A Socio-Behavioral Model for the Treatment of Addiction

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Abstract

This paper describes an application of social exchange and social role theories in the development of socio-behavioral strategies for treatment of addiction. Socio-behavioral modalities include social empowerment, resocialization, effective referral and linkage to social resources, and the therapeutic relationship. The model incorporates these socio-behavioral strategies with behavioral self-management, medication-assisted treatment, and psychoeducation to create a comprehensive approach. The framework addresses bio-psycho-social-spiritual dimensions as well as the micro and macro practice arenas in the treatment of addiction.

Keywords: social exchange; social role theory; social empowerment; social connectedness, advocacy; recovery capital

Introduction

This paper will discuss a new socio-behavioral model for social work practice in the field of addiction. The key concepts of social empowerment, social connectedness, client self-advocacy, referral and linkage to social resources, and resocialization will be of particular interest. Also, the focus will be on micro- (individual, family, small group), meso- (neighborhood and voluntary associations such as church and school), and macro- (community, state, national policies) levels of recovery (White, 2008, 20). Social exchange and social role theories will be used to develop key concepts (McDonell, 2006; Dulin, 2007).

Early socio-behavioral formulations sought to apply behavioral theory in concert with the incorporation of knowledge from social systems and role theories. The goal was the application of theories of organization, socialization, and deviance, with a focus, not only upon the individual but concern for intervening with family, organizational, and community as well (Thomas, 1967, 17).

Edwin Thomas was among the first social work theorists to apply behavioral techniques to social work practice. He edited a monograph in which behavioral approaches within a variety of social work settings (social casework, group work, administrative practice, and community organization) were discussed (Thomas, 1967). Richard Stuart, another socio-behavioral social work pioneer, edited a publication with multiple authors whose chapters addressed behavioral self-management as the overall strategy for change (Stuart, 1977). He also applied social exchange theory to couples therapy through behavioral exchange therapy (Stuart, 2003, 237-251).

The BE-SMART Model: An Integrative Socio-Behavioral Approach

This article will present information regarding the BE-SMART Model, a new socio-behavioral approach for social work treatment of addiction. The model incorporates traditional techniques (behavioral self-management, medication-assisted treatment, and psychoeducation) with socio-behavioral modalities (social empowerment; social connectedness, client self-advocacy, referral and linkage, and resocialization). It is designed to treat addiction as a chronic disorder (Saitz, 2008).

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B: Behavioral Self-Management

Self-management is the use of behavioral techniques to change one's own behavior (Sarafino, 2010, 4). The approach has been used in various settings, including chronic disorders (Grady & Gough, 2014), mental health (Druss et al., 2010), and addiction (Dive, 2003). Common techniques are self-reward, self-monitoring, relaxation techniques, and assertiveness training.

Self-management techniques have been focused upon abstinence through relapse prevention (Haack et al., 2005; Marlatt & Witkiewitz, 2005. These techniques also have been directed toward controlled drinking (Koerkel, 2006, 35-49). Self-management techniques have been applied to couples therapy and family therapy as well (Fals-Steward et al., 2004, 30-41; Ryan & Sawin, 2009, 217-225).

Self-management techniques enhance personal strengths (e.g., distress tolerance, self-confidence, and rational thinking) and challenge relapse risks (inadequate coping skills, drug craving, and addictive thinking). Cognitive restructuring, relaxation techniques, mental rehearsal for relapse prevention, and assertiveness training to resist peer pressure are common strategies.

Self-Management and Recovery Training (SMART Recovery) is a primary social resource for the BE-SMART Model. SMART Recovery includes clinical materials available for in-session and extra-session practice (SMART Recovery, 2018). Other self-management resources include technology such as smartphone apps (Luxton et al., 2011; Scott, Dennis,&Gustafson, 2017, 374).

Just as in the case of other chronic conditions such as hypertension and bipolar disorder, recovery check-ups are a necessity (Dennis, 2009; Dennis, Scott, & Funk, 2003). These periodic reassessments would be scheduled at progressively lengthened intervals up to annual check-ups after discharge. Part of these periodic evaluations would include a review of behavioral self-management techniques in need of updating for purposes of relapse prevention (or management if substance use has resumed).

The concept of "behavioral" self-management has evolved to include non-behavioral techniques. Usually described only as "self-management," the broader concept includes lifestyle decisions (nutrition and exercise) and spirituality.

Spirituality in self-management includes more than religious practices (Harvey & Cook, 2010). Spirituality is a multidimensional concept, with one dimension involving transcendence and another dimension related to the purpose and meaning of life. Transcendence refers to a belief in something or someone that is greater than oneself.

Transcendence may be related to institutional religion (God, Higher Power) or secular, based upon national or political identity, ethnic identity, or nature(Van der Veer, 2011; Wallach, H., 2015; Fischer, 2011). Harvey (2005; 2009) described spirituality as a coping mechanism for older adults. The inclusion of spirituality in treatment has been described as essential in addiction recovery (Allen et al., 2014).

Common spiritual techniques or practices in addiction recovery include prayer, meditation, surrender, confession, mindfulness, yoga, gratitude, journaling, and personal inventory. These methods aid in coping with stress, finding meaning in one's life, managing chronic pain, and gaining the courage to resist craving through a Higher Power.

E: Effective Referral/Linkage and Social Role/Exchange Theories

Referral of clients for services from community resources is a core responsibility of social work (NASW, 2004). From a sociological perspective, the client is expected to perform a social role at the referral location. Role theory describes expectations that guide the client before and during participation at the referral resource. Clients with a severe substance use disorder often are referred to other agencies for services unavailable at the treatment facility. Common referrals are directed at medical care offices, vocational rehabilitation, literacy centers, and schools. Role theory suggests that clarity of role expectations and obligations will improve role performance. Therefore, if the client is well-informed about what he/she is expected to do at the referral agency, the obligations that he/she will incur, and the value of participation, the referral and linkage process will be more successful. Also, such clear communication will avoid confusion at the referral agency.

Also, evidence-based practice guidelines require written patient instructions to clearly define expected role behavior (SAMSHA, 2015; King & Hoppe, 2013, 385-393;   Lingle, 2013). In addition to discharge instructions, written referral instructions should be provided to the client (and family, if appropriate) to facilitate contact with the receiving agency. Referral instructions should include the following: (1) An explanation of the reason for the referral, (2) The services that the referral resource will offer, (3) Instructions for preparation before initial contact, (4) The expected benefits of involvement with the resource, and (5) Costs involved, including fees, travel time, and time commitment of services, (6) Answers to client questions should be written down as well as clearly discussed.

Also, case managers and peer support specialists can enhance linkage by transporting clients to the initial appointments (Center for Substance Abuse Treatment, 1998). This can address not only transportation needs but social support if the client has anxiety about contact with the referral agency. Motivational interviewing by the referring agency to facilitate the client's compliance has been found to be effective (Carroll et al., 2001; Rapp et al., 2008; Freeman, 2012). Motivational interviewing also would be advisable when the client arrives to strengthen retention at the new agency.

Contingency management is an established strategy for rewarding client behavior such as abstinence during treatment (Bartholomew et al., 2005). The approach awards vouchers redeemable for goods when a client exhibits negative urinalysis results or other recovery-oriented behavior. Contingency management has been found to be useful for maintaining abstinence during treatment (Pendergast et al., 2006). This approach provides a technique to reward client compliance with attendance and retention at an agency to which the client was referred. This exchange of vouchers (goods) for acceptable behavior (service/attendance) is an example of planned interpersonal resource exchange.

S: Social Empowerment

"Empowerment is understood as an intentional process that includes the initiative and action of persons in gaining power, taking over control in their lives and gaining greater access to social resources with the aim of achieving personal and collective goals" (Radovic, 2008, 215). Thus, the source of empowerment rests in client strengths and social resources. This evokes the concept of "recovery capital," a concept derived from the application of "social capital" to addiction.

Recovery Capital

"*Social capital*is the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (Bourdieu, P. & Loïc J., D. Wacquant. 1992). The concept has relevant to general social work (Overcamp-Martini, 2007; Hawkins & Maurer, 2012). One indication of the importance of social capital for the addiction field is reflected in a national study that found an inverse relationship between social capital and drug overdose rates (Zoorob & Salemi, 2017).

Granfield and Cloud (1999) applied the concept of social capital to addiction recovery. Grandfield and Cloud defined recovery capital as the "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and another drug] problems." The concept of recovery capital has been widely applied in the substance use disorder field within the past 15 years.

Personal resources (client strengths) are the client's skills, knowledge, and beliefs that support recovery. Enhanced personal resources allow the client to change. "Individual change becomes a bridge to community connectedness and social change" (Wilson, 1996). Traditional psychotherapy has addressed improvement in client strengths. The socio-behavioral approach views the goal of individual change as a vehicle for social change at micro-, meso-, and macro- levels. Social resources are people, groups, organizations, community attitudes, policies, and laws that support and promote the client's recovery.

Personal Resources (Client Strengths)

Physical Capacity: Adequate physical condition; **Motivation:** Agreement with treatment goals/plan (Commitment to treatment); **Intellectual:**Average or above intelligence; Normal cognitive functioning; **Knowledge Capacity:**Educational attainment at a High School Diploma or higher; Average or above knowledge of current

events; Adequate knowledge of relevant mental illness(es) (substance use disorder; depression, etc.); **Emotional Capacity:**Adequate distress management skills; Adequate control of Impulsivity; Adequate self-management of psychiatric symptoms; **Spiritual Capacity:**Positive sense of purpose in life; Positive sense of meaning in life; Internalized beliefs and values derived from a Higher Power; **Social Competence Capacity:**Ability to show empathy; Assertiveness; **Vocational Capacity:**Adequate job skills; Ability to accept supervision.

Social Resources

Agency Social Resources: Strong therapeutic alliance between client and therapist; Flexible appointment schedule to accommodate working clients; Use of clinical practice guidelines and measurement-based care; Availability of Medication-Assisted Treatment; Skilled professional and administrative support staff; Adequate security procedures; **Intimate Interpersonal Resources:** Supportive, safe family members; supportive, safe, close friends; Sponsor or other mentor; **Spiritual Social Resources:** Community religious organizations (e.g. church, synagogue, temple; mosque); faith-based peer support groups (e.g. Celebrate Recovery), Twelve-Step fellowships (e,g, AA, NA), National and international religious organizations, Faith-based social welfare organizations; a Higher Power (as individually or socially constructed); **Community Social Resources:** Peer support meetings; Safe neighborhood; Adequate employment opportunities; Affordable housing; Adequate public transportation; Adequate child care; Adequate police protection; Affordable health care; **Societal Social Resources:** Federal and State social welfare benefits; Laws and regulations that benefit recovery; Insurance policies that support treatment; Public support for recovery and efforts to reduce stigma; National and State consumer advocacy organizations; Professional organizations that advocate for prevention and treatment services.

A client's empowerment then is partially derived from the possession of personal resources (strengths) such as distress tolerance, assertiveness, and advocacy skills which allow the client to advocate for personal or collective rights if they are threatened. Secondly, clients derive power from social connectedness with social resources such as family, peer support groups, and advocacy organizations. The client can share the empowerment of social resources (family, friends, sponsor, peer support group, or advocacy organization) and use self-advocacy when rights are denied to increase personal empowerment and promote recovery. Reciprocally, the client provides his/her resources (affection, approval of other members, money, or service) to these social resources in exchange. The higher the recovery capital, the higher the probability of sustained recovery (Laudet & White, 2008; Moos & Moos, 2007).

Social empowerment, therefore, involves access to and connection with personal and social resources as well as efforts to expand resources through personal and group action. Some primary mechanisms that fuel empowerment are: Social connectedness and advocacy. Social connectedness addresses available resources, while advocacy responds to the need for additional resources.

Social Connectedness and Social Exchange Theory

Social connectedness is critical to addiction recovery as it is a protective factor in physical and mental health as well as abstinence (Seppala, 2014; Bathish et al., 2017, pg. 3). Unfortunately, social connectedness has declined in modern society, and subsequent polarization has increased (Hawkins et al., 2018; Putnam, 2000; Hortulanus et al., 2009). This has led to a weakening of the social fabric, increasing risk factors for physical health, mental health, and substance use disorders. *The power of mutual social support has been a critical component of addiction recovery (White, 2009). Both face-to-face and online social connectedness have been described as an essential ingredient for recovery.*

However, social networking (e.g., peer support meetings and online recovery communities) provides both resources and threats (Reardon, 2010). There are benefits to reducing social isolation. For example, clients experiencing social anxiety may be more comfortable initially participating in online meetings. However, progression to face-to-face contact would be a necessary next step. Risks of social networking include misinformation; exploitation, and privacy concerns. Fortunately, credible websites are available (e.g., http://aa-intergroup. org/directory.php;http://nachat.yolasite.com;*and* https://www.smartrecovery.org /community). Social connectedness has no universal definition. However, measures tend to describe subjective experiences rather than behaviors associated with social connectedness (Lee & Robbins, 1995; Zavaleta, 2017; Malone et al., 2012;   (Russel, 2010). The socio-behavioral approach offers another mode of definition and measurement.

This paper will apply social exchange theory to the definition of social connectedness to obtain a behavioral, objective definition. Recovery capital will be integrated with Foa and Foa's (1974) work in social exchange theory to discuss social connectedness. Foa and Foa organized the personal and social resources that people can exchange into six categories: affection, status (approval), service (labor), information, goods, and money.

The first three in the list are exchanged more selectively. They are selective in that one is particular with whom one exchanges affection, approval, and service (labor/physical activity). The remaining three categories are neutral, i.e., people are generally not particular about with whom they exchange information, goods, and money. While the exchanges of affection, approval, and service more often occur in intimate relationships, exchanges of neutral resources are found more often in formal situations such as commerce, social media, and education.

Whether such an exchange involves selective, neutral, or a combination of these categories of resources, there is a reciprocity of giving and receiving in the connections between the client and others. For example, a client's affection/empathy (listening attentively and being non-judgmental) can be exchanged for the other person's approval ("You are a very kind").

If the client is to continue to receive the desired resources from family members, close friends, and acquaintances, reciprocity of desired resources and access to them is essential. If the client fails to provide interpersonal resources desired by others or behaves in a manner that withholds or withdraws resources from others, the client will be perceived as a social burden (costs outweigh benefits to others) rather than as socially profitable (benefits exceed costs to others). Examples of withholding/withdrawing resources include hostility rather than affection, disrespect rather than approval, forcing labor from others rather than providing services, or theft rather than providing goods or money owed to others.

Therefore, it is essential to help clients plan their interpersonal exchanges to maintain social profitability in their relationships. The social worker can help the client to learn which resources other people want and those that the client can give. This is especially important in intimate relationships. It also applies to all social situations (e.g., work, school, voluntary associations, and religious or spiritual involvement). Client attention to resource exchange meaningful to both the client and others will sustain social connectedness. Thus, social connectedness not only benefits clients but also strengthens the social fabric of the couple, family, peer support group, neighborhood, and community.

Volunteer work is an example of a multi-level intervention. The client provides service, while the volunteer agency provides approval, and indirectly, the betterment of the social environment in which the client lives. Such volunteer activities include neighborhood improvement projects, homeless shelters, hospitals, animal shelters, or advocacy organizations. Also, volunteer work is a productive activity. This is important because the productive activity has been found to be a protective factor for recovery (Zapata et al., 2007; White, 2010; SMART Recovery, 2013; SAMSHA, 2018). Volunteer activities are especially important for the unemployed, disabled, or retired. Volunteerism also reduces social stigma. Many community members view persons with severe substance use disorders as "taking more from the community than they contribute, i.e., "social burdens." They are perceived as living a deviant social role (Stephens, 1991). Another aspect of social connectedness is the issue of civility.

Most Americans believe that there has been a decline in civility (Weber Shandwick and Powell Tate, in partnership with KRC Research, 2018; Spector, 2017). Sociologically, civility has been connected to behavior which expresses the worth (approval) of the other person (Masztal, 2001). Social work values, therefore, encourage civility by an emphasis upon dignity and respect for the individual. From an interpersonal resource exchange perspective, it may be helpful to use the metaphor of temperature to describe the resource categories.

Metaphorically, selective resources (affection, approval, service) may be thought of as "warm," while the neutral resources (information, goods, money) may be considered "cool" in tone. The injection of selective resources into social interaction will enhance civility within one's family, voluntary associations, and formal settings such as shopping. For example, expressing appreciation (approval) for the partner after he/she has mowed the lawn (service), increases civility in intimate relationships. Addressing store clerks as Sir or Ma'am (when appropriate) or "Thank you" to the clerk for bagging one's groceries (a service) promotes civility. Behaviors that withhold respect, promote hatred, and harm others are examples of incivility.

Metaphorically, civility provides "warmth" to the social environment, healing the social fabric and individuals within it. Therefore, treatment materials focused upon civility training are included social connectedness and resocialization training.

Client Advocacy and Social Role Theory

Clients are socialized into a new social role of self-advocate, involving expectations, norms, and behaviors. Advocacy seeks to increase control of social resources that have been withdrawn or withheld unjustly. Indeed, it has been suggested that recovery involves addressing discrimination and transcending shame and stigma (Sheedy & Whitter, 2009). It is also essential that clinicians trust in clients' insight and judgment to use the skills wisely (Rose, 1990).

The inclusion of self-advocacy training within treatment programs has been an innovation during the past decade (de Miranda&, 2008). The BE-SMART approach assists clients in learning self-advocacy skills and opportunities within the recovery movement (White, 2016; de Maranda, 2008). The social worker facilitates clients learning these skills by role play, mental rehearsal, and assertiveness training and provides information about New Recovery organizations such as Faces & Voices of Recovery (https://facesandvoicesofrecovery.org/about/mission-history.html).

National, state, and local advocacy organizations for severe substance use disorder prevention and recovery are available to clients for involvement in a collective activity. Faces & Voices of Recovery (www.facesandvoicesofrecovery.org), Facing Addiction with NCADD (www.facingaddiction.org), Shatterproof (www.shatterproof.org), and the National Alliance for Medication-Assisted Recovery (http://www.methadone.org) are some examples.

Clients are encouraged to explore the above advocacy organizations and consider donations, volunteer work, and recruitment of additional persons (other recovering persons and family members) to support the organizations. Information about local issues and efforts to confront them are integrated into group sessions about problem-solving skills and discrimination as a relapse trigger.

M: Medication-Assisted Treatment

Medication-Assisted Treatment (MAT) has been a controversial issue due to the use of addictive medications such as methadone and buprenorphine to treat addiction (SAMSHA, 2014, Narcotics Anonymous, 2018). However, the Federal government passed the Comprehensive Addiction and Recovery Act of 2016 which provided increased access to MAT in response to increased opioid use disorder (Littrell, 2016).

Social workers were found to be more favorable toward evidence-based treatment and MAT than other mental health clinicians and addiction counselors in one study (Bride et al., 2013). Social work literature also has promoted MAT as an evidence-based treatment (Reardon, 2014; Getz, 2018). It is important to note that the MAT addresses the biological aspect of addiction, but addiction creates psycho-social-spiritual issues that must be addressed as well. Other BE-SMART components complement MAT by enhancing personal and social resources that reduce threats such as distress intolerance, social isolation, and spiritual emptiness.

A: Addiction and Co-Occurring Disorders Client and Family Psychoeducation

Client and family education about the nature of addiction/severe substance use disorder and recovery is an essential component of treatment. An adequate understanding of the bio-psycho-social-spiritual nature of addiction is essential. Also, an awareness of addiction as a chronic disorder can help clients and significant others to understand relapse risk, and that recovery efforts and support must be on-going to achieve stability. Hazelton published a valuable psychoeducation curriculum, Living in Balance, containing a core package (12 sessions), 25 recovery management sessions, and ten co-occurring disorders sessions (Hazelton, 2015). The curriculum is adaptable to different levels of care and client populations. It uses a reflective learning approach, providing not only instructional content but also exercises for clients to reflect upon their experiences with various topics (e.g. withdrawal symptoms, emotional distress, peer pressure, and seeking meaning and purpose in life).

Also, Hazelton published a family approach that complements the Living in Balance program (Jay, 2014). Family members learn about client and family relapse warning signs, family peer support, and ways that family members can be positive influences (social resources) rather than negative influences (social threats).

R: Resocialization and Social Role Theory

The resocialization process has been described as initially desocialization, i.e., withdrawing from social roles that are no longer functional and then resocialization, i.e., adopting new social roles that are functional in the social environment (Bar-Yosef, 1968). A client may have performed these social roles in the past but had adopted the dysfunctional social roles due to addiction, or the client may be performing the new, effective social roles for the first time. Therefore, the essence of resocialization is "role change" (Fein, 1990, pg. 12).

For example, a client with a severe substance use disorder may have developed an addiction after a successful life but then adopted new social roles (e.g., deal dealer to support legal use) while failing to perform social roles such spouse, parent, or employee. However, other clients may have been raised in families immersed in the drug culture. Resocialization for the former cases is a return to previous role performance, while for the latter cases, initial socialization.

Resocialization also has a history within the socio-behavioral practice. For example, Thomas described an example of resocialization regarding the transition of former British World War II prisoners of war from a war-time prison camp subculture to the civilian culture to which they had returned (Thomas, 1967, 7-8). Civil Resettlement Units were located in different parts of Great Britain. The British resocialization program viewed the problem as desocialization, "consisting of failure to take proper social roles, to sustain social relationships, and most importantly, to assimilate the culture of one's surroundings." (Thomas, 1967). Civil Resettlement Units were deemed successful, and valuable lessons were learned and applied to the care of civilian refugees (Wilson et al., 1990).

Resocialization has become an important concept for addiction recovery. For example, a change in social identity toward a feeling of belonging to the recovering community has been found to be significant for rehabilitation (Dingle et al., 2015).

Resocialization is illustrated by William White, who described a culture of addiction and culture of recovery in his book, Pathways: From a Culture of Addiction to a Culture of Recovery (White, 1997). White described the culture of addiction in the following way: "The culture of addiction is an informed social network in which group norms (prescribed patterns of perceiving, thinking, feeling, and behaving) promote excessive drug use." The two cultures are:

The Culture of Addiction: Lifestyle is dominated by drug use; relationships are superficial and manipulative; language includes angry vulgarity, incivility, and degrading of others' efforts to abstain; immediate gratification is emphasized, and social networks include high-risk persons. White (1996, 182) observed that the rehabilitation system is not designed to treat those clients who are enmeshed in the culture of addiction. He noted that traditional outpatient and intensive outpatient treatment are not effective with clients who have been immersed in the relationships, ethics and values, and other characteristics of the culture of addiction due to family background or since adolescence. These risk factors also challenge the BE-SMART model, because such culturally enmeshed clients continue to identify with a deviant social role and social identity. Criminal records and a low educational level also hinder employment.

The Culture of Recovery: Lifestyle is focused upon positive physical and mental health; relationships involve honest communication and fulfillment of social roles; language is calm and respectful of others; gratification is deferred; social networks are diverse, including recovering persons and others from different backgrounds. Some clients have not been immersed in a culture of addiction but still require resocialization to return to social roles that have been neglected during active addiction. Such cases are similar to prisoners released to the community or military service members who return from extended, multiple deployments (Junger, 2016). These clients will still need assistance in reestablishing themselves in social roles such as spouses, partners, parents, and employees. Role theory can assist whenever there is role ambiguity between the client and significant others. For example, spouses may be reluctant to give up some of the important activities such as budgeting that the client sees as his/her role upon returning home.

T: Therapeutic Alliance and Social Exchange Theory

Multiple studies have demonstrated the necessity of a therapeutic alliance between the therapist and the client (Lambert & Barley, 2001; Horvath & Greenberg, 1994; Henriques, 2014).; Horvath & Symonds, 1991,). However, what does this mean concerning social exchange theory? A therapeutic alliance, as is true of all relationships, involves interpersonal resource exchange. What are the interpersonal resources exchanged between the client with a severe substance use disorder and social worker who is treating addiction?

The relationship may be seen as a simple commercial transaction involving the social worker providing service and information (helping the client learn relapse prevention techniques and making referrals to social resources) in exchange for payment of a fee to the social worker who is in private practice. Each participant, therefore, has equal control over their resources. The client will withhold the fee due to a perception that costs exceed benefits from the service provided.

Of course, there are other interpersonal personal resources exchanged that are integral to a therapeutic alliance. It is important for the social worker/therapist to offer one's personal resources (affection and approval) through empathy, expression of respect, confidence, and a non-judgment attitude toward the client.

If the social worker is agency-based, and the client is not in private pay status (paying entirely out-of-pocket), a "third party" is in control of some resources. For example, insurance companies control which level of care will be covered and the amount provided. Also, as an agency employee, the social worker does not have control of the duration of contact with the client. The agency may reassign the client to another staff member due to a staff shortage. If an authority (e.g., drug court) mandates that the client attend treatment or more severe charges or incarceration will result, the therapeutic relationship will be more complicated. The third party in control of specific resources may be a court, probation/parole office, child protection agency, or the client's social worker who affects organizational decisions due to reports to courts. The client may perceive the social worker as an extension of authority and thus an agent of social control.

The social worker as a social control agent can influence the withdrawal or restriction of social resources available to the client. If the social worker's reports to authority are negative about client participation, the client may lose custody of a child, or the client may be incarcerated and therefore denied access to many resources. Thus, a power differential between client and social worker results in instability in the relationship (Barstow, 2015; Urbanoski, 2010). The social worker, in reality, has another "client" in this situation, i.e., a "shadow client," who may be the child under state protection, the family member in need of protection from domestic violence, or the community in need of protection from the client's violence or property crime.

This places the social worker in the role of a social control agent. Some social workers will be uncomfortable with this reality because it seems to contradict the social work values of client self-determination and empowerment. The social worker, therefore, occupies a social role requiring the protection of others in the community as well as the client's interest. It is more useful to be candid that there is another person,/group/community ("shadow client") whose interest is sometimes primary (whether that is a child protection case, abused family, or the community). Limitations upon the client's control of resources will continue until the welfare of the "shadow client" is secure. Failure to cooperate with treatment will diminish the social profitability of both the client and, collectively, the recovering community. This will reduce the community's willingness to invest in recovery resources, reducing opportunities for continued and future treatment programs, residence in homeless shelters, and opportunities for vocational training for the entire recovering community. The effect will be fewer opportunities, stigma, and discrimination for all.

There is a risk that the priority upon the "shadow client" may be obscured by the traditional focus upon the individual in treatment. Unlike certain other cultures, Americans tend to think less about the common welfare, while individualism is dominant (Goa, 2015). This can blind the social worker from the primacy of the "shadow client's" interests at certain points in treatment when they are vulnerable. Social workers' recommendations to courts will influence decisions regarding regaining child custody, client permission to return home, or a return to jail.

Social exchange theory can clarify the power differential between the therapist and the client with a severe substance use disorder. It is helpful to consider the source of power. Power is based upon access to and control of social resources. The client comes to the therapeutic relationship with fewer relevant personal resources needed to cope with addiction. The therapist is a social resource controlling access to methods that will restore or establish the needed personal resources (strengths). These enhanced personal resources include craving management, adequate coping skills, assertiveness, and self-esteem.

Discussion and Conclusion

In efforts to apply this model in outpatient and intensive outpatient settings, some limitations of this model have emerged. First, implementation of the BE-SMART integrative model is complicated because many clients receive other treatment approaches at homeless shelters, sober living residences, faith-based facilities, and peer support meetings. Twelve Step attendance also has been frequent, creating a barrier to acceptance of medication-assisted treatment. Also, some clients remain in settings such as households and gangs that discouraged treatment and maintained a culture of addiction environment.

The socio-behavioral model is more compatible with social work's mission than other behavioral models. It intervenes with the "person-in-environment" (micro-, meso-, and macro- systems): the client, the family, the neighborhood, and the community as well). Indeed, Best and Gilman (2010, 10-11) have suggested that recovery capital grows beyond the individual to the family, neighborhood, community, and societal levels. As members of the recovering community increase their recovery capital through positive contributions such as civility, volunteerism, and challenging stigma, their families, neighborhoods, and communities gain in collective social capital.

The BE-SMART socio-behavioral model also provides a bridge between micro and macro social work practice. This long-standing divide has been divisive for the social work profession (Austin et al., 2016; Austin et al., 2005; Hennig, 2016; Rothman & Mizrahi, 2014). The BE-SMART approach encourages the client to be a change agent to improve the social environment. The client's behavior, therefore, benefits the neighborhood and community (e.g., by improving a neighborhood park, donating to an advocacy group, voting, political activities, or volunteering). The BE-SMART model is inclusive of bio-psycho-social-spiritual dimensions of addiction: biological (MAT), psychological (behavioral self-management and psychoeducation), social (effective referral and linkage to social resources, social empowerment, resocialization, and therapeutic alliance), and spiritual (personal and social resources: belief in the purpose and meaning of life; Higher Power, religious institutions, spiritual groups).

Collaboration between social work and sociology in the addiction field has provided invaluable assistance through the recovery capital concept (derived from the sociological concept of "social capital"). Further collaboration in the addiction field would assist both micro and macro social work practices (Offer, 1999, 170). This would counter the increasing emphasis on individually-oriented methods (Levin, Haldar & Picot, 2015). Social workers would benefit from the further development of this work and other socio-behavioral practices.

Greater focus on the topics of social empowerment (social connectedness, client self-advocacy, and spirituality), effective referral and linkage strategies, resocialization, and client-therapist interpersonal exchange would better distinguish the social work role from other mental health providers' roles in the field of addiction treatment. This would clarify the value of social work involvement in the treatment team or group involved in advocacy or macro-level issues.

References

Allen, J. P. , Nieuwsma, J.A., Pollitt, M.J., & Blazer, D.G. (2014). Recovery on higher ground: Spirituality in the treatment of substance abuse, Current Psychiatry, 13, 29- 40.

Austin, M. J., Coombs, M.,& Barr, B. (2005). Community-centered clinical practice: Is the integration of micro and macro social work practice possible? *Journal of Community Practice*, 13, 9-30.

Austin, M.J., Anthony, E.J., Knee, R.T., & Mathias, J. (2016). Revisiting the relationship between micro and macro social work practice, *Families in Society*, 97, 270-277.

Bar-Yosef, R. W. (1968). Desocialization and Resocialization: The Adjustment Process of Immigrants, *International Migration Review*, 2, 27-45.

Barstow, C. (2015). The power differential and why it matters so much in therapy, GoodTherapy.org.   (2015). https://www.goodtherapy.org/blog/power-differential-why-it-matters-so-much-in-therapy-1009154

Bartholomew, N. G., Rowan-Szal, G.A., & Simpson, D.D.(2005). Texas Institute of Behavioral Research. I-28.

Bathish, R., Best, D., Sivic, M., Beckwith, M., Mackenzie, J., Lebman, D. (2017). Is it me or should my friends take the credit? The role of networks and social identity in recovery from addiction, *Journal of Applied Social Psychology*, 47, 35- 46.

Best, D. & Gilman, M. (2010, February). Recovering happiness, *Drink and Drugs News*, 10-11. Retrieved from: https://drinkanddrugsnews.com/wp-content/uploads/2012/12/DDN2feb10.pdf

Bride, B. E., Abraham, A. J., Kintzle, S., & Roman, P. M. (2013). Social workers' knowledge and perceptions of effectiveness and acceptability ofmedication-assisted treatment of substance use disorders. *Social Work inHealth Care*, 52, 43- 58.

Brown L.D., Tang, X., &Hollman, R.L. (2014). The structure of social exchange in self-help support groups: Development of a measure, A*merican Journal of Community Psychology*, 53, 83-95.

Bourdieu, P. & Wacquant, L. 1992. An Invitation to Reflexive Sociology. Chicago and London: University of Chicago Press.

Carroll, K. M.,Ball, S. A.,Nich, C., Martino, S., Frankforter, T. L., Farentinos, C.,

Woody, G.E. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence*. 81, 301–312.

de Miranda J. (2008). Training your patients to become advocates for themselves and for systems change. *Alcoholism and Drug Abuse Weekly*, 3.

 de Miranda, J. & McGirr, K. (2010, March-April). Mixing advocacy with treatment. *Addiction Professional*, 8, 22-24.

Dennis, M. (2009). Managing addiction as a chronic condition. Webinar [video] National Council for Community Behavioral Healthcare.

Dennis M., Scott, C. K., Funk, R. (2003).An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorder. *Evaluationand Program Planning*, 26, 339-352.

Dennis, M. & Scott, C.K. (2007).

Dingle.G., Cruwys, T., & Frings, D. (2015). Social Identities as Pathways into

and out of Addiction. *Frontiers of Psychology*, 6, 1795.

Diver, L. (2003). Self-management and addiction, *Visions Journal*, 1, 12-13.

Druss, B.G, Zhao,L., Von Esenwein,S.A., Bona, J.R., Fricks, L., Jenkins-Tucker, S. ……. Lorig, K. (2010). *Schizophrenia Research*. 118, 264–270.

Dulin, A. M. (2007). A lesson on role theory: An example of human behavior in the social

environment theory. *Advances in Social Work*, 8, 104-112.

Fals-Stewart, W., O'Ferrell, T.J., & Birchler, G.R. (2004). Behavioral couples therapy for substance abuse: Rationale, methods, findings. *Science and Practice Perspectives*. 30-41.

Fein, Melvyn L.(1991). **Role change: A resocialization perspective.** Social Forces, 69, 1275–1276.

Kathleen, Fischer (2011). Long Life on a Fragile Planet: Nature, Spirituality, and Aging, Journal of Religion, Spirituality & Aging,*23*, 3.

Foa, E. B. & Foa, U.G. (2012). Resource Theory of Social Exchange. Chapter 2. In Tormblom, K. & Kazemi, Handbook of Social Exchange: Theoretical Extensions, Empirical Insights, and Social Applications, Critical Issues in Social Justice. Springfield Science + Business Media. New York.

Freeman, S. D., (October 9, 2012) Using motivational interviewing as a strength-based model. [Webinar] Building and Nurturing Communities of Color. Retrieved from https://docplayer.net/33140167-Using-motivational-interviewing-as-a-strength-based-model.html.

Getz, L. (2018). Medication-Assisted Treatment: Tool Tackling Opioid Crisis Faces Stigma, Other Barriers. 18, 10.

Goa, G. (2015). How do Americans stand out from the rest of the world? Pew

Research Center. https://collections.lib.utah.edu/details?id=706409.

Granfield, R. and Cloud, W. (1999). Coming Clean: Overcoming Addiction Without Treatment. 213. New York, NY, US: New York University Press.

Haack, M., Alemi, F., Nemes, S., Harge, A., Burda-Cohee, C., Benson, L. (2005).   Facilitating   the   self-management
        of substance use disorders with online   counseling. *Journal of Addiction Nursing*, 16, 41-46.

Harvey, I.S. (2009). Spiritual self-management: A look at older adults with chronic illness,   *Spirituality & Aging*, 3, 200-
        218.

Harvey, I.S. & Cook, L. (2010). Exploring the role of spirituality in self-management among older African American
        and non-Hispanic women with chronic conditions, *Chronic Illnesses*, 1-14.

Hawkins, R. L, and Maurer, K. (2012). Unraveling social capital: Disentangling a   concept for   social   work.   *British
        Journal of Social Work*, 42, 353-370. Hawkins, S., Yudkin,   D., Juan-Torres, M., & Dixon, T. (2018). Hidden
        Tribes: A   Study of America's   Polarized Landscape. More in Common,

Henriques, G. (2014). The Key Ingredients to Good Psychological Therapy

Nine ingredients to ensure good therapy. Psychology Today. October 29,   2014. Retrieved from
        https://www.psychologytoday.com/us/blog/theory-knowledge/201410/the-key-ingredients-good-
        psychological-therapy.

Hazelden Publishing and Educational Services. (2015). *Living in Balance: Moving from a life of addiction to a life of recovery*.
        Center City, MN. Author.

Henning, B. L. Connections. *Why should macro social work matter to a micro social worker?* (2016). NASW.CT Newsletter,
        NASW   Connecticut   Chapter.   Rocky   Hill,   CT.   1,   4.   Retrieved   from: http://naswct.org/wp-
        content/uploads/2016/10/October-December-2016-Newsletter.pdf.

Hortulanus, R., Machielse, A.,&jMeeuwesen, L. 2006.*Social Isolation in Modern Society*. Abingdon, U.K.: Routledge.

Horvath, A. O., and Greenberg, L.S. (1994). *Working Alliance*. New York: Wiley.

Horvath, A.O. & Symonds, B., D. (1991). The relation between a working alliance and   outcome   in
        psychotherapy: A Meta-Analysis. *Journal of Counseling Psychology*, 38, 139-149.

Jay, D. (2014). *It Takes a Family: A Cooperative Approach to Lasting Sobriety*. Hazelden Publishing: Center City, MN.

King, A, Hoppe, R.B. (2013). "Best practice" for patient-centered communication: A narrative review. Journal of
        Graduate Medical Education, 5, 385-393.

Koerkel, J. (2006). Behavioral self-management with problem drinkers: One-year follow-up of a controlled drinking
        group treatment approach. *Addiction Research and Theory*, 14, 35-49.

Krentzman, A.R. (2016). What is spirituality? Retrieved from https://www.takingcharge.
                    csh.umn.edu/what-spirituality.

Laudet, A., White, W. (2008). Recovery Capital as Prospective Predictor of Sustained Recovery, Life satisfaction, and
        Stress among former polysubstance users, *Substance Use &Misuse*, 43, 27-54.

Lambert, M., J. & Barley, D., E. (2001). Research Summary on the therapeutic relationship and psychotherapy
        outcome. *Psychotherapy*, 38, 357-361.

Leven, I., Haldar, M., & Picot, A. (2015). Social work and sociology: historical separation and current challenges,
        Nordic Social Work Research, 5:sup1, 1-6,

Lingle, C.L., (2013). Evidence-based practice: Patient discharge education barriers to patient education. Nursing
        Thesis and Capstone Projects, 67.

Littrell, J. (2016). Expanding access to medication-assisted treatment: The U.S. government 's response to the current
        heroin epidemic, Social Work Faculty Publications, 66, 1-39.

Luxton, D., McCann, R.A., Bush, N.E., Mishkind, M.C., Reger, G.M. (2011). mHealth for mental health: Integrating
        smartphone technology in behavioral healthcare. *Professional Psychology: Research and Practice*, 42, 505-512.

Malone, G.P., Pillow, D.R., Osman, A. (2012). The General Belongingness Scale (GBS): Assessing achieved
        belongingness. *Personality and Individual Differences*, 52, 311-316.

Mattocks, N.O. (2018). Social Action among Social Work Practitioners: Examining the Micro-Macro Divide, Social
        Work, 63, 7–16.

Marlatt, G.A., & Witkiewitz, K., (2005). Relapse Prevention for Alcohol and Drug Problems   Chapter   in   Relapse
        Prevention, Second Edition, Maintenance Strategies in the Treatment of Addictive Behaviors, Marlatt, G.A.
        & Dennis M. Donovan, Guilford Publications, 1-44.

McDonell, J., Strom-Gottfried, K. J., Burton, D. L., & Yaffe, J. (2006). Behaviorism, social learning, and exchange
        theory, in S. P. Robbins, P. Chatterjee, and E. R. Canda, Contemporary human behavior theory: a critical
        perspective for social work. Pearson, 349-85.

Misztal, B. (2013). Trust in Modern Societies. Cambridge, UK: Polity.

Moos, R. H. & Moos, B.S. (2007). Protective resources and long-term recovery from alcohol use disorders. Drug and Alcohol Dependence, 86, 46-54.

Overcamp-Martini, M., (2007). Advances in Social Work, 8, Indiana University School of Social Work, 196-207.

Narcotics Anonymous (2018). WORLD SERVICEBOARD OF TRUSTEES BULLETIN #29, Retrieved from https://www.na.org/?ID=bulletins-bull29

National Association of Social Workers. (August 4, 2017). NASW Code of Ethics (Guide to the Everyday Professional Conduct of Social Workers). Washington, DC: NASW. Retrieved from: https://www.socialworkers.org/
About/Ethics/Code-of-Ethics/Code-of-Ethics-English.

Offer, J. (1999). Social Workers, the Community, and Social Interaction: Intervention and the Sociology of Welfare. Philadelphia: Jessica Kingsley Publishers.

Prendergast, D. D., Podus, D., Finney, J., Greenwell, L., Roll, J. (2006). Contingency management for treatment of substance use disorders: a meta-analysis. *Addiction*, 101, 1546-1560.

Putnam, R. D. (2001) Bowling Alone: The Collapse and Revival of American Community, New York, NY: Simon & Schuster.

Radovic, M. (2008). Theory of social empowerment in social work. *Annual of Social Work*, 15, 215-242.

Rapp, R. C. & Otto, A. L. (2008). Improving linkage with substance abuse treatment using brief   case   management and motivational interviewing. *Drug and Alcohol   Dependence*, 94, 172-182.

Reardon**, C. (2014). Medication-Assisted Treatment: A Tool to Support Addiction Recovery,** *Social Work Today,***14, 30.**

Reardon, C. (2010). **Social Networking in Addiction Recovery — Raising Hopes, Concerns,** *Social Work Today,* **10, 8.**

Rose, S. (1990). Advocacy/Empowerment: An approach to clinical practice for social work, *Journal of Sociology and Social Welfare*, 17, Article 5.

Rothman, J. and Mizrahi, T. (2014). Balancing Micro and Macro Practice: A Challenge for Social Work. *Social Work*, Volume 59, 91–93.

Ryan, P. & Sawin, K.J. (2009). The Individual and Family Self-management Theory: Background and Perspectives on Context, Process, and Outcomes.   *Nursing Outlook*, 17, 217-225.

Saitz, R., Larson, M.J., LaBelle, C., Richardson, J., Samet, J.H. (2008). The Case for Chronic Disease Management for Addiction, *Journal of Addiction Medicine,* 2, 55–   65.

Sarafino, E. (2011). Applied Behavior Analysis: Principles and Procedures in Behavior Modification, Hoboken, N.J., Wiley, 352.

Scott, C.K., Dennis, M.L., Gustafson, (2017). Using smartphones to decrease substance use via self-monitoring and recovery support: Study protocol for a randomized control trial, 374.

Seppala, E., Rossomando, T., Doty, J. (2013). Social Connection and compassion: Important predictors of health and well-being. *Social Research: An   International Quarterly*, 80, 411-430.

Self Management Addiction Recovery Program. (2013). SMART Recovery Handbook, 3rdEdition. Mentor, OH: Alcohol and Drug Abuse Self Help Network, Inc.

Shandwick, W. and Tate, P. (2018). Civility in America: A Nationwide Survey. Retrieved from: https://www.webershandwick.com/wp- content/uploads/2018/06/Civility-in-America-VII-FINAL.pdf.

Sheedy, C.K., Whitter, M. (2009). Guiding principles and elements of recovery-oriented   systems of care: What do we know from the research? HHS Publication no. (SMA) 09-4439. Rockville, MD: Center For Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 9.

Stephens, R. (1991). The Street Addict Role: A Theory of Heroin Addiction. SUNY Series: The New Inequalities. Albany, NY: SUNY Press.

Stuart, R. (Ed.). (1977). Behavioral Self-Management. New York, NY: Brunner/Mazel.

Stuart, R. (2003). Helping Couples Change: A Social Learning Approach to Marital Therapy. New York, NY: Guildford.

Substance Abuse and Mental Health Services Administration. (Producer) (2015). *Three strategies for effective referrals to specialty mental health and addiction   services* [Video webinar]. Retrieved from
         https://www.integration.samhsa.gov/about-us/Referrals_Webinar_PPT_FINAL.pdf.

Substance Abuse and Mental Health Services Administration. Comprehensive
        Case Management for Substance Abuse Treatment. (2012). Treatment Improvement Protocol (TIP) Series
        27, 87-88.
Thomas, E. (Ed.). The socio-behavioral approach and applications to social work. Council on Social Work Education,
        New York, 1967. 1-18.
Urbanoski, K.A. (2010). Coerced addiction treatment: Client perspectives and the implications of neglect. *Harm
        Reduction Journal*, 7, Article ID 13.
*Van der Veer, Peter (2011-03-01). "Spirit". Material Religion. **7** (1): 128.*
Walach H. (2015) Secular, Non-dogmatic Spirituality. In: Secular Spirituality. Studies in Neuroscience, Consciousness
        and Spirituality, vol 4. Springer, Cham, 18.
Wilson, A.T., Trist, E., & Curle, A. (1990). Transitional communities and social connection: The civil resettlement of
        British prisoners of war. In Trist, E., Murray, H., & Trist, B. (Eds.). The Social Engagement of Social Science,
        1, The Social Psychological   Perspective (pp. 88-111). Philadelphia: University of Pennsylvania Press.
Wilson, P. (1996). Empowerment: Community economic development from the inside out. *Urban Studies*, 33, 617-630.
White, W., (1996). Pathways: From the Culture of Addiction to the Culture of Recovery. Center City, MN: Hazelden.
White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals, *Counselor*, 9, 22-27.
White, W., (2008). Recovery management and recovery-oriented systems of care: Scientific rationale and promising
        practices. fifth in a series of monographs, Addiction Technology Transfer Center.
White, W. (2009).The mobilization of community resources to support long-term addiction recovery, 36, 146-158.
White, W. (2016).William White: The State of Recovery Advocacy in the U.S.: An interview with Patty McCarthy
        Metcalf. Retrieved at https://facesandvoicesofrecovery.org/news-
            events/newsroom.html/article/2016/12/12/william-white-the-state-of-   recovery-advocacy-in-the-
        US-an-interview-with-patty-McCarthy-metcalf.

Zapata, Mario A.; Segura, Angela, M. (2007). Predictive Factors for Drug Addict Patients' Treatment Results,
        NIDA International Drug Abuse Research Abstract Database,
        https://www.drugabuse.gov/international/abstracts/predictive-factors-drug-addict-patients-treatment-
        results.
Zavaleta, D., Samuel, K., Mills, C. (2017). Measures of social isolation. *Social Indicators Research*, 131, 367-391.
Zoorob, M.J., Salemi J. L. (2017). Bowling alone, dying together: The role of social capital in mitigating the drug
        overdose epidemic in the United States. *Drug & Alcohol Dependence*, 173, 1-9.