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Failing to Diagnose and Failing to Treat an Addicted Client: Two Potentially Life-Threatening Clinical Errors

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Psychotherapists risk making 2 types of errors with clients who struggle with addictive behaviors: failure to *diagnose* addictive behaviors and failure to effectively *treat* addictive behaviors. Given the high prevalence of addictive behaviors in clinical populations, therapists are in a unique position to assist individuals with these problems. It is assumed that therapists possess general diagnostic and treatment skills and yet many do not diagnose or do not treat addictive behaviors. Reasons for making these errors include prohibitive beliefs and limited knowledge about addictive behaviors. We offer specific recommendations to reduce these psychotherapy errors. These include: (a) more deliberate screening and diagnosis of addictive behaviors, (b) increased application of empirically supported addiction treatments, (c) required education and training in addictive behaviors, (d) modification of prohibitive attitudes about addressing addictive behaviors, and (e) increased attention paid to the addictive behaviors by professional psychotherapy organizations.

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Most of the scholarly work on clinical errors is found in the medical literature (O'Donohue & Engle, 2013), at least partly due to the fact that errors are more evident when problems are physical versus psychological. The following fictitious case example illustrates how a medical error might occur. "Bill" has difficulty breathing and sharp pain in his right side. He visits the emergency room where hospital staff run tests and discover blood in his urine. Assuming he must have kidney stones, they warn him that the pain might get worse before it gets better and they prepare to discharge him. As he gets dressed he insists that he is still concerned about his breathing. His physician says, *Pain makes it hard to breathe.* Seeing that the patient is unsatisfied, the physician orders one more test: a CT scan of the chest. It is then discovered that he has a pulmonary embolism (PE) that might have killed him if he had left the hospital.

Bill's PE was detected because the physical pain and discomfort were lucidly described by Bill, who was able to point to his right side and exclaim, *It hurts right here. It's really hard to breathe!* Medical technology (i.e., a CT scan of the chest) also aided in the detection and confirmation of his life-threatening condition. Even if Bill's PE had gone undetected and proven fatal, the error would likely have been uncovered after Bill's death.

Emotional pain is different from physical pain. When clients are depressed or anxious they rarely cry out and point to the origin of their pain. During the diagnostic process there are no technologically sophisticated scanners to uncover psychological problems. As a result, therapists risk making errors without knowing these have occurred, and when therapists do not know they have made errors they cannot learn from them. This problem is not exclusively the responsibility of individual therapists; psychology as a profession has not invested substantial effort into addressing therapeutic errors (O'Donohue & Engle, 2013).

We propose in this paper that therapists are at risk for making errors when working with clients with addictions. Therapists have unique opportunities to detect and assist individuals with addictive behaviors. They possess general diagnostic and treatment skills and yet many do not apply these skills to directly address addictive behaviors.

In order to address addictive behaviors, therapists must have certain attitudes, knowledge, and skills that support doing so. For example, they need to believe that it is within their purview to address addictive behaviors. They need to believe that addressing addictive behaviors will facilitate positive outcomes. They cannot allow stigma or stereotyping to get in the way of helping clients with addictions. And they must overcome the occasionally awkward feeling associated with telling another person that their personal choices (i.e., addictive behaviors) are unhealthy or maladaptive. This is particularly important in a society where alcohol consumption is legal, common, and sometimes even glorified.

Therapists' reluctance to address addictive behaviors may reflect a lack of education or training in this area. Corbin, Gottdiener, Sirikantraporn, Armstrong, and Probber (2013) surveyed APA accredited doctoral programs across the United States and found that only ~30% offered courses on substance use disorders. Furthermore, only 50% of all courses were a required part of the curriculum. In the absence of adequate coursework or training, therapists are likely to doubt that their skills can be used to effectively diagnose or treat addictive behaviors.

In contrast to Bill, we present another fictitious character, "Ann," who is being treated for hypertension by her physician. Ann appears otherwise healthy. She reports that she eats well and

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exercises daily. When her blood pressure does not improve with medication, Ann's physician refers her to a therapist for "stress management." She sees the therapist for several months and is taught to relax, regulate her emotions, and meditate. Nonetheless, her blood pressure remains high. One night, driving home from a restaurant with her husband, she has a motor vehicle accident and is arrested for driving under the influence (DUI). As it turns out, Ann has an alcohol problem that has gone undiagnosed by her physician and therapist. This alcohol problem is the likely reason for her elevated blood pressure. If it had been diagnosed and effectively treated, she might not have put lives at risk by driving under the influence (and her blood pressure might be well under control).

In this paper we describe two specific types of clinical errors that may occur when addicted individuals seek services from therapists: (a) failure to *diagnose* addictive behaviors and (b) failure to *treat* addictive behaviors. We address these problems in the next two sections.

Failure to Diagnose Addictive Behaviors

It is essential to identify addictive behaviors in order to effectively treat them. Between 5% and 15% of American adults experience some form of addiction (Sussman, Lisha, & Griffiths, 2011) and individuals with other mental illnesses are significantly more likely to consume addictive substances such as alcohol, cocaine, and cigarettes (Saffer & Dave, 2002). One study found that more than a third of patients receiving outpatient mental health services might also be diagnosed with a substance use disorder (Ford, Snowden, & Walser, 1991). Based on these prevalence rates, therapists might potentially encounter addicted clients every day.

In Ann's case, the therapist failed to ask about addictive behaviors during early visits. Perhaps he was uncomfortable asking Ann about her drinking. Perhaps he believed it was not his place to do so. Or perhaps he just didn't think to ask questions about addictive behaviors, since Ann was referred for stress management and blood pressure control. Regardless of the reason, Ann's problem with alcohol did not become apparent until therapy was well underway. The following discussion only occurred after several months of therapy:

Therapist: *Have you been monitoring your blood pressure?*

Ann: *Yes and it's still high.*

Therapist: *As I think about all the things that can cause high blood pressure, one we haven't discussed is drinking. Ann, how much and how often do you typically drink?*

Ann: *I drink wine with dinner. My husband and I share a bottle of red wine every night.*

Therapist: *When you say you share a bottle of wine, how much of a bottle do you drink?*

Ann: *We split the bottle, so we each drink about half the bottle, and then sometimes we open a second bottle. You know, they say that red wine is good for your health.*

Therapist: *Thanks Ann, it's helpful for me to learn about your drinking.*

Ann: [After a pause] *There's something else I should probably tell you . . . I recently got in a car wreck and was charged with a DUI while driving home from a restaurant with my husband. We drank wine at dinner like we always do and while driving home I was distracted by a text message. Fortunately, no one was hurt. I'll be going to court to deal with a DUI charge next month.*

Therapist: *So given these circumstances, what are your current thoughts about drinking?*

Ann: *I guess . . . um . . . I might have to face the fact that I need to cut back on drinking.*

Ann's therapist now understands that Ann likely has a drinking problem. The therapist moves from screening to a more thorough diagnostic process. Based on criteria in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) the therapist asks Ann about drinking more than intended, unsuccessful efforts to cut down or quit, craving, tolerance, drinking under hazardous conditions, withdrawal, failure to fulfill major role obligations, and drinking despite adverse consequences. In doing so, the therapist determines that Ann has a mild to moderate alcohol use disorder. While it is good that Ann's alcohol use disorder was eventually identified, it should have happened sooner. The therapist focused on stress management for months before considering Ann's alcohol use to be clinically important. As a result, Ann failed to receive earlier treatment for this serious problem.

Unfortunately, mental health professionals fail to detect alcohol use disorder in ~50% of patients (Mitchell, Meader, Bird, & Rizzo, 2012), despite the fact that alcohol use disorder is the most prevalent of addictive disorders. There are various reliable, valid methods and instruments available to detect addiction problems (Zgierska, Amaza, Brown, Mundt, & Fleming, 2014). Most are readily accessible and in the public domain. Brown, Leonard, Saunders, and Papasouliotis (2001) have devised a screening procedure requiring only two questions: "In the last year, have you ever drunk or used drugs more than you meant to?" and "Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?" Based on their research, they report that these questions accurately identify 80% of adults with substance use problems. In addition to specific screening procedures, the Substance Abuse and Mental Health Services Administration (SAMHSA) has formulated an empirically supported, systematic approach to detecting addictive behaviors, consisting of screening, brief intervention, and referral to treatment (SBIRT). Many of the SBIRT resources offered through SAMHSA can be found at http://www.integration.samhsa.gov/clinical-practice/sbirt.

Addictive behaviors can also be detected by simply observing relevant cues. For example, a therapist might observe a pack of cigarettes tucked away in a client's pocket or purse. Or the therapist might smell cigarette smoke on a client's clothing or alcohol on the client's breath and inquire about it. When this occurs the therapist has an opportunity to initiate a conversation about addictive behaviors. The following example takes place during a diag-

nostic interview with a client seeking help with depression. The therapist asks about the client's smoking history late in the first session.

Therapist: *I notice that you have a pack of cigarettes in your shirt pocket.*

Client: *Guilty as charged.*

Therapist: *How do you feel about me asking about your smoking?*

Client: *Like I said before, ask anything you like.*

Therapist: *Thanks. So tell me about your smoking. For example, how much and under what circumstances do you smoke? And how often have you tried to quit smoking?*

This therapist notices the client's cigarettes and asks about them in the first visit. The therapist clearly believes that it is appropriate to ask and also believes that doing so may facilitate a good outcome. These beliefs reduce any awkwardness the therapist might feel about asking. And as a result of asking it becomes possible, as they move forward, to simultaneously address both the client's chief complaint (depression) and the comorbid tobacco use disorder. Early detection enables therapists to conceptualize the reciprocal impacts of both sets of problems. It is important to note that the symptoms of addiction (e.g., anxiety, mood, and sleep difficulties) can resemble symptoms of other mental illnesses, and therefore be easily missed (Shivani, Goldsmith, & Anthenelli, 2002). Through the use of screening instruments and clinical observation, the identification of addictive behaviors can become a standard part of the diagnostic process.

Failure to Effectively Treat Addictive Behaviors

Even when addictive behaviors are detected they often go untreated, or inappropriate treatment recommendations may be proposed. Therapists who specialize in addictions know that effective treatments for addictive behaviors exist, yet many of these specialists choose not to initiate empirically supported treatments (Herbeck, Hser, & Teruya, 2008). Many therapists ignore addictive behaviors, preferring to focus on anxiety, depression, or other problems. Some therapists never offer to treat addictive behaviors or even provide referrals for addictive behavior treatment. Again, it is likely that some therapists do not address addictive behaviors because they believe that doing so may be futile.

When clients have other mental health disorders that co-occur with addictive behaviors, combined ("integrative") treatment approaches targeting both areas of difficulty tend to be more effective than standalone therapies (Cleary, Hunt, Matheson, & Walter, 2009). An example of integrated treatment is the use of motivational interviewing (discussed in detail later in this paper) to address addictive behaviors, along with cognitive–behavioral therapy.

Another significant error takes place when therapists attempt to address addictive behaviors without considering clients' readiness to change or clients' goals for modifying addictive behaviors. In their second edition of the text *Substance Abuse Treatment and the Stages of Change* (Connors, DiClemente, Velasquez, & Donovan, 2013), the authors describe the five stages of change: precontemplation, contemplation, preparation, action, and maintenance. In the *precontemplation* stage, individuals do not realize they have an addiction or they do not wish to make changes necessary to resolve their addictive behaviors. In the *contemplation* stage individuals realize they have a problem, but have not yet fully made a commitment to change. In the *preparation* stage, they both acknowledge and are taking steps to change or resolve their addictive behaviors. In the *action* stage they actually make a commitment and begin the process of change. And in the *maintenance* stage they have made desired changes and are in the process of sustaining them. Connors et al. (2013) point out that individuals in each of these stages are likely to benefit from therapist interventions appropriate to their readiness to change. For example, consider the following exchange, where Ann's therapist fails to consider her readiness to change and any goals she might have regarding her alcohol consumption.

Therapist: *So Ann, are you saying that you and your husband drink wine every night?*

Ann: *Yes, it's become like a hobby. We love discovering new wines from all over the world.*

Therapist: *Ann, it might be time for you and your husband to cut down on your drinking.*

In this brief exchange Ann's therapist makes a fundamental mistake. The therapist fails to inquire about Ann's readiness to change. As Ann appears to be in the precontemplation stage, her therapist's approach may be met with some resistance. It might even damage the therapeutic relationship. Action-oriented approaches tend to be ill suited to earlier stages of change (Miller & Rollnick, 2013). A better therapeutic strategy would be to engage Ann in a discussion about her readiness to change.

Motivational interviewing (MI; Miller & Rollnick, 2013) is an empirically supported approach to helping people change addictive behaviors (for review see Dunn, Deroo, & Rivara, 2001). MI involves "conversations about change" (Miller & Rollnick, 2013) wherein therapists guide clients to consider changes that will benefit them. In MI, it is recognized that people who engage in addictive behaviors typically feel ambivalent about these behaviors; they have contradictory thoughts, beliefs, and feelings about changing. For example, individuals who smoke cigarettes both *do* and *do not* want to stop for various reasons. On one hand they *do* want to quit smoking in order to improve their health, save money, satisfy friends and family, and end the "dirty looks" of strangers who see them smoking. On the other hand, they *do not* want to quit because they believe they will be irritable, gain weight, and ultimately relapse as they try to quit.

Therapists practicing MI are most effective when they encourage clients to generate their own internal reasons to change. The following dialogue illustrates how Ann's therapist might have addressed Ann's drinking with MI techniques:

Therapist: *So Ann, you and your husband drink at least a bottle of wine every night.*

Ann: *Yes, is that too much?*

Therapist: *Your question about what is "too much" is a good one. What do you think?*

Ann: *I've wondered whether we drink too much. When we're enjoying a bottle of wine over dinner I do*

not give it any thought, but when I wake up the next morning feeling under the weather I sometimes think maybe I shouldn't have drunk so much.

Therapist: *What do you mean by "under the weather?"*

Ann: *I guess I mean that I have hangovers once in a while.*

Therapist: *And what do you mean by "once in a while?"*

Ann: *Well maybe I have hangovers most mornings. Sometimes I feel groggy and other times I have a headache and nausea.*

Therapist: *How do you feel about telling me about your hangovers?*

Ann: *I'm embarrassed.*

Therapist: *Please do not be embarrassed. I'm simply trying to better understand your drinking pattern. And I appreciate your honesty.*

Ann: *So maybe I need to seriously think about my drinking. I should probably talk to my husband.*

Therapist: *Sounds like a good start. Thanks for being so honest with me.*

In this example the therapist has followed the principles of MI by guiding Ann to draw her own conclusions about alcohol consumption and the consequences of her drinking. According to Miller and Rollnick (2013), the four processes essential to MI include *engaging* clients in a strong working relationship, *focusing* on topics important to clients, *evoking* clients' own reasons for change, and *planning* change. Core skills required for achieving these processes include asking open questions, providing affirmative responses, reflecting important ideas shared by clients, summarizing themes discussed, and eventually planning. When done effectively, clients feel engaged in the MI process, empowered to change, open, and understood. This is apparent when Ann admits to contemplating that she has a drinking problem.

Among the many strengths of MI is the identification of two forms of client communication: *change talk* and *sustain talk*. *Change talk* is characterized by drive and optimism regarding change, while *sustain talk* is characterized by tentativeness or even a directly expressed desire to continue the addictive behaviors. Miller and Rollnick (2013) describe these two forms of client communication as "conceptually opposite," reflecting the ambivalence felt by most people about their addictive behaviors. The goal of the MI therapist is to guide clients to focus on their own motivation for change, reflected in increased *change talk* and decreased *sustain talk*. Ann shifts from *sustain talk* ("They say that red wine is good for your health.") to *change talk* when she says, "I need to cut back."

Summary and Conclusions

In this paper, we have proposed that therapists are at risk for making two types of clinical errors when working with clients with addictions: failing to *diagnose* addictive behaviors and failing to effectively *treat* addictive behaviors. We have argued that failure to address addictive behaviors can result in substantial adverse physical and mental health consequences. We conclude this paper with five recommendations, hoping to influence therapists to avoid these errors:

1. We recommend that therapists consistently screen and diagnose addictive behaviors during initial assessments, aware that there are symptoms common to both addictive behaviors and other mental health problems.

2. We recommend that therapists offer empirically supported treatments to clients with addictive behaviors, taking clients' readiness to change carefully into consideration (e.g., MI and integrated therapy approaches). Even the simple addition of MI to standard treatment options, such as cognitive–behavioral therapy, can have long-term benefits (Cleary et al., 2009; Lydecker et al., 2010).

3. We recommend that psychotherapy training programs require at least basic education and training in the diagnosis and treatment of addictive behaviors, so all therapists have relevant addiction-related knowledge and skills.

4. We recommend that education and training programs address *prohibitive attitudes* about addictive behaviors, so therapists realize it is within their purview and potentially helpful to diagnose and treat addictive behaviors.

5. We recommend that professional organizations representing psychotherapists pay greater attention to addictive behaviors. These organizations are especially well positioned to raise awareness about addictive behaviors among general psychotherapy practitioners.

We believe that these recommendations provide a foundation for reducing the two errors described in this paper: failure to diagnose and failure to treat addictive behaviors. When these errors are reduced, damage done by addictive behaviors will decrease, and lives will likely be enriched or even saved.

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