



INSIDE REHAB

THE SURPRISING TRUTH ABOUT
ADDICTION TREATMENT—AND HOW
TO GET HELP THAT WORKS

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NEW YORK TIMES BESTSELLING
AUTHOR OF
SOBER FOR GOOD

Sober for Good: New Solutions for Drinking Problems—Advice from Those Who Have Succeeded Thin for Life: 10 Keys to Success from People Who Have Lost Weight and Kept It Off Thin for Life Daybook: A Journal of Personal Progress Eating Thin for Life: Food Secrets & Recipes from People Who Have Lost Weight & Kept It Off Weight Loss Confidential: How Teens Lose Weight and Keep It Off—and What They Wish Parents Knew Weight Loss Confidential Journal: Week-by-Week Success Strategies for Teens from Teens

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For all of the people who so selflessly contribute to my books

And in memory of Dr. Alan Marlatt, who encouraged and inspired me to write about addiction and recovery

Just because it is written in stone it does not mean it cannot change.

—*On a stone outside a rehab dormitory*

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NOTE TO READERS

The ideas, procedures, and suggestions contained in *Inside Rehab* are not intended to be a substitute for consulting with a physician, mental health professional, and/or credentialed substance use disorder treatment professional in dealing with any kind of drug or alcohol problem or any underlying psychiatric conditions, such as depression or anxiety. Neither the publisher nor the author is engaged in rendering professional advice or services to the individual. Anyone who has been overusing alcohol or drugs consistently should consult a physician and/or consider going to a professional detoxification unit or a hospital emergency department before giving up drugs or alcohol completely. Neither the author nor the publisher shall be liable or responsible for any harm, loss, or damage allegedly arising from any information or suggestion in this book or omitted from this book.

The names and, in some cases, identifying details of people who shared their stories about their drug and alcohol problems have been changed. Some remarks that are in quotations were edited slightly for clarity. Most of the information in this book was gathered over the course of the years 2009–12, and some information, such as any particular facility's rehab policies and procedures, may have changed since that time. While an effort was made to provide a comprehensive picture of the nature of and possibilities for substance use disorder treatment, this book does not cover every aspect of treatment or every type of program.

Readers should bear in mind that some programs operate multiple sites and that statements about a particular facility may not apply to other facilities in the same program. The rehab stories collected for this book involve many more than those from programs the author visited. Information about programs other than those the author visited is largely taken from interviews with clients who attended those programs and/or staff members who are currently or were previously employed at such programs. The experiences of any one person may or may not be representative of the experiences of others who attended the same facility. Praise or criticism of one aspect of a program should not be construed as a representative view of the entire program.

Because of the possibility of post-publication developments in behavioral, mental health, and medical sciences, readers are encouraged to confirm the information in this book with other reliable sources. Neither the publisher nor the author vouches for the value, merit, or accuracy of any of the outside resources (books, articles, Web sites, etc.) mentioned in *Inside Rehab*, nor are they responsible for the use of any information or advice found in any of these outside resources. For the resources discussed in this book, the author has made every effort to provide accurate telephone numbers and Internet addresses at the time of publication, but neither the publisher nor the author assumes any responsibility for errors or for changes that occur after publication.

WHAT'S WRONG WITH ADDICTION TREATMENT? WHAT WILL HELP?

AN INTRODUCTION TO *INSIDE REHAB*

Inside Rehab is filled with disturbing accounts of seriously addicted people getting very limited care at exhaustive costs and with uncertain results—but in my experience, they are accurate accounts. Indeed, my research on addiction treatment programs suggests that this discouraging picture may even underestimate the conceptual and procedural problems in this very distressed but essential treatment system. But how did it get this bad?

There has never been a question that alcohol and other drug addictions are immense problems for society. The question instead was always, Just what kind of a problem is addiction—and who should manage it? Because the stereotypical “drunk” or “junkie” was often seen as violent, a liar, a thief, and in general disruptive of family and social life—problems that were viewed as moral or lifestyle failings—addiction was addressed by laws, social sanctions, and moral teachings. But when unparalleled numbers of America’s veterans returned from service with drug and alcohol problems after the Vietnam War, it became politically untenable simply to punish these young addicts. In the early 1970s a national addiction treatment system was called for. Few physicians or nurses knew much about addiction medicine—there was very little to know. Almost no scientific research on the origins of alcohol or other drug addiction was available upon which to develop treatment. Instead, the treatments were derived from the earnest efforts and experiential wisdom of those who had overcome their *own* addictions and were willing to help others. The Minnesota model of residential care that has grown out of do-it-yourself treatments offered at “Hazelden” (the name of the farm property on which Hazelden’s main campus now stands) several decades earlier proliferated at rehabs across the country, and “therapeutic communities” employing ex-addict counselors grew in number.

Perhaps most significant, the addiction treatment system was purposely designed as a segregated system—separated financially (through funding largely with government block grant dollars, not medical insurance), culturally, and often physically from the rest of general health care. (The Veterans Administration was an important exception because its general health care, addiction treatment, and mental health care have long been integrated.) That segregated system grew into today’s network of over thirteen thousand addiction “programs”—still largely isolated from the rest of medicine and health care; still largely financed by separate protected dollars; and still largely distinct in terms of the types of interventions applied and the professional providers involved. Like other segregated systems, it is loaded with stigma. Few addicted individuals (about 10 percent) are willing to enter care. Drop-out rates are high. And among treatment completers, one-year relapse rates are 40 to 60 percent. The public deserves more and our society desperately needs reliably effective care.

Addiction has not been the only segregated illness, however. Many “conditions,” including depression, polio, and tuberculosis, were not recognized as medical illnesses and have only recently been taught in most medical schools and treated by physicians. They were seen as “lifestyle problems” and care was typically provided by concerned, committed individuals or institutions not well connected to mainstream health care. Tuberculosis provides an instructive case. While TB had long been considered a serious threat to the health and safety of most societies, science had not developed to the point where it could explain the causes or the course of the illness. Those with “consumption”

were offered the treatments of fresh air, nutritious food, and relaxation in sanatoria under the view that this “lifestyle problem” would benefit from those healthy conditions. By 1935 there were more than fifteen thousand sanatoria in the United States. In fact, this type of care—though based upon inaccurate conceptions of the disease—often produced recovery, particularly among those who were otherwise healthy and in whom illness was detected early. Thus it was seventeen years before TB was recognized and treated by many traditional physicians and health-care facilities as a bacterial disease and labeled as such in medical textbooks. The parallels with contemporary addiction treatment are hard to ignore.

Thanks to four decades of NIH-sponsored research there is a new foundation for the treatment of addiction. This science now suggests that addiction is best considered a chronic illness. As in other chronic illnesses, a still incompletely understood combination of genetic and environmental risk factors combined with risky personal behaviors—particularly repeated drug use itself—produce the chronic illness of addiction. Most scientists agree that the genetic, brain, and behavioral changes associated with addiction do not appear to be completely reversible—like other chronic illnesses, in most cases of severe addiction can be managed, but not cured, with continuing care. But as revealed by Anne Fletcher’s research in *Inside Rehab*, continuing care according to a chronic care model is very hard to find—and there are still few insurance plans that support such evidence-based treatment.

This divide between what we know about the genesis and development of addiction, and how we insure, treat, and evaluate it cannot last. As was the case in tuberculosis treatment, addiction science has advanced, and both the public and policy makers are becoming more informed and aware. Ultimately, the insurance and treatment systems will meet the new scientific understanding and the new public demand. Addiction treatments in the near future will build upon the emerging science and will borrow from advances in disease management practices, team treatment methods, tailored treatment planning, and continuous patient monitoring that are now common in the management of other chronic illnesses. Group counseling, individual counseling (hopefully, more of it than we see now), and recovery support groups will likely remain key elements of future addiction treatment because they are economical and effective methods for changing and maintaining a recovery lifestyle. But these good old-fashioned elements of addiction treatment are likely to merge with greater use of currently approved and to-be-developed medications, remote telemonitoring of blood drug and alcohol levels, continuous patient contact outside of clinic settings, and marital and family therapy, as well as team-based disease management to foster treatment adherence and forestall relapse. And thanks to health-care reform legislation, the great majority of addiction treatment—as well as prevention and early intervention for less severe substance use disorders—is expected to be reimbursed by health care insurance. As in the case of treatments for polio, depression, and tuberculosis, addiction treatment will become integrated into conventional medical and nursing education and into mainstream health care.

In closing I admit that it was personally difficult for me to read about the problems within this distressed field that Anne Fletcher has documented so carefully in *Inside Rehab*. I have made my income and professional identity from work in the addiction treatment field. More important, I owe the lives of several of my family members to very fine addiction treatment. My deepest regrets to this day are that even as an expert in this field, I was not able to get my brother or son into the kind of treatment that could have saved their lives. But as you will see as you read *Inside Rehab*, addiction treatment must change and it *can* change. My hope is that the important information provided in this book promotes public demand for the kind of effective addiction treatment that now is well within reach.

A. Thomas McLellan, PhD, CEO and Co-founder

REHAB NATION

THE QUESTIONS AND THE ISSUES

Lindsay and Britney have been there, along with Robin Williams, Robert Downey Jr., Charlie Sheen, Eminem, a former Miss USA, Mel Gibson, Congressman Patrick Kennedy . . . and the list goes on. Rehab seems to be the place where celebrities and politicians go when they mess up, not only to “get clean” from whatever addiction ails them but, sometimes, in an attempt to change their public personas from ne’er-do-wells to helpless victims.

Media and public interest in addiction, drugs, and rehab is fervent, fueled by accounts of famous people yo-yoing in and out of celebrity programs, along with sensational stories of untimely deaths caused by prescription drug abuse, a number of which, sadly, took place during the writing of this book. That, and the popularity of reality shows on addiction interventions and “celebrity rehab” all indicate that a lot of people want to know what really goes on inside addiction treatment programs—sometimes in a voyeuristic way, but more often for compelling personal reasons.

It seems to be accepted as fact that when someone is struggling with addiction, we should simply send him or her away to a place to “get fixed” by a team of experts. But does the view of addiction treatment we get from TV shows and movies provide an accurate picture of what happens when most people go in for help? Is the rehab to which wealthy and famous people flock much like the rehab available to the general public? And are most people with serious addictions likely to “get fixed” from a month-long stint in rehab? As *Inside Rehab* will demonstrate, the answer to all three questions is a resounding No.

• • •

Why *Inside Rehab*?

My desire to write a book on rehab was kindled by a shocking front-page story titled “The Treatment Myth” that ran in the *Minneapolis Star Tribune* shortly after I’d moved to Minnesota from the East Coast in 1993. As someone who had personally struggled with a drinking problem, I was immediately drawn to the subheadings of the four-page feature: “Chemical dependency programs exaggerate their success rates”; “Treatment has little scientific support”; “For many clients it’s a revolving door”; “Even an elite treatment program has many failures.” As I found in researching this book, the current treatment system continues to suffer from many of the issues that were documented in this article.

I recall thinking at the time that at some point I’d like to write a book about all of this, and I did go on to write a book that challenged many myths about overcoming addiction: *Sober for Good: New Solutions for Drinking Problems—Advice from Those Who Have Succeeded* (Houghton Mifflin, 2001). It is about the many different ways people achieve long-term sobriety and personal guidance for recovery rather than rehab for addiction.

After the publication of *Sober for Good*, my interest in drug and alcohol rehab grew as I got to know A. Thomas McLellan, PhD, cofounder of the Treatment Research Institute (TRI), a group dedicated to conducting studies to evaluate what works in addiction treatment, and why. I

periodically call him to find out about developments in the field. Much of what he shared was appalling. “If you’ve seen one rehab, you’ve basically seen all of them. Yes, there are exceptions, but of the many thousands of treatment programs out there, most use exactly the same kind of treatment you would have received in 1950, not modern scientific approaches. Counselor training is impoverished, and staff and director turnover in these programs is higher than in fast-food restaurants.” Of the rehab consumer, Dr. McLellan said, “When it comes to picking a rehab, most people ask more questions before buying a vacuum.” In 2009, McLellan became deputy director of the Office of National Drug Control Policy, or what’s commonly known as the “deputy drug czar” for the Obama administration, but has since returned to be president and CEO of TRI.

Early in this book’s writing, I spoke with the late renowned Alan Marlatt, PhD, former director of the Addictive Behaviors Research Center at the University of Washington in Seattle. Our conversation made me realize that it’s not unusual for addiction experts themselves to be in the dark about what happens inside the walls of treatment centers. Amid the media frenzy over one of Lindsay Lohan’s early trips to rehab, *People* magazine interviewed Marlatt, who later told me, “This reporter called and one of the first questions he asked me was, ‘How can we find out what goes on inside these places?’” The truth is that even Dr. Marlatt didn’t know.

When people I cared about were struggling with addictions, I’d also faced frustrations in seeking treatment that was effective, affordable, and timely. Most people simply know little or nothing about the extensive range of rehab and recovery options, the uneven quality across treatment programs, and the big-picture problems within the addiction treatment infrastructure in the United States.

Through visits to programs, stories of people who went to rehab, and interviews with experts, *Inside Rehab* explores the strengths, weaknesses, and current state of the addiction treatment industry in the United States. More specifically, the goals of the book are:

- To give consumers a realistic picture of what goes on when a person goes to residential or outpatient rehab
- To uncover myths and facts about addiction treatment in the United States
- To address problems and issues faced by people in rehab and by the treatment industry itself
- To provide a guide to different types of treatment and ways to recover
- To inform consumers about science-based practices that *should* form the basis of addiction treatment and to spotlight programs and professionals using those practices
- To provide guidance for finding quality treatment

GETTING THE INSIDE STORY

To get a firsthand picture of what really goes on inside rehab, I visited fifteen addiction programs—from so-called celebrity rehabs to the outpatient options available to most people—in different parts of the country. “Rehab” usually refers to residential programs in which the traditional stay is about a month (unlike outpatient treatment, where people typically go multiple times a week to group sessions lasting several hours during the day or evening). For the purposes of the book, I use the word “rehab” to describe all types of addiction programs. After all, the goal, regardless of where you go, is rehabilitation from drug and/or alcohol problems. (For more on the different types of rehabs, see [chapter 2](#).)

At most of these programs, I was able to get a close-up view of what treatment is like by attending group counseling sessions, sitting in on individual client* appointments with counselors, and/or participating in activities such as relaxation exercises. In so doing, I promised to protect the privacy of clients. My visits focused on primary or “phase one” care, which refers to the first stage

treatment, typically about a month at a residential rehab and variable but often longer at an outpatient program. (~~Extended and continuing care refer to subsequent phases of treatment, and are discussed in~~ [chapter 9](#).) My goal from the visits was to get an overall, day in, day out picture of what went on in each setting—to see for myself what different types of programs are like, to find out if things I had heard were true, and to answer my many questions.

I also spent countless hours reading questionnaires completed by and interviewing more than one hundred current or past program administrators, staff members, and other clinicians from various programs and practices across the country, many at the places I visited. I read scientific studies on what works best for recovery and frequently queried leading experts in the field, particularly those who study addiction treatment to determine what's effective and what's not.

I realized, however, that the best way to get an accurate picture of what goes on inside rehab was to interview people who had recently gone through treatment themselves or were currently going through it, again making it clear that any information they gave me would be rendered anonymous. Hence, my decision to collect more than one hundred stories* from clients and/or their family members, many of whom I met at the programs I visited, and include a subset of individuals who recovered from drug and alcohol problems without going to rehab. Some people came my way by word of mouth or through recruitment notices I sent to addiction professionals or posted on e-mail lists. I had the opportunity to follow quite a few individuals over time, sometimes for several years and also periodically as they struggled through relapses and went to multiple programs. Knowing that it's hard to admit a setback, I give them credit here both for staying in touch with me and working so hard on their sobriety.

Some of their rehab stories are disturbing while others are inspiring. All provide an honest and critical look at addiction treatment in the United States. Their accounts illustrate serious issues facing individuals in rehab *and* the treatment industry today, yet they also highlight some of the innovative approaches used by selected programs across the country. Perhaps most important, *Inside Rehab* gives a voice to people who have been there, whether their treatment experiences were good or bad. Those who had a positive outcome eagerly showed that they wanted to reach out and share the great news, often in the hope that others would benefit from their experiences. Those who had a negative time of it often felt beaten down and as though they had nowhere to turn; as a form of catharsis, and to spare others from a similar misfortune, they welcomed the chance to divulge what had happened to them.

WHO OPENED THEIR DOORS

In selecting rehabs I went coast to coast, making an effort to visit a wide range of programs, some famous for the celebrities who've walked through their doors and others better known for working with individuals on public assistance. It turns out that my home state of Minnesota is renowned for its multiplicity of addiction facilities—from traditional twelve-step-based residential and outpatient programs representative of those across the country to unique programs that serve certain subgroups of people. So I rounded out my visits by also visiting a number of places close to home.

I wondered if at high-end rehabs I'd find posh, indulgent vacation-like settings where clients were having massages and getting their nails done. I also was curious about whether I'd observe what had been described to me as harsh, in-your-face approaches designed to break down addicts and alcoholics. In reality, I came across neither one. Contrary to the notion that high-end rehabs are more like resorts than places that heal, even at the most expensive ones I witnessed no kid-glove handling, no fancy "spa" cuisine (and I ate plenty of patient fare), and saw no luxurious bedrooms—in fact, some of them were quite basic, even dormitory-like. Two high-end places only provided chair massages, and at one that's been called a celebrity rehab, I saw young men getting haircuts while

sitting in a straight-backed chair—which reminded me of when I used to trim my kids’ hair in my own kitchen.

And although I sometimes questioned the approaches used in treatment, I saw almost none of the old-school, confrontational strategies common in the past. However, I was told about some more recent, rather demeaning experiences people had had at certain programs I didn’t visit.

What astounded me most in my travels was the number of places that opened their doors to me and how open they were, some having prepared elaborate schedules for my stay. Following my visits, many helped me contact clients for anonymous interviews for the book. For a complete list of programs I visited, please see [The Inside Rehab Tour](#).

WHAT’S AN ALCOHOLIC OR AN ADDICT?

In rehab parlance, if I were in a traditional residential program, I’d no doubt introduce myself this way many times each day: “I’m Anne, and I’m an alcoholic” (or “an addict”). So would my fellow group members at the opening of every group session. One day, at one of the residential rehabs, I heard women in the same unit, all of whom knew one another, introduce themselves this way many times. Someone forgot to do this at one point, and a fellow client who was leading the group said, in a rather confrontational way, “What *are* you?” as if everyone needed to be reminded, and that the label somehow defined the person.

Personally, I don’t care for the words “alcoholic” and “addict” because, in my opinion, both labels come with a lot of stigmatizing baggage. (For more on this, see “What’s in a Name?” in [chapter 7](#).) I’d rather ask, “What does it mean to be a person who’s addicted to alcohol and/or drugs?” (In this book, alcohol and illicitly used drugs are sometimes collectively referred to as “chemicals” or “substances”; and alcohol is a drug, too.) The word “addiction” comes from a Roman law having to do with “surrender to a master.” When she first contacted me, Shari P. shared what it was like to lose control to her “master” as follows: “I come from a good family and even managed to attend a university, although I wasn’t able to graduate because the drugs became too important. My life has been a never-ending cycle of chaos in which heroin is the central cause. The sheer amount of time spent finding, getting, and using the drug is exhausting. You feel like the biggest loser on earth but you just do it over and over and over again. I am desperate for change.”

The definitions that professionals typically use to diagnose someone with alcohol and drug use disorders are determined by a guidebook called the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The DSM edition that was in use for many years and was just about to be retired as *Inside Rehab* was being written used the term “dependence” to describe what most people think of as addiction. (“Abuse” is another category, often used to describe less serious drug and alcohol problems.) However, it is expected that the new edition—the DSM-5, due for release in May of 2013—will do away with the terms “dependence” and “abuse” and instead use the term “substance use disorder” and employ subcategories such as “alcohol use disorder,” “cocaine use disorder,” and so on. The list of eleven possible defining characteristics of a substance use disorder includes failure to meet work, social, or family obligations because of substance use; continued use despite persistent negative consequences; tolerance (needing more chemicals to get the desired effect); regularly taking a substance in larger amounts or over a longer time than intended; devoting a lot of time to getting, using, or recovering from the effects of a substance; withdrawal (physical or mental symptoms if the drug is abruptly stopped); craving; and a number of others. People with two to three of the characteristics would be considered to have a mild substance use disorder, while those with four to five of them would be in the moderate category. Neither of these categories would be considered to be addiction. A person who meets six of the criteria, however, would be considered to have a severe substance use disorder or what most people would term an addiction.*

It’s important to note, however, that tolerance to and withdrawal from some medications—such as certain painkillers, antidepressants, and anti-anxiety medications—can occur even when these medications are taken at appropriately prescribed doses without a user having a substance use disorder. Many individuals use these drugs without any evidence of abuse or aberrant behavior.

Alcohol and drugs produce their pleasurable, euphoric effects by directly or indirectly targeting what’s known as the brain’s reward system, flooding it with a neurotransmitter or chemical messenger called dopamine and motivating use again and again. With repeated use, dopamine’s impact on the reward system in the brain can become abnormally lowered, so that even heavier and more frequent use results in less pleasure or “high.” Other brain systems such as the stress response system become overactive and result in unpleasant feelings such as anxiety and “the blahs.” As addiction worsens, afflicted people are driven to repeated use more in order to relieve these unpleasant feelings than to seek pleasure. In other words, they use to feel “normal” or “not sick” more than to get high. Addictive use eventually leads to profound changes in the brain and its memory systems such that reminders of drug or alcohol use—for instance, seeing a needle or a martini glass—can trigger cravings, even after many years of abstinence. In short, chronic heavy drug and alcohol use can alter the brain’s structure and function, resulting in changes that last long after someone stops using and may explain why relapses can occur after prolonged periods of abstinence.

Certainly, some people are more prone to addiction than others, depending on their genetic background. Genetic factors are believed to account for between 40 and 60 percent of a person's vulnerability to addiction. Use of drugs and alcohol at an early age also increases the odds of addiction, as does having a history of childhood trauma, including physical or sexual abuse and serious neglect. Plus, living, working, or going to school in places where alcohol and drug use is common increases the likelihood of addiction. The bottom line is that there's a biological as well as an environmental component to becoming addicted to drugs and alcohol, and the role that each plays varies from person to person.

THE QUESTIONS

The stories of clients and interviews with treatment professionals, as well as visits to treatment facilities, helped me find the answers to questions like these:

- What determines whether someone should go to rehab in the first place?
- How do most people choose a rehab? Is there much variation from one rehab to the next?
- How much money do people spend on rehab? What percentage is typically covered by health insurance—and what if you don't have health insurance?
- Does more expensive treatment mean better treatment?
- Who are the professionals who work with patients in rehab, and how are they trained?
- What do people actually do in rehab? How do they fill their time, and what do they do on weekends?
- If someone is struggling with another psychological problem, such as depression, can he or she expect to get help with that at rehab? Should one problem be tackled before the other is treated?
- Are family members usually included in treatment? What does that entail?
- How much of a say do clients have in what goes on in their rehab experience?
- What happens if someone has a slip with drugs or alcohol while in rehab?
- What happens after you get out of rehab? What occurs next for both the client and his or her family members?
- How do you know if a program is effective?

A QUESTION OF HONESTY

Have you ever heard this joke?

Q: How do you know when an addict is lying?

A: When his lips are moving.

Quite frankly, I find it offensive. It stems from the widespread notion, often promulgated in addiction treatment itself, that virtually all people with alcohol or drug problems are dishonest. Even a nationally known expert in the field included "they're all liars" in his definition of an addict when talking with me. Emily E. said that at a halfway house she attended, "They told us we're addicts and we lie and can't be trusted. It made you feel like crap." And at one outpatient group I visited, where the counselor seemed to have a good overall rapport with her clients, she said to them with a smirk, "The one thing we know about alcoholics and addicts is that you're always one hundred percent honest." It's hard to imagine that this is therapeutic, but is her implication accurate?

I had to think this through, realizing that some people might question the veracity of the stories I heard, particularly those from people who shared negative treatment experiences. There's no question that in most cases I was only getting one side of the story. For a variety of reasons, it would have been very difficult to try to confirm the client's version by going to the treatment programs to get their views of what had happened. Not only would this have violated the confidentiality of the clients who shared personal information with me, but there's no way of knowing if the rehabs would have given me a balanced view either. Indeed, psychologist Tom Horvath, PhD, director of Practical Recovery, a California program I visited, said, "Self-deception is a process any of us can develop. It can occur in providers just as easily as in clients."

What does the research reveal about whether you can trust the reports of people with addictions? In response to this question, respected addiction experts Mark Sobell, PhD, and Linda Sobell, PhD, psychologists at Nova Southeastern University in Florida

summed up their findings from extensive research on this topic: “The bottom line is that if people believe what they are telling you will be confidential—particularly that it will not incur adverse consequences—and they are asked in a clinical or research context then what they say tends to be reliable and valid. (This all holds if the person has no substances in their system at the time of the inquiry.) But people are not stupid—if telling the truth about using drugs or drinking to a significant other, probation officer, schoolteacher, or work supervisor is going to bring trouble, why not lie and avoid the negative consequences? In short, if people have no reason to lie to you, the evidence suggests they will be truthful.”

Certainly, the people I interviewed had no reason to be threatened by participating in my book anonymously. Still, when tackling a subject like this, there’s bound to be some distortion from the client’s perspective, at least part of the time, even if it’s just the result of faded memories. To get another perspective on some of the stories, I did ask certain individuals to sign a release form that allowed me to talk with their counselors, therapists, and/or family members. In some other cases, I talked with other people who’d been to the same treatment program around the same time period.

However, so many of the same issues were raised—both by clients and professionals—so often and with so much similarity, that it’s difficult not to believe them. And many of the negative impressions shared with me were representative of problems consistently reported by experts who have studied the field.

MYTHS UNCOVERED IN *INSIDE REHAB*

As I interviewed person after person who’d been through treatment, talked with staff members, queried experts, and read studies on addiction treatment, the following myths became apparent. They will be explored in greater depth throughout the book:

MYTH: To recover from addictions, most people need to go to rehab.

FACT: While the knee-jerk reaction when someone has a drug or alcohol problem is “Get thee to rehab,” the truth is that most people recover (1) completely on their own, (2) by attending self-help groups, and/or (3) by seeing a counselor or therapist individually. ([Chapter 5](#) takes a look at who belongs in rehab and who doesn’t.)

MYTH: Most people who go to addiction treatment programs go to overnight residential rehabs.

FACT: Of the more than two and a half million people who go to a treatment program each year, the vast majority do not “go away to rehab.” After numerous studies showed no difference in how people fared after going to residential versus outpatient programs, insurers and other funding sources drastically cut back on paying for residential rehab. Today, various forms of outpatient help comprise more addiction treatment experiences in the United States than residential stays.

MYTH: Thirty days is long enough to “fix” most people with addictions.

FACT: The idea that someone goes away to a thirty-day rehab and comes home a new person is naïve. Rather, there’s a growing view that people with serious substance use disorders commonly require care for months or even years, just as they would for other chronic medical conditions, such as diabetes. Unfortunately, the length of treatment often depends less on a person’s needs and more on financial coverage limits imposed by health insurers, and/or the patient’s ability to pay. This short-term-fix mentality partially explains why so many people go back to their old habits. The majority who complete treatment start using alcohol or drugs again within a year, and at least half do so within thirty days after leaving rehab.

MYTH: Group counseling is the best way to treat addictions.

FACT: While group counseling is the staple approach in the vast majority of programs, there’s little evidence that the type of group counseling used at most of them is the best way to treat addiction. On the other hand, individual counseling, which has been found to be helpful, is used infrequently at most programs and may not even exist at others. Zack S., who first went to an outpatient

program where there was no individual counseling, told me, “I’m fairly introverted and didn’t participate much at all in groups.” When I interviewed him, he was still struggling with alcohol and attending a unique program that primarily provides individual counseling. ([Chapter 6](#) has a discussion of group versus individual counseling.)

MYTH: Highly trained professionals provide most of the treatment in addiction programs.

FACTS: Addiction counselors provide most of the treatment at rehabs, and states have widely varying requirements in both educational level and training for a person to become a drug and alcohol counselor. Some states don’t require any degree for becoming a credentialed addiction counselor, and many require just a high school diploma, general equivalency diploma (GED), or associate degree, according to a groundbreaking 2012 National Center on Addiction and Substance Abuse at Columbia (CASA Columbia) report on the state of addiction treatment titled “Addiction Medicine: Closing the Gap Between Science and Practice.” Although there’s been a movement to professionalize treatment, much counseling still is provided by minimally trained addiction survivors-turned-counselors whose own rehabilitation forms much of the basis for their expertise. And sometimes, when standards are raised for new counselors, old-timers are “grandfathered in” with their existing credentials (or are given a certain amount of time to obtain the new ones), and they may or may not be well qualified. Most of the people I interviewed for *Inside Rehab* were oblivious about the credentials of the people who provided their care. When I asked Ann B. about the counselors at the outpatient program she attended, she responded, “You just assume you’re seeing a doctor or that they know what they’re talking about.” In the state in which she was treated, a licensed addiction counselor was not required to have a college degree. These facts are particularly disturbing given the complexity of substance use disorders and the fact that more than half of people in the general population with addictions suffer from at least one other mental disorder such as depression, anxiety, or bipolar disorder, which also must be treated to optimize their chances of recovery. One woman I interviewed went to a famous celebrity rehab, where she never received any professional psychological counseling for her troubled past. While I was writing the book, she died from a cocaine overdose when dealing with a possible reunion with someone who’d sexually abused her throughout her childhood. (For a discussion about the rehab work force, see “[Who’s Minding the Store?](#)”.)

MYTH: The twelve steps of Alcoholics Anonymous (AA) or a similar program, such as Narcotics Anonymous (NA), are essential for recovery.

FACTS: When I wrote *Sober for Good*, more than 90 percent of rehabs in the United States were based on the twelve steps. While the ratio appears to have dropped somewhat, most programs still base their approach on the twelve steps, include a twelve-step component, require twelve-step meeting attendance, and/or hold twelve-step meetings on-site. As was well documented in *Sober for Good*, however, the twelve-step approach isn’t for everyone, and many people overcome addictions using other methods. Yet it’s hard to find a program that doesn’t include the twelve steps, and most people I interviewed were offered no alternatives. When I asked Elizabeth F., who went to a renowned high-end residential rehab, about this, she said, “The only thing they’ll talk about is the twelve steps. When I brought up Women for Sobriety [an alternative group to AA], I was met with a blank stare. When I asked about when we’d be getting into other modes, the counselor said, ‘We are a twelve-step program.’ There was no other literature, discussion, etc. They were fairly adamant that ‘this is what we have to offer, and if you want what we have, this is how you get it.’ (See [chapter 6](#) for more about twelve-step programming and information about alternative routes to recovery.)

MYTH: Most addiction programs offer state-of-the-art approaches shown in scientific studies to be effective.

FACTS: Although many say they use them, rehabs commonly fall short on implementing practices that studies show lead to the best outcomes for clients. The 2012 CASA Columbia report mentioned earlier concluded that “the vast majority of people in need of addiction treatment do not receive anything that approximates evidence-based care” and that “only a small fraction of individuals receive interventions or treatment consistent with scientific knowledge about what works.” To bring practice in line with the evidence and with the standard of care for other medical conditions, it said, “Nothing short of a significant overhaul in current approaches is required.” The report went so far as to raise the question of “whether the insufficient care that patients with addiction usually do receive constitutes a form of medical malpractice,” given the prevalence of substance problems, the extensive evidence available on how to identify and address them, and continued failure to do so. When it comes to providing services that address the whole person and thereby improve the chance of success, a 2010 report from the University of Georgia’s National Treatment Center Study suggests that fewer than a third of 345 representative private rehabs offered any kind of vocational services, housing or shelter assistance, legal assistance, educational services, or financial counseling. (The full five-hundred-plus-page CASA Columbia report can be found at <http://www.casacolumbia.org/templates/NewsRoom.aspx?articleid=678&zoneid=51>. For more on the gap between what goes on and what should go on in addiction treatment, see [here](#) in this chapter and [chapter 4](#).)

MYTH: If you relapse and go back to rehab, they’ll try something new.

FACTS: Rather than being offered a new approach, clients who return to using alcohol or drugs are commonly blamed for “not getting with the program” or not trying hard enough, and often have to “start all over again,” even though they’ve experienced very similar programming many times before. Sometimes, they just were not ready to tackle their addiction and could benefit from more of the same; other times, they need a completely different approach upon returning. Emily E. went to multiple twelve-step-based programs in an effort to get off prescription painkillers (initially prescribed for severe migraines) and heroin. She finally met a counselor-intern who said, “You don’t need more treatment, you need to go on methadone.” When I interviewed her, Emily had a year of sobriety with the help of a methadone program and its non-twelve-step outpatient program. She concluded, “So many addicts just go to rehab again and again, and the same basic kind of treatment never changes. It’s ridiculous.” ([Chapter 8](#) addresses the topic of relapse.)

MYTH: Addiction treatment programs have high success rates.

FACTS: “Treatment works” has long been a mantra of the rehab industry, but reliable statistics supporting it are hard to come by. There’s a great deal of inconsistency in the quality of care provided across programs and in how success is measured, if it’s measured at all. In a *Los Angeles Times* article, University of Texas researcher Scott Walters, PhD, coauthor of a landmark study on treatment success rates, said, “Anybody can make any claim they want and get away with it. . . . It’s essentially an unregulated industry.” Yale University School of Medicine’s Kathleen Carroll, PhD, one of the foremost experts on addiction treatment in the United States, asks, “In what other area of medicine can you go to a place for treatment and not have them be able to give you any idea of their outcome rates or point to the scientific basis for the treatments you might receive? I think if consumers started pushing for information on outcomes, a lot of these places would dramatically change how they deliver and measure treatment.” (For more on success rates, see [chapter 9](#).)

MYTH: You shouldn't use drugs to treat a drug addict.

FACTS: ~~Research clearly shows that certain prescription medications help people addicted to drugs and alcohol get sober and stay sober. Yet many rehabs are unfamiliar with them or refuse to use them because of the old-fashioned notion that drugs should not be used to treat an addict—or that they should be used *very* sparingly. In the course of writing *Inside Rehab*, I got to know addiction psychiatrist Mark Willenbring, MD, who had just stepped down from his position as director of the Division of Treatment and Recovery Research at the National Institute on Alcohol Abuse and Alcoholism. In practice as an addiction psychiatrist in Minnesota, he told me, “I’ve been particularly disturbed by several patients of mine who recently went to a treatment program for opioid addiction, and none of them received maintenance Suboxone. All of them relapsed. This is unconscionable.” Sometimes rehabs will use drugs like Suboxone just to “detox” a patient during treatment, but research suggests that most people addicted to opioids* or heroin need to be discharged on “maintenance” doses of such medications or they are very likely to relapse. Shari told me that one of the rehabs she went to actually gave patients Suboxone and took it away depending on whether their behavior was “good or bad.” (See [chapter 9](#) for a discussion of medications for people with drug and alcohol problems.)~~

MYTH: More money gets you better treatment.

FACTS: Not necessarily. Sometimes, programs that treat clients who rely mostly on public funds have counselors with more qualifications and use more state-of-the-science approaches than expensive rehabs. Margaret F., who went twice to both an expensive high-end rehab and a community outpatient program said, “I thought the outpatient program was at least as good as the residential one.”

MYTH: Treatment approaches used for adults work for teens, too.

FACTS: According to the nonprofit research institute Drug Strategies, “Treatment experts agree that adolescent programs can’t just be adult programs modified for kids”—which is often what happens. And sometimes, kids are put in programs with adults, a practice definitely against professional recommendations. Also, despite minimal research support, the majority of teen programs incorporate AA’s twelve steps. What works best for adolescents, according to a plethora of studies, is family-based treatment, something rehabs seldom offer, instead favoring teen group counseling, twelve-step approaches, and family education groups, none of which have been found to be as effective as interventions involving the entire family. ([Chapter 7](#) is devoted to adolescent rehab.)

THE FACTS OF THE MATTER

How many drug and alcohol rehabs are out there and how many people use them? The grand total for 2010 was 13,339 according to the National Survey of Substance Abuse Treatment Services (N-SSATS), a figure based on a yearly inventory of all known special facilities that treat drug and alcohol problems maintained by the federal government’s Substance Abuse and Mental Health Services Administration (SAMHSA). (An unknown number of other rehabs exist, probably fewer than a thousand, but they either didn’t respond to the survey or were ineligible for participation.) Of the types of care offered at these programs, 81 percent were outpatient, accounting for nine out of ten of all clients in treatment. About a quarter of the programs offered residential (nonhospital) treatment, which accounted for about one out of ten clients in rehab. Hospital inpatient treatment was offered by 6 percent of facilities and only accounted for 1 percent of clients in treatment. (See [chapter 2](#) for the differences in these types of programs.)

Another way that SAMHSA tracks how many people go to addiction treatment programs and where they go for help is through the National Survey on Drug Use and Health (NSDUH), which queries a large nationally representative group of noninstitutionalized U.S. civilians (about 67,500 people), age twelve and older, about drug and alcohol use, problems, and treatment in the past year. (

the 22.1 million individuals (almost 9 percent of the population age twelve or older) who were estimated to have a substance use disorder in the past year, according to the 2010 NSDUH, 2.6 million received help at a specialty facility. Another 2.3 million people went to a self-help group, such as AA, but this is not considered formal treatment. That same year, just over 7 percent of teens (about 1.8 million) age twelve to seventeen were reported to have a substance use disorder but only 138,000 of them went to an addiction treatment program.

The message is that with more than thirteen thousand residential and outpatient rehabs out there and more than twenty-two million adults and teens estimated to have a drug or alcohol problem, only a small minority receive professional help each year. Of those who do, far more go to outpatient programs than to residential programs.

DRUG OF CHOICE

What kinds of substance problems brought the *Inside Rehab* participants to treatment programs? “Drug of choice”—meaning the drug (or drugs) that a person prefers—ran the gamut. For many it was “just alcohol” that took its toll. In fact, alcohol can be a dangerous drug—heavy drinking is the third leading preventable cause of death in the United States. Marijuana was the primary drug problem for others. Some administrators told me things like, “Alcohol is a given” and “alcohol and marijuana are always mainstays,” suggesting that most clients had a problem with *at least* those two.

For many people, a combination of drugs wreaks havoc. Steve R. began abusing drugs and alcohol at the age of fourteen and told me, “I’ve used almost every drug, ending with an addiction to meth. I couldn’t get through a day without being high or drunk or both. I was thirty-nine when I was finally busted with a meth lab.” When I interviewed him, he had had a successful experience at a Christian rehab, followed by a drug court program.

At high-end programs, the preferred drugs of abuse were alcohol, opioids such as Vicodin, OxyContin, and Percocet, and benzodiazepines, commonly known as “benzos” and included brand name drugs such as Valium, Klonopin, and Xanax. At one of the programs that serves a low-income population, the most commonly abused drugs were less likely to be pills and benzos and more likely to be crack cocaine, alcohol, and PCP (phencyclidine, which has hallucinogenic effects). Programs that treat teens told me they were seeing abuse of painkillers (often taken from parents), heroin, Adderall (a stimulant drug commonly used to treat attention-deficit/hyperactivity disorder), and inhalants—all in addition to alcohol and marijuana. Rural programs were seeing a resurgence in methamphetamine problems.

At the national level, according to the 2010 National Survey on Drug Use and Health, of those who received help from a facility, about 37 percent said they did so for alcohol use only; 34 percent for illicit drug use only; and 24 percent for both alcohol and illicit drug use. (The numbers don’t add up to 100 percent because some people didn’t specify whether their treatment was for a drug or an alcohol problem.)

ONE PROGRAM, CONTRASTING EXPERIENCES

As I visited rehabs, I told administrators, “I will no doubt find people who say that your program saved their lives. But others may tell me that your program was wrong or even destructive for them. Indeed, that’s what I found. Chantal R. says of one of the most prominent residential treatment programs in the country, “It was one of the best experiences I have ever had. I can’t think of one thing that didn’t help me. They lectured AA and the importance of it—the tools are so simple to use. I would recommend every person I meet to go there in a heartbeat. It changed my life.”

Another woman who went to the same place told me, “While there were some valuable lessons there, I was very unimpressed with most of the counseling and the facilitating of group discussions.”

What I really got was that the most important thing was AA, reading the Big Book [*Alcoholics Anonymous*, the so-called bible of AA], doing the twelve steps, living your life every day a day at a time, and all the other ‘-isms’ that were thrown around. From day one, it didn’t resonate with me, and the day I left I knew that it was not how I was going to live in recovery and be happy about it. I was humbled by the people that I met and the places their addiction had taken them, but there was a lot that I just hated. I can’t believe they have the reputation that they do.”

One explanation for such contrasting experiences at the same program is that, sometimes, people are simply at different life stages when they enter treatment: one may be more ready to get sober; one person may have a different or more severe addiction than others. People may go into a facility with very dissimilar expectations or levels of experience—perhaps one person has had years of psychotherapy while others have not. Also, one’s reaction to a certain program may compare unfavorably to previous treatment. The variable reactions may also stem from differences in personality, religiosity, or education. Sometimes, it’s a matter of the counselor the client is assigned or the unit he or she is placed in that colors their experience. And although most of the people I spoke to had been in treatment within a few years of one another, programs can change within a very short period of time depending on owners, directors, and funding sources. One woman whose son had been to several different rehabs told me, “The director changes, and the whole place changes.”

I found that some of the rehabs I visited became more progressive in the course of the three or four years that I was in contact with them. For instance, a mental health professional called one of the programs “a dinosaur” because she felt it used antiquated approaches. One year later, however, after a change in leadership, she was making referrals to the place.

WHEN TREATMENT ISN’T RIGHT

In some cases, people were hurt by what they’d experienced in treatment. I heard sad tales of repeated visits to rehab with the implication that the client had somehow failed, when it seemed apparent that something about the treatment had very likely failed the individual. Other stories came from people who didn’t belong in rehab at all, but were coerced to go. The following is just a sampling of what I heard:

- Will R.’s alcohol abuse was secondary to serious psychological issues left unaddressed by his first rehab, where no individual counseling was provided over the course of residential treatment. When I interviewed him, Will had found a second rehab with highly individualized care that recognized the complexities in his case and realized that his psychological needs should be the primary focus of his treatment rather than substance use itself. This is counter to the philosophy of many treatment programs.

- Carrie G. went to two famous residential rehabs, one of which, she said, “had no medical staff at all for \$40,000 a month.” (She qualified that by stating that a psychiatrist came in once a week and that “we’d be called out for five minutes for random assessment, no conversation.”) When she was in their “detox,” she felt her medical needs were not managed appropriately, and she wound up in a hospital emergency room. (For this amount of money, it would be logical to expect that a rehab would provide adequate medical supervision of someone in detox, but she got the impression that they were not “equipped for a hard-core physical addiction.”) As far as counseling was concerned, she said, “I never saw a psychologist or social worker. All the therapists were recovered addicts.” The only one-on-one counseling she received for her money was a once-a-week session with a woman she believed was a drug and alcohol counselor. The rest of the time, it was group counseling.

- Sam D. overcame his addiction to painkillers through individual counseling despite the fact that

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