Sacred Cows and Greener Pastures: Reflections from 40 Years in Addiction Research

William R. Miller PhD

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Sacred Cows and Greener Pastures: Reflections from 40 Years in Addiction Research

William R. Miller, PhD

Emeritus Distinguished Professor of Psychology and Psychiatry, University of New Mexico, Albuquerque, New Mexico, USA

ABSTRACT

In this invited editorial, Prof. William R. Miller reflects on lessons learned through 40 years in addiction research and treatment on topics including evidence-based treatment, client-treatment matching, waiting lists, brief intervention, therapist effects, empathy, polydrug use, relapse, diagnostic labels, manual-guided treatment and standard care, abstinence and moderation, acute treatment and case management, residential and outpatient care, concomitant disorders and integrated care, motivation for change, and spirituality. Concluding that there are ample reasons for humility about our professional expertise, he offers recommendations in nine areas for improving the care of people with substance use disorders.

KEYWORDS

Addiction; treatment; substance use disorders; outcome; relapse; empathy

“Look how far we’ve come; how can we have so far to go?” This line from a song by Santa Fe singer/songwriter Don Eaton captures well my current sense of addiction treatment. On one hand I am heartened by how much has changed, mostly for the better, since 1973 when I was drawn to this work. I am also frequently reminded of how much more change is needed to better serve those suffering with substance use disorders (SUDs). As Kathleen Carroll once quipped regarding our field, “The glass would be half full if only we had a glass” (Carroll & Rounsaville, 2006).

At the invitation of the editor I offer here some reflections on the history of addiction treatment along with some suggestions for further growth emerging from research of which I have been privileged to be a part across five decades. My focus is specifically on treatment, having spanned broader swaths of addiction science elsewhere (Heather, Miller, & Greeley, 1991; Miller & Carroll, 2006). As shorthand I use the term addiction generically to refer to the full range of SUDs (American Psychiatric Association [APA], 2013), much as Jellinek (1960) used the term alcoholism.
Evidence-based treatment

From our first reviews of treatment outcome research, Reid Hester and I were struck by the wide gap between science and practice: that what research supported as effective approaches seemed to overlap very little with what was usually delivered in U.S. treatment systems (Miller & Hester, 1980, 1986a). There was no requirement at the time to offer science-based treatments with evidence of efficacy, even though within health care more generally a failure to do so could be grounds for malpractice.

Gradually this began to change with the publication of hundreds of clinical trials and ever-improving research methodology. States started requiring the use of “evidence-based treatment” (EBT) to be reimbursed for service delivery (Miller, Zweben, & Johnson, 2005). The era of “anything goes” in addiction treatment was, it seemed, coming to an end (Miller & Moyers, 2015).

Yet in practice, at least so far, the de facto requirement has been just to say that one is delivering EBT, because services are typically delivered behind closed doors with content that can be difficult to audit (Miller, 2007; Miller & Meyers, 1995). A federally funded National Registry of Evidence-Based Programs and Practices (NREPP) began compiling allegedly science-based approaches for prevention and treatment but set the bar so low—essentially one positive trial regardless of the number of negative trials—that as of this writing the list includes 350 “evidence-based” interventions. Imagine if you had cancer and were handed a list of 350 possible treatments. In other words, the NREPP list is practically useless to consumers and agencies alike in identifying those treatment approaches with the best evidence of efficacy.

In a series of systematic reviews with Paula Wilbourne we evaluated the strength (amount and quality) of evidence for each of 90 different interventions for treating alcohol use disorders (AUDs), eventually encompassing more than 200 clinical trials (Miller, Andrews, Wilbourne, & Bennett, 1998; Miller & Wilbourne, 2002; Miller, Wilbourne, & Hettema, 2003). Treatments ranged from some with strong evidence of efficacy across multiple clinical trials to approaches found in many studies to be ineffective. The good news emerging from these reviews is that there is an encouraging menu of about a dozen treatment alternatives with reasonably strong scientific evidence of efficacy.

Matching clients to treatments

If there is a menu of good treatment options, then how should one go about helping people find the best approach for them? This process is often called client-treatment matching (Miller & Cooney, 1994; Miller & Hester, 1986c) or in statistical terms” attribute by treatment interactions.” Which approach is best for whom? That was the central question in Project MATCH, the largest randomized trial ever conducted with treatments for alcohol problems
The study tested three promising treatments with very different theoretical rationales: 12-Step facilitation, cognitive-behavior therapy, and motivational enhancement therapy. All three yielded similarly positive outcomes at 1 (Project MATCH Research Group, 1997a) and 3 years after treatment (Project MATCH Research Group, 1998a).

The investigator team, highly experienced in clinical practice and research, developed 19 detailed a priori hypotheses about who would fare best in each of the three different therapeutic approaches (Project MATCH Research Group, 1997a 1997b). Only a few of these hypotheses were confirmed at one or more follow-up intervals, and often in an opposite direction from what had been predicted, with the authors acknowledging that “Considering the large number of interactions tested, it is entirely possible that all of the interactions observed may be attributed to chance” (Longabaugh & Wirtz, 2001, p. 306). It seems that even acknowledged experts in alcohol treatment are not much better than chance at predicting what approaches will be best for whom. Similarly, attempts to validate various versions of the widely-used American Society of Addiction Medicine (2001) criteria for matching clients to levels of treatment intensity have found few and chance-level outcome differences between matched and unmatched cases (Angarita et al., 2007; Magura et al., 2003; McKay, Cacciola, McLellan, Alterman, & Wirtz, 1997; McKay, McLellan, & Alterman, 1992; Sharon et al., 2004).

A reasonable alternative is to encourage people to make informed choices from a menu of evidence-based options, as is common in cancer treatment. This assumes the availability of such a range of options rather than a one-size-fits-all approach. It also requires giving people a fair and accurate description of available treatment options along with what is known about their outcomes and possible side effects.

**The limits of horse races**

Hundreds of clinical trials for SUDs have been designed like horse races: line up a stable of two or more presumably different treatments, start them off on equal footing, and see which one wins the race. Whenever bona fide treatments are compared, a very predictable result is no clinically significant difference in outcomes (Imel, Wampold, Miller, & Fleming, 2008; Miller & Manuel, 2008). This can lead to the nihilistic view that the content of treatment is irrelevant and addiction counselors should therefore be allowed to do whatever seems best to them.

There are, however, systematic factors beyond the theoretical rationale of treatment that do substantially affect clients’ outcomes (Miller & Moyers, 2015; Norcross & Wampold, 2011). To dismiss these as “general” or “non-specific” factors is a frank admission that we have failed to do our homework in determining what actually helps clients recover (Duncan, Miller,
Wampold, & Hubble, 2010). For example, simply placing people on a “waiting list” can be pernicious, because the implicit instruction is that they should wait and the expected outcome would be no change until they can be treated. Brief and empowering counseling, even a single session and self-help material, is robustly more effective than no intervention or a waiting list (Apodaca & Miller, 2003; Bien, Miller, & Tonigan, 1993; Harris & Miller, 1990; Miller & Wilbourne, 2002). Rather than just a fact-gathering “intake,” why not offer people something that is likely to help them in the very first contact?

**Therapist effects**

Prominent among determinants of clients’ outcome in addiction treatment is the particular counselor to whom they are assigned. Even if therapists are trained together, closely supervised, and are following a specific treatment manual, there are usually large differences in the outcomes of their caseloads (Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Najavits & Weiss, 1994; Project MATCH Research Group, 1998b). The clients of nine counselors in one clinical trial had positive outcome rates ranging from 25% to 100%, with a 60% improvement rate for clients randomly assigned to a self-help condition (Miller, Taylor, & West, 1980). In a natural experiment clients’ outcomes varied substantially by which of four arbitrarily assigned counselors had treated them, with one caseload growing worse on all measures (McLellan, Woody, Luborsky, & Goehl, 1988).

Nor are these differences among therapists randomly distributed. In a clinical trial of manual-guided behavior therapies for AUDs there were no outcome differences based on the content of treatment. However counselors’ in-session listening skill in accurate empathy (as operationally defined by Truax & Carkhuff, 1967) predicted two thirds of the variance in client drinking outcomes at 6 months, one half at 12 months (Miller et al., 1980), and still one third of the variance in drinking 2 years after treatment (Miller & Baca, 1983). Similarly Valle (1981) found that alcohol relapse rates were 2 to 4 times higher across 2 years of follow-up when clients were treated by therapists with low (vs. high) interpersonal skills as described by Carl Rogers and his students (Truax & Carkhuff, 1967). In a multisite trial, counselors’ pretrial skillfulness in accurate empathy prospectively predicted their clients’ drinking outcomes (Moyers, Houck, Rice, Longabaugh, & Miller, 2015). It matters not just what you do, but how you do it!

**Polydrug use as the norm**

Treatment was once quite segregated for alcohol versus other drug problems. Programs were geographically and often ideologically isolated: a client was either an alcoholic or a drug addict. I recall vividly the organizing meeting in
the early 1970s for an Oregon Substance Abuse Professionals Association. The meeting hall in Bend, Oregon, had an aisle down the middle. On one side sat neatly dressed alcohol counselors, often with crewcuts and ties. Across the aisle were the drug counselors with long hair, jeans, and tattoos. We didn’t speak the same language or attend the same meetings, but it was a beginning.

These days, of course, it is difficult for clinical trials to find clients who use only one chemical, and treatment programs have responded to the population’s poly-drug use by combining alcohol and other drug treatment. This further complicates the evaluation of outcomes, particularly when adhering to a binary relapse model. It is quite possible to quantify the use of multiple drugs (Tonigan & Miller, 2002), but if there are only two possible outcomes—“clean” or relapsed—then where is the dividing line? Does any use of any psychoactive substance constitute failure? If so, how much and for how long?

The problem, I believe, is in the black-or-white thinking about outcomes that is inherent in the concept of “relapse” (Miller, 1996; Miller, Forcehimes, & Zweben, 2011). Few chronic illnesses are treated in this manner. People with asthma or diabetes who turn up in the emergency room are seldom told that they have “relapsed.” Episodes of elevated blood pressure do not constitute failure of antihypertensive treatment. A goal and common pattern in chronic disease management is to have longer spans of remission and to reduce the length and severity of symptomatic episodes. That is also a pattern in alcohol outcomes: gradually longer periods of abstinence interspersed with shorter and less severe episodes of drinking (Miller, Westerberg, Harris, & Tonigan, 1996).

One review summarized 1-year posttreatment drinking outcomes for 8,389 clients across seven clinical trials (Miller, Walters, & Bennett, 2001). On average, 24% of clients had abstained from alcohol throughout 12 months. By binary standards that is a 76% treatment failure rate. Among the drinkers, however, alcohol consumption had decreased by 87% throughout follow-up (from an average of 77 to 10 standard drinks per week). For any other chronic illness, 24% complete remission and an 87% reduction in symptoms for the remainder would constitute dramatic success (McLellan, Lewis, O’Brien, & Kleber, 2000). Why not use more realistic standards than perfection when evaluating outcomes?

**Treatment as usual**

Most of the outcome studies in the above-mentioned review (Miller et al., 2001) did not standardize the content of psychosocial treatment that was delivered. It was treatment as usual or standard care that had yielded such
good outcomes. Nor is there empirical reason to believe that people receiving standardized manual-guided treatment will automatically have better outcomes. In a meta-analysis of 72 outcome studies of motivational interviewing, the effect size when no treatment manual had been used was twice as large as when treatment had been manual guided (Hettema, Steele, & Miller, 2005). At the Albuquerque site in Project MATCH we compared the outcomes of clients enrolled in the MATCH study with those for clients treated during the same period in the same treatment agency (the University of New Mexico Center on Alcoholism, Substance Abuse and Addictions, or CASAA). The latter group of clients were assigned to whichever CASAA counselor was available and received usual care at the discretion of counselor and client. MATCH clients came from the same clinical population but received highly supervised manual-guided treatments. Drinking outcomes for the two groups were virtually identical (Westerberg, Miller, & Tonigan, 2000), averaging 88% reduction in drinking over one year, though the standard care group attended fewer treatment sessions and had somewhat more severe pretreatment drinking.

The National Drug Abuse Clinical Trials Network (Tai, Sparenborg, Liu, & Straus, 2011) has conducted an impressive array of randomized trials comparing standardized treatments with treatment as usual, with both being delivered by the regular clinical staff with the usual clients of front-line community treatment programs. The manual-guided treatments being tested were usually chosen because they had shown efficacy in prior clinical trials. Yet most of these trials have failed to find a clinically (Miller & Manuel, 2008) or even statistically significant advantage of manual-guided treatments over standard care (Miller & Moyers, 2015; Wells, Saxon, Calsyn, Jackson, & Donovan, 2010). It appears that, on average, treatment as usual is a tough standard to beat, at least in programs that participate in clinical trials (Roman & Johnson, 2002). This does not obviate the important influence of other treatment factors (such as therapist effects) on treatment outcome, nor is it justification for “anything goes” in addiction treatment. There are large differences in the weight of evidence for (and against) particular treatment methods (Miller & Wilbourne, 2002; Miller et al., 2003) and some approaches appear to inflict harm (Moyers & Miller, 2013; White & Miller, 2007).

**Diagnostic labels**

Diagnostic labels and criteria have undergone major changes over the decades. Alcoholism and drug abuse were classified as personality disorders in the first two editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA, 1952, 1968). The diagnosis of “alcoholism” was displaced in DSM-3 and DSM-4 (APA, 1980, 1987, 1994) by a distinction between abuse and dependence. There was no substantial evidence, however,
that substance abuse and dependence represented different disorders, and so even this distinction was removed in *DSM-5* in favor of continuously distributed SUDs (APA, 2013).

These diagnostic changes parallel corresponding shifts in public and professional understanding of alcoholism. The early binary “disease concept” of alcoholism (Milam & Ketcham, 1984; Moyers & Miller, 1993) provided a satisfying remedy to the cognitive dissonance that followed the U.S. repeal of prohibition. During prohibition alcohol education had emphasized the harms of drinking as medically damaging, potentially lethal, and difficult to control. Then in 1933 alcohol was again made freely available. It was an appealing solution (particularly to the alcohol industry) to conclude that it was only certain unfortunate individuals who are at risk: alcoholics, who are qualitatively different from other people who can drink as they please with impunity. The logical course then was to identify these rare individuals and persuade them to accept that they are alcoholic and incapable of drinking at all. Treatment thus began placing a premium on “admitting” one’s alcoholism or drug addiction, although Bill W., the cofounder of Alcoholics Anonymous, advised against imposing this label on other people (AA World Services, 2001; Miller & Kurtz, 1994).

In spite of a “quest for the test” and a plethora of screening instruments (e.g., Selzer, 1971) research failed to reveal any qualitative distinction or characteristic personality or defense mechanisms of “alcoholics.” Alcohol instead emerged as a public health issue much like smoking (Babor et al., 2010; Institute of Medicine, 1990), and even the distinction between “abuse” (or problem drinking) and “dependence” (or alcoholism) turned out to be an arbitrary cut-point on continuously distributed dimensions of use and impairment (Miller et al., 2011). There is growing public and professional awareness that alcohol is a danger for anyone who uses it immoderately or in hazardous situations (Babor et al., 2010).

**Moderation goes mainstream**

With increasing awareness of drinking as a public health issue, U.S. per capita alcohol consumption decreased by one half from a mean of 20 standard drinks per week in the 1960s (Cahalan, 1970) to fewer than 10 in the first decade of the 21st century (LaVallee & Yi, 2011). Physicians are now urged to assess their patients’ frequency of heavy drinking and counsel them to reduce their consumption (National Institute on Alcohol Abuse and Alcoholism, 2005; Whitlock, Polen, Green, Orleans, & Klein, 2004). Even alcohol manufacturers urge customers to use their products “responsibly.”

Effective treatment and self-help strategies for moderating alcohol use have been available for decades (Bien et al., 1993; Hester, 2003; Miller & Muñoz, 1976, 2013; Sanchez-Craig, 1980) but have been slow to find their
way into the U.S. continuum of care. Up through the 1980s American treatment for alcohol/drug problems almost exclusively focused on dependence and required clients to accept a goal of total and lifelong abstinence from psychoactive substances (with the notable exception of tobacco). This was linked in part to the postprohibition disease concept that moderation was either impossible (for alcoholics) or unnecessary (for normal people). At least 35 clinical trials of behavioral self-control training and 48 of brief interventions have yielded ample evidence that it is possible to help heavy drinkers moderate their alcohol use (Miller & Wilbourne, 2002). Perhaps more importantly, research indicates that moderation is a feasible goal for people with less severe alcohol use and problems, whereas in moving up the scale of severity, abstinence emerges as the more stable outcome (Miller, Leckman, Delaney, & Tinkcom, 1992). The relative feasibility of each goal can be evaluated via at least two assessment instruments: the Michigan Alcoholism Screening Test and the Alcohol Dependence Scale (Miller & Muñoz, 2013). For some, moderation is the more likely outcome; for others with higher severity, abstinence is the better choice. Why not address the full continuum of alcohol problems rather than focusing only on those most impaired (Institute of Medicine, 1990)? My early interest in moderation strategies was to intervene farther upstream before drinking engenders worse consequences. That appears to be precisely where such strategies are useful, in targeted or indicated prevention.

An unexpected finding in our longer-term follow-up (Miller et al., 1992) was that many of those who came to us for help in moderating their alcohol use had actually stopped drinking, and not for the expected reason. One might anticipate that they would try moderation, fail, and thus conclude that they had to abstain. Instead these were people who did get their drinking down to a moderate level and then told us one or both of two things: (1) “This is really hard! I feel like I am on a tightrope and could fall off at any time” and (2) “What’s the point in drinking so little?” Thus they decided that it simply wasn’t worth all the work to drink moderately. Incidentally, if they did then drink after a year or two of abstinence, we found that it was typically one or two drinks for a day or two, then back to long-term abstaining. It reminded me of these words from Bill W’s “working with others” (AA World Services, 2001):

Be careful not to brand him as an alcoholic. Let him draw his own conclusion. If he sticks to the idea that he can still control his drinking, tell him that possibly he can – if he is not too alcoholic. (p. 92)

Concomitant disorders as the norm

“Dual diagnosis” was once thought of as a small and special subpopulation: those having a SUD as well as a diagnosable mental disorder. What has since become apparent is that SUDs seldom occur alone but are usually
accompanied by other psychological and/or medical problems. In the early days of addiction treatment these were thought to be secondary consequences of alcohol/drug use that would recede with abstinence. Indeed, concomitant problems often do improve when people stop or reduce their drinking (Miller, Hedrick, & Taylor, 1983). It is also clear, however, that not all problems are secondary to addiction; they can also persist or worsen as substance use is addressed. Mood and thought disorders, anxiety and personality disorders, learning and attentional disorders, neuropsychological problems, family conflict, sleep, and sexual disorders all occur at elevated rates among people with addictions.

A somewhat unique American problem is that we have trained a generation of addiction counselors who have been prepared only to treat SUDs. Yet it is increasingly clear that integrated treatment of concomitant disorders is the preferred approach, rather than referring people back and forth between addiction and mental health services and arguing about which should come first (Mueser & Drake, 2007; Mueser, Drake, Turner, & McGovern, 2006). In a career of treating addictions one may encounter the entire DSM. This trend toward integrated treatment is reflected in the concept of “behavioral health” professionals who are prepared to address a broad spectrum of psychosocial problems.

**Integrated care systems**

A related aspect of addiction treatment in America has been its segregation from mental health and health care services more generally. Mainstream mental health and medical professionals have often been given the impression that addiction is “not my problem” and should be referred out for treatment in specialist clinics that are isolated socially, politically, and often geographically from other health services. Health professionals often receive very little training in how to treat SUDs even though these constitute the second-most-common mental health diagnosis (after depression) and commonly present with a host of concomitant medical and mental health problems (Miller & Brown, 1997; Miller & Weisner, 2002).

A sea change in this segregation is occurring as providers are being encouraged not only to screen for but also to treat SUDs within the context of health care (Blount & Miller, 2009; Butler et al., 2008). This can be done directly through brief interventions by nurses and physicians (E. Bernstein et al., 2009; J. Bernstein et al., 2005; Fleming & Manwell, 1999; Senft, Polen, Freeborn, & Hollis, 1997) or perhaps more feasibly by colocating behavioral health providers in medical settings (Ernst, Miller, & Rollnick, 2007). The availability of effective pharmacotherapies has also increased the feasibility of managing SUDs in medical clinics (Garbutt, 2009; O’Malley & Kosten, 2006; Pettinati et al., 2004). Most people with SUDs never darken the door of a...
specialist treatment program but do appear regularly in health care, social service, mental health, and correctional systems. It makes sense to be treating addictions where they are most likely to be found (Miller & Weisner, 2002).

**Acute treatment**

Although widely recognized as a chronic condition, SUDs have often been treated as if they were acute illnesses. In the 1970s and 1980s it was common to treat alcohol problems in inpatient or residential settings of 28 days’ duration. Any incident of substance use following a treatment episode was regarded to be a relapse (Miller, 1996). Yet there are no 28-day treatment programs for diabetes, heart disease, asthma or hypertension, and the recurrence of symptoms of a chronic illness is seldom dismissed as patient failure. SUDs are, in essence, the sole “chronic disease” for which there has been only specialist care, no ongoing primary care (McLellan et al., 2000).

Given that about three fourths of clients have a recurrence of use after any particular treatment episode, it would seem more appropriate to think of ongoing monitoring and case management with stepped-care treatment as needed, as is common in managing other chronic conditions (Alexander, Pollack, Nahra, Wells, & Lemak, 2007; Kakko et al., 2007; Sobell & Sobell, 2000). It would also be appropriate to dispense with vestiges of an acute care model such as a “graduation ceremony” that implies that treatment has been completed.

Studies have long reflected no aggregate difference in client outcomes from more intensive (such as inpatient or residential) versus less intensive (such as day treatment or outpatient) treatment settings for adults (Alterman et al., 1994; Miller & Hester, 1986b), and as discussed above attempts to identify patient correlates of differential success at different levels of intensity have borne little fruit. There is enduring consensus that “aftercare” (i.e., outpatient treatment and mutual help groups) is crucial following a residential treatment episode (Ito & Donovan, 1986), but the very term aftercare is a remnant of an acute care model and implies that the “real” treatment has already happened. Residential treatment remains a useful part of a continuum of care, but it is not a place to start unless there is some other persuasive reason for intensive supervision such as suicidality or acute medical or psychiatric illness. If anything, a period of residential treatment constitutes a form of “fore-care” stabilization after which the ongoing work of recovery and maintenance begins in the community (Miller et al., 2011).

**Motivation for change**

Client motivation for change is widely acknowledged as a crucial factor in treatment and recovery. Prior to the 1980s it was largely assumed that low
motivation was the client’s deficiency, and people were sometimes told, “Come back when you’re motivated” or “You haven’t suffered enough yet. We’ll see you when you hit bottom.” A breakthrough on this issue was the emergence of the trans-theoretical model of change (Prochaska & DiClemente, 1984), the best-known aspect of which is its stages of change. A key insight of this model is that clients need different things from providers depending on where they are in the change process. Most treatments had assumed readiness for change (the action stage) as a prerequisite. The revolutionary shift was to see facilitating readiness for change as an important part of the provider’s job. When people are ambivalent about change (contemplation stage) they need help resolving that ambivalence in the direction of change. Charging directly into action-focused interventions is likely to evoke resistance when someone is ambivalent. Motivational interviewing (MI) fit with a trans-theoretical perspective precisely because it was designed to promote readiness for change, helping people advance from contemplation to preparation and action (DiClemente & Velasquez, 2002).

An early surprise in our research was how often MI appeared to be sufficient to trigger a significant change in drinking (Miller, Benefield, & Tonigan, 1993; Miller, Sovereign & Krege, 1988). Comparisons of MI-based interventions with longer treatment alternatives have usually yielded similar outcomes (Hettema et al., 2005; UKATT Research Team, 2005). Combining MI with other active treatments, however, often yields an enduring additive effect (Bien et al., 1993; Brown & Miller, 1993; Hettema et al., 2005), perhaps by increasing treatment retention and adherence. A combined approach like this seems more sensible than a horse race pitting treatment approaches against each other (Anton et al., 2006; Longabaugh, Zweben, LoCastro, & Miller, 2005).

MI also represents a fundamental shift in helping roles (Miller & Rollnick, 2013). Addiction treatment of the 20th century was often highly authoritarian, working from a deficit model that people lacked insight, skills, knowledge, reality, or wisdom that had to be installed by the experts. MI is about evoking from people their own expertise about themselves, their own wisdom and motivations for change. It involves a shift from “I have what you need and I’m going to give it to you,” to “You have what you need and together we’re going to find it.”

**Spirituality and addiction**

For much of the history of psychology, psychiatry, and other mental health professions, religion was a taboo topic derided by vocal critics from Sigmund Freud (1928/2010) to Albert Ellis (1988). It is no coincidence that my own publications on spirituality and psychology did not begin until after the year I received academic tenure. Clinicians could ask clients about their sex life,
money, fantasies, family secrets, emotions, irrational beliefs, and drug use but never about their religion. Spirituality has since become a more acceptable subject among American psychologists, who nevertheless remain far less religious than the people they serve (Delaney, Miller, & Bisono, 2007). The august American Psychological Association now publishes volumes on spirituality (Miller, 1999; Richards & Bergin, 1997) and religion (Miller & Delaney, 2005; Shafranske, 1996).

At least in the United States, addiction treatment is one field in which spirituality never got lost, largely because of the 12-Step programs (AA World Services, 2001). In Alcoholics Anonymous as in psychology a difference is often emphasized between spirituality and religion, a distinction that would have been alien to William James (1902). Studies do support an inverse relationship between spiritual/religious factors and addiction. Religiousness predicts lower risk for current and future SUDs (Miller, 1998, 2003) and spiritual changes are associated with recovery from addiction (Jarusiewicz, 2000; Kelly, Stout, Magill, Tonigan, & Pagano, 2011; Robinson, Cranford, Webb, & Brower, 2007).

Although there is wide acknowledgment of the importance of spirituality in recovery, few treatment programs employ religiously trained professionals or place much emphasis on spiritual development except to encourage 12-Step meeting attendance. Two randomized trials did evaluate the impact of spiritual direction when added to addiction treatment (Miller, Forcehimes, O’Leary, & LaNoue, 2008). Clients in a residential program who agreed to participate were randomly assigned to receive or not receive counseling from a professional spiritual director in addition to standard care. We predicted that spiritual direction would yield changes on spiritual measures that in turn would be associated with decreased substance use. In fact, neither occurred. In retrospect we realized that these people were down at the bottom of Maslow’s (1943) hierarchy of needs, concerned about food, housing and safety, whereas our intervention was focused up at the top of the hierarchy: spirituality and meaning. Perhaps after stabilization of sobriety and case management to address immediate concerns there would be opportunity to focus on spiritual practices. As it was, we were on Step 11 (“Sought through prayer and meditation to improve our conscious contact with God as we understood God, praying only for knowledge of God’s will for us and the power to carry that out”) and not attending to our clients’ immediate needs. Acute treatment intervention is a limited model for addressing both addiction and spirituality.

**Reasons for humility**

One way of summarizing what I have learned over 40 years working in this field is that we have ample reasons for humility. Most recovery happens without any professional treatment. A cherished therapeutic approach does
not turn out, on average, to yield superior results when compared with other treatments. We are no better than chance at predicting which treatment approach will be best for our clients. Often people may need far less therapeutic help from us than we think they do. And the effectiveness of what we do appears to depend more on how we relate as people than on the content of the treatment manual we keep on the shelf. These learnings also point to ways in which we might better serve people with addictions.

**Directions for growth**

Drawing together the developments and learnings discussed above, here are some recommendations for how treatment for addictions might be improved in the decades ahead. It is a progress report based on what is known from research so far, necessarily subject to revision as new knowledge emerges.

**Evidence-based care**

As we learn more about what treatment approaches offer the most promise, it is appropriate to expect that this knowledge will be reflected in practice. This is what we expect in health care more generally, and given the volume of research available it is not plausible to argue that we do not yet have enough science to guide practice. The blessing of an approved list of brand-name treatment methods is a very limited and problematic way of accomplishing this. “What works” should encompass therapeutic relationship and systemic factors (like waiting lists) as well as addressing obstacles in access to care. Clinical research should move away from simplistic horse race trials toward identifying what actually promotes change.

It is a reasonable and testable question whether retraining current clinical staff in newer treatment methods is a cost-effective way to improve client outcomes (Miller & Moyers, 2015). A reasonable step forward would be to train the next generation of behavioral health providers from the outset in addiction treatment approaches with the best evidence of efficacy.

**A menu of options**

Treatment cannot be individualized when only one approach is available. An analogy would be a cancer treatment system that offers only radiation. Providing a range of treatment options requires having staff who are properly qualified and trained to deliver them. Within a single program this may mean hiring staff with varied expertise in evidence-based treatment methods. A larger menu of options may be possible within a community treatment system comprised of multiple programs (Martin, 1995).
Given our demonstrably limited wisdom about what treatment is best for whom, a reasonable approach is to provide clients with a fair and accurate description of the options that are available and to help them make an informed choice, a process termed “shared decision making” in medicine. Given a natural bias for programs and providers to recommend their own services, one possibility is a “core/shell” model with an independent assessment and referral service to help clients consider their options (Martin, 1995; Pierce, 1995).

**A continuum of care**

Most disorders are easier to treat at earlier stages of development. Yet services, at least in the United States, have been focused primarily on the severe end of spectrum of SUDs, in part because of the isolation and stigmatization of specialist treatment programs. “Broadening the base” of treatment (Institute of Medicine, 1990) involves screening and early detection of emerging problems (indicated prevention) and offering an appropriate continuum of services. Screening for at-risk drinking and drug use in health care services is a good start. The same can be done in other social service and correctional settings where earlier detection is feasible.

Such broader screening also involves moving away from a binary (yes or no) model of detection toward risk assessment. Cut-points for diagnosing hypertension and diabetes have decreased over the years, recognizing that blood pressure and glucose are continuously distributed and any cut-point is somewhat arbitrary. People one point above the cut-point are not very different from those one point below it. The practical question is when and what treatment is appropriate.

As discussed earlier, drinkers with lower levels of consumption and dependence are more likely to stabilize with moderation than with lifelong abstinence. Targeted and indicated prevention of AUDs should include moderation-oriented interventions within the menu of options, and these need not be limited to formal treatment. Brief interventions and some self-help materials (“bibliotherapy”) have been shown to reduce alcohol use and risk. Counseling for moderation is uncontroversial in primary care but is less often available within specialist treatment.

A stepped care approach is also sensible, starting with interventions that are least intrusive, disruptive, and expensive. This again is common practice in treating chronic medical conditions. Brief intervention, motivational interviewing, and self-help materials may be enough to trigger change. If not, a continuum of care provides other options for stepping up intensity of treatment.

Finally, we need to shed acute-care thinking. Addressing SUDs is a process that occurs over time, as is the case with chronic illnesses. An episode of
specialist treatment is usually insufficient and should not be thought of as a completed course of care. Monitoring, case management, stepped care, and an open door for ongoing consultation should be the norm.

**Fidelity of care**

People cannot benefit from a treatment to which they have not been exposed (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). A hard lesson from my clinical research was that therapists do not necessarily deliver the treatments they say or believe they are providing. Even with thorough training in an evidence-based approach there is large variation in fidelity of practice. In a variety of evidence-based treatments, fidelity of practice matters and predicts outcome (e.g., Miller & Rollnick, 2014). Yet if practice is unobserved, there is little chance to reliably assess fidelity.

Quality assurance thus means bringing treatment out of the closet, out from behind closed doors (Miller, 2007). Accountability is only one reason for doing so. Fidelity of practice generally improves client outcomes. Furthermore, practice in isolation restricts feedback that is vital to clinician learning and practice improvement. For skill development in motivational interviewing we have been encouraging the development of collaborative learning communities where practitioners meet to observe each other’s practice with the sole goal of getting better at what they do (Miller & Rollnick, 2013).

**Integrated Care**

There is already a trend toward delivering addiction treatment within the context of ongoing health care, through interventions by medical staff (such as brief counseling, motivational interviewing, or pharmacotherapies) and via colocation of behavioral health providers in medical settings. Treatment for substance use and other behavioral health problems should also be integrated within mental health, social service, and correctional settings. The sheer prevalence and concomitance of SUDs in these settings are reason enough. It follows that preparation to competently assess and treat SUDs should be a routine part of mainstream training in medical and behavioral health professions.

**Holistic care**

Patient-centered care and the “medical home” movement encourage providers to treat people, not disorders. Although one need not explore every aspect of clients’ lives, effective treatments for SUDs often address far more than substance use. The community reinforcement approach, for example, focuses on family, social skills, and developing a drug-free life that is too good to give up (Meyers & Miller, 2001; Meyers & Smith, 1995). Treating
clients as whole people includes at least openness to their spirituality, which can be central to their identity and relevant in recovery (Toni, Toscova, Connors, & Miller, 1999).

**Providers of care**

Addiction treatment is not solely a matter for specialists, but a concern to be addressed by health care providers more generally. Some additional knowledge is needed by generalists (Miller et al., 2011), but most health professionals will be seeing many people with SUDs throughout their careers, regardless of their preparation to recognize and treat them.

But what of specialist providers? One implication of research to date is to screen for and hire professionals who already show a high level of skill in accurate empathy, in the ability to listen to, accept, and understand their clients. It is an evidence-based practice. High-empathy providers have better outcomes, and low-empathy providers have worse outcomes in addiction treatment (Moyers & Miller, 2013). Accurate empathy is a learnable skill that can improve with practice, but we have found it far easier to hire clinicians who already have a reasonable level of skill than to teach it afterward (e.g., Miller, Moyers, Arciniega, Ernst, & Forcehimes, 2005).

**Obstacles to care**

McLellan (2006) averred that treatment should ideally be perceived as “attractive, easy to access, potent, rapid, and delivered at a price that is affordable” (p. 291). We have a long way to go for this to be an accurate public perception of addiction treatment. Besides tinkering with the content and providers of treatment, however, there are structural aspects of care that could be changed to move in this direction.

One example is the “waiting list” in many public service systems. Common practice has been to conduct a fact-gathering “intake” and then ask people to wait for weeks or months until they can be seen for treatment. Often a relatively small percentage of people make it through the intake gauntlet and waiting period. Achieving treatment on demand would require a huge infusion of resources, but there is at least a better alternative than telling people to wait. Why not offer them something immediately that is likely to benefit them in the very first contact? That way, even if they do not return they have received a helpful service. An intake can gather whatever minimal information is essential, but begin with an open invitation: “After a while I will need to ask you some questions that we ask everyone, but first tell me something about what is happening and how you hope we might be able to help.” A half hour of quality listening and MI may yield more information than a list of questions and can strengthen motivation for change.
Then a second component is to communicate that the client does not just have to wait. What steps might this person take to get started on the road to recovery? There are research-based bibliotherapy materials that can offer self-help guidelines (Apodaca & Miller, 2003). 12-Step and other mutual help groups are probably available. The message is one of activation and empowerment rather than implying that nothing can happen until “treatment” begins. The delayed consultation thus becomes not passive waiting, but a follow-up consultation: “We’ll check back with you in ___________ and see how you’re doing, then take it from there.” In our earliest studies we assumed that people would be disappointed when assigned to a self-help bibliotherapy, and some were, but just as often they were pleased that there were things they could do on their own and by the time we saw them again (8–12 weeks later) they had, on average, managed as much change in drinking as those who had been treated immediately.

**Collaborative care**

Whenever you sit in counseling with someone there are two experts in the room. You have some potentially helpful expertise by virtue of your training, experience, and keeping up to date on new developments in addiction treatment. When what is needed is a change in the person’s lifestyle and behavior, however, no one knows more about your clients than they do themselves. They have a lifetime of experience in what works for them and how to manage change. Research shows that one of the best predictors of successful counseling is deep, empathic listening with acceptance and respect for the person’s own wisdom—precisely what Carl Rogers and his students were teaching half a century ago. Why listen? Because the answers are already there within your clients and your task is to call them forth. Addiction treatment is necessarily a partnership of expertise, a collaborative process of finding together (rather than prescribing) what works. This also lifts a burden from your shoulders. You don’t have to make people change. In truth, you can’t. You don’t have to come up with all the answers. The person who has them is sitting right there across from you.

**References**


