Substance Abuse as a “Niche” Area for Psychologists
By Vic Pantesco, Ed.D.

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Webster’s internet dictionary provides the primary historical meaning of “niche” to be a recess in a wall for a statue, and near the end of alternative definitions lists “a specialized market.” The first definition suggests stasis, reverence, and protection from the elements; the second appears to have evolved from that protection. At any rate, society, insurance benefit management companies and the health industry generally hardly revere substance abuse treatment, so the niche in point here has more to do with market survival.

Given these factors – poor resources and exploding need – set in a context of market survival in a beleaguered field, why pursue substance abuse as a specialty? In my personal and professional responses to that question, the assignment for this article, I hope to convey through reflection here why it is and has been rewarding for me and maybe for others. I present them with no particular hierarchy in mind.

First, I think the substance abuse field is rich in its history and ability to reflect political, economic, cultural, and clinical thinking- or lack thereof. For example, classifying substance abuse as a disease landed it squarely within the discourse about disease as socially constructed, as Robert Aronowitz, M.D. (Making Sense of Illness 1998) has so thoroughly and articulately pointed out. As a “disease” substance abuse enjoys the status and benefits bestowed by such classification, but it thereby becomes vulnerable to a core paradox ushered in (like the “risk factor” and “Type A” research movements within cardiology). Calling risk factors such as hyperlipidemia “diseases” in themselves introduced a moral quality into one’s contraction of the disease, i.e.: “If I lived better or made better choices, I would not have plaque clogging my arteries.” Profiting from classification as disease, substance abuse then becomes fair game for moral considerations surrounding use. It is a short bridge from that to managed benefits refusing to fund treatment for “moral violations.” In addition, A.A. for decades has denounced anything moral being involved in the “disease.” I think psychologists in their training and research capacity can add much to these debates and anomalies by seeking clarity and compelling evidence for classifications and understanding.

Second, this field offers psychologists a chance to make a difference in society and communities. The political and cultural climate appears to be ripe for advocating better comprehensive treatment for substance abusers. Most psychologists have been frustrated and alarmed at trying to find good- no, make that any- treatment for substance abuse.

Further, we can break denial and social sanction patterns surrounding this problem. A couple of years ago, I was asked to assess an adolescent. I had permission, even encouragement, to do a full scope: personality, pathology, learning, etc. There was only one proscription: “You are not to ask anything about drugs or alcohol.” And, I think such attitude has a lot to do with the proliferation of ADHD false diagnoses in adolescents and adults hiding family system-substance abuse dynamics, the self-medication of ADHD hypothesis notwithstanding. Good diagnosing
and confronting societal or economic pressures to avoid substance abuse is appropriate territory in which psychologists may bring their expertise to bear.

Third, the substance abuse field inherently provides challenging and enriching territory to exercise and develop skill as diagnostician and clinician. An early mentor of mine while I did internship work on the close-observation intake unit in an addictions hospital told me: “If you can diagnose on this unit, you can diagnose anywhere.” Of course. Where else would you have to wrestle with alcoholic hallucinosis versus psychosis, complicated by the physiology of detox? Or lithium toxicity versus alcoholic amnestic disorder in a middle-aged bipolar substance dependent man out of control with prescribed and other “medications?” Or, true borderline versus ersatz borderline secondary to the co-mingled conditions of untreated sexual abuse PTSD and substance “medications” over the years? We did this on a daily basis. Treatment facilities where we have the luxury to treat thoroughly are few and far between, so the challenges of doing this in more compressed outpatient settings are great. Psychologists have the training and skill to do this work once properly prepared in this specific area.

Fourth, there is more opportunity to work as evaluators. I get many calls to do assessments for substance abuse, and they run the gamut from very young pre-adolescents to older adults. I have both the LADAC and the Substance Abuse Professional certifications. These credentials provide me with the opportunity to perform assessments for third parties and take part in assuring safety in society. In addition, this expertise has allowed me to present on state, national, and local levels. This has been a great joy.

Finally, working in this field for 12 years in hospitals and 17 years in general practice has been inspiring to me personally. My co-workers in hospitals were among the finest, healthiest colleagues I have encountered. The malady necessarily takes us to the worst and most tragic that human life has to offer, but it also, in recovery, opens up huge vistas of humor, edification, health, and gratitude. I have learned so much from the people I have walked with, however briefly, in their battle against drugs and alcohol.

I would be most happy to talk more with colleagues interested in this area or to consult about cases.

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