational Interviewing and CRAFT (Community Reinforcement and Family Training), two of the least coercive approaches, and then discuss Johnsonian Interventions and civil commitment as being the more coercive alternatives. It's important that students appreciate that each individual with an SUD is unique and therefore treatment approaches also need to match the needs of the client. For example, Motivational Interviewing is a very useful treatment approach however, what if the client is in danger of overdosing? What if the client's continued use with result in a parole violation which would result in re-incarceration? What if the client continues to drive under the influence on a daily basis? What if the client is in danger of serious medical complications if they continue using? Each of the aforementioned motivational approaches has advantages and disadvantages. Also, Sam Quinones (2023) author of *Dreamland* (2019) and *The Least of Us* (2023) talks about the value of "recovery pods" within State prison systems. He contends that for some individuals, detoxing in prison and entry into these recovery-promoting treatment "pods" may be their only chance at recovery. Treatment is not a "one size fits all" proposition and we need to impress on our students the need for individualized treatment approaches.

**References can be found on pages 15-16 **

So You Want to Write a Book: Some Recommendations & Things to Consider

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Since the publication of our textbook entitled, *A Comprehensive Guide to Addiction Theory & Counseling Techniques* (Routledge/Taylor-Francis) last year, we often have colleagues ask us for advice on how to get a book published. Our answer usually begins with "Well, it depends…"

Let's take a moment to explain. Many colleagues are usually thinking of either writing a textbook or a popular-press type of book. Although there are some similarities in how to write up the book proposal, there will be essential differences in writing a scholarly textbook (complete with APA-style references, tables, graphs, charts etc.) versus a popular-press type of book that might appear in Barnes & Noble or independent bookstores, where referencing is helpful but often not essential or as carefully scrutinized. Also, keep in mind that the publishers that you (or your literary agent) will pitch your book proposal to, will be vastly different. I've (AAC) had the opportunity of having written both popular-press (e.g. *Toxic Co-workers,* 2001), as well as textbooks and for each book, publishers had different requirements and expectations. Keep in mind however, that we're working off of our somewhat limited experience of writing textbooks for the addiction counseling and mental health counseling profession. As you begin to conceptualize the type of book you want to write, here are some things to consider:

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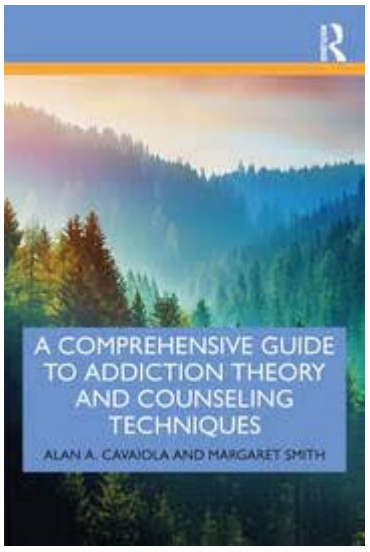

The Proposal

In order to communicate your book idea to a prospective publisher, you'll need to flesh out your ideas in a written proposal that will be usually be reviewed by the publisher's DE, or Development Editor. The DEs are the folks who will review your proposal and will make recommendations on how to best express what you want to convey in your book. The proposal is then sent out to several colleagues (some that you select and some the DE may select) who will then comment on your proposal and make recommendations. The most important recommendation made by these outside reviewers is whether they feel your book is worthy of publication. Some reviewers are very helpful in offering constructive suggestions, while others may be hypercritical or dismissive. This latter group are usually faculty who have been using the same textbook for the last 20 years and are disinclined to adopt a more recently published book no matter how good it is. If you're writing a popular-press book the DE may bypass this review process step entirely and instead consult with their own team within the publishing company.

Your proposal will usually need to include the following: 1) a brief overview of your book, 2) an explanation of how and why your book differs or is better than similar book, 3) an explanation of your target audience (i.e. who your book is intended for, e.g. undergraduates, graduate students, professionals, general public etc.) 4) a listing of similar textbooks and how your book differs from the competition, 5) ways that you can market your book once its published, 6) a listing and brief explanation of each chapter, 7) two or three sample chapter drafts. If this seems like a lot of work for a proposal that might not ever come to fruition, you're right. Writing a book is somewhat similar to the decision you made to go to graduate school…you knew you would have to invest a lot of time and money and there were no guarantees that you would be successful in your chosen career. Writing a book has similar elements of risk, in that there are no guarantees the publisher will accept your proposal and no guarantees your book will continue to generate sales once it's in print. However, that doesn't mean that you should pack up your tent and go home. If a publisher rejects your proposal, ask for feedback, then polish up your book proposal and pitch it to another publisher. (There's a great story in the publishing world about author Mary Pipher, who had sent her book proposal for *Reviving Ophelia* to approximately 25 publishers before one publisher decided to offer Mary a contract). The rest is history because *Reviving Ophelia* became a national, popular-press, bestseller.

By the way, as soon as you pitch your book to a publisher, often their next question will be, "what's your author platform?" Here publishers are interested to know whether you have a following on social media or within your professional circles. In other words, do you have a bunch of groupies who will be interested in reading and recommending your book to others once it's in print. There are ways to develop your professional presence or "platform" through writing a blog, taking on editorial reviewer responsibilities for various professional journals, or becoming actively involved in professional organizations, e.g. INCASE, NAADAC, NASAC or ACA, NASW, APA etc.. Also writing articles for journals and doing conference presentations are helpful (which you'll need to document in your updated CV that publishers require). In other words, it's not enough that your student's love you and give you great teaching reviews, you need to have a presence outside your college/ university in order for publishers to be interested in your book.

The Contract

Let's say you're offered a contract by a publisher. Congratulations. Before you run out and lease a new Range Rover with your prospective royalties, there are a few things you need to consider. First, a decent contract will usually offer authors anywhere from 8 to 12% of net profits from your book. Make sure you read the fine print or better yet, have an attorney review the contract to make sure you're not being taken advantage of. A quick example why this is important. The first book I co-authored, (*Assessment & Treatment of the DWI Offender)* offered a 12% royalty, however, in reading the fine print, the contract indicated that 12% was the rate for hardcover sales while the softcover sales royalty was only 8%. Obviously, the softcover sales far exceeded that of the hardcover sales. Also, the contract may specify different royalty rates for e-book sales, book rental sales and international sales so make sure you or your attorney is aware of differential royalty rates.

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Other things to keep in mind when writing a textbook is whether the publisher will be asking you (and/or your co-authors) to write an instructor's manual which is a whole other time-consuming project in and of itself. As you know, instructor's manuals often include classroom exercises, PowerPoints and test banks. Also, make sure you know whether you will be required to compile the author and subject index for your book. This too is a time-consuming task and publishers have professionals who do nothing but indexing for a living. However, it's going to cost you, as most publishers back you against a wall by giving you the option of compiling the index yourself or paying to have it farmed out to a professional indexer. These fees are usually taken out of your first royalty check and can range from $500. to $1000. depending on the length of your book and how many references you've included. It's often disappointing when you receive your first royalty check to see that indexing fees have eaten away at your royalties. (There goes your Range Rover! You may be able to get a good deal on a used Yugo) And speaking of royalty checks, publishers differ on how often they pay royalties. The best ones will pay out quarterly, most will pay royalties once-a-year or twice-a-year.

So, here's another problem. If you're writing a textbook that will used by all students in an Intro to Psychology or Intro to Social Work class, you'll probably be offered a more lucrative contract and perhaps even an advance. (I had a colleague who co-authored a research methods book where she and her co-authors were each given a $20,000 advance). However, not all students take addiction counseling courses, so any textbook we write will fall under what's referred to as a "niche market" (i.e. a more specific market with fewer students). Also, books have a certain "shelf life" which we'll discuss later in this article.

Writing Your Book

If you enjoy writing and you appreciate the solitude of writing, you may actually enjoy seeing your book take shape. If you have co-authors, you may enjoy the collaborative discussions and exchange of ideas that comes with developing your book proposal and the outline of your chapters. However, if let's say you're writing and edited textbook where various colleagues will be responsible for writing chapters of your book or you're writing with two or more co-authors, then everyone needs to be on the same page regarding content and deadlines.

One of the most frustrating things about writing a co-authored or edited book is when your colleagues are not as conscientious about deadlines as you are and you have the publisher breathing down your neck asking when your work will be submitted. In academia, we refer to this horrible situation as "dragging dead bodies" (see prior issues of *Addiction Educator* for an article on this topic). In one instance, I had a co-author who bailed from the contract a few weeks before the first drafts were due. When choosing co-authors or colleagues to author chapters for an edited textbook, make sure they can write. Don't assume that just because someone has an advanced degree that they are adept at writing.

Publishers versus Self-Publishing

Finding a publisher who will be interested in your book is not easy. If you're writing a textbook, you should first look at those first-tier, well-known publishers who are currently publishing textbooks in the addictions studies area. All the major publishers (e.g. Houghton-Mifflin, Oxford, Wiley, Allyn & Bacon, Guilford, Taylor & Francis, Routledge, Pearson, Sage and Springer) publish a basic addiction counseling text and some (e.g. Taylor & Francis, Springer) publish more advanced addiction counseling textbooks. There are also second tier publishers that you may want to consider (e.g. Cognella and other smaller independent publishers). With regards to popular-press books, publishers such as Hazelden, Healthcare Communications, Anchor Press and New Harbinger are known for publishing popular-press and self-help type books. Again, look at your bookshelf and see what publishers have published books similar to the one you want to write.

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Self-publishing is another option which has become more popular, especially with the ever-growing popularity of Amazon. Naturally, there are advantages and disadvantages to self-publishing. The main advantage is that you, the author, will have final say on the content of your book, and even things like your cover design and typeface. Also, you will be reaping a much larger percentage of the royalties however, you will need to consider other expenses. For example, there are companies that can assist you in self-publishing your book and will handle everything from the copyright, obtaining an ISBN number, cover design, and formatting your book into a publishable format, but naturally, they will charge fees for their services. Similarly, Amazon will also take a percentage for every copy of your book they sell and ship. The advantage is that you won't have boxes of your book that you have to ship to buyers.

There are several disadvantages of self-publishing. For example, you will be solely responsible for marketing your book and marketing expenses add up depending on the type of marketing you do. For example, if you take out an ad to promote your book in a professional journal or magazine the cost can anywhere from $500. to $1200. depending on the size of your ad. There are other ways to market your book using social media. Another disadvantage to self-publishing is that you will be responsible for hiring a proofreader and a indexer, as well as an artist to do your cover design. You'll also be responsible for obtaining an ISBN number.

If you are interested in self-publishing, we suggest that you go on Amazon's website and under Books, type in self-publishing. Here, you will find a number of books all devoted to the steps needed to self-publish (see Rich, 2006; Yager, 2019).

A Final Thought

Hopefully, we've not turned you off entirely to writing a book. There's nothing more gratifying than seeing your book in print and sharing copies with your colleagues, family, and friends. Also, teaching a class using your own book can also be very gratifying, (although in some instances faculty colleagues or administrators (and even some students), look down on the practice, based on what they might perceive as a "conflict of interest" for faculty to use their own book.) But here's something to consider; when we decided to write *A Comprehensive Guide to Addiction Theory and Counseling Techniques*, we felt that we wanted to write a book that would be unique and therefore would be an improvement on existing textbooks, so we set about writing our book with this goal in mind. So, why use other textbooks that are inferior or don't meet the needs of your students or the curriculum you're attempting to cover? And if you've been reading between the lines, no one in our profession gets rich writing a book. It goes back to the niche market thing we mentioned earlier. Also keep in mind that in some universities, textbook selections are made by the department chair and faculty have little or no say in which book they will be using. So much for academic freedom.

If your textbook is successful, your publisher may offer you the opportunity to write a second edition. This a good sign that your book is selling and it also gives you an opportunity to update your book and to add up-to-date research. Unfortunately, books have a "shelf life" and the sale of used copies of your book will often account for decreased royalties with each passing year. A second edition will breathe life into an existing textbook, however, what we've sometimes seen is that unscrupulous publishers and authors will merely change a few chapters around and pass that off as "new edition" knowing that many university bookstores will automatically order the most recent edition of a textbook which then forces students to buy the new edition rather than chancing using an older, used copy edition. There's been a lot of controversy regarding the sometimes, outrageous prices of college textbooks and why e-books and textbook rentals have become popular in the past few years. Some professors have opted to forego using textbooks and instead will assign students specific journal articles to read that coincide with their lectures.

References can be found on page 16

Do you have an interesting classroom exercise you use with your students or discussion topics that are engaging and get students participating?

Think about writing a brief article for *Addiction Educator* to share with the rest of us!

Any news or announcements you'd like us to include in our next issue? Submit your article or announcements to msmith@keene.edu or acavaiol@monmouth.edu

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