1

Background and Overview

Alcohol and drug use[1] is a common occurrence in today's society, with such use often associated with a variety of medical, psychological, and social problems (Galanter & Kleber, 2008). As we discuss later in this chapter, the financial costs to society are extremely high, and the human suffering is considerable. For these reasons society has looked to treatment as one way to modify an individual's substance use and its concomitant problems.

This book is a practical guide to treatment of alcohol and drug use disorders in adults that is based on the most current theory and research. We devote this chapter, as a foundation, to highlighting the prevalence of drug use and the consequences of harmful drug use. We then discuss efforts to formally define patterns of alcohol and drug use that are identified with people who participate in professional treatment programs. Following that, we note that treatment has been given a lot of attention in the alcohol and drug fields because of the urgency felt to change alcohol and drug use patterns that are harmful to individuals, society, or both. Accordingly, we then introduce the stages-of-change model, a conceptual approach to behavior change that has had a substantial impact on the treatment of substance abusers and is used as a focal point for crystallizing the diverse information presented in this volume.

[1]In this volume we use the terms "alcohol and drugs" or "drugs" as mutually *inclusive* terms. In fact, to say "alcohol and drugs" is redundant, since alcohol *is* a drug. However, because of the ways in which reports of basic and clinical research and other literature in the field have been written or organized, we will at times distinguish between alcohol and other drugs. We also should note that alcohol and other drugs typically are talked about by the population in general as though they are distinctly different.

ALCOHOL AND DRUG USE

The emphasis of this book is on alcohol and drug use that is excessive and results in problems in functioning. A step toward understanding such drug use patterns is to view an individual's use in the context of drug use in society in general. Along these lines, the national surveys of alcohol and other drug use that have been taken periodically over the past several decades are instructive.[2]

In the 2010 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2011), data about drug use in the United States were collected from participants from the civilian, noninstitutionalized population aged 12 years or older. The data include overall prevalence of use during the past year and past month for different drugs, including alcohol and tobacco cigarettes. In this case, "use" means the respondent used that specific drug in question at least once during a particular time period (usually the last 30 days or past year). Several findings stand out. First, alcohol (used by 66% in the past year) leads the use list, followed by cigarettes (used by 27%) in a distant second place. Marijuana and hashish (at 12%) head the list of illicit drug use. These relationships hold up both for use in the past year and for use in the past month.

In terms of illicit drug use (a category including marijuana/hashish, cocaine [including crack], heroin, hallucinogens, inhalants, or prescription medications used in a manner not prescribed), current (i.e., past month) use was reported by 8.9% of the sample. The most commonly used illicit drug in the past month was marijuana, currently used by 6.9% of the sample. Current use of other illicit substances was considerably lower: 2.7% for nonmedical use of prescription-type psychotherapeutic drugs and less than 1% for cocaine (0.6%), hallucinogens (0.5%), and methamphetamine (0.2%). The presentation of percentages, however, sometimes underappreciates the numbers of individuals involved. For example, the 2.7% current use rate for prescription-type psychotherapeutics used in a manner not prescribed represents seven million individuals across the United States.

[2]For this discussion we use data from the 2010 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2011). In this survey, interviews were completed with over 68,000 persons age 12 years or older in the civilian, noninstitutionalized population of the United States. Although the sample did include persons living in places like shelters, rooming houses, and college dorms, it did not include those who were in jail or military personnel on active duty. Overall, the national household surveys provide the best single description of frequency and quantity of different drug use in U.S. society.

For alcohol use, the survey revealed than just over half (52%) of the sample aged 12 or older reported being past-month drinkers of alcohol, translating into an estimated 131.3 million people. Almost one-quarter of the population (23.1%) reported having participated in binge drinking (with binge drinking defined as having five or more drinks on at least one occasion during the previous month).

The survey also gathered useful information on substance abuse, substance dependence, and treatment. In 2010, an estimated 8.7% of the population were classified with substance abuse or dependence in the past year, based on criteria specified in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). Over two-thirds of these individuals (67.8%) were dependent on or abused alcohol but not illicit drugs; the remainder were either classified with dependence on or abuse of both alcohol and illicit drugs (13.1%) or with dependence on or abuse of illicit drugs but not alcohol (19.0%). The illicit drug with the highest level of past year dependence or abuse was marijuana, followed by pain relievers and cocaine.

Finally, in terms of treatment, it was estimated that 9.3% of those surveyed (representing 23.5 million individuals) needed treatment for an illicit drug use or alcohol use problem. Only 2.6 million of these 23.1 million individuals needing treatment actually received treatment (representing 1.0% of the sample overall and 11.2% of those identified as needing treatment). Thus, the vast majority of individuals identified as needing treatment for an illicit drug or alcohol use problem did not receive treatment during the previous year. Noteworthy is that among those classified as needing treatment but not receiving treatment, only 5.0% reported that they actually felt they needed treatment for their illicit drug or alcohol use problem.

The national survey data provide clinicians with the best single frame of reference to evaluate and interpret substance use by their clients.[3] Quality of the interpretation tends to improve with attention to subgroup differences. That is, any given client's pattern of substance use

[3]In the treatment of substance use disorders there is inconsistency among professionals in their use of the words "patient" or "client" to refer to individuals presenting for treatment. Often the term chosen depends on the treatment setting—that is, individuals in hospital inpatient settings are more likely to be referred to as "patients" while persons receiving treatment in outpatient community clinics are more likely to be referred to as "clients." In this volume we use the terms "patient" and "client" as synonymous to refer to an individual who is in formal treatment for his or her substance use problems.

can best be viewed in the context of what is typical for his or her subgroup as defined by characteristics such as age or gender. Of course, this principle might be applied to a range of sociodemographic (e.g., years of education) and other characteristics of the person. Substance use problems occur across all classes and groups in individuals and there is no typical substance abuser. However, knowledge of the norms of substance use for a client's subgroup can help the clinician and client to plan treatment goals and to anticipate the likely obstacles and supports in achieving and maintaining them.

THE PRICE OF DRUG USE

The consequences of alcohol and drug abuse are costly. "Cost-of-illness" studies provide a detailed estimate of the cost, in dollars, of a given illness or disease. In 2011, an economic study of the impact of illicit drug use on U.S. society was released by the U.S. Department of Justice (2011). Using data for 2007, the cost of illicit drug use totaled over $193 billion. This cost estimate was attributable to illicit drug use as gauged in three principal areas. The first, representing a cost estimated at $61.4 billion, was crime, predominantly capturing criminal justice system costs. The second principal area of cost, at $11.4 billion, was health. Major contributors in this area were hospital and emergency department costs for both nonhomicide and homicide cases and specialty treatment costs. However, the largest cost associated with illicit drug use, at $120.3 billion, was in the domain of productivity. This principal area included labor participation costs, incarceration costs, premature mortality costs, and specialty treatment costs for services provided at either the state or federal level.

The Department of Justice study only considered illicit drug use (including nonprescription use of prescription medications) and did not include alcohol use in its calculations. The additional costs associated with alcohol use in the United States are estimated to total $185 billion annually (Harwood, 2000). The majority of these costs are associated with reduced, lost, and forgone earnings, with the remainder attributed to costs associated with medical consequences and alcohol treatment and with lost workforce productivity, accidents, violence, and premature death.

The combined annual costs associated with alcohol and illicit drug use in the United States thus are in excess of $375 billion, a monumental

figure using any standard. And the United States is not alone in experiencing enormous costs associated with alcohol and illicit drug use. Indeed, significant economic impacts of alcohol use and of illicit drug use have been reported globally (e.g., Baumberg, 2006; Rehm, Taylor, & Room, 2006; Thavorncharoensap et al., 2009). Looking only at alcohol consequences, the World Health Organization (2011) has estimated that approximately 2.3 million people die each year from the harmful use of alcohol, representing about 3.8% of all deaths in the world. Over half of these deaths occurred as a consequences of noncommunicable diseases, such as cancers, cardiovascular disease, and liver cirrhosis. Indeed, the World Health Organization estimates that 4.5% of the global burden of disease, as measured in disability-adjusted life years, is a consequence of harmful alcohol consumption.

It is noteworthy that although the economic impact of substance use extends well beyond the substance user, there are consequences closer to home for the families and significant others around the user. In the case of alcohol, for example, Casswell, You, and Huckle (2011) found that greater degrees of exposure to a heavy drinker are associated with lower health status and personal well-being on the part of the family member/significant other, even after controlling for demographic variables and the family member/significant other's own drinking. Comparable findings have been reported by Livingston, Wilkinson, and Laslett (2010).

Taken together, the estimated costs of alcohol and other drug abuse are staggering. While cost-of-illness studies are recognized as imprecise, such research nevertheless brings home the striking level of significant and far-reaching consequences that providers are addressing in alcohol and drug treatment. Moreover, financial cost-of-illness studies barely tap into the cost in human suffering related to substance abuse.

A BRIEF INTRODUCTION TO TREATMENT

As with many of the other concepts in this field, treatment has been variously defined. We use the definition arrived at by consensus in the Rinaldi and colleagues (Rinaldi, Steindler, Wilford, & Goodwin, 1988) Delphi Survey study. According to that study, the definition of treatment was agreed to be an "application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive, or health injuring; or to restore appropriate levels of physical, psychological, or social functioning" (Rinaldi et al., 1988, p. 557).

With this definition, it is easy to imagine many different procedures that could be called "treatment." The majority of procedures that are used in the treatment of the substance use disorders can be broadly classified into individual treatment, marital/couple/family treatment, and group treatment. We discuss each of these modalities in detail in subsequent chapters. Note that the major modes of treatment are practiced in different settings, including inpatient/residential, partial hospital, and outpatient. In addition, we discuss the use of brief interventions in a variety of opportunistic settings.

THE STAGES-OF-CHANGE MODEL

A person's resistance to a given treatment effort has been a long-standing and sometimes frustrating problem for clinicians. In particular, individuals who present for treatment of substance use disorders have the reputation among clinicians of being unduly resistant or unwilling to change. Therefore, it would be useful to have a model or theory that would help to address the problem of how to match an individual's treatment to his or her commitment to change and personal journey through the process of change. One way to achieve this end would be to have a roadmap of the course of change in general and then to coordinate the treatment procedure that best fits where the person is in the course of change. Such a chart would be descriptive of a model of change.

In fact, several stages-of-change models have appeared in the psychotherapy literature over the years (e.g., Horn, 1976; Kanfer, 1986; Rosen & Shipley, 1983). We have chosen to use the Prochaska and DiClemente (1982, 1984, 1992) "stages-of-change" model as our preferred way of addressing a person's readiness for change. This model was developed from research on the treatment procedures or techniques that were identified in theories of change and that people use in modifying a particular problem behavior. We have selected this model from among the other possibilities for three reasons. First, the model describes dimensions of the change process in terms of stages and also describes how coping activities or processes of change interact with these stages. Second, it has generated more research than other models, and much of that research has pertained to people trying to change their patterns of substance use. Finally, this research has provided evidence for the validity of the stages-of-change construct and for its clinical utility (e.g., DiClemente, 2003, 2005b, 2006).

During the past 30 years the stages-of-change model itself has undergone changes to some degree, mainly as a result of the now fairly extensive research findings on the model that have been published. However, the changes in the model relate more to content than to underlying concept so that the ideas that originally generated the model remain largely intact. The most detailed versions of the model are presented by Prochaska and DiClemente (1992), DiClemente and Prochaska (1998), and DiClemente (2003).

The current model posits five stages of change, called, from earliest to latest, precontemplation, contemplation, preparation, action, and maintenance.[4] People who are in the precontemplation stage show no evidence of intent to change a problem behavior. They may be unaware that their behavior is a problem, or aware that it might be but unwilling to do anything about it, or may be discouraged about changing the behavior as a result of past failed attempts to do so. Individuals in precontemplation tend to see the behavior as having more positives than negatives for them and therefore judge that the behavior is under control or at least manageable. More importantly, they lack the interest and concern that would lead to a serious consideration of change.

During the contemplation stage, individuals are considering changing a particular behavior. Thoughts about change might include specific personal cost and benefits related to the behavior and what the consequences of change might entail. Individuals in contemplation are more visibly concerned and distressed about their problem behaviors than are those in precontemplation and have begun to weigh the positives and negatives of the current behavior and the change. They also are more likely to search for information relevant to the problem behavior and possible solutions.

The preparation stage represents people who have made a decision and are ready to change. These individuals intend to change soon and have begun to make small changes or to incorporate their experiences of previous tries at change in their planning for the current attempt to change. As noted in DiClemente et al. (1991), people in the preparation stage may have begun to increase self-regulation and to change the problem behavior. The key task for these individuals is committing to

[4]This discussion draws heavily on a chapter by Prochaska and DiClemente (1992). The stages presented are but one component of a broader transtheoretical model of behavior change (Prochaska, 1984; Prochaska & DiClemente, 1982) that also addresses levels of change and the process of change, components of which are discussed as appropriate in other sections of this volume.

and prioritizing the change efforts and creating an effective, acceptable, and accessible plan (DiClemente, 2003).

When people are in the action stage, behavior change clearly has begun and the plan implemented. Accordingly, individuals in the action stage need skills to implement specific behavior change methods they included in their plan and revise the plan as needed. They also need to be aware of various psychological (cognitive, behavioral, emotional) events that may work against their efforts at behavior change. Furthermore, there is a need to learn ways to prevent major reversals, such as an abstinent alcoholic taking a drink and returning to prechange patterns and levels of alcohol use. Such skills are essential to maintaining the desired change in a problem behavior and are especially important in changing alcohol and drug use disorders. According to Prochaska and DiClemente (1992), the action stage lasts an average of about 6 months in people working to change their substance use.

The last major stage of change is maintenance. In this stage individuals sustain and strengthen any changes they have made in the problem behavior. The change behavior becomes the new normative behavior and is integrated into the lifestyle and lifespace of the individual. In this regard, such changes, even after 6 months, may not be well established and may take a few years to be "secure."

We should pause here to highlight several fundamental points about the stages of change. First, as may have been clear in our presentation of the stages, the stages describe attitudes, intentions, and behaviors about change (Prochaska & DiClemente, 1992) as well as a series of tasks that the individual is confronted with during the change process (DiClemente, 2003). Second, the "change" sought after represents a specific targeted behavior and goal, such as abstinence from alcohol use or cocaine use. That is, commitment to change one behavior, such as alcohol use, may say nothing about commitment to change another, such as cigarette smoking. Commitment to reduce use of a particular substance, like alcohol, differs from commitment to abstain. Third, the model is used to describe voluntary change processes rather than mandatory or coerced change, in which the individual has or believes he or she has no option regarding engagement in his or her problem behavior. Moreover, the model is assumed to apply to efforts to change with or without the help of formal treatment and that the client's change process occurs before and after as well as during treatment. And last, each stage refers to a period of time and to specific tasks one must complete before

moving to the next stage. People may differ in the amount of time they spend in a stage, but the activities and processes involved to progress from one stage to the next one are similar for everyone.

Table 1.1 summarizes each of the stages of change and the features associated with it. The first column describes the stages, the second describes what is needed to move forward, and the third highlights some considerations, strategies, and processes of change relevant for matching. Interventions that are most effective in each stage are a major topic of this book and of ongoing research projects by a number of investigators. For precontemplation, we have also highlighted "negative" interventions in that we suggest what *not* to do. Clearly the field needs to do more research on increasing the commitment to change in individuals who do not see they have a problem that is causing themselves or others distress. In the alcohol and drug treatment field such lack of awareness is commonly referred to as "denial" (a topic addressed in greater detail in Chapter 2). Imposing action-oriented behavioral change methods is not as likely to be as effective with individuals in precontemplation or contemplation as with those at other stages. Moreover, in response to the concept of the stages of change, a variety of verbal persuasion approaches and techniques, such as motivational interviewing (Miller & Rollnick, 1991, 2002), have been developed that have demonstrated considerable potential for eliciting interest and concern and dealing with ambivalence so clients can advance through the precontemplation and contemplation stages.

The second column heading of Table 1.1 summarizes what has to happen for a person to progress to the next stage of change. As we noted, the model assumes that these tasks must be accomplished or events must occur for progress to be made toward sustained change. It is also important to realize that these tasks can be accomplished more or less well so that moving forward has both qualitative as well as quantitative dimensions. Decisions, for example, can be based on well-formed and strong considerations or impulsive and extrinsically driven ones. The quality of the decision making as well as the strength of the decision will affect successful movement through the stages. Central to this movement through the stages of change is the client's engagement in stage-relevant processes of change. As described by DiClemente (2003), processes "represent the internal and external experiences and activities that enable individuals to move from stage to stage" (p. 32). Although there may be others, there are 10 identified processes. Five

TABLE 1.1. Stages of Change and Associated Features

Stage of change	Main characteristics of individuals in this stage	To move to next stage	Intervention match
Precontemplation	• No intent to change • Problem behavior seen as having more pros than cons	• Acknowledge problem • Increase awareness of negatives of problem • Evaluate self-regulatory activities • Create interest and concern	• Do *not* focus on behavioral change • Use motivational strategies
Contemplation	• Thinking about changing • Seeking information about problem • Evaluating pros and cons of change • Not prepared to change yet	• Make decision to act • Engage in preliminary action	• Consciousness raising • Self-reevaluation • Environmental reevaluation
Preparation	• Ready to change in attitude and behavior • May have begun to increase self-regulation and to change	• Set goals and priorities to achieve change • Develop acceptable and effective change plan	• Same as contemplation • Increase commitment or self-liberation
Action	• Modifying the problem behavior • Learning skills to prevent reversal to full return to problem behavior	• Apply behavior change methods for average of 6 months • Increase self-efficacy to perform the behavior change	• Methods of overt behavior change • Behavioral change processes
Maintenance	• Sustaining changes that have been accomplished	• Integrate change into lifestyle	• Methods of overt behavior change continued

Note. Data from Prochaska and DiClemente (1983, 1992) and DiClemente (2003).

have been categorized as experiential processes because they reflect internal thought processes and perceptions. The other five processes of change have been categorized as behavioral; they focus on actions and behaviors that operate in service of behavior change. The experiential processes are particularly relevant to accomplishing the tasks of the early stages of change, while the behavioral processes are particularly relevant to the later stages of change. The 10 processes of change are presented in Table 1.2. We will be referring back to these processes frequently throughout this volume.

Intervention matching involves focusing both on what the provider does and what activities or experiences the client needs to engage in to complete the tasks of the stage and move forward. The interaction of the stages and client processes of change are central to this model and will be described more fully in later chapters. In the third column of Table 1.1 some of the processes of change as well as provider strategies are highlighted for specific stages of change. For example, although developing awareness and knowledge about the problem and the solution is critical in all preaction stages, consciousness raising is critical in the contemplation stage to process decisional considerations. Similarly, self-reevaluation involves looking at oneself and changing the way one sees the problems or the solution. For example, the person asks the question "How does cigarette smoking or getting drunk make me feel about myself?" (Prochaska & DiClemente, 1983). Environmental reevaluation, on the other hand, entails reviewing how the problem in question affects the people and situations in the person's life space.

Note that at the earlier stages of change, overt behavior change methods are not the best match for the person. Better timing for such methods would be when the individual is in the action and maintenance stages, although there may be some initial use of behavior change methods in the preparation stage. Examples of these initial methods are varied and include use of behavioral processes of change including a helping relationship, counterconditioning, reinforcement management, and stimulus control (Prochaska & DiClemente, 1983).

Although we describe a person's progress through the stages of change as linear (one stage leads to the next), in practice people commonly regress and/or cycle back from an advanced stage to an earlier one. The stages-of-change model represents a cyclic progression for most changers—that is, individuals may go back to earlier stages of change after reaching a later one. This may occur a number of times before the

TABLE 1.2. Processes of Change

Experiential processes

- *Consciousness raising.* The client gains information and knowledge that increases his or her awareness about him or her, the current behavior pattern, and/or the potential new behavior.
- *Emotional arousal/dramatic relief.* The client experiences a significant, often emotional, reaction about the status quo and/or the new behavior. Clients often become motivated to initiate change efforts when their emotions are aroused by either external or internal stimuli.
- *Self-reevaluation.* The client studies and evaluates how the status quo and/or the new behavior relate to his or her personal values. As such, the client performs a thoughtful and emotional reappraisal of the behavior and begins to visualize the kind of person he or she might be after making a positive change.
- *Environmental reevaluation.* The client assesses the positive and negative effects that the status quo and/or new behavior will have upon others and the environment. The client is often motivated by the realization that his or her substance use has not only negatively affected him or her but also other, external areas (such as people in his or her life and the environments in which he or she function).
- *Social liberation.* The client notices and increases social alternatives that are in support of behavior change. Through this process, the client can be seen as utilizing resources in the environment to alter and maintain changes in behavior.

Behavioral processes

- *Stimulus control.* The client alters or avoids stimuli and cues that could trigger or encourage substance use. For example, the client who has maintained an association between a specific environment (such as a bar or a particular social situation) and substance use will be less likely to engage in substance use if he or she avoids such situations.
- *Counterconditioning.* The client begins making new connections between internal and environmental cues and substance use and/or substituting new, competing behaviors and activities in response to cues previously associated with substance use.
- *Reinforcement management.* The client starts rewarding his or her positive behavior changes (and as warranted eliminating reinforcements for substance use). The rewards themselves might be as concrete as going to a movie or buying a desired book, or it may be simply experiencing the positive consequences associated with not using substances.
- *Self-liberation.* The client develops a belief in his or her ability to make choices and change behavior, and acts on that belief by making and maintaining a commitment to that course of action.
- *Helping relationships.* The client seeks and nurtures relationships that provide support, care, and acceptance with respect to the behavior change endeavor. These relationships can be with family, friends, or peers.

Note. Based on Velasquez, Maurer, Crouch, and DiClemente (2001) and DiClemente (2003).

person makes it into the maintenance stage for good. In the addictions, cycling or recycling is normative—individuals often "successfully" attempt to change a problem numerous times before the change is stable (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). Mark Twain's comment that "Quitting smoking is easy—I've done it many times" is an apt description of recycling hopefully on the road to successfully sustained change. In Chapter 9 we expand the stage of maintenance to include the critical topic of relapse. Although an individual can relapse while still in the action stage, the problem of relapse traditionally has been thought of and discussed most in the context of maintenance of change.

An excellent illustration of the typical course people take in changing addictive behavior was presented by DiClemente (2003) and is reproduced here in Figure 1.1. The cyclical model reflects the time-tested observation that the course of change is not linear.

The cyclical model reflects another critical facet of change that gives hope to changers and clinicians alike. Even though clients may

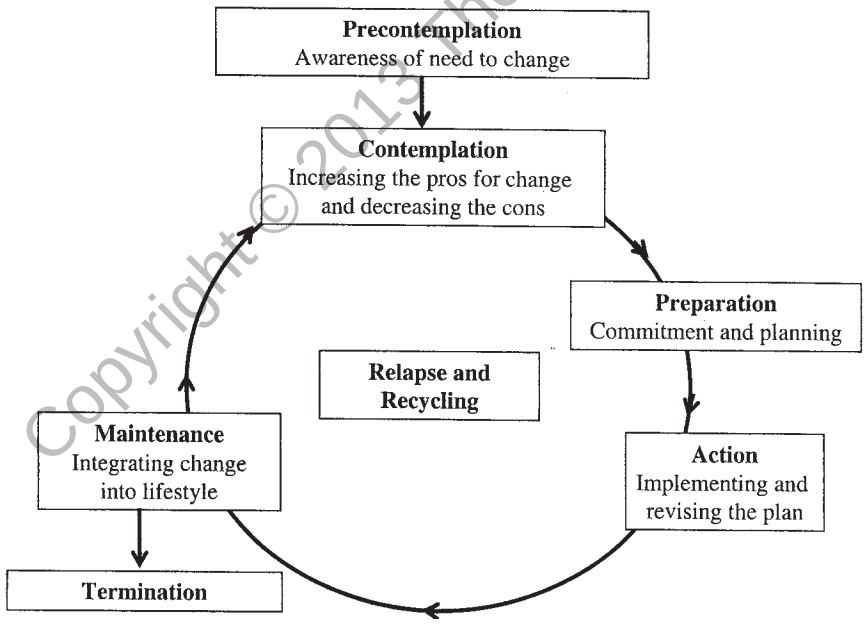

FIGURE 1.1. A cyclical representation of movement through the stages of change. From DiClemente (2003, p. 30). Copyright 2003 by The Guilford Press. Reprinted by permission.

work and make progress to a later stage of change, they often experience problems that send them back to an earlier one. However, in most cases, the person does not go all the way back to the precontemplation stage. Instead, he or she typically reverts to the contemplation or preparation stage for varying periods of time before advancing again. Most often, this represents a learning process and something is learned from a relapse so that the person does not fall all the way back to the cycle's entrance and learns something important about what is missing or what is needed to adequately complete the tasks of the stages. Of course, the challenge is to get people out of the cycle of advance–revert–advance and into the exit of the cycle. Terminating this change process is labeled "termination" in Figure 1.1—the point at which the person feels secure in his or her maintenance of change.

The stages model presents an excellent way to organize the vast amount of information that is available on treatment of substance use disorders. The model is based on clinical research and has important implications for clinical practice. We elaborate on these implications throughout this volume.

SUMMARY

- Alcohol and drug use are common among the general population. Use varies with several social and demographic variables, such as age, gender, and race.
- The effects of alcohol and other drug use cost society staggering sums of money and impose enormous human suffering on millions of individuals.
- Treatment has been defined in many ways. In this volume, we use the definition set forth by Rinaldi et al. (1988), namely, the "application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive, or health injuring; or to restore appropriate levels of physical, psychological, or social functioning."
- The content of treatment and a person's receptiveness to change and treatment are fundamental to successful behavioral change. This volume utilizes the stages-of-change model to conceptualize the process of change and as a basis for deriving treatment content and implementing treatment strategies. The stages of change include five stages, called precontemplation, contemplation, preparation, action, and

maintenance, each with a unique set of tasks, attitudes, and behaviors. The termination of this process occurs when the person is secure in his or her maintenance of change.

- Movement through the stages of change is facilitated by the client's engagement in stage-relevant experiential and behavioral processes of change.

Guilford Publications
72 Spring Street
New York, NY 10012
212-431-9800
800-365-7006
www.guilford.com