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Context of Practice

Myths, Realities, and Quagmires Related to Alcohol, Tobacco, and Other Drugs

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Alcohol, tobacco, and other drugs (ATOD) are so much a part of daily life in our society that few individuals remain untouched by their impact (Fisher, 2008; NASW, 2006). That influence spans the gamut from womb to tomb. Professional literature and mass media reports are replete with evidence supporting the effects of ATOD use by pregnant mothers on their fetuses; the negative influence of such substance use on the care and development of their older offspring; the impact of use by workers on their performance and safety; and the results of alcohol and other drug use on driving safety, on family relationships, on overall individual performance, on school performance, on health, and on general community safety (Cook, Peterson, & Moore, 1990; Dutra et al., 2008; Grant et al., 2004; Jacobson, 1997; Larkby & Day, 1997; Lasser et al., 2000; National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2000; National Institute on Drug Abuse, 2008; Redman, 2008; Serdula et al., 1991; Substance Abuse and Mental Health Services Administration [SAMHSA], 2008; Welsh, 1996; Wolfgang, 1997). Evidence not only emphasizes the negative effects of so-called "street drugs" or illegal drugs, but also informs us of the dangers of misusing prescription drugs, mixing prescription drugs with alcohol or illicit drugs or using prescription drugs in combinations not prescribed (Fisher, 2008; SAMHSA, 2008).

All one has to do is turn on the radio or television, scan the Internet, or open the morning newspaper to learn of the ill effects of ATOD: Death, crime, neglect, violence, and abuse are the events making the headlines. These reports reflect but a tip of the iceberg with many other individuals beneath the spectacular surface struggling to overcome depression, poverty, unemployment, fear, stress, pain, and other

overwhelming challenges. All share the common thread of using ATOD for relief from physical or psychological suffering, a range of disappointments, or the sense of ennui or meaninglessness that seems so pervasive throughout contemporary society.

In one's capacity as social worker, if one does not work directly with clients whose ATOD use is impinging on their performance, one will certainly be confronted by those who bear the scars of others' involvement with these substances. The scope of the problem is broad. A number of years ago, Daley and Raskin (1991) suggested that each user affects or seriously influences four to six other people. This continues to ring true today. Although challenges inherent in poverty and discrimination may increase vulnerability to substance use, use of such substances knows no geographic, economic, or cultural boundaries. Its use spans the broad historical spectrum, knowing no time limits. The past is filled with stories reflecting the impact of substance misuse, the present is ridden with evidence reflecting the same, and the future purports to hold additional challenges for those working in the field (van Wormer, 1995). Although only 2 percent of members of the National Association of Social Workers (NASW) indicated ATOD problems were representing their major area of practice, the magnitude of the problem was sufficient to serve as a driving force behind the NASW social policy statement on ATOD abuse endorsed by the 2005 Delegate Assembly of the organization (NASW, 2009). ATOD issues are encountered in every aspect of social work. The breadth of the problem is pervasive: child welfare, health care, criminal justice, schools, the workplace, community centers, mental health clinics, senior centers, and day care, to name a few (NASW, 2009).

To be effective in meeting those challenges, social workers, and others working in the field of addictions, need to understand the realities of working with clients presenting with problems stemming from the use of ATOD. They need to be able to decipher myth from reality, to understand the complexity of life's challenges that contribute to the murky quagmires that confound the field, to be knowledgeable about various treatment options, to be skillful in selecting and using relevant intervention strategies, to understand the full impact of providing service in a managed care environment, and to appreciate and commit to a systems approach in addressing the complex nature of ATOD. They need to be able to recognize the value of evidence-based practice, contribute to sound research, and support practice based on well-documented research findings.

The Scope of the Problem

Because of the illegal nature of many drugs, it is not possible to accurately report the extent of their use; however, we do know that each year the federal government spends billions of dollars on the control of substances and the treatment of their

ill effects (NIAAA, 2000; SAMHSA, 2008). More than half the inmates in federal prisons are there because of drug law violations; over one-fifth of workers in the United States are working under the influence of drugs, costing employers and the general public billions of dollars; over two-thirds of young people under the age of 25 have experimented with various substances (Goldberg, 1998; Hart, Ksir, & Ray, 2009; SAMHSA, 2008); between 40 percent and 60 percent of people in long-term psychiatric facilities are classified as patients suffering from co-occurring disorders, with one diagnosis being a substance-related disorder and the other a mental health disorder (American Psychiatric Association, 2000; Coffey et al., 2008; Orlin & Davis, 1993; SAMSHA, 2008; Woody, 1996).

Cost of the Problem

The cost of addictions currently exceeds $500 billion annually (Potenza, 2007). The most recent report issued to Congress by NIAAA (Harwood, Fountain, & Livermore, 1998, as cited in NIAAA, 2000) estimated the economic cost of alcohol abuse was $148 billion in 1992. Costs for 1995 were $166.6 billion, and for 1998, $184.6 billion (Harwood, 2000, as cited in NIAAA, 2000). If history continues on its current trajectory, projected costs for 2010 could well exceed $260 billion.

Harwood and colleagues (1998), in analyzing 1998 projections for alcohol abuse costs, attribute more than 70 percent ($134.2 billion) of estimated costs to lost productivity (consisting of 87.6 billion or 65.3 percent for lost work and productivity, 36.5 billion or 27.2 percent for lost future earnings because of premature death, and 10.1 billion or 7.5 percent for lost productivity because of alcohol-related crime). Of the remainder, 26.3 billion or 14.3 percent of the total was spent on health care costs related to alcohol abuse, 15.7 billion or 8.5 percent on property damage or administrative costs related to alcohol-related motor vehicle accidents, and 6.36 billion or 3.4 percent on criminal justice system costs stemming from alcohol-related crime, with the remainder or approximately 2 billion related to fire destruction and social welfare administration (Harwood, 2000; Harwood et al., 1998).

Comparable costs related to other drug abuse for 1992 were $98 billion. Costs for 1995 approximated $110 billion and for 1998 $120 billion. Given the above rates and using the Harwood (2000) method of projection, costs for 2010 could well exceed $170 billion.

It is anticipated that 2010 expenditures could be much greater given that drug use is increasing at a greater rate than alcohol abuse, which is reported as showing minimal growth (National Institutes of Health [NIH], 1998).

Data for the mid-1990s collected by NIH estimated that of the total amount spent addressing alcohol and other drug abuse-related issues, 60 percent was spent

on alcohol-related activities, with the remaining 40 percent used for other drug abuse and dependence (NIH, 1998). The above figures are more than 40 percent higher for alcohol and 50 percent higher for other drugs than those reported for 1985. Adjusting for inflation and population growth, the costs of alcohol are comparable to the average cost estimates for the previous 20 years; the costs of other drug abuse have shown a steady increase over that time period (NIH, 1998). Information from NIH (1998) revealed that more than two-thirds of the costs spent on alcohol abuse were related to lost productivity because of alcohol-related illness or death. For other drug abuse, almost 60 percent of the costs were because of drug-related crime—including lost productivity by victims and incarceration of perpetrators (20.4 percent), lost productivity by users (19.7 percent), and such costs as property damage, drug traffic control, and police, legal, and corrections services (18.4 percent). Of the remainder, it is estimated that only 10.2 percent was spent on related health care.

Expanse of Alcohol Abuse

Former Secretary of the U.S. Department Health and Human Services (HHS), Donna Shalala, in the forward to the *10th Special Report to the U.S. Congress on Alcohol and Health* stated that:

> alcohol problems, both those of individuals and those that affect society at large, continue to impose a staggering burden on our Nation. Domestic violence, child abuse, fires and other accidents, falls, rape, and other crimes against individuals such as robbery and assault—all are linked to alcohol misuse. Alcohol misuse also is implicated in diseases such as cancer, liver disease, and heart disease. Although often not aware of it, everyone shares a portion of this burden. For example, an estimated 20 to 40 percent of patients in large urban hospitals are there because of illnesses that have been caused or made worse by their drinking. This means that out of every 100 patients in such hospitals, *almost half* may be there because of their alcohol use. Each of us shares the price of these illnesses through rising health care costs. Because one in four children under the age of 18 lives in a household with one or more family members who are alcohol dependent or who abuse alcohol, our Nation will continue to be robbed of its future. As these children grow up, they too will be at risk for continuing the cycle of alcohol abuse and dependence that has plagued too many of our citizens for too long. (NIAAA, 2000, p. ix)

In the *Ninth Special Report to the U.S. Congress on Alcohol and Health* (NIAAA, 1997), former Secretary Shalala noted that approximately 14 million Americans, or almost 10 percent of adults, met diagnostic criteria for alcohol abuse and alcoholism. The report, which highlighted new knowledge uncovered since the *Eighth Special Report to the U.S. Congress on Alcohol and Health* (NIAAA, 1994) showed that although prevalence rates remained steady over time, some positive changes occurred: Abstention from use of alcohol increased, heavy drinking decreased, per capita consumption decreased, legal and social sanctions especially related to drinking and driving increased, and people were becoming more health conscious and less tolerant of substance abuse. Although the per capita rate of consumption fell, the decline was not uniform across age and gender: Men continued to have more alcohol-related problems than did women; consumption by women did not decrease as much as that of men; alcohol use and abuse were becoming more prevalent among young adults; alcohol-related traffic accidents remained a major cause of death, especially among young people; a growing elderly population contributed to an increase in problems among that group; and heavy drinking continued to contribute to overall poor health (Brennan & Moos, 1996; NIAAA, 1997; Parker, 1998; Wolfgang, 1997). Alcohol-related morbidity and mortality continued to be major challenges in American society.

The *10th Special Report to the U.S. Congress on Alcohol and Health* (NIAAA, 2000) indicated new knowledge in the areas of genetics, neural circuitry, fetal development, prevention, education, and therapies. Perhaps the single most important finding during the three-year period covered was the discovery that 50 percent to 60 percent of the risk for developing alcoholism was related to genetics.

Expanse of Other Drug Abuse

Although problems related to alcohol consumption continue to plague society and challenge those working in the field, the use of other drugs continues to put additional stress on the system. Results from the 2007 National Survey on Drug Use and Health [SAMHSA, 2008]; known as NSDUH since 2002, when it replaced the National Household Survey on Drug Abuse [NHSDA]) indicate that almost 20 million Americans age 12 or older had used an illicit drug in the month prior to the survey. This figure represents 8 percent of the population age 12 or older. Illicit drugs include marijuana or hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used for nonmedical purposes. Slightly more than 50 percent (126.8 million) of Americans age 12 years or older reported being current drinkers of alcohol. Almost 71 million Americans age 12 or older indicated they were users of tobacco (SAMHSA, 2008, p. 10).

According to findings presented in the 2007 NSDUH (based on inquiry about past-month usage), marijuana was identified as the most commonly used illicit drug among 5.8 percent of people age 12 and older (14.4 million users in the month preceding the survey) (SAMHSA, 2008). It was followed in descending order by prescription-type psychotherapeutic drugs (2.8 percent or 6.9 million users), cocaine (0.8 percent or 2.1 million users), hallucinogens (0.4 percent or 1 million users), and methamphetamines (0.2 percent or 0.5 million users). The survey also revealed that among youths ages 12 to 17, illicit drug use remained stable between 2006 (9.8 percent) and 2007 (9.5 percent); however, between 2002 and 2007, illicit drug usage in that age group declined by 2 percent. However, it is important to note that among baby boomers ages 50 to 54, illicit drug usage increased more than 2 percent during the same time period from 2002 (3.4 percent) to 2007 (5.7 percent). Among unemployed adults age 18 and older in 2007, 18.3 percent reported being current users of illicit drugs, with full-time employed workers reporting 8.4 percent usage rates, and part-time employed workers reporting 10.1 percent. Of the current 17.4 million drug users age 18 and older in 2007, 75.3 percent were employed either part-time or full-time (SAMHSA, 2008).

In terms of reported alcohol use, in 2007 more than half (51.1 percent) of Americans age 12 and older (126.8 million) reported being current users of alcohol. More than one-fifth of this group reported participating in binge drinking (having five or more drinks on at least one day during the prior 30 days). This figure (57.8 million) approximates that reported in 2006. Rates of youth drinking reported in the 2007 survey were comparable to those reported in the 2006 survey findings (SAMHSA, 2008).

In terms of cultural differences, among users age 12 years and older reporting past-month alcohol use in the 2007 survey, the usage rates were 56.1 percent for whites, 47.5 percent for individuals reporting two or more races, 44.7 percent for American Indians or Alaskan Natives, 42.1 percent for Hispanics, 39.3 percent for blacks, and 35.2 percent for Asians (SAMHSA, 2008). In 2007, almost 13 percent of respondents indicated that they had driven while under the influence of alcohol during the previous year. On a more positive note, the reported figure is slightly less than that reported in 2002 (14.2%).

Expanse of Tobacco Use

The 71 million Americans age 12 years and older who reported being current users of tobacco represent almost 29 percent of the population, with 24.2 percent of the population reporting cigarette smoking, 5.4 percent cigars, 3.2 percent smokeless tobacco, and 0.2 percent pipes. Reported use of any tobacco product decreased by one percent between 2006 and 2007, and between 2002 and 2007 by approximately

2 percent. Usage rates among youths between 2002 and 2007 declined by more than 3 percent. This may be a misleading figure because reported use among this age group increased between 2006 and 2007 (SAMHSA, 2008).

On the basis of the above figures, the fact remains that no segment of the population is immune from the effects of substance abuse. Over 15 million Americans experience serious alcohol-related problems; almost 4 million experience serious drug-related problems, and more than 3 million meet the criteria for both drug and alcohol (NASW, 2009). Many others experience the fallout or indirect effects of ATOD use.

The Tip of the Iceberg

Although the surveys cited above seek broad representation, the numbers may not reflect the true breadth of the problem. Unfortunately, many individuals who are experiencing the problems, or fallout resulting from problematic use by others, may not be identified in surveys or may not come to the attention of treatment providers and, therefore, may not be reflected in actual figures provided. Many users seek treatment on their own through self-help groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA; both for users) or Al-Anon or Nar-Anon (for family and friends) and never surface in treatment statistics or through substance abuse surveys. Others rely on self-change efforts to deal with their problematic use (Klingemann & Sobell, 2007). This latter group is particularly difficult to quantify.

Many individuals experiencing substance-related problems are diverted into the criminal justice system, rarely receiving appropriate ATOD services during or after their incarceration (Anderson, 2003; U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics [BJS], 2008). In 2002, an estimated 1.5 million individuals were arrested for drug law violations, 1.5 million for driving under the influence (DUI), more than a half million for drunkenness, and almost two-thirds of a million for liquor law violations (Dorsey, Zawitz, & Middleton, 2003; NASW, 2009). The 1990s experienced more than a 60 percent increase in individuals incarcerated because of drug offenses (BJS, 2008). In 2002, 20 percent of incarcerated men and 30 percent of incarcerated women were serving time for drug offenses (BJS, 2008).

The Impact of International Drug Trade

As challenges in the global economy have increased, many developing countries have found significant financial success in providing illicit drugs to users in developed countries. Several examples include the opiate and heroin brought to the United States from Asia and Africa, or cocaine brought to the United States from Latin America. As the influx of drugs has increased, federal, state, and local governments have tended to spend more resources on drug control (law enforcement and

interdiction) than on treatment initiatives. Although some efforts may have been successful in decreasing the supply of illicit substances or providing greater control of legal substances, many times these efforts have been accompanied by increased violence, with negative fallout for neighborhoods and their residents. On the one hand, increased availability itself can lead to increased crime and usage; on the other hand, more limited availability of substances has contributed to competition, crime, and related violence (Hammersley & Reid, 2002). The question remains as to where limited resources should be allocated to make the greatest impact on the serious problems surrounding the use of ATOD.

The above statistics and accompanying concerns contribute to the major challenge confronting social workers today, that being how best to address the full range of problems related to substance use and the complications associated with it. There are no absolutely correct answers. The best, or most informed, approach lies with policymakers and clinicians, working together, guided by wisdom founded on well-executed research.

Separating Myth from Reality

Despite increasing emphasis on evidence-based practice, grounded on sophisticated research, a number of myths continue to proliferate within the field (Brown, 2003). These myths are frequently compounded by the quagmire-like challenges surrounding the very nature of addiction or inappropriate use of substances. To perform effectively in addressing problems stemming from ATOD, social workers should not only be aware of these myths, but also must know reality and challenges the myths seek to mask. Prior to addressing popular myths related to ATOD, one must understand the nature of myths and accompanying quagmires. According to *Webster's Deluxe Unabridged Dictionary* (2nd ed.), a *myth* is defined as follows:

1. a traditional story of unknown authorship, ostensibly with a historical basis, but serving usually to explain some phenomenon of nature, the origin of man, or the customs, institutions, religions, rites, etc. of a people: myths usually involve the exploits of gods and heroes.
2. such stories collectively; mythology.
3. any fictitious story.
4. any imaginary person or thing, spoken of as though existing. Synonym: fable, fiction, legend, falsehood. (Dorset & Baber, 1983, p. 1190)

Joseph Campbell (1988), the 20th century master of myth, stressed the importance of the first and second definitions—stories that guide civilization

and frequently transcend culture. Historically, social work has placed significant emphasis on the cultural heritage and the relevance of myth, which contributes to understanding and appreciation of client diversity. However, in social work practice with clients involved in problems stemming from ATOD, social work must go beyond, dispelling fictitious stories, beliefs, or falsehoods that impinge on the understanding and treatment. In this latter case, the definition cited by Brown (1993) has more relevance:

1. a traditional story, either wholly or partially fictitious, providing an explanation for or embodying a popular idea concerning some natural or social phenomenon or some religious belief or ritual; specifically one involving supernatural persons, actions, or events; a similar newly created story.
2. a widely held (especially untrue or discredited popular) story or belief; a misconception; a misrepresentation of the truth; an exaggerated or idealized conception of a person, institution, etc.; a person, institution, etc., widely idealized or misrepresented.
3. myths collectively or as a genre; the technique or habits of creating myths. (p. 1874)

It is the second definition that is probably the most pernicious because it often contains an element of truth. The skillful social worker must learn the underlying facts and how to separate fact from fiction, especially as it influences the effectiveness of social work practice. So much about the field of ATOD falls into the "gray" area of being neither fact nor fiction. Thus, frequently, it takes great skill and ongoing surveillance on the part of the social worker to separate reality from the predominating myth. At times an even greater challenge is posed by myths that primarily are exaggerations of the truth.

In addition to understanding the nature of myths, one must understand what makes myths so powerful, and so strongly and persistently believed. Myths are so powerful because they both reflect and direct our behavior and typically are accepted as unchallengeable fact. They provide "a clear, if impractical, answer to drug problems" (Hammersley & Reid, 2002, p. 12). They tell us how to live, how to proceed (Campbell, 1988). Humans seek a guiding force, a prescription, a set of beliefs (myths) to guide behavior (Hillman, 1995). And because of that need, they buy into the legitimacy and veracity of myths. In other words, myths persist because they are "functional" (Hammersley & Reid). However, myths do not always reflect complete reality. As we will see, there are many such myths, falsehoods, or partial truths operating in the field of ATOD today. They are based on inaccuracies of perceived influences of culture, gender, and nature of substance. It

is hard to counter a myth. Any truth behind a myth gives it credence. Any challenge to the myth typically generates a rebuttal geared to supporting its continued merit.

Avoiding Quagmires Stemming from Mythical Thinking

Unless myths are untangled and clarified they can lead the social worker and his or her client onto a "slippery slope" or into a very complicated situation, similar to a quagmire from which it is very difficult to extricate oneself and more forward. For sake of clarification, *Webster's Deluxe Unabridged Dictionary* (2nd ed.) defines a *quagmire* as:

1. soft, wet, miry ground that shakes or yields under the feet;
2. a difficult position, as if one is sinking or stuck … synonymous with a swamp, marsh, morass, bog or slough. (Dorset & Baber, 1983, p. 1473)

It is the second definition that more accurately describes the challenges of attempting to operate on beliefs that are not firmly grounded. It is difficult enough to address the frequent ambivalence and stigma associated with clients struggling with the ATOD. But to work under false assumptions or partial truths makes it even more difficult.

The focus here is not only to challenge some well-known myths, partial truths, or exaggerations in the field of ATOD, but also to replace them with a questioning mind—one geared toward seeking new data, resulting in more accurate understanding and appraisal of human behavior, especially as it relates to ATOD use, and the avoidance of quagmirelike minefields.

General Myths Related to Substance Abuse

A number of general myths related to substance abuse are prevalent in the field. One major one that affects both assessment (including surveys) and treatment is based on the belief that people answer questions honestly when asked about their ATOD use. In reality, they frequently will reveal what information they want to be known (Davies, 1992). In some cases, it may entail minimizing or denying use; in other cases, it may emphasize maximizing use.

A number of theorists (Davies, 1992; Hammersley & Reid, 2002) challenge the idea that people are compelled to use substances because of the pharmacological impact of the substance. Davies (1992) suggested "that people take drugs because they want to and because it makes sense for them to do so given the choices available" (p. x). He contended that we are geared to believe that the behavior of drug

users is beyond their control—that self-control is lost to the power of the drug or the earlier myth that once addicted, the individual is sentenced to a life of addiction (Gibson, Acquah, & Robinson, 2004; Hammersley & Reid, 2002). He noted that much of this belief is based on users' self-reports; he questions whether the self-reports are true or whether they are primarily self-serving.

Davies (1992) based his beliefs on attribution theory that focuses on the ways in which people explain why things happen. Attribution theory offers insights into the ways in which people explain their actions and those of others. The processes of attribution theory shed light on the difference between causal explanations and scientific statements. The former are based on the state of the explainer, and the latter on the state of confirmed knowledge. Davies contended that a lot has to do with locus of control. If people have a greater sense of internal control, they will have more control over substance use and will be more aware of their ability to affect use.

Ten years later, Hammersley and Reid (2002) questioned "why the pervasive addiction myth is still believed" (p. 7). They suggested that this myth persists because it is functional—the drug use took over the user's free will. They suggested that "abdicating control is often confused with losing it" (p. 22). If locus of control or degree of ability to control is important and an understanding of the role of control is put into the equation for each individual, the veracity of this myth varies for each individual.

If lack of control is verified, one is NOT responsible for one's actions, one's addiction, or one's crimes or abuse related to that addiction (Hammersley & Reid, 2002). Apparent loss of control is challenged repeatedly by users who give up drugs or alcohol on their own or with minimal support (Gibson, Acquah, & Robinson, 2004).

Allamani (2007) suggested that a primary myth surrounds the idea of free choice and control over the power of drugs. He charged contemporary marketing ideology with advancing the idea that anyone can achieve whatever she or he wishes, that individuals are endowed with free choice when confronted with options. Once ATOD abuse entered the realm of medicine in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2000), however, substance abuse was removed from being a vice or defect in personal character or a lack of personal control to being a disease requiring appropriate outside intervention. At this point, if one accepts the disease model, the role of control becomes minimized in the equation.

Bailey (2005) believed it is not that simple; these myths or beliefs need further study. She suggested examining popular discourse on addiction to understand society's influence on the popular views on addiction. She suggested that society in general helps to maintain such beliefs as one being helpless in the grips of addiction, or the alternative, that a person can simply give up use if she or he wants to.

For the social worker, what this suggests is the need to undertake a comprehensive assessment, one focusing on assessment of control, primary substance being used, and client sense of hopelessness and helplessness. It also involves an assessment of strengths, supports, and a history of previous attempts at change. Specific details pertaining to assessment, the process of change, the power or impact of various drugs, and intervention will be addressed in subsequent chapters.

Examples of Myths Related to Culture

"The similarities among people affected by addiction and among those trying to help them are striking, but so are the cultural differences" (Straussner, 2008, p. 1). In dealing with substance abuse with clients from different cultures, it is important to understand the nuances and cultural differences (Cox & Ephross, 1998; Straussner, 2001). It also is critical to recognize the influence of myths that abound about the drinking patterns of different cultural groups. Many of these myths may, in fact, reflect an exaggeration of ongoing cultural observations. For example, many practitioners believe that the Irish are more likely to have a higher proportion of heavy and problem drinkers than individuals of Jewish background. Although the media may reinforce these myths, and one may note that predominately Irish communities have more pubs per capita than do Jewish communities, it does not follow that being Irish equates with problematic drinking or that being Jewish equates with minimal or nonproblematic drinking. If one buys into these myths, one is likely to step into a quagmire. The myth will likely influence one's assessment of both Irish and Jewish clients, the type of treatment provided to them, and the level of optimism surrounding change or the expectations for change—the result being the first step into the quagmire, or the route toward getting stuck and being diverted from the task at hand.

Another culturally based myth involves the use of alcohol by Native Americans. Leland (1976) pointed out that many individuals believe in the myth of the "drunken Indian," that Native Americans have an excessive craving for alcohol and are more susceptible to its influences. Navajo people themselves believe in the physiological susceptibility of American Indians (May & Smith, 1988). Although the myth is widely accepted, many components are questionable (SAMHSA, 2008); Native Americans do not suffer a major deficit in the rate of alcohol metabolism, and research has not supported a physiological predisposition to alcohol abuse among this group (Leland, 1976; May & Smith, 1988; Moran & May, 1997; SAMHSA, 2008).

As leaders in the Native American community have become more aware of rates of alcohol and other drug use within their communities, they have made major efforts

toward elimination of substance abuse as a problem (Gilder, Lau, Corey, & Ehlers, 2008; Westermeyer, 2008). To a large extent they have been successful as illustrated by high-level remission rates. Twenty-five years ago remission rates of 0 percent to 21 percent were common; current rates triple those reported earlier (Gilder et al., 2008; Tan et al., 2008; Westermeyer & Peake, 1983; Westermeyer, 2008).

To counter the influence of such mythical thinking, one needs to assess each individual with an open mind, anticipating a full range of assessment outcomes, and offering a full range of treatment options. If one buys into the above myths, one might anticipate greater substance abuse, for example, drinking on the part of an Irish client or American Indian, and poorer prognoses given the so-called (mythical) propensity to alcohol abuse. In a similar vein, one may minimize the drinking of a Jewish client, be more optimistic about treatment outcomes, or entirely negate or deny the need for treatment.

Equally misleading myths relate to other cultures. For example, one might harbor the belief (myth) that to be Russian is to be addicted to vodka. Yes, vodka is readily available in Russia; yes, many Russians drink it regularly; no, not all Russians, or people of Russian heritage, are addicted to vodka (Abbott, 1996). Other examples of mythical thinking concern Italians typically drinking wine with their main meals and the French (Abbott, 2001) who are well known for their appreciation of fine wine. Because wine is considered a staple or key component of each meal, akin to food, it poses minimal risk of addiction or problematic use. If appreciating wine is expected of the culture, it must be a positive attribute with little inherent danger. In the earlier mentioned cases, these myths must be unraveled and examined in light of individual behavior, individual use, or addiction. Assessment, treatment strategies, and prognoses must be based on individual evaluation, not on general expectations or beliefs concerning specific cultural groups.

Examples of Myths Related to Gender

Numerous examples of gender-related myths, or exaggerations, have surfaced (Welsh, 1994b). For example, if women are viewed as inferior to men, it is anticipated that they will do less well in treatment. The effects of such thinking may be evident in a variety of ways, such as the fact that staff expectations of treatment outcome may reflect this inferior perspective and may contribute to a self-fulfilling prophecy. Data actually suggest that women and men have comparable success with treatment, if the treatment is geared to their specific individual needs (Abbott, 1995) or if men and women reflect comparable sociodemographic characteristics—such as marital status, economic level, employment status, and social stability—and

similar levels of problem severity (Institute of Medicine, 1990). For the most part, women and men pose different treatment needs; however, once those needs are accommodated, treatment can proceed with equal chances for behavioral change and successful outcome. For example, women frequently leave inpatient treatment programs early because they fear that their children will be taken from them in their absence. If sufficient child care is provided, these women are more likely to remain in treatment.

Alcohol or other drug use by women, especially mothers, is frequently overlooked or minimized because of the belief (myth) that good women (good mothers) do not use such substances to excess. In addition, citations indicate that a smaller percentage of women than men experience ATOD-related problems. As a result, doctors, mental health professionals, clergy, family members, and even substance abuse counselors frequently overlook problems stemming from alcohol and other drugs and resist the accompanying need for treatment. Primary care physicians, for example, have been known to dismiss evidence of substance misuse in light of other, more acceptable, diagnoses for women. Because of this bias, both on the part of professionals and family members, women frequently enter treatment later, and at a more serious point in their addiction.

A third example of a myth related to gender is that men can "hold" their liquor better than women. In situations in which it appears that they cannot, they are perceived as being "on the town" or "just having fun with the boys," a more benign interpretation than that typically assigned to their female counterparts: "easy mark" for sexual advances or "scum," "second- or third-class citizens." Thus, negative repercussions run higher for women. In addition to being subjected to more castigation, women under the influence of alcohol and other drugs are frequently the targets of sexual harassment, sexual exploitation, and increased violence, including rape. This myth not only affects assessment and treatment, it also serves to perpetuate the denigration of women, or the historical sexual hierarchy that has existed in society.

The latter scenario can best be understood as social stereotypes or societal views of acceptable or unacceptable gender-specific behavior. A double standard prevails not only for the behavioral expectations but, as previously noted, for expectations for treatment or treatment outcomes. In reality, a smaller number of women use substances, and, as a result, such dependence is not systematically addressed.

In terms of the former scenario regarding the ability to "hold" alcohol, given comparable size and body fat, men and women should have similar capacity to metabolize alcohol. However, physiological differences exist that put women at greater risk. Because the body fat–water ratio of women typically differs from that

of men, alcohol enters their systems at a less diluted rate, resulting in a higher blood alcohol level (BAL) and more potent impact (Abbott, 1994; Blume, 1992; Corrigan, 1985). So yes, men appear to "hold" their liquor better; however, it is not based on superiority of will and self-control but, rather, on physiological attributes. Clients and practitioners need to be aware of these physiological differences. In addition to differences in alcohol impact, physiological differences contribute to additional health-related problems among women who drink. These difficulties may be partly because of the more limited ability of women to metabolize alcohol, resulting in a greater amount of alcohol being directly absorbed through the stomach's protective barrier (Abbott, 1994; Blume, 1992; Van Den Bergh, 1991; Wilsnack, Wilsnack, & Hiller-Sturmhofel, 1994).

An additional gender-related myth that has been repeatedly challenged in recent years is one involving HIV/AIDS as being primarily contracted and spread through sexual activity of gay males. Such a myth misrepresents reality and negates the dangers of unprotected heterosexual activity and minimizes the dangers of needle sharing among injection drug users. The perpetuation of this myth has tremendous implications for prevention and early intervention. Such myths cause efforts to be turned from much-needed intervention and, in turn, contribute to the spread of HIV and the neglect of women.

Examples of Myths Related to Age

A number of myths exist related to age. Crome and Crome (2005) highlighted a few of them. One concerns older adults not misusing substances, when, in fact, a large number do—intentionally or unintentionally. Many older adults have received prescribed medications for a variety of ailments. Frequently they do not share their medication history with their full contingent of medical personnel. As a result, physicians may be prescribing medications that counteract, interfere with, or potentiate in other harmful combinations with other prescribed medications. Crome and Crome (2005) reported that 10 percent of older adults are receiving a drug that is "potentially inappropriate" (Gottlieb, as cited in Crome & Crome, 2005). Many older adults are also given low-dose opioid analgesics sufficient for developing dependence (Edwards & Salib, as cited in Crome & Crome, 2005). In addition, some older adults do not realize or do not appreciate the fact that medications should not be taken in combination with alcohol.

Many older adults do not seek treatment and, therefore, their addictions are not identified. When they are seen, medical personnel tend to overlook the possibility of misuse of both legal and illegal substances (Crome & Crome, 2005).

A myth that serves to compound misuse is one that suggests the outcome for older adult users is poor (Crome & Crome, 2005). Most large studies do not include older adults, many times because of ageism. When older adults do engage in treatment, the outcome is frequently very positive. As might be expected, better success is gained by treatment protocols that are geared to the specific needs of the older adult user (Brennen, Nichol, & Moos, 2003).

It is interesting that when older adults do engage in treatment they are more likely to have abstinence as a goal. Providers report that, once engaged, older adults tend to stick with the program to a great degree (Crome & Crome, 2005).

An additional risk that is frequently overlooked is that older adults may metabolize various substances at a slower rate than their younger counterparts. Thus, providers must modify doses to accommodate these differences. Family members, social workers, or friends should be more diligent in monitoring change related to substance use, including medications, by older adults, and report such changes to medical providers.

Myths about Drug and Alcohol Users in General

A widespread myth supports the idea that drug users, in general, are a different class from alcohol users, that people who use illegal drugs (or drugs that have criminal penalties associated with their use) are of lower caliber than those who are physically or psychologically dependent on alcohol. An additional, somewhat-related myth, which adds support, is that because alcohol is legal, it is a less dangerous drug to use than heroin, for example.

Challenging these myths, it is important to note that any one—regardless of socioeconomic status, gender, or cultural background—can become dependent on any one or any combination of the full range of substances. Psychological and physical dependence know no boundaries. Yes, certain drugs are illegal and their possession could prompt criminal penalties; no, illegal drugs are not more dangerous than legal drugs. All one has to do is examine the research related to the use of two legal drugs—tobacco and alcohol—to recognize their negative impact on health and quality of life (Hart et al., 2009).

Classifying drugs along a danger or risk scale or assigning a risk quotient may support the belief that marijuana is less harmful than other drugs and, thus, is all right or preferable to use. Although the immediate dangers may be less, marijuana is viewed as a "gateway drug" or one that frequently leads to or opens the door to more dangerous drugs. Research shows that over 75 percent of young people who reported using marijuana on a regular basis (200 times or more) go on to experiment

with more dangerous drugs, such as cocaine (Hart et al., 2009; HHS, 1991). Tobacco is viewed as a "gateway" to alcohol and marijuana. However, a word of caution is in order. By assigning the gateway label, the myth could surface that cigarettes are less dangerous than other drug use that may follow. It is important to recall that all substances pose risks: risk to life, risk to health, risk to performance, and risk to opportunity. The challenge to avoid is minimizing the gateway and the resulting opportunities it may introduce. Another related myth is based on the idea that the use of any gateway drug will automatically lead to the use of other drugs. In reality, there is no proof that use of gateway drugs is synonymous with and directly contributes to the use of more dangerous drugs. What research has shown is that only 1 percent of adolescents begin their substance use with marijuana or another illegal drug; the vast majority started their use with cigarettes. And the majority who report using hard drugs used marijuana before their use of hard drugs began (Hart et al., 2009).

An additional myth related to dangers of using various drugs concerns beer. It is a common misperception that beer is okay to drink, that it is neither potent nor offers the same potential for dependency as does hard liquor. In fact, many believe that alcohol can be divided along a danger hierarchy with beer being the least dangerous, followed by wine, and then hard liquor or spirits. All three substances hold similar potential for dependence; all three hold similar potential for drunkenness. Typically, they are served in different-sized glasses, the result being one glass of each contributing to comparable ends. More specifically, 12 ounces of beer (at 4.2 percent alcohol), four ounces of wine (at 12 percent alcohol), and one ounce (at 100 proof or 50 percent alcohol) of hard liquor or spirits produce similar effect (Corrigan, 1979; Hart et al., 2009).

Another popular myth is that because vodka has no odor, its use cannot be detected. Therefore, it should be the beverage of choice. The fact is that vodka contains an amount of alcohol similar to other hard liquors or spirits and, as a result, will produce similar effects. It may not produce the characteristic smell of alcohol, but using vodka will produce similar physiological and behavioral responses as do equal amounts of other hard liquors.

Many people support the myth that if one does not drink multiple drinks in one hour, one will not achieve a 0.10 BAL. In reality, because of the cumulative effect, consumption of a relatively few drinks over several hours will also produce a BAL of that magnitude. The fact is that alcohol can only be processed or metabolized at a rate of about 0.25 or 0.3 ounces per hour. Whenever intake is greater than output, or the amount of alcohol ingested is more than the amount being metabolized, alcohol builds up in the system or accumulates, contributing to a rise in BAL (Hart et al., 2009; Ray & Ksir, 1999).

Another general myth is that it is okay to drink more alcohol when eating, that food neutralizes or offsets the impact of alcohol. Like many myths, this one contains elements of truth and may cause one to challenge use of the term "myth." However, one is reminded that the concept—"myth" according to Brown (1993)—does recognize partially fictitious stories. In this case, yes, presence of food does slow absorption rate of the alcohol, but it does not negate its impact completely. The absorption rate depends on the concentration of alcohol. If the alcohol is mixed with food or water, the concentration level in the stomach will be reduced and, thus, the effects will be tempered (Hart et al., 2009).

Additional beliefs involve the impact of drugs on sexual performance. For example, one such belief contends that cocaine enhances sexual desire, especially among women; another supports the use of heroin as an aphrodisiac; still another endorses quaaludes as sexual stimulants. Research has shown that alcohol and other drugs affect sexual sensation; however, the price of using typically outweighs the benefits. These myths definitely increase interest in using drugs and, for many, provide justification for using. The component that these myths disguise, or fail to disclose, is the fallout or repercussions of using (Covington, 1997; Hart et al., 2009; Roman, 1988).

Another myth grows out of the more recent emphasis on research findings about the influence of heredity on dependence. Because of the emphasis on these findings in the popular literature, many individuals buy into the myth that if one does not have a family history of alcohol or other drug dependence, one should use and not worry about becoming dependent. Yes, research does indicate that vulnerability or susceptibility to dependency on alcohol and other drugs may be inherited (Hart et al., 2009; NIAAA, 2000; SAMHSA, 2008); however, as previously noted in this chapter, no segment of the population is immune, and ATOD dependence knows no boundaries.

An additional myth advanced by the media is that smoking is an indication of sophistication, especially for women. It makes one appear youthful and glamorous. Needless to say, the current emphasis on the dangers of smoking has greatly challenged that myth; but the sale of cigarettes and their use by young people continue at a relatively high level (Hart et al., 2009; SAMHSA, 2008).

A similar message is offered by many beer commercials (Parker, 1998). If one drinks a certain brand of beer, one will win a beautiful mate or live the beautiful life; if one drinks another brand, one will not gain weight based on advertised low level carbohydrates (University of California–Berkeley, 2004). Parker (1998), in her study of alcohol advertisements, found a number of suggested myths appearing in commercials: beer as reward for hard play or work, beer as key element in rites of

passage or initiation, beer as a way of gaining social acceptance, beer as a vehicle for male bonding, and beer as the beverage of athletes. And the list goes on. These myths are advertised as positives, and the implications of use are totally overlooked or hidden.

Some Myths Regarding Treatment

One myth perpetuated in the field is that "one size fits all," or one treatment program is suitable for all clients. This frequently has been the case advanced by many substance abuse programs. For example, typically substance abuse has been identified as a male problem and treatment has been developed with this bias in mind. Historically, the vast majority of treatment programs were designed by men, for men and, as a result, most research was based on male subjects and their experiences (Abbott, 1994; Van Den Bergh, 1991). Even the most popular self-help effort, AA, was developed by two white men. Treatment options based on feminist principles and expanding on the traditional biopsychosocial approach have begun to recognize the diversity present in the substance-abusing population and have begun to develop treatment programs and strategies that are more effective in responding to those individual needs (Abbott, 1994). Even AA has recognized the importance of addressing the needs of women by supporting women-only AA meetings. A variation on the treatment myth centers around the belief that intense 24-hour inpatient treatment—the traditional being of 14- to 28-day duration—is more effective than day hospital or outpatient treatment. Yes, intensive inpatient treatment is more effective for some clients; however, many clients benefit more or equally from a full range of outpatient services. Many benefit from the ability to continue to reside within the family structure; to work on a daily, although frequently reduced, basis; and to confront daily struggles with added support and encouragement (Anderson, 1992; Kaufman, 1992; L'Abate, 1992).

A myth permeates the field that recovered counselors are much more effective in treating recovering clients than are counselors who personally have not experienced dependency. This view is being challenged every day; however, for those who believe it, whichever side of treatment they represent—provider or client—the impact can be severe. In reality, counselors who have not used substances or personally experienced the challenges of misuse can provide effective treatment. Much depends on the fit between the worker and the consumer.

Some believe the myth that change can only be facilitated by professionally trained ATOD counselors, and suggest that the ideal of quitting "cold turkey" is highly impossible. In reality, many users respond best to self-help groups or

self-change efforts. Although it is unknown how many individuals achieve sobriety or controlled use on their own or with the help of their peers, it is anticipated the rate is quite high (Klingemann & Sobell, 2007). Examples of individuals who quit on their own include the many patients who are prescribed high doses of opiates for pain and stop suddenly without major difficulty; the same holds true for many heroin users (Fitzpatrick, 2003). This latter group defies the myth that links success only to engagement in professionally guided treatment. It also defies the myth that addiction is instantaneous (Coomber & Sutton, 2006) and irreversible (Gibson et al., 2004).

Brewer (2003) challenged what he refers to as Fitzpatrick's myth supporting a "pull-your-socks-up" attitude describing the ease with which heroin addicts can give up their drug of choice "cold turkey." He does not dispute the fact that it may be possible for individuals to break bad habits on their own, but reminds us that fewer than half the individuals who engage in inpatient detoxification successfully complete the process (Gossling, Gunkel, Schneider, & Melles, as cited in Brewer).

Part of Brewer's challenge is based on the fact that frequently alcohol abusers experience delirium tremens or convulsions during withdrawal. He also noted the "demoralizing" abstinence syndrome experienced by many in opiate withdrawal, frequently sufficient to trigger relapse (Brewer, 2003). Brewer recognized that many heroin users age out of their addiction and give up the drug on their own. (This has been confirmed by the author in conversations with former users of a broad spectrum of substances.)

Another myth surrounds the belief that naltrexone leads to dysphoria by blocking the flow of endorphins. On the basis of this myth, many do not wish to use naltrexone in their treatment. The above is a medical myth or an opinion that is not substantiated by research (Miotto et al., 2002); however, it may come up in consultation with a client or for the social worker as member of a treatment team.

As noted previously, myths typically contain an element of truth. Fitzpatrick's (2003) beliefs may accurately reflect *his* experiences. Brewer challenged Fitzpatrick's beliefs, noting that withdrawal differs for different individuals and for different substances. Cave and Hallam (2003) bluntly stated that "the withdrawal syndrome is not a myth" (p. 1240). At least withdrawal is not as simplistic as Fitzpatrick and others suggest (Cave & Hallam, 2003).

Recently the criminal justice system has attempted to divert individuals with substance problems to drug courts that are designed to sentence individuals to appropriate treatment options (Anderson, 2003; Crunkilton & Robinson, 2008). An existing myth involves the belief that drug court efforts solve the myriad of substance abuse problems brought to the attention of the criminal justice system. Many hold to the belief that drug courts do work miracles. However, Anderson

(2003) purported that the very idea of drug courts being an answer to many related problems is a myth that has more to do with "reducing prison roles than liberation from addiction" (p. 260). One reason it appears that drug courts are so successful is that many individuals choose to participate to avoid the alternative of incarceration. Unfortunately, the courts frequently focus on one outcome measure—recidivism. Given this measure, it appears that the courts focus on treatment failures rather than successes.

An additional treatment-related myth surrounds the idea that incarceration in the criminal justice system will help address a pre-existing ATOD problem. Data support the fact that more than half the individuals contained in the criminal justice system are there because of substance-related activities; however, there is little supporting evidence that individuals receive appropriate treatment; some may even increase their use through subversive means while incarcerated, and some may have no real opportunities to address the underlying determinant of their addiction.

More recently, the newer approaches in drug courts have been designed to shift the focus to one of therapeutic jurisprudence, similar to the approach being used by mental health law, one based on justice and due process. McGuire (as cited in Anderson, 2003) noted that criminal sanctions alone are related to increased recidivism, whereas skill-oriented therapeutic programs can reduce recidivism by 25 percent to 30 percent. In this case, the half-truth associated with the myth is that the success of drug court depends on the humanistic, therapeutic support provided. As in other cases, success may also depend on the readiness and motivation of the participating consumer.

The impact of this relatively new concept within the criminal justice system is yet to be sufficiently tested (Anderson, 2003; Belenko, 1998; Redman, 2008). With the establishment of a number of drug courts, individuals who could be incarcerated for drug-related offenses are being court ordered to treatment. The jury is still out on the effectiveness of these efforts. The challenge posed to the social worker—to avoid that dangerous step into the quagmire—is to know the therapeutic dynamics of drug court and specific intervention strategies, to know the personal dynamics of each consumer, and to seek plans involving the most appropriate course of action.

Another challenge for both identification (diagnosis) and treatment is related to the fact that many ATOD users also have mental health issues, or other co-occurring disabilities (Coffey et al., 2008). These individuals frequently come under the veil of dual or triple stigmatization. If they are fortunate enough to connect with treatment, it may not be sufficiently integrated to meet the demands of their multiple problems and challenges. In addition to mental health and substance abuse problems, many individuals may suffer from such medical challenges as spinal cord

injuries, traumatic brain injury, or a range of related medical conditions such as multiple sclerosis.

Some other issues that pose additional challenges to treatment include the fact that ATOD problems are not treated as medical conditions for various entitlement programs. ATOD alone is not sufficient to qualify for Supplemental Security Income, Social Security Disability Insurance, or various public assistance programs such as food stamps, housing, student loans, or Temporary Assistance for Needy Families. As a result, ATOD-using individuals have more limited access to treatment options and financial support as they attempt to successfully move away from a problematic life based on ATOD-related activities (NASW, 2009).

A number of so-called myths or fallacies may be presented by users themselves (Kowalksi, 2001). Consumers may state: "I can keep a clear head when drinking," denying the fact that alcohol interferes with normal brain functions such as judgment and motor skills, or "I can hold my liquor," denying the fact that people who drink heavily are unable to judge the effect liquor is having on them. "Alcohol will make me popular," but in reality, it could seriously interfere with good social relationships. "Everybody's drinking" (therefore, it cannot be that bad), is not supported by existing research.

Thinking that there is one underlying factor contributing to the dependency problem—and that sobriety or abstinence depends on discovering what that factor is—is another myth operating in the field. Multiple factors contribute to the problem. The key is not to seek one definitive underlying factor, but to discover effective ways to control behavior and to control the use of substances.

Carpenito-Moyet (2003), working as a nurse practitioner in a community health center serving predominately Hispanic men, identified three reasons why the center's consumers entered drug rehabilitation: family pressure, legal mandates, or being tired of a life on drugs. The ones who were most successful in achieving their goal were those who were tired of life on drugs. However, once they make the choice to leave that life, they must grapple with the multiple factors that contributed to the problem in the first place, for example, poverty, abuse, family problems, unemployment, and discrimination. Quitting or changing one's use sounds easy; in practice it is not free from difficulty.

The idea that abstinence must be the goal for all is another challenging myth. Although many professionals in the field believe that abstinence is essential to overcome dependency, others advocate a harm-reduction model that emphasizes controlled drinking or controlled using. The underlying philosophy is that this approach is less offensive to some clients and may facilitate their route to ultimate control or sobriety—and if it does not lead to that end, it will help to minimize the

harm generated by the using of various substances (Duncan et al., 1994; Mancini, Linhorst, Broderick, & Bayliff, 2008; Marlatt, Larimer, Baer, & Quigley, 1993).

Two competing myths surrounding recovery or treatment are pervasive in the field (Mattaini, 1998). First is that of the "moral" model; second is that of the "disease" model. The first suggests that *all* it takes for a person to overcome his or her dependence on substances is an "act of will"; the second suggests that *all* it takes is sufficient treatment. Professionals in the field find that both are partially correct, that each extreme works for a small number of individuals, but that for the majority both segments are essential. The person needs to want to change, and frequently, he or she can do so if sufficient help, support, and treatment are available.

Some adhere to the "myth of labeling," believing that referring to someone as an addict or substance abuser will help to identify those in need of services, and, in turn, will facilitate their connection to appropriate treatment. On the one hand, it may lead to a treatment connection; on the other hand, labeling may lead to increased stigmatization, and doors to treatment may be blocked before an appropriate connection is made.

A number of professionals believe that identification of a co-occurring disorder will provide the necessary link to ATOD treatment. In reality, the presence of a co-occurring mental health diagnosis may result in additional stigmatization, closing the doors to treatment for both diagnoses. This is not to suggest that one should avoid diagnosing. What it does suggest is that the worker should examine the diagnoses and think carefully about a strategy to connect the consumer with treatment that is most likely to address both problems.

An additional challenge frequently surfaces when working with clients presenting with co-occurring disorders (APA, 2000). If a client accepts the value of abstinence, he or she may refuse to continue taking prescribed antipsychotic medications. The resulting confusion or psychological change may result in increased dependence on other substances such as illicit drugs or alcohol, many of which were taken in the past to combat the discomfort associated with psychiatric disorder.

Some additional myths involve the idea that illegal drug use occurs for very different reasons than does legal drug use. Many factors contribute to the use of ATOD, but choice of substance does not depend on or flow from particular factors or reasons. For some, it is availability of drugs, for others it is introduction to a specific drug or drugs, the sense of camaraderie created among users, or the relief or response offered. The reasons are as diverse and plentiful as the number of users.

The idea that "my doctor prescribed it, therefore, it cannot be bad" is another example of mythical thinking. The development of psychotherapeutic drugs has had a liberating effect on those suffering from mental illness. Phenothiazines,

neuroleptics, and other antipsychotic drugs, for example, have virtually freed many psychiatric patients from the confines of institutions. If these patients take medications as prescribed, and not in combination with other mind-altering substances, the effects can be extremely positive. In some instances in which patients do not disclose their complete medication record to their physicians, the physicians do not closely monitor the full regimen of drugs they themselves are prescribing, or patients intentionally seek treatment from a number of different physicians who are unaware of the full extent of medications being prescribed, the results can be devastating. The same impact can befall nonpsychiatric patients taking multiple medications. This is of special concern among elderly patients who may be seeking treatment for a range of disorders. Not only must the physician be vigilant, but the clients, their families, and other professionals working with them around substance abuse must be also. In many instances, the social worker must help the clients and their support system become informed consumers.

Some believe that addictive drugs lead to instant addiction. In some instances this may be the case; however, in most other situations, it takes longer-term use before addiction occurs (Coomber & Sutton, 2006; Hammersley & Reid, 2002). Hammersley and Reid highlight another myth: Drugs force addicts to stoop to any crime and depravity to finance their addiction.

Hammersley and Reid (2002) and Davies (1992) believed that if one buys into the myths mentioned in the preceding paragraph, users do not have to take responsibility for their actions. Users argue that they cannot be held responsible for their behavior because of their addictions.

One myth related to death by drugs is that users of heroin frequently die from overdose. Yes, some die from heroin, but the greater reality is the ones who do die from polydrug use and related toxicity (Darke, 2003).

Many other myths are not really challenged in the research literature but raise examples of biased, myth-like, or fallacious thinking. A few examples include the following: Addicts are responsible for their sorry condition; one cannot believe a word that addicts say; every addict makes for five more addicts. The challenge for the professional is to recognize the absurdity of these examples and interact with the client with an open, inquisitive mind.

Connection to Content that Follows in Subsequent Chapters

The first step to prevent sinking into myth-supported quagmires is to recognize myths, appreciate the partial truths they represent, and maintain an open mind ready to assess the readiness, commitment, and characteristics of the consumers

and substances involved. In some instances it may also involve the education of family members and significant others about myths and potential quagmires associated with ATOD problems.

Myths, partial truths, and exaggerations must be challenged. It is one thing if they permeate the views held by society at large; it is another if professionals buy into these inaccuracies as guides for practice. In many cases, if professionals do, they most likely would not ask the right questions, seek appropriate information, arrive at an accurate assessment, develop appropriate treatment options, formulate adequate prevention strategies, or facilitate the development of relevant social policy. Buying into myths and faulty thinking would definitely bias the vision and influence behavior, possibly leading to a giant step into a so-called quagmire, or at least a path filled with greater obstacles to successful outcomes.

Although the list contains several dozen myths, many more exist. The worker must learn to challenge strongly stated preferences or beliefs, seeking to validate or negate them based on current research and practice experience. Unfortunately, research in the field of ATOD has been quite uneven, especially in relation to gender, culture, and even drug of choice. Alcohol research has a much longer history and, therefore, is more plentiful than other drug research; however, noted gaps do exist. For example, the bulk of the research on women tends to be limited to their child-bearing years. One could question whether this is the direct result of the value assigned to women in their role in procreation (Abbott, 1994, 1995). More recently, greater research emphasis has been placed on understanding dependency of women across the life cycle (Welsh, 1994b, 1996) and on developing and assessing relevant treatment options (Welsh, 1994a). The same holds true for research pertaining to culture and the understanding and development of culturally relevant treatment variations (Straussner, 2001).

To date, the research on tobacco has been limited. Litigation ruling against the tobacco industry, and resulting in special support funding, has prompted increased interest in initiatives designed to better understand tobacco dependency and to guide the development of appropriate initiatives and treatment protocols. Greater emphasis has been placed on understanding the smoking patterns of young adolescents and the role cigarettes play as gateway drugs to other substances.

Much has been done to challenge existing myths, partial truths, or inaccuracies. The work is certainly not complete. As a result, the professional, working with clients struggling with ATOD abuse, must be constantly vigilant of the influence of myths and must strive to enhance an accurate understanding of reality. This is not a task to be accomplished on one's own. It requires continued learning, collaboration and consultation with other professionals in the field, participation in and support

of research, and a strong commitment to truth and knowledge. Social work has a long and positive history in the field of addictions. Social workers appreciate the importance of a positive attitude toward change, a sincere appreciation of consumers and the challenges they confront, and the belief in their ability to tackle the tasks at hand. They also recognize the importance of research in supporting both policy and practice. With these convictions in mind, more myths will be uncovered, more quagmires will be avoided, and more positive treatment outcomes will be shared with clients.

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