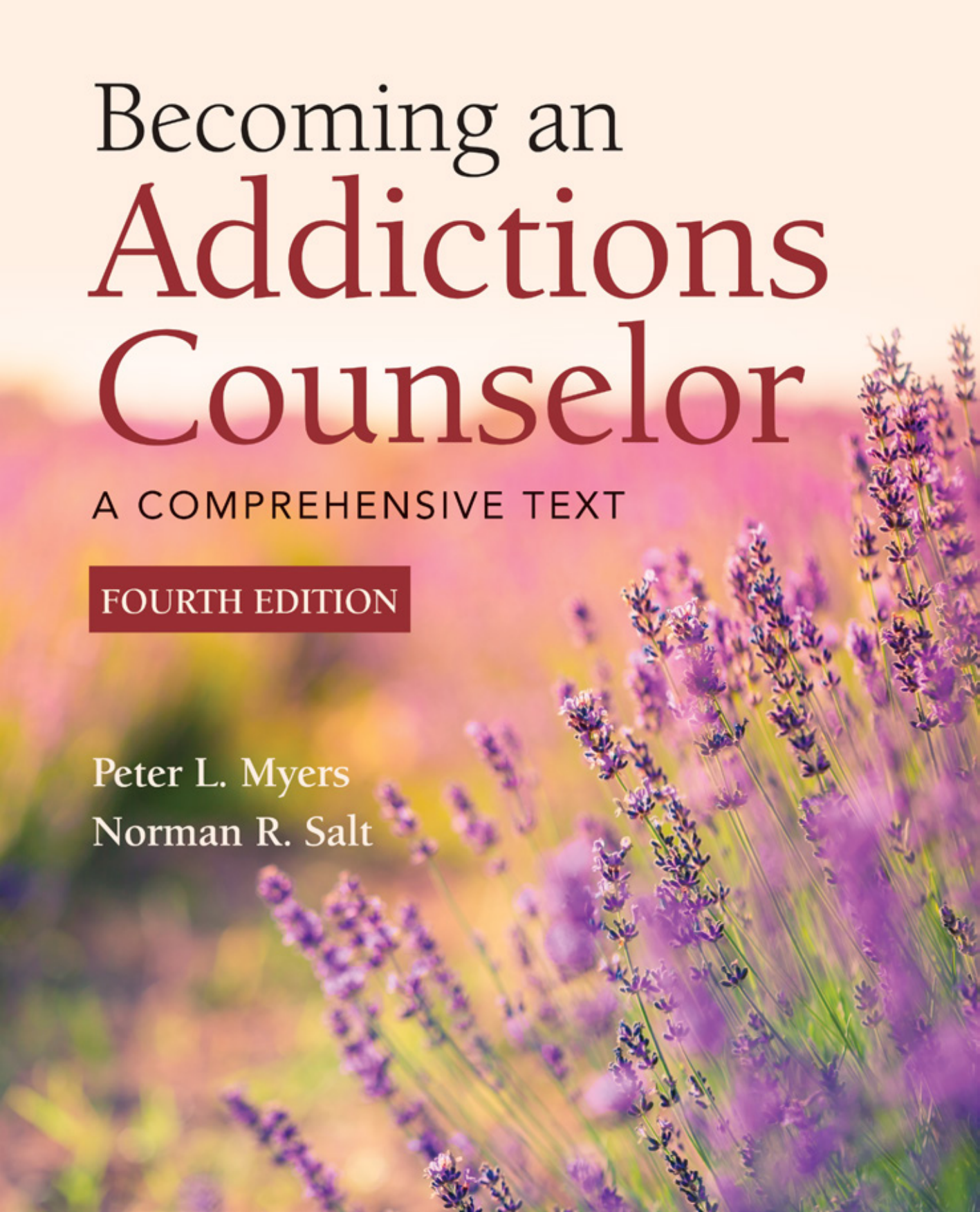
Becoming an Addictions Counselor

A COMPREHENSIVE TEXT

FOURTH EDITION

Peter L. Myers
Norman R. Salt



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Peter L. Myers, PhD
Professor and Director of Addiction (Retd.)
Counselor Training Program
Essex County College

Norman R. Salt, MA, CPS
Former Director of Training
Division of Addiction Services
New Jersey Department of Health

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World Headquarters
Jones & Bartlett Learning
5 Wall Street
Burlington, MA 01803
978-443-5000
info@jblearning.com
www.jblearning.com

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CONTENTS

PREFACE

As we send the Fourth Edition of this text into production, opioid overdosing has become the leading cause of death for Americans under the age of 50, claiming almost 60,000 lives in 2016. 2017 is promising even graver statistics. The need to train and expand the substance abuse workforce is more critical than ever.

This text is designed for undergraduate and graduate curricula in substance use disorder (SUD) studies, counseling, and social work, and for preparation for entry to or career enhancement within the helping workforce.

Tremendous changes are sweeping the field of counseling and treatment of SUDs. It is important to eliminate outmoded preconceptions.

- Harsh, confrontational treatment practices are rapidly becoming obsolete. Treatment is empathetic and collaborative; it is done "with" a client, rather than "to" them, focusing on inherent motivations to change and on client strengths.

- Substance abusers are much less likely to be forced to accept the label of "addict." There is a new nonstigmatizing "language of recovery" (chart in Chapter 3.)
- Afixed length of stay in an inpatient rehabilitation facility as "treatment" has been discarded. Most treatment is outpatient, and furthermore, recovery support services are needed for years. New roles and credentials, such as recovery mentors, have come into existence.
- Police departments in many states are diverting substance abusers into treatment rather than arresting them, through alternative-to-incarceration programs.
- Recovery is increasingly celebrated rather than kept hidden. The New Recovery Movement is a new and powerful force, involving many "recovery community organizations."
- Becoming a counselor simply by being in recovery and attending some workshops is no longer adequate. Most of the workforce has at least a bachelor's degree in a helping or counseling profession. Half of the states in America have master's level licensure. The Addiction Studies Accreditation Commission (a coalition of educator and counselor associations) is evaluating addiction studies curricula.

WHAT'S NEW IN THIS EDITION?

- We have upgraded to *Diagnostic and Statistical Manual of Mental Disorders*—5th edition (DSM-5) in our chapter "Co-Occurring Disorders" and wherever the DSM is cited.
- A new chapter, "Sustaining Recovery," has been added, including topics not previously covered: building recovery capital, mindfulness; trauma informed care; and the third wave of cognitive behavioral therapy, such as the acceptance and commitment therapy and dialectical behavior therapy.
- In our renamed chapter, "Initiating Recovery," sections have been added on nonstigmatizing language and new police initiatives, such as thePolice Assisted Addiction Recovery Initiative or/Gloucester model which get help for substance users rather than arrest them.
- In our chapter on ethics," the professional codes of ethics have been updated and a new section on ethical digital marketing has been included.
- We have included a new section on crisis intervention in our chapter on individual counseling.
- Our chapter on culture supplies more information on the complexities of cultural change and assimilation and how to address these with clients.
- In our chapter on family, we introduce an alternative to the "disengagement" model of Al-Anon and the forceful Johnson Intervention Model—the Community Reinforcement and Family Trainingsystem of working with family members.

Perhaps, the most important aspects of our training philosophy are the following.

- We encourage and even insist on *critical thinking* about the assumptions underlying traditional and habitual use of treatment models.
- We insist that counselors meet the unique set of client needs by offering a menu of treatment options rather than a "cookie-cutter" response (Myers 2002).
- We advocate the new collaborative, strength-based modality embodied in the recovery-oriented systems of care.
- We encourage experiential training via structured exercises in the classroom setting.
- Finally, we support recovery advocacy and the celebration of recovery and encourage students and faculty to join recovery community organizations, the Association for Addictions Professionals, and the International Coalition for Addiction Studies Education.

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Norman Salt wishes to thank the New Jersey Prevention Network (NJPN) for allowing him to train counselors and gain their insight and feedback for the last 20 years. I thank my wife Margie for her patience and my daughters and grandchildren (Kelsey, Colin, and CJ).

ABOUT THE AUTHORS

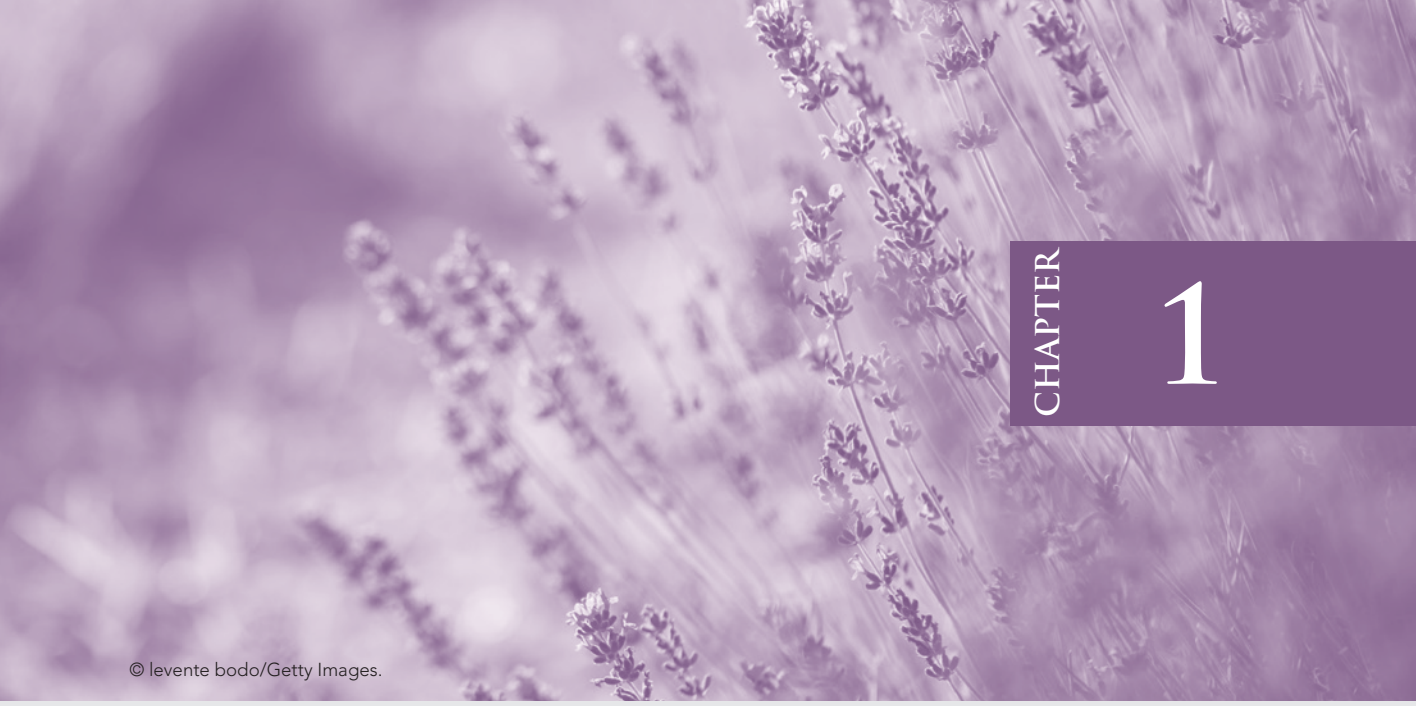
Peter L. Myers, PhD

Peter L. Myers, PhD, is a former President of the International Coalition for Addiction Studies Education and Emeritus at National Addictions Studies Education Commission. He retired from directing an addictions curriculum and Student/Employee Assistance Program at Essex County College in Newark, New Jersey (1981–2008). He was the Emeritus Editor in Chief of the *Journal of Ethnicity in Substance Abuse* and was on the editorial board of *Substance Abuse*. He is also the coauthor or editor of six texts in the drug- and alcohol-abuse field. He is on the Board of Directors of Columbia Pathways to Recovery, which is a recovery community organization in upstate New York.

Norman R. Salt, MA, CPS

Norman R. Salt MA, CPS (Certified Prevention Specialist), has over 45 years' experience in the field of alcohol- and drug-abuse treatment and prevention. He has been a counselor, supervisor, substance-abuse and

mental-health trainer and prevention specialist. He has a Master's Degree in Rehabilitation Counseling from Seton Hall University, South Orange, New Jersey. He was the Director of Training for the New Jersey Division of Addiction Services, Department of Health. Mr. Salt is presently retired and has continued as a freelance consultant trainer for the New Jersey Prevention Network; Organization for Recovery; Mental Health Association in New Jersey; and Stockton State College, Galloway Township, New Jersey. He has taught as an adjunct at Fairleigh Dickinson University in Teaneck, New Jersey; Georgian Court University in Lakewood, New Jersey; and Essex County College in Newark, New Jersey.



CHAPTER 1

INTRODUCTION TO THE TREATMENT OF SUBSTANCE USE DISORDERS

OBJECTIVES

By the end of this chapter, students will be able to:

1. Describe the eight practice dimensions of substance use disorder counseling according to the Center for Substance Abuse Treatment.
2. Explain the importance of the therapeutic relationship.
3. Describe the levels of care as outlined by the American Society of Addiction Medicine (ASAM).
4. Differentiate services among detoxification, inpatient, outpatient, and intensive outpatient services.
5. Describe medication-assisted recovery.
6. Describe the major influences and traditions in the substance use disorder field.
7. Provide examples of critical and uncritical thinking in the substance use field.

BASIC CHARACTERISTICS

Substance use disorders are treated with an array of professional interventions, techniques, and organized services designed to initiate, facilitate, and support recovery from dependency on psychoactive chemicals. This section features substance use disorder (SUD) treatment and distinguishes it from other forms of counseling and therapy. It is also important to distinguish proper treatment from recovery. Treatment is but a short episode for a chronic condition that requires long-term recovery support. Later chapters will describe recovery support services. Readers will note that the term "substance use disorder, or SUD" is used rather than the term "addiction," which carries with it judgmental and stigmatizing connotations and excludes levels of severity that fall short of what could fairly be called "addiction." One would not engage successfully with a person who often drinks heavily on weekends by calling them an "addict" nor a teenager who smokes marijuana two or three times per week, nor would the term "addict" be warranted. Even if the term is clinically warranted (that is, discontinuing drug use results in withdrawal symptoms, and the person's life is centered around acquiring and using alcohol or drugs), the term does not attract potential clients and it is not a good strategy to put a label on the individual. However, many people in the New Recovery Movement proudly self-identify as a person in long-term recovery from addiction. Finally, we (as well as many other texts) will frequently use the acronym SUD for "substance use disorder" in the interest of being concise.

The Focus

When a person is actively using a destructive amount of alcohol or other drugs, and then enters counseling and treatment, the substance use is usually treated first. Personal growth is unlikely when an individual is chronically intoxicated or when life revolves around acquiring and using drugs. The saying in the treatment field is, "You're just talking to a chemical." However, the treatment of substance use disorders, along with coexisting psychiatric disorders dictates special considerations. An exception to "treat the addiction first" may occur where an individual is actively psychotic and needs to be stabilized to the point where he or she can participate in counseling.

The Client

People referred to SUD counseling vary tremendously on a spectrum of severity; degree to which they have remained functional; and behavior patterns typical of people using depressants, stimulants, hallucinogens, or a combination of them (*polyabuse*). Clients with severe and chronic SUDs are often emerging from chemical anesthesia and are typically more mentally confused and psychosocially and medically deteriorated than clients who are usually sober. They may suffer from every sort of medical and social problem and may resist or refuse help. However, some people are approaching a life-threatening situation. Typically, this type of client needs more guidance, care, and a wider scope of services than other clients; for example, a person who is seeking help for mild depression or an adjustment problem.

Practice Dimensions

SUD treatment includes, but is not limited to, what many people call counseling. A simple, up-to-date definition of *counseling* and *psychotherapy* follows:

> *A supportive, collaborative and empathic professional relationship that provides a framework for the exploration of emotions, behaviors, interpersonal and thinking patterns, and the facilitation of healthy changes.*

Treatment may involve several levels of a multiphasic system, which requires professional counselors with detailed knowledge, skills, and attitudes in a wide range of areas. The National Steering Committee on Addiction Counseling Standards, which represented the major accreditation, counseling, and educational organizations in the SUD field, chose as its consensus document *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of*

Professional Practice, which was endorsed and published as Technical Assistance Publication (TAP) 21 of the Center for Substance Abuse Treatment, U.S. HHS. This document, authored by the Addiction Technology Transfer Center National Curriculum Committee in 1998 and updated in 2006 (CSAT, 2006), details eight practice dimensions of SUD counseling, which include 100 discrete competencies. The practice dimensions are as follows:

1. *Clinical evaluation*, which includes screening and assessment, knowledge of diagnostic criteria, assessment instruments, and treatment options.
2. *Treatment planning*, in collaboration with the client, based on assessment, and including long-range goals that are broken down into shorter, concrete measurable objectives.
3. *Referral*, based on knowledge of resources.
4. *Service coordination*, which includes implementing the treatment plan, consulting other professionals, case management, and continuing assessment and treatment.
5. *Counseling* individuals and groups, including families, couples, and significant others.
6. *Education* of client, family, and community.
7. *Documentation*, including management of records and preparation of reports, plans, and discharge summaries.
8. *Professional and ethical responsibilities*, including confidentiality of personal health records.

Benchmarks for competency in the practice dimensions are described in the Performance Assessment Rubrics (Gallon & Porter, 2011). They describe levels of competence, including awareness, understanding, applied knowledge, and mastery, which may be attained by counselors and supervisors. Links to the consensus document (CSAT, 2006) and the complete rubric of competency benchmarks (Gallon & Porter, 2011) are provided in the bibliography. Phelps et al. (2011) have prepared a practical guide to the Technical Assistance Publication 21 Practice Dimensions.

In addition to the practice dimensions, a competent counselor must have a vast knowledge base, which the addictions document (CSAT, 2006) calls transdisciplinary foundations. These include familiarity with the categories; range and effect of legal and illegal psychoactive chemicals; risk and resiliency factors in the development of substance use disorders; models and theories of SUD and treatment; cultural competency in working with a wide variety of client populations; standards of conduct in helping relationships, diagnostic criteria, insurance and health maintenance options; and the roles of family, social network, and community in recovery.

The Counseling Relationship

A supportive, empathetic counseling relationship is the glue that binds the client and counselor through assorted treatment stages, facilities, anxieties, and growing pains. The importance of the collaborative, therapeutic alliance cuts across and indeed supersedes the particular therapeutic approach or model employed. The necessity of mastering the multiplicity of administrative, or "housekeeping," tasks (in the broadest sense, case-management tasks) might seem to shift the focus away from the counseling relationship and define the SUD counselor as little more than a caseworker. But intake, assessment, and treatment planning are opportunities to engage clients and establish a collaborative relationship.

The counseling relationship in SUD treatment is often turbulent. Unprocessed emotional history ("baggage") that may include abandonment issues, trauma, and grief that a client brings to counseling and the emotional response of the counselor are important in all counseling efforts. The client may approach the counselor with any of a number of newly tapped dependency needs, rage and resentment, grief and loss, evasive tactics, and attempts to manipulate or test the relationship. The counselor must develop skills to anticipate his or her strong reactions to a client's behaviors and maintain a professional and helpful role.

Treatment of people with SUD in general is typically more directive, structured, and managed than counseling and mental-health services for non-SUD and nonpsychotic individuals. For

example, the use of a formal treatment plan is not common in counseling for adjustment, self-esteem, and relationship issues. A large amount of SUD treatment is interfaced with criminal-justice and social-service institutions that mandate treatment. Even in a situation in which counseling is initiated involuntarily, this does not mean that the counselor tells the client "what to do." It operates on the basic principle of empathetic, collaborative planning to facilitate recovery, focusing on the client's short-term recovery and abstinence from addictive substances and trying to influence the client toward healthy behaviors and decisions. SUD treatment uses simple, direct, concrete methods and treatment concepts, which produce some results in a relatively short amount of time. Counseling modalities that complement this approach are often used in SUD treatment.

Counseling methods for chemically dependent people are not standardized. There is a strong influence of self-help groups from which formal SUD treatment emerged. As the field has become more professional, counselors and trainers have gravitated toward integrated, eclectic, transtheoretic counseling models. SUD counseling does not claim or attempt to be a comprehensive psychotherapy; however, the broad goals of psychotherapy complement those of SUD treatment. To achieve stable sobriety and avoid relapse, with professional help, the client must identify, communicate, accept, and manage emotions and learn nonchemical and assertive coping strategies, communications and interpersonal skills, self-efficacy, and responsibility. The client must unlearn negative self-statements that may cause catastrophes and other unhealthy thinking patterns. These dimensions of recovery are covered in this text.

Substance abuse specialists recognize that treatment is carried out in stages. In early treatment, the counselor should not forcibly introduce deep-seated, painful, and threatening issues, except when necessary to maintain the client's sobriety. Gradually, the client will internalize mechanisms to govern his or her recovery. Self-statements by clients will progress from "I can't drink" to "I won't drink" and hopefully, to "I don't have to drink" (Zimberg, 1987, pp. 17–19). SUD treatment most closely approaches or converges with generic counseling and psychotherapy in the last stage. Counselors must pay close attention to the special treatment needs at each stage. For example, when treatment includes a phase of inpatient or intensive outpatient rehabilitation, there may be a tendency to consider later outpatient counseling sessions as less critical. This would be a dangerous mistake.

> "Factors that emerge during aftercare, such as changes in motivation, reactions to treatment, patient–therapist interaction variables, environmental cues, may be more important determinants of continued participation than factors present at the beginning of aftercare, with the possible exception of alcohol and drug use during intensive outpatient treatment"
>
> (McCay et al., 1998, p. 160).

A formal aftercare phase is only the start of building a stable recovery, as care and support, even at a reduced level, may be needed for years.

Effectiveness of Treatment

The study of the effectiveness of counseling and psychotherapy is notoriously complex and controversial. There is a plethora of competing models of the human personality, its health and dysfunction, and methods of change. Each of these could be applied to hundreds of possible diagnoses and to variable populations according to gender, ethnicity, and so on. In the SUD field, some of the difficulties in evaluating the effectiveness of treatment outcome include:

- Variety in the patient mix that influences retention, completion, and success.
- Variation in definitions of success, for example, graduation, abstinence, stabilization of social functioning, moderation of use, and reduction in harmful effects. As Miller et al. (2001, p. 211) state, "It is unclear how much imperfection constitutes a 'relapse' and how much deviation from perfect abstinence defines a treatment failure."

- Programs that weed out all but the most motivated, resulting in "graduates" who tend to stay clean and sober.
- Outcome studies or analyses of outcome studies conducted by individuals who are strongly associated with one point of view; those individual's methods tend to confirm their biases.
- Treatment-effectiveness studies conduct follow-ups of clients who may skew results because these clients are not using substances (or are using very little) when staff are around and due to the fact that severe relapse can result in the counselors facing challenges with regard to reaching the client for follow-up.

Most major treatment modalities are associated with a significant drop in use of alcohol and other drugs (SAMHSA, 1994) and in the associated health, social, and legal ramifications and costs. A major meta-analysis conducted by Miller et al. (2001) found that one-fourth of people exposed to treatment remained totally abstinent in the year following treatment, and one-tenth drank moderately. However, the remaining clients reduced alcohol consumption by 87% on average, abstained 3 out of 4 days, and had 60% fewer alcohol-related health problems. If the measure of success is total abstinence, it seems as though treatment has pretty poor results; however from the perspective of public health and harm reduction, it is a smashing success! Comprehensive studies by Belenko, Patapis, and French (2005) and Harwood et al. (2002) provide current evidence of the tremendous cost–benefits of SUD treatment to society.

The authors discourage trying to calculate exact cost–benefits, such as the famous "one dollar spent on treatment is paid back seven times" (Swan, 1995), as it varies wildly by situation, client type, drug used, and so forth (Springer, McNeece, & Arnold, 2003).

No particular personality type fits a person with a SUD. A wide variety of etiology and risk factors predispose, encourage, and drive chemical abuse and its progression (Doweiko, 2011). These risk factors exist on many system levels: genetic/neurological, personality and psychosocial development, peer and family influence, community, societal and cultural. Each client suffers from a unique mix of these factors; a person may emerge from a hard-drinking family, college fraternity, or community; he or she may inherit vulnerability for depression or hyperactivity and insomnia; or childhood or adolescent trauma may play a part. Counselors need to be educated in what drives substance abuse; however, that is beyond the scope of this volume. It is usually covered in a basic course on substance use and abuse, which readers in a college and university program will have taken.

UNIQUENESS OF THE FIELD

Most individuals treated for chemical dependency do not simply "go to a counselor." In the majority of cases, the person participates in an organized treatment program. Programs and self-help fellowships provide a great deal of social support, an alternative to the culture of abuse, and the therapeutic effects of a therapeutic milieu. Most treatment occurs in group settings, even aside from client participation in self-help programs such as Alcoholics Anonymous and Narcotics Anonymous.

There is a tremendous diversity in type, intensity, and length of stay in treatment. Some people with SUD qualify for admission to inpatient therapeutic communities funded to treat indigent clients, with a length of stay of 18 months. Others participate in insurance plans that reimburse for only a 5-day detoxification. Schuckit (1994, p. 3) remarked, "We function in a complex world where health-care providers must share scarce resources while reaching out to a pool of impaired individuals who, at least theoretically, have many more needs than we can possibly meet."

Treatment programs are part of or influenced by broader regulatory, economic, and political systems at state or national levels. Changes at these levels (e.g., legislative and funding initiatives, managed care regulations) reverberate swiftly throughout the system of treatment providers, bringing rapid change in the status of facilities and employees alike. For example, as a result of such regulatory changes, a large proportion of inpatient rehabilitation facilities closed during the 1990s.

TREATMENT SETTINGS

There is a great range and variety of SUD-specific treatment settings, such as freestanding clinics, units in hospitals, mental health centers, and other social service agencies (Methadone maintenance programs are discussed separately later in this chapter.). In an attempt to move away from segregated treatment for SUD, and in an attempt to recruit more clients, SAMHSA (the Substance Abuse Mental Health Services Administration, U.S HHS) provided grants in 2017 to integrate substance abuse treatment into primary care settings.

Model of treatment is the treatment or recovery tradition upon which a program is based. The different traditions and models, such as the therapeutic community and the Minnesota Model Inpatient Alcoholism Program, are discussed later in this chapter.

Level of care is the intensity of treatment dictated by the severity of the client's SUD and the degree to which his or her psychological and social functioning has deteriorated. It is indicated by the number of hours per week of treatment; the degree of structure and supervision; and the scope of services. Facilities often specialize in providing a particular level of care. The evolution of a rational system of placement criteria to refer clients to an appropriate level of care is fairly new. Although use of such criteria may seem an elementary necessity, level of care had often been arbitrary, based on faith or tradition or the desire to curtail costs.

To provide a simple example, a homeless, physically and mentally ill client with SUD would likely start out in a medically-managed inpatient facility (level IV), whereas a full-time office worker who has a family and who has been identified as occasionally coming back from lunch in an intoxicated state would probably be referred to an outpatient treatment program (level I). **FIGURE 1.1** shows the levels of care as outlined by the American Society of Addiction Medicine (ASAM).

Continuum of care is the movement of clients through a process of recovery. Although it may be woven out of treatment at disparate facilities, the ideal plan is to tailor a fairly seamless treatment "career." It may begin with intervention and referral from any of a range of referring agents. Employee assistance programs in industry, member assistance programs in organizations, and student assistance programs in schools assess, intervene, and refer but do not treat SUDs and substance abuse. The treatment career may include movement through several specialized facilities, such as a withdrawal

0.5	Early Intervention Services for Individuals with Problems/Risk Factors
I	Outpatient Treatment
II	Intensive Outpatient Treatment (II.1) and Partial Hospitalization (II.5)
III	Residential Inpatient Treatment
III.1	Clinically Managed Low Intensity Residential Treatment
III.3	Clinically Managed Medium Intensity Residential Treatment (Adults)
III.5	Clinically Managed Medium/High Intensity Residential Treatment
III.7	Medically Monitored Intensive Inpatient Treatment
IV	Medically Managed Intensive Inpatient Treatment (Hospital/Medical center)

Note 1: IV may include withdrawal management (detoxification).
Note 2: Clinically managed refers to nonmedical treatment professionals.

FIGURE 1.1 ASAM Levels of Care.

management facility (formerly a detoxification or "detox" unit, then a residential or outpatient rehabilitation program and halfway house or sober living housing. Case management tries to ensure smooth continuity of treatment. As stated, initial referral and admission should be determined by assessment of the severity of the disorder and the client's needs, and should be to a facility that provides an appropriate level of care.

Recent Changes in Treatment Settings

The types and range of facilities in which treatment takes place have changed in response to several factors. Three of them are cost containment, tradition, and the correctional system.

Cost containment efforts by managed care entities have led to an overall move away from retrospective payment ("blind" reimbursement) and toward efforts to limit benefits for treatment services not considered medically crucial. Unfortunately, many mental health and substance abuse services are often seen as "not medically necessary." Some states have established parity for mental health coverage with other medical care, but even among these, some exclude substance abuse services.

Because no research has demonstrated that inpatient rehabilitation is necessary for the vast majority of people with SUD, it has become easier for medical reimbursement and managed care entities to deny approval for inpatient care. This has quickly reverberated throughout the SUD service provider industry. Since 1987, more than half of the inpatient residential treatment facilities have closed or converted to shorter-term treatment settings. In addition, there has been a decrease in the reimbursability for outpatient care, regardless of the need for more intensive care as assessed by SUD or medical staff.

More funding has been available from correctional and other criminal justice systems. Referrals for treatment of offenders with SUD occur in the forms of pretrial intervention, alternatives to sentencing, serving sentence in treatment, and parole to treatment. In several states, drug courts and collaborative planning between criminal justice personnel and SUD treatment providers have resulted in a new subfield for treatment of offenders with SUD (Springer et al., 2003).

Trends in the treatment of offenders vary by state. Arizona reported extensive savings from a system to treat rather than imprison nonviolent drug offenders (Wren, 1999). In the Northeast, there are alternatives to arresting users—they are instead taken directly to treatment by the police themselves, with civilian assistance (this is discussed later in the text).

Types of Treatment Facilities

- *Outpatient treatment*. Most SUD treatment takes place in outpatient treatment programs. These are organized nonresidential treatment services in which the client visits the clinic at least once a week, up to about 10 hours per week. There may be any number of activities such as individual, group, family, or didactic therapies. The multiple functions that may be served by outpatient facilities include the following:

  A setting in which the entire course of treatment takes place; for example, as for the client who may be stabilized and moved toward recovery without removal from the community or disruption of his or her occupational status.

  An initial point of contact for the many people who enter treatment at an outpatient treatment program, either as "walk-ins" or because that is the agency known to an employer or family member.

  Upon discharge from an inpatient program, a referral is usually made to an outpatient treatment program that may last 3 to 6 months or even longer.

- *Intensive outpatient programs (IOPs)* or *intensive outpatient treatment programs (IOTPs)*, are

more full and structured treatment settings in which the client is present from about 10 to 30 hours per week. The broad category of intensive outpatient treatment may include programs that term themselves day treatment or, in a medical setting, partial hospitalization. Since the mid-1980s, IOPs have grown exponentially (Washton, 1997). This is a result of both cost containment by third-party payers and research that indicates that the 28-day inpatient stay, formerly the mainstay of SUD treatment, is a "faith" system not based on rational criteria. The IOP fills a large service gap in the treatment system between inpatient and outpatient care. Its cost is about half that of residential care, and it allows clients to continue in work and family life; promotes bonding among clients; and allows clients to practice recurrence-management techniques in real-life situations. In addition, assessment of a client's readiness to complete treatment and of his or her problems and progress can be made in a realistic setting.

Clients of IOPs may be living at home, in a therapeutic or long-term residence of some sort, or in apartments as part of special programs. IOPs can even be operated in prisons. All of the components of rehabilitative treatment should be provided, including counseling (individual, group, and family), treatment planning, crisis management, medication management, client education, self-help orientation, case management, and discharge planning (CSAT, 1994; Gottheil, 1997). IOTP is similar to "partial hospitalization."

- *Inpatient rehabilitation* or *intensive inpatient treatment*, involves a live-in setting. This category is quite diverse and includes therapeutic communities in which the length of stay varies from 4 to 24 months, and a variety of other rehabilitation units, such as those based on the Alcoholics Annonymous or Minnesota Model, which usually involve 4-week stays. Inpatient treatment may be medically managed, medically supervised, or nonmedical. Individual, group, and family treatment may occur as well as considerable patient education and recurrence-management training. Treatment plans are constructed collaboratively by client and counselor, who identify long-term and short-term goals that are continually reassessed and updated. Plans are made for re-entry into the community and ability to cope after discharge; they might include vocational, educational, and sober housing referrals as well as continuing care as an outpatient of either the rehabilitation agency itself or another agency. Recovery coaches or recovery mentors act as case managers who conduct regular checkups on the sobriety and stability of the client.
- *Detoxification* (or *detox*) *units (now often referred to as withdrawal management)* may be freestanding facilities or inpatient medical units in which the client can be stabilized medically and withdraw safely from drugs before entering a rehabilitation setting. Not all people with SUD require formal detoxification. It can also be an initial stage of inpatient rehabilitation, in the same unit. Detoxification is only the very first stage of recovery; it is not a complete, or even a partial, treatment process. Many people with SUD have gone through withdrawal management repeatedly. The mistaken idea that detoxification is treatment contributes greatly to the idea that treatment is useless. Some people with SUD check themselves into detoxification units to reduce their level of tolerance, to "get their heads together" when they are homeless and cold, or to satisfy some impending legal proceeding. Others enter with the intention of recovery but leave when the worst withdrawal symptoms have abated.

Detoxification from alcohol traditionally has taken place in inpatient settings. During the 1990s, outpatient detoxification units were set up; some SUD counselors were skeptical of these units. However, some

studies (Hayashida et al., 1989) suggest that outpatient detoxification is acceptable for a good portion of the population in need (those with mild to moderate symptoms of alcohol withdrawal) and, in fact, it can free scarce resources to help more individuals with SUD.

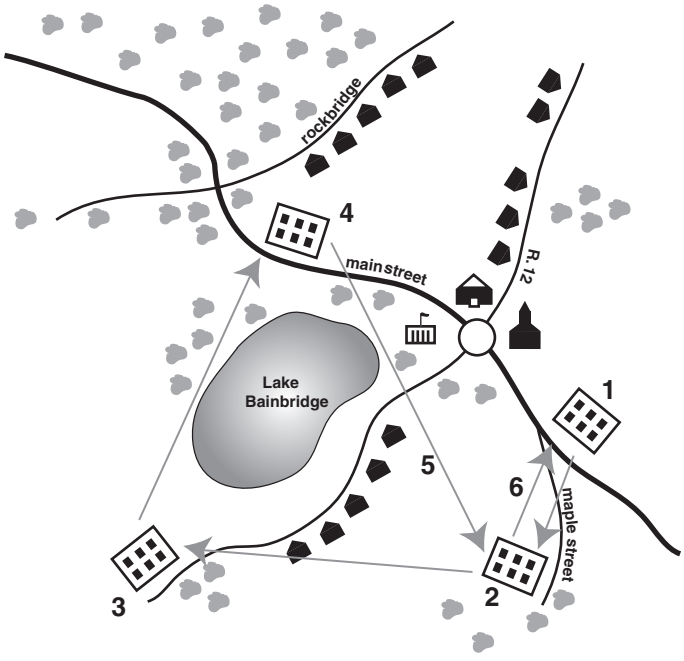
- Intermediate steps between treatment and total re-entry into society. The *re-entry residence* or *halfway house* may be a built-in segment of the therapeutic community treatment of SUD. Independent halfway houses, recovery residences, or sober living facilities range from simple cooperative and democratic living arrangements, to therapeutically structured residential settings that follow rehabilitation; they usually require that residents work or pay a fee. The term *halfway house* is also used to refer to a variety of supportive and transitional residences for psychiatric patients and offenders just released from prison. Oxford Houses, which arose in the Capitol District in the late 1970s (CSAT, 1992), are democratically operated, financially self-supporting houses with no paid staff. These are essentially communes of people in recovery, living in buildings rented by the residents. This participatory democracy is believed to strengthen responsibility and end dependency, replacing it with self-sufficiency. The democratic operation of Oxford Houses extends to votes on admission of members and election of officers for 6-month terms. The only house rule is sobriety, and use of alcohol or drugs results in immediate expulsion. All of the houses belong to the Oxford House, Inc., network. As a prerequisite to receiving federal block grants for alcohol and drug treatment, states must establish a revolving loan fund to help open new Oxford Houses. According to researchers at DePaul University (Jason & Ferrari, 2010), the Oxford House model builds autonomy, community, and self-esteem, and is underused and under-recognized. A national organization of sober living facilities/recovery residences (National Association of Recovery Residences [NARR]) was founded in 2011. A code of ethics/standards has been developed by NARR and also by the Joint Commission.
- *Long-term residential care* can be arranged for clients who are not yet capable of independent living; it is provided by the Salvation Army and many other nonprofit entities. Often, these are little more than a structured shelter situation, although the "Sallie," as clients call it, also has a work requirement. Salvation Army residences may refer to themselves as rehabilitation programs, but this is a misnomer by most treatment community standards.
- *Programs that serve special populations* include those set up to treat clients with a co-occurring psychiatric disorder and those for pregnant women with SUD or mothers with SUD and their children.

Continuity of care in the treatment career is essential. A large percentage of clients are "lost" when there is a gap between intervention and detox, detox and rehab, and so forth. Referring agents or case managers spend a great deal of time and effort struggling with the timing of available beds at the right time and place. For example, if a client referred by her human resources department (HRD) needs to complete a 5-day detoxification program, followed by a 21-day rehabilitation stay at a facility with a 10-day waiting list, the client would have to wait 5 days before going into detox so that she could shift neatly into the next phase, preferably transported directly between the facilities. **FIGURE 1.2** shows the route this client's treatment would take.

Pharmacologic Treatments or Medication-Assisted Recovery

Treatment for Opiate Use Disorder

Methadone maintenance (MM), the most common opioid substitution therapy, is simply the systematic dispensation of a synthetic opioid that enables a



1. Meeting with EAP administrator
2. Evaluation at outpatient clinic
3. Inpatient detoxification (5 days)
4. Inpatient rehabilitation (21 days)
5. Aftercare at outpatient clinic
6. Ongoing reports to EAP

FIGURE 1.2 The route of one client's treatment career, which is monitored by her case manager.

client to attain social stability; abandon the criminal career; and enter the educational or occupational world. Last but not least, it reduces the risk of contracting or spreading HIV/AIDS by reducing the number of individuals with SUD who use and reuse hypodermic needles.

Methadone maintenance is effective for the following reasons:

- It is administered orally, in controlled doses.
- It can be administered only once a day.
- The rushes, highs, and lows that accompany much substance use are absent. The client can study, operate a vehicle, or file library books without falling asleep or experiencing changes in mood or functioning.

There is a wide range among MM programs, for example, in counseling and other services offered, in the attempt to screen for substance use, and in attempts to wean the patient to a truly substance-free status. Although MM programs wish it otherwise, many clients drink and use drugs, and many increase their use of alcohol and other drugs (AOD) if and when they taper off their methadone dosage.

Methadone maintenance occupies an unusual position in SUD treatment. Although this modality serves more clients than drug-free treatment programs, MM is the shabby, outcast stepsister in the SUD field. Methadone-maintenance clients are stigmatized by the public at large, by the healthcare system, and within the SUD field itself. To many,

their participation in the dispensation of an opioid substitute denies them the pride of "recovering addict" but rather institutionalizes and ritualizes their addiction. This attitude dehumanizes clients and discourages the goal of being sober and clean.

Substance-free treatment models seem to make MM and treatment mutually exclusive categories. Yet, methadone maintenance, whatever its shortcomings, need not be limited to a grim routine of early morning dispensation of the opioid. In fact, programs that are so limited often fail, even in their mission to replace illegal opioids with a legal one.

Methadone programs vary along several axes, and so are difficult to compare. First, they may vary in the extent to which the program monitors and tolerates the use of other psychoactive substances. A philosophical paradox arises when creating standards for polyabuse behavior in methadone programs, which fall roughly under the rubric of the harm reduction model.

Another continuum along which MM programs fall is the degree to which there is individual, group, and family counseling. At one end of the spectrum, are the programs that offer infrequent case management sessions; in the middle, are various levels of intensity to which programs attempt to involve clients in counseling processes; at the most treatment-intensive end of the spectrum, are a few therapeutic community (TC) day programs, such as the Passages Program (De Leon, Sacks, & Hilton, 1993). Other MM program enhancements improve the retention rate and, indirectly, help reduce the spread of HIV. For example, substitution of intravenous drugs with this synthetic narcotic substance decreases associated needle sharing and participation in crime or sex industries to finance a habit (Anglin, Miller, Mantius, & Grella, 1993, pp. 3–6).

Maddux (1993, pp. 23–24) shows that a low or absent fee is associated with better retention, as is the client's role in regulating his or her dosages. While some may assume that an individual with SUD will maximize the dosage, it is unlikely because the methadone client is motivated to avoid withdrawal symptoms rather than seek a euphoric rush. The client may be re-entering the workforce and also wish to avoid excessive sedation. Maddux (1993, pp. 24–25) reports that the client-regulated dose reduces conflict with staff as well as clandestine return to illicit drug use and that, indeed, clients do not markedly increase their doses. Rapid admission is also a must in successful maintenance programs.

A standard methadone-maintenance program protocol may include the following:

- Intake
- Annual medical examination
- Attainment of increasing take-home dose privileges, in stages
- Monthly testing for drug use, with refusal to submit counted as a positive test (pregnant women tested more often, perhaps weekly)
- Two 1-hour counseling sessions each month, with crisis intervention sessions on request
- Disciplinary detoxification resulting from any violation of program rules

Successful program enhancements cited by Anglin et al. (1993) should be designed to match an individual client's needs. These may include the following:

- Training for counselors and case managers
- Intensive contact during the first month
- Contingency contracts, that is, provision of rewards such as food or movie coupons in exchange for the client's compliance and progress
- Enhanced program services, such as bus passes, off-site psychiatric consultations, additional urinalysis (perhaps with swift onsite processing)
- High-risk counseling and support groups for HIV-infected clients, cocaine users, and women

Methadone-maintenance programs also vary in their attempts to wean the client completely from this synthetic opioid. A combination of counseling and psychopharmaceutical support to methadone detoxification is most effective (Milby 1988). Although the rates of detoxification have improved gradually since the early days of MM, many clinics do not encourage the ultimate goal of being sober, and, in fact, compare opioid substitution therapy with insulin treatment for diabetes.

Methadone maintenance is associated with the harm reduction model. Methadone is also increasingly popular for alleviation of pain, and its use for that purpose has tripled in recent years because it is relatively cheap and long lasting. Unfortunately, it has been the cause of many overdoses—the abuse of methadone as a prescription pain killer is a major cause of overdose fatalities.

Buprenorphine

A major innovation in the treatment of opioid addiction is the introduction of buprenorphine (colloquially known as "bupe" or "subs"), which promises to be a major improvement over methadone maintenance treatment. Buprenorphine (BYOO-pre-NOR-feen), short for buprenorphine hydrochloride, is a generic name for a chemical compound ($C_{29}H_{41}NO_4$). It is a semisynthetic opioid. Subutex and Suboxone are brand (trade) names for buprenorphine-based medications. Suboxone contains four parts buprenorphine and one part naloxone. Subutex contains only buprenorphine as an active ingredient. Buprenorphine has the properties of a partial opioid agonist. It is taken as a sublingual tablet.

An *opioid agonist* is a drug that causes an opioid effect, similar to the effect caused by Vicodin, OxyContin, or heroin, because it binds to opioid receptor sites in the brain and activates them. As the agonist is active at opiate receptor sites, clients will not get "high" if they take other opioids during the time that the agonist is functioning; moreover, they will not experience symptoms of opioid withdrawal.

Antagonist drugs occupy receptor sites and block them, blocking and reversing the effects of agonist drugs. They prevent the client from getting "high" and can also prevent overdoses. Examples of opiate antagonists are narcan and naltrexone.

Because buprenorphine is a partial and not a full agonist, it does not provide a morphine or heroin-like "high;" but it blocks withdrawal and craving. Clients will not "nod off" as may be the case with methadone maintenance treatment. In addition, buprenorphine has a ceiling effect, adding to its safety. Other opioids continue to provide more effect as more is taken, eventually leading to respiratory depression and death. Buprenorphine's effects level off at a relatively low dose. That is, even if more is taken, there are no significant increased effects. Overdose risk is low.

In the United States, Suboxone is vastly preferred over other forms of buprenorphine medications because of the limited potential for abuse—first because of its "ceiling" effect, and second, because it contains one-fourth naltrexone. If a client attempts to crush the tablet and inject it, the opiate antagonist will take effect and precipitate an unpleasant withdrawal symptom.

Buprenorphine was originally prescribed as an analgesic (pain killer). Based on experiences in other countries, the Drug Abuse Treatment Act (DATA) of 2000 allows physicians to prescribe buprenorphine at their private practice offices or in general care settings such as hospitals, clinics, and substance abuse programs, for opioid dependence problems. The Federal Drug Administration approved Subutex and Suboxone in 2002 for office-based opioid treatment by physicians who are properly trained and certified. Thus, individuals with opioid dependency who wish to be treated do not need to attend a large, institutional clinic, where they may be stigmatized. Instead, they can take their dose under a physician's supervision every 2 days or even 3 times per week as opposed to the daily regimen of the methadone client. Clients, therefore, feel more positive about the experience.

The National Institute for Drug Abuse (NIDA) and the Center for Substance Abuse Treatment (CSAT, SAMHSA) are optimistic about the use of buprenorphine as a pharmacotherapy for opioid abuse, and they are cooperating in training professionals as to its use. The New York City government sponsored a white paper (Johnson, Rosenblum, & Kleber, 2003) advocating getting thousands of individuals with heroin use disorder into buprenorphine programs. Another exciting innovation is the integration of buprenorphine with standard treatment programs, even those based on principles of AA/NA (Alcoholics Anonymous/ Narcotic Anonymous) or the traditional

substance-free therapeutic community. Phoenix House, one of the first therapeutic communities, has a combined opioid detoxification/residential program utilizing buprenorphine at its First Step Program in Long Island City, New York.

In the treatment of acute alcohol withdrawal, the use of benzodiazepine sedatives has been standard for decades. The sedatives include chlordiazepoxide (Librium), diazepam (Valium), and lorazepam (Ativan). They prevent seizures and reduce the physical and psychological effects of acute withdrawal symptoms but are not used as a treatment to reduce drinking or reduce cravings. Benzodiazepines are physically addictive although safe to use for the 3 to 5 days of alcohol detoxification.

- Naloxone (Narcan) is an opioid antagonist and has become common in the reversal of opioid overdose. Many segments of the public can be trained in the use of Narcan. Distribution of nalaxone to nonmedical personnel has resulted in thousands of overdose reversals. Narcan training is increasing across the nation. Drug courts have begun to make take-home naloxone available to clients; Narcan kits are available, even at schools and libraries. Injection Nalaxone and Nasal Nalaxone kits are also used (www.health.ny.gov/overdose).
- Naltrexone (marketed as ReVia, Depade, and Vivitrol) is an opiate antagonist, but it has been adapted for use by individuals with alcohol use disorder; it does not allow the user to get "high" but retains the sedative effects of alcohol. Research shows that naltrexone reduces the craving for alcohol; users have fewer recurrences of heavy drinking and drink on fewer days than those who do not take the drug. Vivitrol is the injectable form of the drug, which the U.S. Food and Drug Administration (FDA) approved for alcohol use disorder treatment in 2006. Vivitrol can be administered as an injectable once a month, which is associated with a good prognosis for continuing abstinence after six months to a year of administration.
- Disulfiram (trade name Antabuse) has been used for decades as an alcohol use disorder treatment. It prevents the breakdown product of alcohol, acetaldehyde, which is toxic, to be broken down by an enzyme to a nontoxic metabolite. Acetaldehyde makes users ill soon after drinking, with symptoms including flushing, vomiting, headache, and chest pain.
- Acamprosate (trade name Campral) affects neurotransmitter systems involved in alcohol dependence. Studies have shown some promising effects on alcohol cravings.
- Antidepressants known as selective serotonin reuptake inhibitors (SSRIs), including the most famous, fluoxetine (Prozac), have been tested for treatment of alcohol use disorder. They show some effect in helping to reduce drinking, mainly among those who do not have severe alcohol use disorders (De Sousa, 2010).
- Baclofen, a medication originally prescribed for symptoms of multiple sclerosis, has shown efficacy in reduction of cravings and of alcohol intake among alcohol-dependent people (Addolorato et al., 2002, National Institutes of Health, n.d.).

A combination of medication, support groups, and cognitive behavioral therapy is more effective than either medication or psychotherapy alone (Feeney, Connot, Young, Tucker, & McPherson, 2006). Pettinati et al., (2010) found that for the treatment of alcohol use disorders that occurs along with depression, an SSRI antidepressant, such as sertraline (Zoloft), a Prozac-like drug, together with an anticraving medication such as naltrexone, as well as cognitive behavioral therapy, resulted in half of the patients remaining sober throughout the 90-day research period.

There is no contradiction between taking medications and attending AA. The AA pamphlet entitled, "AA Member—Medications and Other Drugs," clearly states that AA members should not "play doctor" and advises others on medication provided by medical practitioners or treatment programs.

ACTIVITY 1.1 Tell me about your agency

It is important for counselors to be familiar with the treatment providers in their communities and with the relationships among those providers. It is interesting and useful to visit an agency with which you are unfamiliar. Request an opportunity to interview a staff member or administrator. Your instructor may be able to provide a letter of introduction to help you get the interview. Note: Do not use the agency at which you are employed, an intern, or a volunteer. Try to avoid using the same treatment modality. To prepare for the visit, bear in mind that there will be an in-class component of this activity. Each student will explain to another student or a small group exactly what services the agency offers and how the agency can be helpful to its clients. Act like the marketing director for the agency and sell its product. Secondly, make a list of questions to elicit information about the following:

- ☐ *Agency philosophy*
- ☐ *Agency policies and procedures*
- ☐ *Administrative and clinical structure*
- ☐ *Staffing patterns*
- ☐ *Treatment philosophy*
- ☐ *Treatment methods and modalities*
- ☐ *Funding sources*
- ☐ *Eligibility requirements*
- ☐ *Length of stay*
- ☐ *Cultural, class, and ethnic makeup of staff and clientele*
- ☐ *Referral patterns*
- ☐ *Success rate*
- ☐ *Method of measuring success*

MAJOR INFLUENCES AND TRADITIONS IN SUBSTANCE USE DISORDER TREATMENT

Self-Help Movements

The history of self-help and temperance movements in America is a fascinating tale outside of the scope of this text. Readers are advised to consult *Slaying the Dragon—The History of Addiction Treatment and Recovery in America* (White, 2014).

In 1935, AA was spun off from the Oxford Movement, a religious organization, by William Griffith Wilson and Dr. Robert Smith.

Alcoholics Anonymous is a peer self-help group, mutual-aid society, or, as members call it, a fellowship of people with an alcohol use disorder in recovery. It has a democratic, nonhierarchical, grassroots structure, and as some call it, a "folk psychotherapy." The AA method is based on the Twelve Steps of Alcoholics Anonymous, and its basic organizational principles are based on the Twelve Traditions. (AA, n.d.)

We may sum up the basic principles of AA as follows:

- Abstinence from alcohol as a requirement for recovery from alcohol use disorder
- Alcohol use disorder is to be considered as a lifelong, chronic, progressive disease
- Anonymity
- Spirituality through a spiritual awakening and giving up control to a higher power
- Self-identification as a sufferer from a lifelong, chronic disease
- Staying sober 1 day at a time
- Group support from a fellowship of people with alcohol use disorder
- Helping oneself by helping others
- Reaching out to others with the AA message

Much of the AA method and philosophy are epitomized by mottos and slogans that are easy

to retain, repeat, and focus on by the barely "dry" individual with alcohol use disorder. Examples are "don't drink, and go to meetings," "easy does it," and "let go and let God." AA publishes a vast number of pamphlets and books, many focusing on the early history of the fellowship (AA, 1957, 1976, 1980).

The success of AA may be explained by its comprehensive network, which supports sobriety and recovery; conversion to a sober ideology and perspective; frequent attendance at AA meetings where role modeling, confession, sharing, and support take place; and participation in the member network or sober subculture between meetings, including obtaining and relying on a senior member or sponsor (Maxwell, 1984).

Al-Anon, a fellowship for relatives and significant others of people with alcohol use disorder, was founded in 1951, although it did not take off as a movement until 1962. Narcotics Anonymous (NA), the third of the three major Twelve-Step fellowships, was founded in 1953. It was relatively small throughout the 1950s and 1960s, with hardly any overlap with the therapeutic community movement. It grew during the 1970s and even more during the 1980s. Although the basic text of NA, *Narcotics Anonymous* (NA, 1988), was written in 1962, its section of personal stories dates from 1981. The counterpart to Al-Anon is Nar-Anon (not to be confused with Narconon, which is a Scientology group).

A wide range of twelve-step fellowships have spun off from AA and NA.

NON-TWELVE-STEP RECOVERY ORGANIZATIONS

- SMART Recovery (Self-Management and Recovery Training) is an abstinence-based fellowship based on rational emotive behavior therapy, which was originally developed by Albert Ellis (Trimpey, 1992, Ellis, McInerney, & DiGiuseppe, 1988). It was initially called Rational Recovery (RR). SMART recovery is not based on spiritual principles and does not consider alcohol use disorder a disease but instead favors the use of appropriate medications, teaches self-empowerment, and is open to changing its approach to include such current practice as motivational interviewing and the stages of change.
- Secular Organizations for Sobriety (SOS), also known as Save Our Selves, was started by Jim Christopher in 1985 as a secular-humanist alternative to AA. It is abstinence based and, like AA, considers alcohol use disorder a disease but maintains a secular approach as opposed to a spiritual outlook (Christopher, 1989). Most chapters are located in California, New York, and Texas. It promotes an approach to recovery comparable both to that of AA and cognitive behavioral therapy; daily acknowledgment of the alcohol problem is emphasized. SOS also presents two concepts—a Cycle of Addiction and a Cycle of Sobriety, which are somewhat comparable to professional paradigms.
- LifeRing is an abstinence-based group spun off from SOS. While it is secular, it welcomes people of all faiths. It is democratically managed and works through a network of meetings that are nonconfrontational and not focused on "war stories" about alcohol and drugs. Members need not take on the label "addict" or "alcoholic." The philosophy of LifeRing is strengths based; it also recognizes the ambivalence that people have over substance use, and denotes these as the Addict Self and the Sober Self.
- Women for Sobriety (WFS) was founded by Jean Kirkpatrick in 1976 to serve the recovery needs of women. Kirkpatrick had been active in AA but believed it did not meet her needs or those of women in general. The program is founded on its Statement of Purpose and Thirteen Affirmations. While Kirkpatrick is now deceased, the program continues to operate.

- The Sixteen Step Program, developed by Dr. Charlotte Kasl, offers a relatively new program that has been called "spirituality lite." It dilutes the emphasis on spirituality and stresses empowerment rather than powerlessness. The Sixteen Step Program also considers the position of women and other minorities in societies. The program incorporates the Buddhist (Reiki Zen) philosophy, in which Kasl has been trained, into its values. Kasl describes the influence of Zen and feminism on her perspective (Kasl, 2002).

  Although AA and NA are the gold standard of the SUD industry, as they are the most available nationwide, and are the recovery culture from which many counselors emerged, it would be the most ethical practice to give clients alternative pathways to sobriety and abstinence. LifeRing and the Sixteen Step Program, for example, are little known in the SUD field.
- Moderation Management (MM) contrasts wildly from AA or any of its secular alternatives. It is a self-help organization supporting people with alcohol disorder in their attempt to cut down to a so-called moderate, responsible level of consumption. Opponents of the MM program consider it a Russian roulette approach, as no one can know who will successfully moderate and who will fall back into a severe alcohol use disorder.

ACTIVITY 1.2 What goes on in those meetings?

It is important for all SUD counselors to experience the atmosphere and process of a self-help fellowship. It is also a requirement of many certification and credentialing authorities.

Attend a self-help group with which you are not familiar, and write a two-page "reaction paper." Include a description of what took place; the format of the speeches; the customs you observed; the atmosphere before and after the formal meeting; and the feelings you had while attending.

Inpatient Rehabilitation Emerges from Self-Help

AA steers clear of institutional affiliation. Early AA members, starting with Bill W., the founder, often filled their houses with those whom they were helping to "dry out." Eventually, inpatient rehabilitation programs based on AA principles grew out of this practice. These programs, which began in Minnesota in the 1950s, kept the AA philosophy but gradually added the professional framework of assessment-based treatment planning as well as individual and group counseling. The length of stay for clients in Minnesota was 28 days. For decades afterward, the dominant form of alcohol use disorder treatment in the United States was based on this so-called Minnesota Model and a disease concept of treatment based on the philosophy of AA (Yalisove, 1997). In the late 1970s and early 1980s, inpatient treatment flourished because of insurance reimbursement. Many expensive, private "rehabs" thrived. Unfortunately, the excesses of that era were used to invalidate the inpatient approach, and many people in need of such a level of care have been denied that option now.

Therapeutic Community Model

The term *therapeutic community* (TC) originally denoted an innovative approach in the inpatient treatment of post-traumatic stress disorder (PTSD) in the immediate post–World War II period. It instituted a therapeutic milieu among patients as well as a structure that allowed patients' input into the management of the unit (Jones, 1953, 1968; Rapoport 1960).

This democratic milieu is still a current mental health model in the United Kingdom and Europe. Students who set out to write a paper on therapeutic communities often are thrown off track because the term means something quite different in the United States, where it refers to a hierarchical and demanding long-term, substance-free residential program largely run by people recovering from SUD themselves. The therapeutic

community model began in 1958 in California when Charles Dederich, an individual recovering from alcohol use disorder, brought people with drug use disorder into an AA group. He then split off to found his own organization, named Synanon, after a mispronunciation of "seminar." It differed from AA in that it primarily addressed drug use disorder, used confrontational methods, abandoned the spiritual component of AA, and was residential. The residential people with the SUD community was run totally by people recovering from SUD. This has been a feature in subsequent TCs, although there may be a supervising layer of professionals who may or may not be people recovering from SUD. Synanon developed a variety of harsh confrontational techniques that were designed to strip people with SUD of their "street" images and defenses. These included confrontational groups, then called "the Synanon guns." Other important features of this modality were work therapy and a hierarchy of rewards, privileges, and grading up until graduation, which were designed to re-socialize the individual with SUD into responsible and mature behavior (Yablonsky, 1965). The stratification system goes beyond graduation; the TC graduate may return as a role model and often becomes part of the staff. There is a tremendous camaraderie among members of a therapeutic community, which is often seen as a substitute family.

Reactions to TCs ranged from the predictable NIMBY (not in my backyard), to awe at the sight of people with SUD transformed into clean-cut young men and women hammering, sawing, and scrubbing the sidewalk. The TC model became dominant in drug treatment during the 1970s. Hundreds of treatment programs follow the TC model, more or less. Many or most of the original, rather harsh practices have been modified considerably.

The programs have seen the influence of social learning and cognitive psychology, and educational and occupational programs have been added to facilitate realistic re-entry into society. In addition, the model has been incorporated into many programs in prisons and programs designed as alternatives to sentencing, as intermediate sanctions, and as sentencing to treatment (Lockwood & Inciardi, 1993). Unfortunately, the TC model is often stereotyped as an incredibly harsh and cult-like environment, as if it had not changed since the 1970s.

COUNSELING APPROACHES

Counseling approaches, sometimes called theories of counseling or counseling models, are systems of ideas concerning the ways that change can take place. They can identify major goals and strategies of treatment. Some approaches, through their name itself, make known that they subscribe to a particular personality model. For example, the term *cognitive behavioral therapy* indicates special attention to thinking (cognition) and behavior, and the relationship between the two.

ACTIVITY 1.3 Thinking about counseling

Form small groups of no more than six people and elect a recorder and a spokesperson for each group. After a 20-minute discussion, each group should have a consensus that defines and describes (1) counseling and (2) SUD counseling.

Process: Group by group, define counseling first. Then describe what happens in counseling. How does this differ from other relationships and conversations? Note differences and similarities among groups. Which group members have gone to a professional for help of any kind (e.g., counselor, physician, nurse, lawyer, accountant)? Explore these relationships.

CRITICAL THINKING

Dogmatism is stubbornly adhering with one world view or ideology and excluding other points of view. Dogmatic thinking is detrimental to counseling and treatment of any behavioral health

problem; it prevents the adoption of helpful and innovative strategies, and is negating (Myers, 2002). Unfortunately, it has been common in SUD treatment. The opposite of dogmatic thinking is critical thinking.

Michael Taleff, a leader in SUD education, defines *critical thinking* as carefully weighing an idea or belief for its value and validity (Taleff, 2006, p. 22). In addition to this definition, we offer this compilation of adjectives:

> Critical thinking means being rational, logical, independent, questioning, analytic, open, creative, curious, and skeptical.

Taleff found the lack of critical thinking in the SUD field to be so pervasive and debilitating to the effort of offering appropriate counseling and treatment that he wrote an entire text on critical thinking for SUD professionals (Taleff, 2006, pp. 105–110). He has identified several fallacies in the thinking of professionals. Space considerations exclude all but a few examples.

- *Altering a definition rather than admitting other possibilities*. Saying, for example, that an individual with alcohol use disorder who returned to social drinking probably did not have an alcohol use disorder in the first place.
- *Slippery slope*. A presumed set of inevitable chain reactions. ("If we don't fight a war with the Zonians, they will take over the next country, and then the next.") In prevention work, the authors have seen youngsters laugh at such predictions of disaster if they experiment with psychoactive substances. (The most extreme example of this fallacy was the 1940 movie *Reefer Madness*, which readers should badger their professor to play for the class.) Yet, the entire disease model so standard in American SUD treatment was precisely the same. Using a career of deteriorated, "low-bottom" gamma people with alcohol use disorder who had ended up, finally, in Alcoholics Anonymous, it postulated that alcohol use disorder was a relentlessly chronic and progressive disease, excluding the majority of alcohol abusers who did not progress into serious alcoholism, not to mention the ones who got better on their own.

Most therapists borrow from various clinical approaches, an approach that can be called eclectic or integrative (Garfield & Bergin, 1994, p. 8; Lambert & Bergin, 1994, pp. 143–144), addressing emotion, behavior, thinking, and interpersonal issues. A similar term is *holistic*, which simply means looking at and integrating all aspects of a system.

One of the major themes of this text is the development of counseling skills that facilitate a helping, empathetic, collaborative relationship between counselor and client. In adaptations to short-term treatment, though, such an approach can lose the human dimension and be reduced to a set of "cookbook" routines, formulae, tricks, or gimmicks, against which the Project MATCH Research Group (NIAAA, 1995, p. 8) specially cautions. Such routines soothe the counselor more than the client, which is another reason to focus on counseling skills. Techniques that address only cognition or that address emotion only in terms of the cognition involved evade the pain, trauma, and tragedies of clients. In warning against taking cognitive psychology's dispassionate, commonsense approach to emotion too far, Fancher and Freeman (1997, p. 195) quote a line from Emily Dickinson: "There is a pain so utter, it swallows substance up."

Paradigm Shifts in Initiating and Sustaining Recovery

Drug treatment through the 1980s adhered to a template of inpatient rehab for more clients than was necessary. The shift to intensive outpatient care and other options began in that decade, both because we became progressively "unstuck" from dogma and because third-party payers were reluctant to pay the exorbitant sums that rehabilitation demanded.

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CHAPTER 2

ETHICS, CONFIDENTIALITY, AND PROFESSIONAL RESPONSIBILITY

OBJECTIVES

At the end of this chapter, students will be able to:

1. Describe the importance of ethical decision making in substance use disorder (SUD) counseling.
2. Describe the need to use supervision in any ethical issue that they see arise.
3. Describe the value and purpose of both the federal confidentiality regulations and Health Insurance Portability and Accountability Act (HIPAA).
4. Explain to a client the meaning of informed consent.
5. List at least four exceptions to confidentiality when disclosure can be given.
6. List two conditions in which there is a duty to warn.
7. Describe at least six principles that may be taken into consideration when an ethical dilemma arises in counseling.
8. Describe at least three ways to become involved in your own professional growth.
9. Provide at least three examples of how clients and counselors can cross boundaries and how these create ethical and legal problems.
10. Identify three examples of unethical representation of services.

INTRODUCTION

Ethical principles define and govern the right, good, and moral behaviors that are expected in proper professional relationships. Ethical standards are developed and maintained by associations and credentialing bodies of real estate brokers, lawyers, helping professionals, and others. They are motivated by a desire to protect clients, to avoid governmental interference and malpractice suits, and to develop public confidence in general and client confidence in particular.[a]

There is a compelling necessity for ethical standards in the counseling relationship. Counselors hold a great deal of power over clients; mechanisms are necessary to ensure that this power is not abused. The overall objectives of counseling ethics are to maintain client welfare as foremost, to do no harm (physical, emotional, or financial), and to maintain standards of responsibility, integrity, and accountability.

Although confidentiality is the area most regulated by legal statutes, not all critical areas of ethics are formulated into legal statutes. Professional conduct can be legal but not ethical.

Many SUD counselors, like their clients, participate in a SUD recovery milieu. This and other relatively informal aspects of the SUD field blur boundaries and roles, creating possibilities for ethically compromising situations.

Ethical standards supersede all other considerations. All counseling actions and decisions must be considered from the standpoint of and be governed by these standards.

In the preparation of SUD counselors, specialized ethics training is the area most often cited as inadequate. Furthermore, internal agency discussion of ethical issues is sometimes muted out of shame, fear, confusion, or expediency; this can be summed up by the term *institutional denial* (Myers, 1990; White & Popovits, 2004, p. i, 1). Counselors must bear in mind that institutional systems of the agency and broader society generate a climate and a range of options that bear on individual ethical choice.

ACTIVITY 2.1 Easier said than done

In a large or a small group, each person states one principle or guideline by which he or she lives (in the broadest sense, an ethics statement). Typical responses are "I never lie," "I never kill or hurt someone," and "Honesty is the most important to me."

Discuss: Consider the following questions and discuss your answers with each other.

- ☐ Do you subscribe to the statement "Thou shall not kill?" Have you killed an animal or put a pet to sleep?
- ☐ Do you believe it is wrong to steal? In what situation is it alright to do so, if any?
- ☐ Have you ever covered up for a friend's mistakes or lateness at work by lying to a supervisor?
- ☐ Have you ever been aware of mistreatment or neglect of a child but did not communicate this information to authorities, nor confronted the perpetrator?
- ☐ Have you taken an office item home from work or photocopied a personal item at the office?
- ☐ What other small or large actions reflect your ethics?

Process: Can you identify connections among the ethics statements you made, your values and morality (preferences and judgments), group customs (traditional ways of doing things), and laws (standards set by legislative authority)? Are ethical choices absolute? For example, are there circumstances in which it would be permissible to plan to kill someone?

[a]We are deeply indebted to William White and Renee Popovitz, whose landmark book, *Critical Incidents* (White & Popovits, 2004), has brilliantly outlined the areas of ethics training for SUD counselors. Their "critical incident" method sets a standard for ethics training and has significantly influenced the format of this chapter.

The mandatory orientation of a client that takes place during the intake process includes information about the agency's confidentiality guidelines and practices. The client receives a summary of regulations concerning confidentiality and signs the summary to attest that he or she has understood. The client and the agency each keep a copy of the signed form. At the same time, for the purposes of case management, the counselor may request that the client sign a Consent for Release of Information form that stipulates exactly what client information can be released and to whom. When information is divulged legally to a third party, that third party cannot release it to anyone. As of March 2017, a client may allow disclosure to "my current and future treatment providers." The two most common uses of the consent form are as follows:

- To allow continuity of care when different facilities are involved in the client's treatment (e.g., detoxification and rehabilitation units)
- To report a client's compliance to a referring agency (e.g., EAP administrator, parole officer)

GRAY AREAS

Activity 2.1 shows the impossibility of devising precise rules for human behavior. In ethical counseling, *knowledge* of guidelines must be supplemented by the *skills* of interpreting complex situations and of *applying* ethical standards to them. Also pertinent to ethical counseling are developing and maintaining awareness of the counselor's personal needs and feelings, evaluating how they influence the counseling relationship, and ensuring that clients' interests are held foremost. Often, counseling situations occur in which there are competing ethical and/or other obligations. Moral dilemmas arise out of conflicts between two or more beliefs, values, laws, or standards. In resolving such dilemmas, it is useful to establish a hierarchy of ethical standards, that is, a list of ethical concerns rated according to which predominate or take precedence over others. Lowenberg and Dolgoff (1988) present such a hierarchy of ethical standards:

1. Protecting human life
2. Fostering independence and freedom
3. Fostering equality
4. Promoting a better quality of life
5. Protecting the right to privacy
6. Truthfulness
7. Abiding by rules and requirements

Standards vary in their attempts to be specific. Some are brief and sketchy; others go into great detail to cover every eventuality.

SUPERVISION AND CONSULTATION

Consultation with supervisors or other professionals is necessary to ensure a continuing ethical relationship between counselors and their clients, especially in situations where there appears to be a conflict among ethical standards or between ethical and other considerations. Seeking appropriate consultation is considered an ethical necessity in most helping professions (NASW, 1999, 2.05). Not to seek advice from others can be unrealistic, inflexible, unwise, and even unethical. One may need to speak to experienced peers or clinical supervisors or to call on the expertise of those trained in other helping professions, such as psychiatry or neurology. Consultation should come sooner rather than later.

Consultation with supervisors about ethical considerations, when carefully documented in clients' records, helps protect both the counselor and the agency in litigation and governmental audit. *Failure to consult* is a subcategory of negligence in malpractice law (Hogan, 1978).

Guidelines for supervision of counselors in private practice vary considerably among the helping professions. Failure to provide adequate supervision is unethical and grounds for action under malpractice law (Hogan, 1978). *Supervision* has both administrative and clinical dimensions. Although it would be ideal to separate these roles so that there is a space where counselors can feel safe

expressing their self-doubts, problems, and errors; in the real world, the immediate supervisor often serves both administrative and clinical functions. This reality challenges the supervisor's own ethics when he or she must weigh the factors of a situation that puts clinical and administrative concerns in conflict. Probably, the most typical example of this conflict is that a client needs more personal attention and a longer stay in treatment, but the supervisor is charged with encouraging counselors to see as many clients as possible during a workday and to discharge them from treatment as quickly as possible.

Ethical supervision must be adequate, nonvindictive, and facilitate growth. The supervisory process should be based, at least in part, on routine objective criteria for evaluation, a structure that helps to avoid, but cannot prevent all, personal or subjective situations. Some SUD treatment agencies hire graduates of the program as counselors. Objective evaluation may be compromised if supervision is assigned to a former primary counselor of this individual. The supervisor should share evaluative data with supervisees on a regular basis, and supervisees need an opportunity to respond (NASW, 1999, 3.01, 3.03).

CASE IN POINT

An Unacceptable Excuse and a Misuse of Consultation

A clinician treating a very hyperactive preadolescent failed to diagnose that the client had attention-deficit hyperactivity disorder. She felt increasingly angry and frustrated, which compromised her ability to counsel the child. Instead of withdrawing from the case, she ended up in a physical struggle with the child, in which she administered a spank. When confronted by the parents, the clinician claimed to have had a post hoc "consultation" with an eminent child psychologist that supposedly justified the events that had transpired. It is not clear if the clinician provided an accurate account either to her consultant or to the parents.

There is a continuum in supervisory relationships: At one extreme, a clinical or administrative supervisor may micromanage the counselor and perhaps employ a punitive or parental style, preventing professional growth and self-sufficiency as well as generating tension between counselor and supervisor; and at the other extreme of the continuum, there may be a detached and/or lazy supervisory relationship, and/or the supervisor may take on a "buddy" role. The zone of effective supervision is the halfway point between the two.

BOUNDARIES

SUD treatment is unique because a large proportion of staff is also in recovery from that which they are treating. Boundaries are an issue in all realms of counseling but come to the forefront more often and more easily in the SUD field, because recovering counselors and clients share similar histories, issues, and even membership in self-help fellowships. Such an issue cuts to the core of the professional counselor–client relationship. With the best will in the world, failure to delineate and differentiate these identities destroys the professional identity and role, and leads to any of a number of ethical compromises, violations, and manipulations. Regardless of the setting, but especially in SUD counseling, counselors are counselors—not bowling buddies or business associates. Counselors cannot paint clients' houses, treat them to lunch, provide lodging, lend them money, or borrow money from them (not even $1 for a cup of coffee). As a real example, a counselor was charged by a state certification board for SUD counselors for taking a client to his home, even though there was no inappropriate behavior during this time.

SEXUAL RELATIONS

Therapy sessions are emotionally intimate, and this intimacy can be confused with romantic or sexual feelings. We discuss this in greater detail in Chapter 3 when we consider transference, a clinical

treatment issue. Counselors must be vigilant that appropriate boundaries are not crossed. In all professional codes of ethics, sexual relations with clients is strictly forbidden. This almost always includes former clients, and even may extend to relatives of clients. Moreover, a majority of states have laws forbidding sexual contact, and in most of those, it is a felony offense (NASW, 2013). Sex with clients is an abuse of power and trust, is harmful to clients, and is a frequent subject of malpractice lawsuits. Not only is sexual relations the subject of ethical and legal codes, but so is sexual touching, fondling, and kissing. Supervisors and the agency itself may be subject to penalties (ACA, 2014, A5b,c; NADAAC, 2016 1-23, 1-42).

NEW ROLES

With the development of new recovery roles, such as the recovery coach, recovery mentor, or peer recovery advocate (terminology varies state by state), one can confuse these paraprofessional roles with that of the sponsor in a 12-step fellowship. Ethics training is almost always part of the credentialing curriculum established by the state or other credentialing agency. In cases in which police departments recruit civilian "angels" in the PAARI (Police Assisted Addiction and Recovery Initiative) or Gloucester Initiative, ethical training may be minimal. Ethical breaches involving "angels" or peer recovery advocates may include using them as "headhunters" for particular treatment facilities. They also may not be familiar with patient placement criteria and bring clients to an incorrect level of care. Worse, they may ignore placement criteria in order to inflate their success rate or get a commission from a treatment agency (ADAW, 2016; White, 2006).

Although there are some very strict standards about personal boundaries, there are also gray areas. For example, how much self-disclosure by counselors is appropriate or ethical? Is hugging, which is permitted and encouraged by many support and self-help groups, appropriate or ethical? Touching a client with the appearance, implication, or suggestion of sexuality is clearly an ethical violation, but is it always wrong to hug or put an arm around a client? Obviously, this is an area where ethical standards vary (Pope & Vetter, 1992, 401; Rhodes, 1992, 43–44).

LEGAL ISSUES

CONFIDENTIALITY

A major legal and ethical obligation of SUD counselors is to maintain privacy regarding information revealed by clients, whether it be in written records (charts, memos, notes, messages, email, and electronic files) or verbal communications. The counseling relationship, like that of lawyer and client, or cleric and penitent, is *privileged*, legally covered with a code of silence. Federal laws protect clients' identities and records. The latest Federal Confidentiality of Patient Records Regulations, CFR 42 Part 2, of the Code of Federal Regulations, went into effect on March 2017 (HHS, 2017). They apply to "Part 2" programs—that is, true SUD treatment programs. State regulations vary, and in recent years, the law of privilege has been strengthened in some states but threatened or eroded in others. In situations in which there is a conflict between these statutes, federal guidelines prevail. Every counselor must be informed as to how specific state regulations interpret federal statutes (see "Professional Growth" later in this chapter).

The Alcoholics Anonymous and Narcotics Anonymous (AA/NA) tradition of confidentiality for their 12-step groups is not a legal statute.

However, in general, the courts recognize AA/NA as religions, and therefore, certain communications within the fellowships need not be admitted as evidence in court cases, as they are covered under clergy privilege, a form of evidentiary privilege. In general, the conversations between a sponsor in AA and the sponsored party would be private and privileged. However, conversations between AA members on the street or in their homes would not necessarily be covered. The courts have vacillated on interpreting such situations, especially

in the case of Cox vs. Miller (Diaconis, 2014), also known as the Paul Cox case , in which Cox, in a blackout, killed two people, but later, as a member of AA, remembered it and shared it with others in the fellowship.

In addition to the CFR 42 rules, there is the complex Health Insurance Portability and Accountability Act of 1996—the HIPAA regulations. HIPAA parallels CFR 42 Part 2 to a great extent. It applies to "covered entities," which are health plans and healthcare providers who transmit health information in electronic/computer-based forms, for submission of claims, coordination of benefits, referral certification, and authorization. According to HIPAA regulations, in a pharmacy, clients have to stand behind a line so they cannot see who is signing for their medications ahead of them; in a clinic, the sign-in sheet is kept out of plain view; computer workstations at agencies log off automatically if the user is away for a long time; passwords change at an alarming rate; and workstations are placed in discrete locations. All staff members of a "covered entity" are expected to be trained in the implementation of HIPAA so as to properly process "Protected Health Information" (PHI). Agencies have found the implementation of HIPAA bothersome; although they do acknowledge that HIPAA has many valuable safeguards for clients in this electronic age. However, it is not enough that all these safeguards are practiced; program participants have to be made aware of these safeguards. Agencies subject to both the old federal (42 CFR) and the new HIPAA regulations can combine them into a single notice. There are some new patient rights, such as the right to request restrictions in the uses and disclosures of PHI, and the right to access, amend, and receive an accounting of disclosure of PHI. Most large agencies compile their own manual of regulations and forms and designate a privacy officer to oversee its administration; it is important to be familiar with this manual.

The governing principle is that all information communicated by clients in programs or individual treatment is privileged and confidential. This principle is based not only on the right to privacy but also on the likelihood that clients will accept and succeed in treatment if they can be confident that information is protected. There are a few, clear exceptional circumstances in which information revealed by clients can be communicated to others.

Duty to Warn

When information reveals a clear danger to the client or others, such as suicidal or homicidal intent, a professional obligation called the *duty to warn*, in which you notify medical personnel or police, supersedes confidentiality. In addition, in most states, it is a legal obligation to inform the police if any crime is threatened or committed against an agency's staff. Penalties for failure to warn vary from state to state. Individuals harmed by such failure often seek compensation by instituting lawsuits.

CASE IN POINT

Duty to Warn: The Landmark Case

On October 27, 1969, Prosenjit Poddar killed Tatiana Tarasoff. Tatiana's father, Vitaly Tarasoff, sued, alleging that 2 months earlier, Poddar had confided his intention to kill Tatiana to psychologist Dr. Lawrence Moore of the Cowell Memorial Hospital at the University of California at Berkeley. On Moore's request, the campus police briefly detained Poddar, but they released him when they concluded that he was rational. They further claimed that Dr. Harvey Powelson, Moore's superior, directed that no further action be taken to detain Poddar. Thus, the victim and her parents were not warned of her peril.

The defendants included Dr. Moore, the psychologist who examined Poddar and decided that Poddar should be committed; Dr. Gold and Dr. Yandell, psychiatrists at Cowell Memorial Hospital who concurred in Moore's decision; and Dr. Powelson, chief of the department of psychiatry, who countermanded Moore's decision and directed that the staff take no action to confine Poddar.

Most counselors have heard of the famous Tarasoff case—*Tarasoff v. Regents of the University*

of California 551 P.2d 334 (1976)—but few are aware that the supervisor as well as the treating psychologists were held liable in this landmark case. The supervisor has the same duty to protect a third party (Tatiana) as does the supervisee.

A later landmark case, *Jablonski v. United States* (1983, Ninth Circuit, U.S. Court of Appeals), found a therapist and the therapist's supervisor negligent for failing to accurately predict a homicide based on the psychological profile of their client.

Legal criteria for predicting dangerousness usually include the following:

- Past violent behavior
- Specific and/or detailed threats
- Repeated threats
- Violent thoughts
- History of irrational and unpredictable behavior

Supervisors must ensure that their supervisees understand and effectively implement mandates on warning a third party and they must carefully document that they did so as well as document any warnings that did take place.

Duty to Protect an Individual at Risk of Suicide

A counselor would be liable if he or she:

- Failed to assess and diagnose the client.
- "Abandoned" the client by abruptly terminating the client, failed to respond in an emergency, or did not have backup coverage when he or she was unavailable.
- Assisted with the suicide, say, by encouraging the misuse of medications.
- Contributed to a suicide through inaction.

A supervisor would be liable if she or he failed to direct the counselor properly in this situation (Falvey & Bray, 2001).

Duty to Report

Initial reports of child abuse and neglect are stipulated by the federal Child Abuse Prevention and Treatment Act of 1974, which denies federal grants to states that do not comply with reporting standards. The Duty to Report to child protective agencies in a region overrides or supersedes confidentiality rights.

The duties to warn and to report child abuse do not throw open agency files; they merely mandate the provision of specific information to the appropriate authorities. State regulations define what constitutes child abuse. Anyone who works with children is a *mandated reporter* of abuse, even abuse that the professional observes on the street or in the home of a friend or relative. However, there is considerable variation in how mistreatment of children is initially perceived, often influenced by the cultural background of the staff involved. In several instances, paraprofessional child-welfare workers in New York City overlooked what later was identified as serious physical abuse of children. In some agencies, a non-degreed counselor identifies abuse that is then "called in" by another staff member.

CASE IN POINT

Eliza Fell through the Cracks

The mother of six-year-old Eliza Izquierdo was mentally ill with SUD. She believed her child was possessed by evil spirits. Eliza was kept home from school, neglected, and abused. She died from beatings in November of 1995. Warning signs had been missed or ignored by her school and her caseworker. Her death became a rallying point for social-service reform.

The Child Abuse and Protection Act also mandates confidentiality regarding specifics of child abuse cases, which has been frustrating to those seeking to eliminate negligence and neglect. Therefore, Congress amended the Act in 1992 to facilitate effective investigation and prevention of abuse.

In New York, the Social Services Law has interpreted in even more stringent terms, the stipulation of total secrecy. When child welfare authorities refused to testify in hearings on cases of severe child abuse that "fell through the cracks,"

legislators concluded that the state regulations functioned to protect bureaucratic incompetence or inaction. After verifying that federal regulators were in line with the 1996 regulations, New York enacted modifying legislation (Eliza's Law, see "Case in Point: Eliza Fell through the Cracks") to permit more disclosure for investigative purposes.

Informed Consent

Informed consent means that the client has been educated as to the nature and form of disclosure. A client can give specific, written consent to the release of information. Every agency has a printed consent form that is explained carefully to every client (**FIGURE 2.1**). It is signed by the client

Macedonia Memorial Medical Center Release of Confidential Information Consent Form

I, _____, a patient in the Addiction Services Unit at Macedonia Memorial Medical Center, hereby authorize the following disclosure of information from my treatment records/files:

I authorize Macedonia Memorial Medical Center to release information listed below to (name, title, organization to which disclosure is to be made):

_____

Purpose or need for disclosure (as specific as possible): _____

_____

Nature or extent of information to be disclosed (as limited as possible): _____

_____

This consent will terminate upon (date, event, or condition): _____

_____

I understand that my records are protected under federal regulations governing confidentiality of alcohol and drug abuse records, 42 CFR Part 2 and cannot be disclosed without my written authorisation unless otherwise provided for in the regulations. I also understand that information disclosed in the party listed above may not be disclosed to a third party without a separate signed consent, and that I may revoke this consent at any time except as legally proscribed.

Signature of Patient: _____

Signature: _____ Parent _____ Guardian _____ Authorized Representative

_____

Signature of staff person: _____

Date: _____

FIGURE 2.1 Sample Consent form.

and by the individual performing the intake procedure and dated. The intake procedure, or the paperwork involved, may be implemented by a SUD counselor or a specialized intake worker. Blanket consent to release any or all information, or from or to any party, is acceptable in the Code of Federal Regulations (CFR). Written consent specifies the type of information that may be released, who is to release it and to whom, and for what purpose. It should include a statement that consent can be withdrawn. A client can usually withdraw consent verbally as well as in writing, although the time frame within which this occurs varies from state to state. The release must be signed and dated.

Confidentiality is not limited to the time of treatment. It starts when the client applies or calls to apply, even if he or she does not make an appointment. Confidentiality responsibilities do not end when the client exits treatment, whether from completion, recurrence, administrative discharge, or other circumstance, or if the client dies. The counselor and other staff must ensure that records are kept in such a manner that confidentiality will be preserved. The disposal of records presents the same expectation. "Dead" files cannot, for example, be taken in cartons to the street or left in unlocked cabinets in a storage room (ACA, 2014, B6.h). They must be shredded or incinerated.

Disclosure and Redisclosure

Release of information with a client's informed consent binds the party to whom it is released not to release it to a third party (**FIGURE 2.2**). The information is bound by the confidentiality guidelines. Information disclosed by consent should be limited to that needed for case management, diagnosis, referral, and rehabilitation, and to process insurance claims or aid in the disposition of criminal proceedings.

The fact that clients are in treatment at a particular agency cannot be revealed without written consent of the client or a court order, regardless of who is inquiring. Relatives cannot simply call to speak with a client or ask if the client has arrived. Nor can staff always trust that a caller is who he or she claims to be.

> This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute the patient.

FIGURE 2.2 Prohibition of redisclosure.

CASE IN POINT

I Can't Give You That Information

One of the authors called a large treatment facility to inform a staff member of a scholarship award. The man who answered the phone gave a detailed and helpful account of the counselor's activities and how best to contact her. When he was asked, "Whom am I speaking with?" he responded, "I'm sorry, I can't give you that information, I'm a client."

Even when a counselor or other professional refers a client to treatment, once the client has completed intake at the treatment agency, staff members are following correct practice if they no longer communicate information about that client to the referring party, unless the client has given consent for release of information.

Legally Incompetent Clients

If the client is incapable of understanding his or her rights and responsibilities, that client might be judged legally incompetent. Special consent

provisions are made for legally incompetent people and for minors; a legal guardian signs (or refuses to sign) consent form(s) [Figure 2.1]. In the case of releasing information about a deceased client, consent forms are signed by the person who has the power of attorney. A medical diagnosis does not constitute legal incompetency: It is only a piece of the evidence presented in courtroom procedures to determine a person's "competency." It is the responsibility of the agency's administration to ensure that privileged information is not released unless appropriate forms have been presented to document such legal determination, according to federal and state statutes.

Clinical Discussion

Confidential information can be discussed for clinical and supervisory purposes. If such agency functions took place only in a strict chain of command, this would be quite clear. However, peer supervision, case conferences, and shift reports multiply the number of people who have access to confidential information. These factors, as well as the informal organization of the profession, make it difficult to define appropriate boundaries of secrecy. A baseline principle should be established that disclosure is on a need-to-know basis, as opposed to freely exchanging information with any and all personnel. Sharing of information cannot occur outside of a treatment unit in a larger institutional setting. For example, a nurse in detox cannot tell her friends on the maternity floor about her hallucinating patient. In addition to people involved in the client's care, the people who deal with billing and other recordkeeping may legally receive limited confidential information.

A counselor or agency must establish clear guidelines for access to confidential records by secretarial workers and volunteers. If they must have access, they must fully understand and implement confidentiality guidelines. The CFRs apply to all support personnel, administrators, volunteers, interns, and so on.

ACTIVITY 2.2 What's the right thing to do?

Phil is a counselor in an intensive outpatient program where you work. He has been employed in the field for three years and has been in recovery for 6 years. You have been close to him for most of that time. A month ago, Phil's son was killed in an automobile accident. In his grief, Phil went out and got intoxicated. He immersed himself without delay in his recovery fellowship as well as in short-term bereavement counseling, and he has confided only to you about the situation. State regulations mandate that counselors have at least 2 years uninterrupted "clean time." Phil is very afraid that if the agency finds out about his relapse, he will lose his job.

Discuss:

- ☐ How do you feel about this situation?
- ☐ What would you say to Phil?
- ☐ Can you consult someone about this to get advice on your position?
- ☐ What should or can you say to the agency administrators?
- ☐ When is withholding information a breach of honesty?
- ☐ If you fail to disclose Phil's relapse, do you think you'd lose your job?
- ☐ How can you reconcile, on one hand, the trust and confidence of a friend and, on the other, loyalty to the agency and safety of clients?
- ☐ What do you think would be the best thing to do for your friend?
- ☐ What would be the right thing to do? Does this conflict with what you think would be best for Phil?

Court-Ordered Disclosure

According to a Substance Abuse and Mental Health Services Administration (SAMHSA) publication on confidentiality (Lopez, 2002, 5),

> A federal, state and local court may authorize a program to make a disclosure of confidential patient identifying information. A court may issue such an order, however, only after following certain procedures and making certain determinations specified in the regulations. A subpoena, search warrant, or arrest warrant, even when it is signed by a judge, is not sufficient by itself to require or even permit a program to make such a disclosure.

It further states that the court must give notice in writing with an opportunity to respond (unless it is prosecuting a patient). It must use a fictitious name in the process. It must have a "good cause" and cannot proceed if there is another source of the information. The information must be limited to the purpose of the order. Obviously, situations such as these must be handled through an attorney retained by the agency, who communicates only with the agency director or legal specialist. Earlier in this chapter, we described the changing rules on "evidentiary privilege," as pertaining to AA/NA and the Paul Cox case.

Emergencies

Medical information usually shielded by confidentiality regulations may be released when necessary for evaluation and treatment of a medical emergency. For example, a diabetic woman may lose consciousness if her blood sugar is too high or too low. Her diabetic status must be communicated without hesitation if the client has such an emergency. Another example is that of a man having great difficulty breathing or appearing to have some sort of heart attack. A counselor is obligated to inform paramedics or other medical personnel about the medications the man takes (**FIGURE 2.3**).

Statistical Aggregates

Information may be provided for statistical aggregates for research or audits, such as the percentage of clients who are entering treatment for the first, second, or third time (Figure 2.3). In releasing confidential information for these purposes, clients' names and other information that could identify clients cannot be released.

Qualified Service Organizations

The services of outside agencies, such as laboratories and accounting firms, are often required. Such agencies, known as *qualified service organizations*, receive information that is necessary to perform their contracted functions. They are governed by a signed Qualified Service Organization Agreement (QSOA), under which they agree to abide by federal and local regulations concerning confidentiality.

ACTIVITY 2.3 Should I tell?

Your 28-year-old male client was married but engaged in anonymous sexual encounters with men. His family and in-laws were very anti-gay. He contracted a sexually transmitted disease, and discontinued treatment. Then you read in the newspaper that he committed suicide. His grief-stricken father called you, requesting any information you have that would help the family understand why his son killed himself. They speculate over what they did or did not do that was responsible for his death. Your memories and notes clearly show that his suicide was related to factors over which they had no control. What do you do? Because the client is no longer alive, can it hurt to share information with the family?

DISCUSS:

- ☐ How should you respond to this family's wishes?
- ☐ Do you have an ethical responsibility to your client's family?
- ☐ Do you have to maintain this client's confidentiality even though he is dead? After all, you have information that would definitely lighten their grief.
- ☐ If the police investigate this unnatural death, what would you contribute to their fact finding?

ESSEX COUNTY COLLEGE STUDENT AFFAIRS AREA
Health Services Department
Office of the Substance Abuse Coordinator
877-3129

THIS PROGRAM IS REQUIRED TO COMMUNICATE TO EACH CLIENT THAT FEDERAL LAW AND REGULATIONS PROTECT THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS. A SUMMARY OF THE LAW AND REGULATIONS MUST BE GIVEN TO EACH CLIENT.

YOUR SUMMARY OF THE LAW IS PROVIDED BELOW.

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a person attends the program, or disclose any information identifying a client as an alcohol or drug abuser *unless*

1. the client consents in writing.
2. the disclosure is allowed by a court order, or
3. the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client, either at the program or against any person who works for the program, or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 290 dd-3 and 42 U.S.C. 290 ee-3 for federal laws and 42 CFR Part 2 for federal regulations.)

I HAVE RECEIVED A COPY OF THE ABOVE SUMMARY.

_____

(Client's signature)

Date:_____

FIGURE 2.3 Exceptions to Confidentiality Rules.
Courtesy of Victor B. Stolberg, MA, EdM.

Training

In situations in which case information or material is used for training counselors, the identity of the client must be disguised. Individuals who participate in such training must be informed of the need to maintain confidentiality. Unfortunately, participants in training who work at a local agency occasionally recognize a client and accidentally divulge either the name or information that provides a substantial hint to the client's identity.

Pending Legislation

Counselors should be aware that specific state regulations that apply to minors, school-based programs, and other institutional settings might differ from those in effect for treatment agencies. These vary considerably from state to state, and litigation is pending concerning the role of parental consent and information that is provided to parents.

Finally, there is also considerable debate, as well as pending litigation, regarding the access of client information by managed-care entities. Many believe there already has been considerable rapid erosion of confidentiality by managed-care audits (Lewin, 1996; Scarf, 1996), which has resulted in harm to clients and decline of trust regarding the privacy of the client–counselor relationship.

ACTIVITY 2.4 Wearing two hats

Two hats is a term for an individual who has dual roles. Employees of SUD agencies often talk about two-hat problems to denote the staffer who is in a recovery fellowship with clients.

Don is a person recovering from SUD who works at Reality Lodge, a large long-term treatment program staffed largely by graduates of this therapeutic community. He attends NA to maintain and strengthen his own recovery from addiction. At one meeting, a young woman named Cheryl makes a comment after the main speaker, in which she shares the difficulty she is having in staying drug-free. Cheryl happens to be a court-mandated client at the outpatient department of Reality Lodge, and Don knows that she has not shared these minor recurrences with the staff.

As an NA member, Don would never carry that information outside of the meeting, but as a counselor, he would notify his agency and then the court. Which hat decides what he does?

DISCUSS:

- ☐ What if Don calls the client on this and urges her to come clean herself? What if Cheryl tells him to mind his own business and warns Don not to break the confidentiality of NA?
- ☐ Should Don tell the agency staff what he heard at the NA meeting regarding this client's lack of sobriety? In weighing the anonymity of NA and the confidentiality of Don's agency, which carries more weight? What information can he share legally?
- ☐ What federal or state (use your state) regulations are relevant to Don's decision?
- ☐ Can you write a guideline for this type of situation to state clearly the agency's obligations? Shouldn't the agency tell counselors to leave a meeting where a client is present?
- ☐ What, if anything, should Don say to Cheryl?
- ☐ If Don remains silent, what are the implications for his interactions and relationships with his own supervisor and Cheryl's counselor?

FINANCIAL ETHICS

In a national survey of "ethically troubling incidents" among psychologists, confidentiality-related problems were the largest category, followed by blurred, dual, or conflicting relationships. The category we are about to consider, the financial realm, ranked third (Pope & Vetter, 1992).

Commissions or rebates (*kickbacks*) for referrals and fee-splitting are unethical and illegal. It is inappropriate for a counselor to seek or accept private fee arrangements with a client who is working with his or her agency. A counselor may not treat a client in an agency-run group and then see him or her "on the side" for a fee; nor can a counselor who has a position with an agency list that position on a brochure or print it in other literature (business card, stationery) to recruit clients to a private practice.

A counselor may not use client contacts to promote a personal commercial enterprise or that of a relative or friend. For example, a counselor who learns that his client needs a good lawyer cannot refer that client to his sister the attorney, even with

all the goodwill and honesty possible. Furthermore, a counselor cannot help out her senior citizen client who has plumbing problems by getting him a good deal with her uncle in the septic tank business.

Borrowing money from a past or present client is a form of financial exploitation by the counselor who is using his or her position of power. It is unethical to accept gifts or tips from clients or their families (NAADAC, 2016, 1-40). For example, a counselor, even in a gesture of generosity, cannot lend money to a pregnant client for a taxi ride so she does not have to struggle with public transportation to get home. Furthermore, a counselor, while knowing the therapeutic value of a client's giving, cannot accept tickets to the ball game.

A counselor or other staff member should not regularly obtain meals from an agency's commissary designed for clients' meals, unless this is considered a convenience of employment, stipulated by contract or bylaw, or at least approved by the governing board or other legal authority.

Regrettably, each of these practices occurs in the treatment community, usually involving some combination of (1) lack of clarity on the part of the treatment agency regarding ethical guidelines, (2) personal or recovery relationships between worker and administrators, leading to enabling of these behaviors, and (3) premature counseling role for an individual in early recovery. Such individuals may have unsolved problems, such as compulsive gambling, overidentification with clients that leads to blurring of boundaries, overextension and burnout, or a need to compensate for low self-esteem by grandiose or narcissistic posturing.

Other financially unethical practices include the following:

- Data manipulated to indicate that more services are provided (such as calls of inquiry logged in as complete referrals) to justify continued funding levels or to boost reimbursement.
- In fundraising, concealing the actual use of funds for administrative purposes rather than for direct services, or concealing fees or percentage paid to fundraisers or to consultants who helped write a grant.
- In fundraising, portraying a "crisis" that threatens the existence of the agency and the loss of services to the deserving clientele.
- Solicitation of funds from former clients or client families who are subordinate in the power relationship and who are vulnerable and grateful. This can also lead to breach of confidentiality.
- In grant or other fiscal reporting, concealing use of funds for administrative purposes or for purposes that benefit administrative personnel, such as meals and travel not necessary for the operation of the facility.

The "Checkbook" Diagnosis

Counselors may recognize that a client needs treatment, yet policy guidelines or gatekeepers of their medical coverage exclude all but the most severely afflicted. Agencies may be tempted to provide a billable or *checkbook* diagnosis. This phenomenon, also called *diagnostic creep*, can be motivated by a desire to provide help for suffering individuals or by the wish to fill available beds and keep reimbursement flowing to the agency coffers. The alternative is to deny care, refer elsewhere, or prematurely discharge clients whose problems are so severe that they might drain agency resources while bringing little reimbursement. Agencies that receive governmental support are often required by state regulations to set aside a certain proportion of treatment slots for "uncompensated care" or "charity care," that is, treatment of clients who have no medical coverage. Providing something other than an objective and proper diagnosis is unethical and, if egregiously inaccurate, could make an agency vulnerable to fraud.

A related practice to diagnostic creep is to use an adolescent SUD unit as a comprehensive unit for adolescents with problems, such as giving chemical dependency diagnoses to one-time LSD users or others without sufficient data. This is an unethical business practice. In addition, labels take on a life of their own: It is unfair, stigmatizing, and self-fulfilling to call adolescent drug experimentation a SUD.

This is but one example of *diagnostic slamming*, making the clients' diagnosis more severe or assessing the level of severity as more severe, in order to retain clients or garner a longer length of stay from third-party payers (White & Popovits 2004, 137–138).

REPRESENTATION OF SERVICES

Claims made for the helping process in general and for the process in SUD counseling in particular must be realistic. People with SUD range from the vulnerable to the desperate, who have completely "hit bottom," or, at the very least, to those who live in chaos, disarray, and unhappiness. Counseling must not be presented as a miracle-working process or cash in on popular but unverified methods. It should not make claims other than the modest and realistic, SUD-specific, facilitation of recovery. A counselor or an agency should pay careful attention to how it represents itself, the services it offers, and the professional qualifications of employees.

Clients and prospective clients must understand the scope of treatment—what is and is not treated—methods of treatment, length and cost of treatment, and limitations of treatment. The client must be informed fully at the onset of counseling—if not before—about the purposes, goals, techniques, and procedures involved (ACA, 2014, A2b). The SUD counselor's core function of orientation is, then, prompted by an ethical standard. One corollary of this principle is that the client cannot be unknowingly or involuntarily the subject of any type of experiment (ACA, 2014, G2a,c).

Neither SUD counselors nor agencies should claim or imply treatment for nonsubstance use psychiatric disorders, related areas such as reduction of stress and anxiety, or solutions to problems of living. However, recurrence prevention may draw upon techniques used in psychotherapies, such as relaxation methods or assertiveness training, for the specific purpose of reducing the risk of recurrence (ACA, 2014, C4a).

Any representation of service must not engage in grandiose impression management that suggests, implicitly or explicitly, charismatic or other special qualities of the counselor. Testimonials from satisfied customers are, in general, ethically inappropriate, as they are selectively chosen and exploit a grateful client and/or unduly influence them from a position of power and authority (ACA, 2014, C3b).

Claims made of counselors' credentials should be specific and not misleading or inflated (NAADAC, 2016, III 9,III 12). The basis for use of terms, such as *clinician, therapist, certified*, and *licensed* must be clear. Some states have a tiered system that recognizes a minimal level of preparedness for the entry-level employee or SUD screening worker in a general social services setting as well as a professional counselor certification. It is unethical to represent the minimal credential as a board certification.

In-house job titles that are abbreviated after names (e.g., "John Smith, S.A.C." for an in-house title of Substance Abuse Counselor) must not be printed on agency stationery or business cards to imply certification or licensure. Some unethical misrepresentations include individuals employed in roles other than counseling at an agency who state or imply that they are counselors; volunteers who imply that they are staff; aide positions that are represented as full counseling positions; and counseling roles that are represented as administrative (NAADAC, 2016, III 9, III12).

An "official seal" of 12-step fellowship should not be claimed to attract clients. An agency should never give the impression that it is an "AA agency," or that many staff members are AA members. Alcoholics Anonymous would be the very first to object to this! Twelve-step fellowships neither recommend nor endorse agencies or organizations. Neither should a personal membership in fellowships be used to enhance recruitment. Not only is this practice unethical but it leads to confusion about the roles of fellowship peers, sponsors, and counselors.

With the managed-care system, treatment options have come under severe limitations. Some managed-care entities have discouraged or even forbidden healthcare providers from speaking freely with patients about their treatment options.

Providers feel that such "gag rules" put blinders on patients, preventing them from intelligently participating in decisions that affect their lives and contradicting the principle of informed consent. For physician providers, it may even violate the Hippocratic Oath, which states, "First, do no harm." Restraining rules on providers are being challenged in litigation in several states.

Unethical Marketing of Services

This includes advertising any kind of specialized care where little is actually present. Examples include a general care unit that is promulgated as having a special women's program or a cocaine abuse program; patients being admitted to a "detoxification program," which is actually a general medical floor of a hospital with one part-time alcoholism counselor, if that, or even a "scatterbed" system whereby chemically-dependent clients are put wherever in the hospital there is an open slot. The point is not that even a "scatterbed" system would be preferable to no treatment at all, but that it is false advertising.

Online (digital) marketing schemes include unethical search engine optimization practices:

- **a.** toll-free numbers that pose as "helplines" and/or offer "free assessments," then tell all callers that they have SUD and refer them to their own programs or to those that have paid to be a designated agency.
- **b.** Related to the previously mentioned practice, ignoring the level of severity that should prompt the appropriate referral to level of care.
- **c.** Using a recognized agency name, but listing a phone number for another agency, thus "pirating" from another agency. A variant of this practice is to automatically redirect a computer from the recognized agency website or weblink to another, sometimes known as "clickbait."
- **d.** Claiming to exist in a state where they do not, or in a region of a state where they have no presence. A search using a well-known directory of practitioners for particular specialties, desiring providers in Berkshire County, MA, on the New York border, turned up clinicians, fine in their own right, but all in the Boston area on the other side of the state. This is perhaps a gray area of search engine malfeasance, but it is not of help to people in need.

COMPETENCE

One of the key functions of ethical standards is to ensure that those entrusted to help are indeed reasonably ready and able to do so. Competency issues include counselor impairment, issues that cloud objectivity or distract from focus on the client's interest, and preparedness in a variety of knowledge and skill areas.

Impairment

Counselors are impaired if they suffer from conditions that cause measurable declines in clinical performance or that compromise their counseling status. These include various psychiatric and neurologic conditions that render the counselor less than competent to perform counseling functions, as well as possible recurrence of substance abuse. NAADAC Principle III 41(2016) states that professional impairment needs appropriate treatment, and the SUD counselor certification boards in many states stipulate that recovering counselors must abstain from addictive substances. In many states, recurrences must be reported to the certification board and a 2-year suspension imposed.

Lack of Preparedness

Lack of or inadequate training is a form of incompetence that jeopardizes the client's recovery. To put it even more strongly, because SUDs are chronic, progressive, often-fatal diseases, the incompetence of treatment staff can threaten the

lives of clients. Various incompetent actions, such as "improper treatment, inadequate treatment, negligence in use of technique, inadequate diagnosis" (Hogan, 1978), are the basis of many malpractice suits. However, competencies of SUD counselors have been a gray area up to this point. The definition of adequate preparedness has varied from state to state and from agency to agency. By the late 1990s, unified models of SUD counselor competency were becoming standard, as seen in the federally sponsored and published document, "Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice" (CSAT, 2006), which has been endorsed by the major SUD counseling constituencies.

It is natural for grateful, recovering persons to wish to assume a counseling role and give back to the community what they have gained. In fact, the SUD field was founded and developed by people recovering from SUD in a self-help milieu, whose commitment, energy, and skills at engaging and motivating people with SUD are often the envy of "straight" staff. The certification process was not linked initially to professional training, such as that required in nursing, social work, or psychology. The competence of nonprofessional or paraprofessional recovering counselors has been a great debate in the SUD field for over 40 years (Krystal & Moore, 1963; Lemere et al., 1964). However, few would claim now that personal recovery alone is sufficient preparation for the counseling role. Bissell and Royce (1994, 4) quote a halfway house director as saying, "Just because you had your appendix out doesn't qualify you to take out mine!" A majority of SUD counselors now have a bachelor's degree.

The SUD counselor without a degree faces disadvantages in completing paperwork, writing case presentations, and dealing with the certification process—topics that are taught in educational programs that lead to degrees. There are also questions regarding service to clients. SUD counselors who have had no training in screening concurrent psychiatric diagnoses are increasingly rare, and the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) diagnoses are included in the classroom hour requirements in many states. In the past, bipolar (manic–depressive) clients were occasionally mislabeled as *dry drunks* (a term used in the recovery milieu to denote the disorganization, impulsivity, and mood swings that may be the aftereffects or consequences of long-term SUD). In 1990, a college intern who had acquired basic knowledge of psychiatric symptoms from his coursework observed a sober client seemingly in the throes of a manic state. His suggestion that a psychiatric consultation be obtained was rebuffed initially by inexperienced staff. He prevailed by petitioning the agency director; the consultation did confirm his suspicion of a mood disorder (Myers, 1991). Failure to refer clients appropriately keeps them from proper treatment and jeopardizes their safety and their lives.

On the other hand, SUD counselors bitterly note that other healthcare providers, including supervisory medical personnel, often sorely lack firsthand knowledge of SUD, miss the diagnosis, and cannot see through denial and deception. In 1988, at a public hospital in Brooklyn, New York, new graduates of foreign medical schools routinely overdiagnosed paranoid schizophrenia among people with SUD in an inpatient psychiatric unit.

The responsibility for ensuring staff competency lies primarily with the agency. Some agency administrators are happy to use untrained, newly recovering individuals, sometimes graduates of their own programs. Their motives usually combine elements of naïveté and the opportunistic use of a cheap labor pool (Bissell & Royce, 1994, pp. 5–6). To start their career, many people might be glad to be so "exploited." Some argue that such hiring practices are not necessarily unethical, if the employer offers or requires a systematic and mandatory program of continuing education, professional growth, and certification. Unfortunately, such programs have often been absent. Hiring untrained individuals generates unsophisticated, clinically limited "hothouse plants" who cannot function occupationally outside of a certain type of recovery program, can hardly differentiate themselves from clients, are prone to ethical compromises or burnout, and have limited writing skills and unsophisticated clinical skills.

Lack of Responsibility

Irresponsible or careless behavior is incompetent and unethical. For example, a counselor's chronic lateness results in inadequate services, impairs the counseling relationship, and sets a bad example to people who are emerging from the personal chaos of SUD. Poor recordkeeping, frequent interruptions of sessions to take phone calls, and failure to follow up in case management are ineffective and disrespectful practices that constitute unethical treatment.

It is no shame to recognize the limits of competence. A counselor may be very good at what he or she does but should not feel impelled to tackle every skill area. The ability to identify one's limits of competency, as well as goals for further growth and training, is a clinical and ethical imperative, usually requiring some guidance and input from clinical supervisors. Not everyone can repair computers or perform brain surgery; why should any counselor who has not been trained as a family therapist feel compelled to assume the role of marriage counselor? Getting drawn into acting in areas outside of the scope of one's competency compromises ethical standards. Again, this can also harm clients and make the agency liable to lawsuits (ACA, 2014, C2a,b).

Many guidelines (NAADAC, 2004, Principle 8) consider it a duty to report incompetence to certification authorities. Private practices, agencies, and hospitals should have guidelines for dealing with incompetence.

PROFESSIONAL GROWTH

Continued growth and ongoing education are tenets of ethics in most helping professions. No one would want a suicidal, bedridden, and biologically depressed relative treated by a psychiatrist who had never heard about Prozac, Zoloft, Paxil, or Effexor. Professional growth involves gaining the latest knowledge, strategies, and skills. It also means avoiding rote formulaic counseling, becoming out of date, and overburdening oneself. There are myriad ways of broadening competency and upgrading knowledge and skills:

- Read addictions treatment journals in your specialty, which might include *Alcoholism Treatment Quarterly*, *Journal of Child and Adolescent Chemical Dependency*, *Employee Assistance Quarterly, Schizophrenia Bulletin*, and so on.
- Attend professional seminars. It is usually best to avoid the expensive lecture circuits and cruises for continuing education unit (CEU) credits that are advertised with glossy brochures and vague inspirational themes, such as "Codependency in the Twenty-First Century"
- Attend agency networking events. Provider networks exist in many states or regions of states, but nonsupervisory staff are often unaware of their existence or are hesitant about asking to attend
- Be active in the Association for Addiction Professionals (NAADAC), which has affiliate organizations in most states, and attend their regional and national conferences
- Complete coursework in a SUD studies curriculum or in criminal justice or mental health curricula pertaining to special populations, such as addicted offenders and mentally ill chemical abusers
- Judiciously peruse Internet resources, including those of the Center for Substance Abuse Treatment (SAMHSA), National Clearinghouse on Alcohol and Drug Information (NCADI), and the Web resources on this text's website

For professional growth, the areas of knowledge that counselors should pursue include the following:

- Biomedical knowledge and practice regarding mentally ill chemical abusers
- Multicultural awareness and sensitivity. The DSM-5 addresses cultural sensitivity, both in diagnostic considerations for many long-recognized disorders as well as in a special appendix of culture-bound disorders.

The American Psychological Association as well as the Addiction Counselor Competency document (CSAT, 2006) consider cultural competency an ethical necessity.

- New medications, such as antipsychotics, antidepressants, and drug antagonists, along with their therapeutic possibilities and side effects. Counselors also need to keep abreast of over-the-counter medications that people with SUD use to supplement or substitute for street drugs, including legal stimulants contained in appetite suppressants and decongestants and "herbal" or "natural" energy boosters.
- New laws and regulations concerning confidentiality, liability, professional duties, insurance, and emergency treatment. SUD staff can be effective advocates for constructive legislation that favors equal standing for substance abuse and mental healthcare. Counselors should be aware of their professional association's stance on and analysis of upcoming legislation so they can be resources for information on how to vote on these important issues.
- Changes in the field, such as the decline in inpatient rehabilitation in favor of intensive outpatient treatment, and new screening and assessment tools, such as the Addiction Severity Index, American Society of Addiction Medicine Patient Placement Criteria, and others. Other developments in the field include the rise of recovery community organizations, and diversion into treatment by police through the LEAD and PAARI (Law Enforcement Addiction Diversion and Police Assisted Addiction and Recovery Initiative) models.

COLLABORATION

As treatment models now emphasize collaboration with clients throughout the treatment process, this has been included in newer versions of ethical standards. A good example is that now, the treatment plan is drawn up collaboratively with the client (NAADAC, 2014, 1–14).

NONDISCRIMINATION

Service cannot be denied to eligible clients because of their gender, race, ethnicity, nationality, sexual orientation, age, or physical characteristics. Neither can the quantity or quality of services vary according to any of these client characteristics. Note the word *eligible*. It is not discriminatory for an agency specializing in the treatment of pregnant women with SUD to refuse to treat a male, nor is it discriminatory for an agency to refuse to treat a child, where such specialized care is not within the scope of services provided by the agency.

Taking this a step further, some ethics guidelines state that a tendency to decline cases based on counselor bias and aversion to or anxiety about certain client types constitutes discrimination. Certainly, indigent, homeless, and mentally ill chemical abusers tend to suffer from discrimination, which creates an army of unwanted clients and people who are not getting the help they need. There is a lack of training for health professionals in SUD intervention and referral skills; confrontation and intervention take more time and energy for these types of clients than may be available to the professional with a large caseload. An old expression among physicians and nurses concerned with alcohol use disorder is the *ash can syndrome*, an ironic reference to a derelict who was discovered in the back (where coal ashes were kept in trash cans) and was subsequently treated for a host of ills directly or indirectly related to alcohol use disorder but never the alcohol use disorder itself. Another expression for the undesirable or demented client is the *GOMER* ("Get Out of My Emergency Room").

Statutes of many states require agencies to accept and treat a number of indigent (nonpaying or charity care) clients. In such cases, it is discriminatory to set up a covert system whereby a referring agent must refer a certain number of paying clients for every nonpaying client.

Using the same logic, a caseload skewed toward types of clients from which the counselor derives

the most personal satisfaction, or with whom he or she is most at ease, discriminates against others not in this category. This does not exclude an agency from assigning a counselor to work with a special population because he or she has the knowledge and skills required. For example, a Creole-speaking counselor may have a caseload primarily of Haitians.

It has become accepted among most helping professions that discrimination and incompetence exist if a particular cultural or ethnic group is not being served because counselors lack cultural competency skills.

OBJECTIVITY

There is an incredibly wide range of opinion, theory, and belief in the SUD field, perhaps greater than in the treatment of nonaddictive disorders. The definition of SUD, beliefs as to the origin and course of SUD, and opinions as to how recovery is to be achieved inevitably vary among counselors and between counselor and client. While counselors need not hide their views, the counseling role is not to preach, lecture, convince, argue a position, or disparage the position of clients or other staff. Any of these stances disrespects the rights of others and certainly deflects from the counseling process. This is another gray area because, as Rhodes (1992, 43) remarks, clients may want help and guidance in an ethical exploration of their issues. The undersocialized client needs habilitation, and the sociopath requires treatment that includes development of a value system. A skilled, objective counselor can facilitate value clarification and development of an ethical system with clients without imposing his or her belief system or disparaging that of others.

ACTIVITY 2.5 Can't handle that God stuff

Marcia, who comes from a Hasidic Jewish family and rebelled to marry a secular Jewish man, enters treatment under family pressure. She goes to a few AA meetings at the urging of her counselor but feels she is being forced to go along with something she considers similar to her "repressive" family environment. "Another dogmatic in-group who only talk to themselves," is the way she puts it. She strongly declares her desire to recover from her alcoholism but does not want to be forced to go along with "the God thing."

Discuss:

- ☐ How would you approach Marcia?
- ☐ Are these religious issues or family issues?
- ☐ Would you address her issues about religion in a treatment plan? If so, how?
- ☐ Would forcing Marcia to attend AA meetings or denying her treatment be religious discrimination?
- ☐ Do you know anything about Hasidism?
- ☐ Would you need to know about Hasidism? Her family?
- ☐ Would it be ethical or appropriate to refer Marcia to another program or agency?

AN ETHICAL TREATMENT SYSTEM

It is important to identify systemic factors in ethical choices. The web of systemic influences (economic and regulatory systems, agency and societal cultures) reaches down to surround client and counselor, determining how policies and procedures are implemented in day-to-day counseling practice. An example is the screening function, which is supposedly an objective determination of appropriateness and eligibility for admission, but, which distorted by market competition and managed-care constraints, stretches or even invents a diagnosis for mercenary or altruistic reasons. A more complex example is the apparent fact that a client cannot make sufficient progress in a particular setting. It is the ethical responsibility

of the counselor and agency to terminate and/or transfer the client and be knowledgeable about resources (ACA, 2014, A11a,b,c,d). Or, within an agency, if a particular counselor is a bad match for the client, the client should be reassigned. All too often, however, clients are retained inappropriately. This situation may be caused by systemic factors, such as the need to maintain client statistics as well as countertransference issues, such as anxiety about appearing to be a failure, overinvolvement, and the need to play a rescuer role. Obviously, a great deal of honest, critical thinking is required to determine all the elements of influence. A climate of secrecy and denial, antithetical to a therapeutic environment, makes it unlikely that accurate assessment of agency practice or personal and professional growth will take place.

UNETHICAL PRACTICES IN POST-TREATMENT HOUSING

Periodically, there are exposés and scandals involving dubious halfway houses. Most recently, it was reported that a chain of so-called "three quarter way houses" received commissions from outpatient programs that residents were told to attend. Worse, in order to stay domiciled, the administration of this chain forced residents to drink or take drugs in order to qualify for the outpatient programs that provided commissions (Barker, 2015a, b). The National Association of Recovery Residences has developed a code of ethical standards to help avert such situations (NARR, 2016).

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CHAPTER 3

INDIVIDUAL COUNSELING SKILLS

OBJECTIVES

By the end of this chapter, students will be able to:

1. Describe at least four qualities of an effective counselor.
2. Demonstrate effective nonverbal skills.
3. Demonstrate effective reflection skills.
4. Demonstrate use of open-ended and probing responses.
5. Demonstrate summarizing skills.
6. Demonstrate self-disclosure skills.
7. Demonstrate effective use of feedback.
8. Describe the important emotional issues in the counseling relationship.
9. Describe how to identify a client in crisis and develop appropriate plans for responding.
10. Describe the major indicators of suicide and appropriate use of supervision to intervene.

INDIVIDUAL SUBSTANCE USE DISORDER COUNSELING SKILLS

Despite great effort over the years, no research has been able to demonstrate the superior efficacy of any particular counseling model (Fiedler, 1950, 1951). The paradigm and format followed are less important than grounding counseling practice in basic counseling and interpersonal skills; insuring the quality of the therapeutic relationship—the therapeutic alliance and involving the client in every aspect of his or her treatment and recovery (Kazdin, 1994; Lambert & Bergin, 1994; Miller & Rollnick, 2013).

It is not within the scope of this text to summarize the numerous psychotherapy models that have evolved since Sigmund Freud developed psychoanalysis at the beginning of the twentieth century. However, substance use disorder (SUD) professionals should be familiar with the major schools and models of psychotherapy, such as the psychoanalytic, neopsychoanalytic, behaviorist, reality therapy, humanist, and existential therapies via a course on models of therapy that is usually a component of a professional training curriculum. Today's SUD counseling practice tends to favor eclectic models, such as cognitive behavioral therapy and client-centered/collaborative approaches, such as motivational interviewing (motivational enhancement therapy) [Miller & Rollnick, 2013].

The "client-centered-counseling" of Carl Rogers (1951, 1986) was one of the first approaches to emphasize empathy and the client's potential growth, shifting away from an attitude of the therapist as a formidable and dominant expert and putting a "human face" on the therapeutic process. Motivational interviewing owes a great deal to the Rogerian approach.

In the 1960s, vocational and educational counselors began to develop a subfield known as *counseling psychology*. They were interested in short-term concrete changes in clients rather than long-term psychotherapy and were among the first to emphasize counseling qualities, such as respect, warmth, concreteness, empathy, and genuineness, again influenced by Carl Rogers. Many students will have been exposed to a taxonomy of skills, such as the pyramid-shaped "microskills hierarchy" developed by Allen and Mary Ivey (Ivey, Ivey, & Zalaquett, 2014), some of which are reviewed later in this chapter.

More than 4 decades ago, Carkhuff (1969a, 1969b), Ivey (2010), and Egan (2014) were principal pioneers in investigating counseling qualities from a behavioral perspective. They studied exactly what counselors did or said that demonstrated helping qualities. This research led to a skills approach to counseling. The behaviors and skills necessary for effective counseling can, in fact, be taught to a large proportion of intelligent, motivated individuals. These skills are those of communicating, not of providing perfect advice, answers, or brilliant commentary. (Another term is *process skills*.) Today, training of most mental health workers, social workers, and counselors is grounded in one of the several generic counseling approaches. This approach includes learnable skills to facilitate a counseling process that helps clients to achieve insight, feel better about themselves, and change behavior patterns in directions that get them what they need (Cournoyer, 1996; Egan, 2014; Corey & Corey, 2015). Recent meta-analytic studies of treatment effectiveness appear to validate such an approach. Nonetheless, many SUD counselors—not to mention many other mental health professionals, such as psychiatrists—have no formal training or preparation in specific counseling skills.

COUNSELING FORMATS

Individual counseling sessions may, to some extent, follow a certain predictable routine, which may be based on a particular counseling or self-help model. Counseling formats translate treatment plans into digestible and understandable steps for client and counselor alike, in the individual counseling setting. The format may also represent an adaptation of a favorite model to accommodate limitations of reimbursement. *Format* refers to both

the sequence of sessions and the structure of the counseling session.

The sequence of sessions in cognitive behavioral therapy, for example, may entail a long-term relationship or it may be limited to seven sessions. A seven-session sequence might be the following:

1. Introducing coping skills.
2. Coping with cravings and urges to drink.
3. Managing thoughts about alcohol and drinking.
4. Learning to solve problems.
5. Learning drink-refusal skills.
6. Planning for and coping with emergencies.
7. Consequences of seemingly irrelevant decisions (NIAAA, 1995, 19).

The structure of the counseling session may or may not follow a predictable routine. Beck, Wright, Newman, & Liese (1993, 97) recommend the following elements as the structure of a cognitive therapy session:

1. Setting the agenda.
2. Checking the mood.
3. Bridging from last session.
4. Discussing today's agenda.
5. Using Socratic questioning.
6. Offering capsule summaries
7. Assigning homework.
8. Giving feedback in the therapy session.

This example shares a concern for budgeting time with many psychotherapies, linking the present session to previous and future sessions, and application of insights gained in the session to the life of the client. Yet, a breakdown into eight segments is an unusually complex format. Moreover, routines may exist but not be immediately apparent. Students should observe counseling with the aim of determining whether there is an unspoken routine, such as a typical lead question or cooling-off segment toward the end to provide an appropriate emotional return to the world.

Motivational interviewing and the stages of change model illuminate the cyclical, fluctuating nature of motivation and the simultaneous approach and avoidance of recovery goals. Many clinicians recognize that a new model can be oversimplified into a faddish gimmick. Barber (1994, 44) and Nealy (1997) have warned against ignoring the broader context of change which includes emotions, self-esteem, and dependence on large and impersonal social institutions"the strengths and weaknesses of our interpersonal relationships, the extent of our social support networks, and the stability of basic survival needs" (Nealy, 1997, 12).

TAILORING COUNSELING SKILLS FOR CLIENTS WITH SUD

There are many ways of itemizing, categorizing, and defining counseling skills and subskills. Definitions of skills overlap considerably, and it is dangerous to try to isolate or memorize definitions. Such a mechanical approach neglects the actual interpersonal process that these skills should facilitate. In fact, the very purpose of a skills approach is defeated by memorizing definitions and using stock phrases.

The skills discussed here roughly follow tasks and stages of SUD counseling. They also fall across a continuum from less pressure to more pressure; and from passive to active. Cutting across the various models, a SUD counselor must first engage the client and build a therapeutic alliance. This provides a safety zone within which the client can reveal feelings and find support for recovery. Then the counselor can facilitate the client's gradual self-awareness and, finally, self-direction.

Engagement Skills

Engagement skills are crucial to establish a positive counseling relationship. To reach treatment goals, a counselor must be able to make personal contact and develop a working alliance with a client (Meier & Davis, 1993, 2–3). Because the typical individual with SUD is isolated emotionally, the counseling bond can be healing; investment in this relationship is a major factor in carrying a client through the difficult phase of early recovery. Engagement can be facilitated through qualities of genuineness, immediacy, warmth, and a nonjudgmental attitude. These qualities are demonstrated when the counselor has developed

the skill of attending. Cited in some form in almost all training protocols, attending refers to providing cues that demonstrate concern, warmth, respect, interest in, involvement with, and awareness of the client's communications. These cues can be nonverbal (such as eye contact, an involved and relaxed body posture, and interactive gestures) or verbal (such as an animated rather than a flat tone of voice, or reassuring and encouraging vocalizations, such as "hmm," "aha," and "go on").

Development of a working alliance also requires orientation and training of clients. Orientation is one of the core functions specified by the International Certification Reciprocity Consortium. Although orientation is not related to particular skills, it is necessary. Part of the engagement process is explaining counseling, which Meier and Davis (1993, 4–6) consider part of "role induction," or socialization into the client role. The idea of talking openly about problems and feelings with a person who is not a family member or close friend is often a new one. The client may expect to be interrogated and given answers, rather than be aided in the process of self-exploration. The interactive nature of the counseling process needs to be explored, and the client needs explanations of confidentiality, treatment goals, and therapeutic culture. The alliance is developed further and cemented by explaining the process by which the counselor and client will develop a treatment plan based on long-term and short-term goals. Even the involuntary client can see the helpful intent and possibilities inherent in this scheme. Successful engagement thus prepares the client to benefit from treatment.

ACTIVITY 3.1 Who are you?

This activity serves as a self-assessment of your skill level in listening, observing, and focusing. Conduct a 5-minute interview of a classmate. Find out as much as possible about the other person. No notes are allowed. Reverse roles and become the interviewee. Both individuals report to a third person (observer). Observer and interviewees provide feedback on what they heard from the interviewers.

Active Listening Skills

Using active listening skills (Egan, 2014), the counselor connects to and can reflect emotions, thoughts, and attitudes of his or her clients. This cluster of skills is known as *attending skills* (Ivey, Ivey, & Zalaquett, 2014) and reflective listening (Miller & Rollnick, 2013). By providing a clear mirror to the client, the counselor interjects an "observing ego" that may be lacking.

Paraphrasing or Restating

The therapeutic qualities of *empathy* (the ability to perceive another person's experience and communicate that perception back to the person) and warmth can be developed by acquiring the skill of paraphrasing. *Paraphrasing* refers to a counselor's verbal response that rephrases the essence of the client's message. It allows the client to hear what he or she has just said, either in parroted form or with added clarity. This interactive process increases trust and reduces resistance. The following interchange is an example of a counselor clarifying a client's message and restating it:

Client: I started to do the bills, but I couldn't stand it and made a phone call instead. I started again, but I decided to have a snack.
Counselor: You kept finding ways to avoid doing the bills.
Simplified mirroring; rephrase the client statement neutrally.
Client: "I don't plan to give up drinking."
Counselor: "You don't think abstinence would work, hmm?"
Exaggerate the statement without sarcasm.
Client: "I don't know why my wife is so worried."
Counselor: "So your wife is worried needlessly?"
Reflecting.

When the content being restated is emotional, it is a *reflection of feeling*. The counselor captures and expresses to the client the essence of what the client is feeling. This facilitates the exploration and identification of emotional needs and states. The emotional message may have been stated directly; however, the client may not be aware of his or her own emotional output or of how his or

her emotional message was understood. Reflection of feeling shows the client that the counselor has understood the message. An alert, nonjudgmental, and friendly ear also acknowledges and validates a client's feelings, allowing him or her to own and accept the feelings and claim the right to have them. The counselor should be careful not to interpret the client's feelings. When reflecting an expressed feeling, the counselor remains neutral, not offering opinions, judgments, or advice. Neither does a counselor tell a client what he or she is feeling. The following interchange shows a counselor's reflection of a client's expressed emotion:

CLIENT: When he told me that, I just lost it. I pushed my plate away and stormed out.
COUNSELOR: You sound very angry with him.
CLIENT: You bet! I could have thrown it in his face!

Not only does the client become more aware of his or her emotions and the emotional content of his or her utterances, but there is also the implicit message that "it is okay to be angry" (or sad, happy, lonely). Reflection of feelings helps the client establish, maintain, and affirm the habit of communicating feelings directly and appropriately rather than resorting to unproductive responses such as violence, drinking, or taking drugs. Some counselors use the expression, "If you learn to talk about it, you won't have to drink about it." If the client is ready, the counselor may move to *leading* skills (discussed later in this chapter).

Reflection of feeling has a particular twist in SUD treatment. SUD counselors must be aware of temporary physical states in withdrawal and early sobriety that should be identified to the client, rather than interpreted as personal or interpersonal issues. For example, a person may drink too much coffee or take too much decongestant medication and have a reaction that is misperceived or misinterpreted as anxiety pertaining to some real issue. During withdrawal from depressant drugs, including alcohol, the central nervous system undergoes rebound activity, which also may be experienced as anxiety and apprehension.

SIMPLIFYING

Reflection and restatement also have the important benefit and function of *simplifying*. Simplification removes confusion, avoids intellectualizations and convoluted explanations, and helps the client stay focused on concrete feelings and problems in the here and now. The famous Alcoholics Anonymous (AA) slogan "Keep it simple" expresses this key element in self-help and counseling systems. Steve de Shazer, founder of the short-term, solution-focused school of therapy, quipped that one should edit the motto "Simplify, simplify, simplify" down to the single word "Simplify" (Berg & Miller, 1992, 9).

A further function for reflection of feeling and restatement of content is to show the client that the counselor understands and is following the client's stream of consciousness. Egan (2014) calls this "pacing" the client, an image borrowed from sports training that connotes a more active form of "attending." It gives a sense of teamwork and collaboration and, in general, builds a positive feeling about the counseling experience. Clients who have clarified their feelings and thoughts from their counselors' restatements and reflections, which they have listened to and absorbed, leave the sessions feeling clearer and more at peace.

Summarizing

A higher level of abstraction in restatement and reflection is summarizing, or tying together the main points, themes, and issues presented by clients during part or all of a session. An added benefit of skilled summarizing is illustrating clients' ambivalence to them, allowing them to see the "positives and negatives simultaneously, acknowledging that both are present."

An elaborate summary of the positives and negatives of using alcohol and drugs is a technique suggested in motivational enhancement therapy and Beck's cognitive therapy. To arrive at this conclusion, the counselor enlists the client in enumerating contradictory motives in the "decisional balance." The decisional balance sheet is also a nonthreatening, engaging, defense-reducing exercise.

Reinforcing and Providing Hope

Many counselors simply affirm, support, and even praise the client for whatever steps he or she has taken. While this is not exactly a listening skill, it is a nonthreatening form of engagement and involvement. Examples of reinforcing are as follows:

- "I appreciate how hard it must have been for you to decide to come here. You took a big step."
- "That must have been very difficult for you."
- "You're certainly a resourceful person to have been able to live with the problem this long and not fall apart."
- "It must be difficult for you to accept a day-to-day life so full of stress."

Such praise must be genuine or it will sound patronizing, disengage the client, and reduce support.

A related concept to reinforcing is the "positive asset search," that is, drawing out strengths. This skill should be built throughout the counseling process but is also sometimes seen as a specific segment of the counseling session (Ivey, Ivey, & Zalaquett, 2014).

ACTIVITY 3.2 Am I a good listener?

After reading through this activity, form groups of three. In each group, one person will play the role of the client, one the counselor, and one the monitor. The "client" will talk about a personal problem or issue or something he or she would like to change. In times when it is possible, keep the focus on issues related to use of drugs or alcohol. The "counselor" will counsel the client, practicing active listening skills (approximately 8 minutes). The "monitor" will give feedback, noting what skills were observed and where they were or were not used appropriately (approximately 1 minute). Note that the purpose of this activity is to practice active listening skills. It is not designed for solving problems or probing deep emotions or secrets.

Discuss: After all groups have concluded their role plays, return to the large group and discuss your feelings about the performances of the roles. Identify specific listening skills.

- ☐ What other counseling skills did you observe?
- ☐ Were they used appropriately? If not, why not?
- ☐ Would the inappropriate use that you observed be harmful or just ineffective? Explain.
- ☐ How would you have done it differently?
- ☐ How did you feel doing the counseling? Receiving the counseling?
- ☐ What did you observe in response to specific questions?
- ☐ How hard was it not to give advice?

Reframing

Reframing is different from reflection or restatement because this skill interprets a client's experience from a different perspective or in a reorganized form. For example, reframing can facilitate the perception of an event in a more positive light, or a "bad" situation can be seen as a challenge and a potential learning experience.

Reframing is emphasized in psychotherapies that are based in cognitive techniques, such as rational emotive therapy (RET; Ellis, 1985a and b; Ellis & Dryden, 1987; Ellis, McInerney, DiGiuseppe, & Yeager, 1988). The counselor should take care, however, not to apply this technique in a manner that seems to trivialize or glibly explain away a client's loss and grief in the face of tragedy or adversity. An example of reframing, via patient education, is the client who begins to see alcohol- and drug-related behavior not as bad or shameful but as symptoms of a disease. Reframing gives the client a different perspective; and this reduces the heavy shame-based feelings with which the client is often burdened.

Leading Skills

Categorizations of helping or counseling skills vary among human services. The category of leading skills discussed here is much broader than the definition found in many counseling textbooks.

Leading skills are ways of encouraging and suggesting connections that help the client move along in self-exploration and keep the client thinking about his or her acts, thoughts, and feelings. These skills also help the client develop the habit of self-reflection.

By using leading skills, SUD counselors help the client gain personal insights. To do so, counselors merely facilitate steps taken by the client in exploring emotions, behavior, and cognition. Leading is effective only if the client has some self-awareness; no one can progress from point A to point B until he or she has gotten to point A. For example, it is premature to discuss the implications of angry feelings if the angry person has not identified and acknowledged those feelings. In addition, leading questions should be open-ended and begin with what, when, where, or how. Various schools of thought, including motivational enhancement therapy (MET; Miller & Rollnick, 2013) and cognitive therapy of SUD (Beck et al., 1993, 104–105), stress the importance of open-ended questions, such as "What else?" "Anything else you can think of?" and "Such as …?" They encourage thinking, talking, contemplation, and exploration. These types of questions can achieve the following (adapted from CSAT, 1999):

- Lead to other examples of a behavior or feeling, which may suggest a pattern. "Do you think that you may do this in other areas of your life?" "Do you feel this way in other situations?" "Do you often feel like this?"
- Lead to elaboration of the original statement. "Tell me more about that feeling." "What was that like?"
- Lead clients to reflect on what they think and feel in particular situations. "How did you feel about that? Him? Her? Yourself?"
- Lead toward links among thoughts, feelings, and behaviors. "How do you act when you feel this way?" "Does that thought make you anxious?" "How do you feel after you do that?"
- Lead toward an understanding of consequences and implications of behavioral choices and patterns. "What would happen then?" "What would that mean?" "Is it OK to have those feelings?" "Why aren't you entitled to your feelings?"
- Return to the crucial topic, the here and now, the topic at hand, and SUD-specific concerns. "How does that relate to …?"
- Lead to discussions of plans and behaviors. "What are you going to do about it?"
- Lead to new directions. *Agree but change direction*.
  Client: "Why are you and my family so damn stuck on my drinking? Geez, you'd drink, too, if you were nagged so much."
  Counselor: "You know, you're right. We shouldn't blame you because drinking problems involve the whole family."

The "*downward arrow*" technique used in the cognitive therapy approach to SUD counseling is based on questions that lead the client through an identification of self-statements or unarticulated assumptions about the "domino effects" of his or her choices. This model states that there are layers of "automatic thoughts" triggered by specific situations that can lead to, among other things, catastrophizing or all-or-nothing thinking. Using this technique, the counselor asks repeatedly about the meaning, consequences, or implications of an idea or situation to "deconstruct" the chains or layers of belief. In one example (Beck et al., 1993, 140–142), a man is afraid of not drinking at an upcoming office party. By asking him a series of questions, each a variation on the question, "What does that mean to you?" (e.g., "What would the implications be?" and "What would the consequences be?"), the counselor finds that the man thinks that he would not be fun sober, that no one would stay with him, that his sales career would suffer, and that he would lose his house and family. The "downward arrow" technique has its counterpart in motivational interviewing. The counselor "leads" the client to elicit motivational statements: "What would happen if you stopped drinking?"

Focusing is important due to the time-limited nature of SUD treatment, especially in the managed-care era. It may be a gentle or more active nudge, as in the probing/questioning skill discussed later. A crucial topic to attend to and focus upon is the counseling process itself. The counselor facilitates awareness of and open discussion of the client's experiences in the session and what happens between the parties. This is perhaps the most curing growth experience that is possible in counseling, far outweighing advice, answers, and therapeutic sleight-of-hand. A popularized expression is "staying in the here and now." As Meier and Davis (1993) advise, "When in doubt, focus on feelings" at a level appropriate to the stage of treatment and with full awareness of anxiety or even pain that this may necessitate. "How does that make you feel?" is a here-and-now question.

The other crucial topic to lead the client to is the relevancy to recovery and recurrence of the content under discussion or the process just revealed. By asking, "Do you think this discussion can help you stay sober?" the skilled counselor lets the client make the connections.

Leading the client to discuss plans and behaviors helps him or her see the link between his or her actions and getting results. It leads to self-efficacy, the confidence that one has some power over one's life. By encouraging the client to make plans assertively, counselors facilitate movement toward the point of taking action to affect his or her recovery.

In developing skills to help clients develop self-awareness, a counselor must pay attention to the timing of questions as well as how assertively he or she pursues the point. The term *probing* carries the connotation of going underneath a surface feeling or idea into deeper, perhaps buried material. In choosing to move faster or more aggressively in leading, counselors tread the fine line between leading and confrontation. It is seldom appropriate for counselors to force clients to "spill their guts," that is, to suddenly access and air intense rage and pain, especially in early treatment. Counselors may feel that the client is ready to go further, ask various questions that lead into new territory, and then sense anxiety that signals them to retreat for now. Several concerns affect the decision of whether to pose potentially threatening questions:

- Stage of treatment
- Degree to which the client has become engaged and invested in treatment
- Degree of coercion involved in the client's participation in treatment
- Awareness of nonverbal cues provided by clients that indicate that the counseling process is generating anxiety

ACTIVITY 3.3 That's a leading question!

After reading through this activity, form groups of three. In each group, one person will play the client, one the counselor, and one the monitor. The "client" and the "counselor" will discuss a personal problem or issue the client would like to change (5–10 minutes). Keep the focus on issues related to drugs and alcohol. The "monitor" will then give feedback about which skills he or she observed (1–2 minutes).

Remember that the purpose of this activity is to practice leading skills, not to solve problems. Also remember that all information shared here is confidential.

Discuss: After all groups have concluded their role plays, return to the large group and discuss your feelings and observations about the performance of the roles.

☐ Identify specific leading skills.

☐ Were they used appropriately? If not, why not?

☐ Would the inappropriate use you observed be harmful or just ineffective? Explain.

☐ How would you have done it differently?

COUNSELOR SELF-DISCLOSURE

In the SUD field, *counselor self-disclosure* often means that the counselor shares his or her recovery from SUD. In generic counseling, the term refers to a counselor's sharing his or her relevant feelings, attitudes, opinions, or experiences for the benefit of the client. Counselor self-disclosure can benefit the client because of the following reasons:

- It reduces shame, guilt, and a sense of isolation by showing the client that he or she is not uniquely horrible.
- It aids in maintaining a here-and-now focus.
- It provides an example of intimacy to a client who has never experienced intimacy or who has lost a sense of how to be intimate.

Counselors should not use self-disclosure to impress the client, or in response to the counselor's need to confess or air his or her feelings. Skillful self-disclosure is relevant in content, occurs in an accurate context, and is timed effectively.

Self-disclosure of a counselor's recovery from SUD has been the subject of an ongoing debate in SUD counseling. Some see this disclosure as a crucial contribution of the recovering counselor in providing hope, inspiration, and role models. Paradoxically, some nonrecovering counselors feel that an agency milieu in which counselors disclose their recovery status puts them at a disadvantage. However, a client who is bent on devaluing the counselor will come up with a reason for each type of counselor (i.e., "You're just a drunk like me, how can you help?" or "You never went through it, how can you help?"). In either case, the counselor should respond by encouraging the client to identify and communicate his or her needs and goals, and exploring how the treatment plan and counseling process will facilitate movement in this direction.

The term *self-disclosure* can refer not only to revelation of recovery status but also to the sharing of any information or feelings by the counselor. Some of the goals of counselor self-disclosure are facilitation of intimacy and bonding and reduction of shame or guilt about feelings. If done appropriately, it can open up people's "hidden spots." Counselors may wish to tell clients how behavior affects them in order to bring out some emotion, tension, or discrepancy. For example, a "chatterbox" client communicated tension and forced cheerfulness to the counselor, who remarked, "While you're telling me all these great things, I'm starting to feel anxious, and I wonder why that is."

ACTIVITY 3.4 Do you know who I am?

Consider the surface and visual issues that make people seem different (e.g., hair color, skin tone, accent, manner of dress, size). Pair up with someone who seems very different from you. In pairs, share a significant experience that made you who you are. These experiences might include a terrible loss, an act of kindness from another person, getting or leaving a job or home, or getting married or divorced.

PROCESS: After 5 to 10 minutes, regather to one larger group and discuss: Were there similarities in your experiences? Did the physical differences begin to be less or more significant? Did one person feel more comfortable than the other in divulging personal information? Did the person who went second feel easier about self-divulging after hearing the first person's story? How did you feel as you listened to your partner's story?

INFLUENCING SKILLS

Simply being in a counseling relationship exerts an influence on clients. But sometimes, counselors actively intervene to influence their clients. This is dangerous territory. Great skill and thoughtfulness are required to exert a positive influence that furthers the client's treatment.

Interpretation

Interpretation is a technique used by counselors to provide a new "frame of reference" or alternative

ways of looking at situations. Interpreting involves seeing connections between situations, beliefs, feelings, and behavior. It involves understanding the influence of experience and the dynamics of different personalities. Of course, it is preferable for the client to develop insights and self-understanding than to be told things about him- or herself. As Meier and Davis (1993) emphasize, avoid advice and avoid premature problem solving. Counselors can cheat clients out of the wonderful therapeutic experiences of struggling with old ways of thinking, uncovering feelings, seeing new connections, and having exciting realizations if they supply ready answers—even when clients demand them and are angry when refused. Growth is liberating.

Confrontation

The term *confrontation* is a minefield. It has many meanings, depending on the treatment modality and setting. Confrontation is a deliberate use of a question or statement by the counselor to help the client face what the counselor thinks the client is trying to avoid. The technique is designed to provide an opportunity for change. Confrontation usually points out discrepancies:

- Within the client's statement or beliefs
- Between statements and behaviors
- Between strengths and weaknesses
- Between what a client states and what the counselor heard or observes

One may develop discrepancies somewhat indirectly. *Acknowledge the statement but use contradictory information the client gave earlier.*

> **Client:** "You want me to stop using, but I won't."
> **Counselor:** "You can see there are some real problems, but you're not willing to consider stopping."

The process skill of confrontation involves five elements: timing, staying concrete, estimating, forcefulness, and monitoring one's own motives and emotions.

Effective *timing* of the confrontation occurs when the client can see the possibility of change or when resistance is causing stagnation. Poor timing for confrontation would be during the throes of a major depression, suicidal ideation, when a client is anxious, and after a loss or defeat. There is no formula for timing of confrontations. Rather, it is related to the counseling skills of attending to the clients' verbal and nonverbal cues, which provide information on their emotional states, and to correctly estimating the development of a therapeutic alliance. One program summed this up in training as, "you may confront as much as you have supported."

Staying concrete and *providing hope* are important in confrontation. Counselors should remember that the goal of confrontation is to facilitate change. Ambiguity, lectures, and pontification can create confusion or even despair. First, it is important to make simple and concrete remarks. An example is, "Is your behavior getting you what you need?" Second, it is important to incorporate the possibility of specific change. This can move the client forward, past the discomfort of the confrontational moment and toward taking the next step. An example is "Can you think of other ways of feeling good?" or "What small thing can you do that will make you feel better about this?" Ending the confrontation with an item for a change plan is also a way of helping the client feel hopeful.

Estimating how much to confront and how forcefully is also critical. Meier and Davis (1993, 12) offer a rule of thumb: "You may confront as much as you've supported." In SUD treatment, the client is often a mandated participant, ambivalence is practically universal, and the amount of time available for the treatment is limited. Although involuntary treatment certainly does not make it permissible to use harsh and unpleasant methods, it does make counselors a little less fearful of being frank with their comments. The supportive SUD counselor provides an opportunity for change without forcing the client to the point of being abusive or destroying the possibility of a therapeutic alliance. Although it is easy to confuse confrontation with rage and raised voices, confrontation can be done with the utmost gentleness.

Drug treatment, in particular, has been associated with extremes in confrontation. In one old-style drug treatment setting, author Myers recalled a group member screaming, "I hate you" for twenty minutes. Certainly, there has been a tremendous decrease in this top-volume, self-stimulating hysteria throughout many or most programs like that one, and hostile interactions have been declining for decades.

Monitoring the counselor's emotional state and motives is very important. Confrontation should always be motivated by a desire to help the client change. That is, counselors must confront clients out of concern rather than rage, annoyance, demonstration of power, transference of issues from their own recovery or other personal issues (countertransference), or need for self-glorification. Counselors must honestly assess their motives and feelings when initiating a confrontation. Confrontations that are forced or are the result of the counselor's frustration and anger usually result in serious damage to the therapeutic relationship. Confrontation in group settings, as we will discuss later, must be monitored by counselors to avoid targeting a person who is weaker, more marginal, or different from other members in some way.

Ellis et al. (1988, 56–57, 72–74) encourage counselors to confront irrational, unhelpful cognitions. They refer to this as *disputing*, which may include the following:

- Challenges to evidence produced by clients
- Identifications of distortions in thinking
- Development of more accurate explanations of events (reattribution)
- Argument in favor of irrational beliefs to bring out the lack of validity for this position
- Disputation of modes of thought that catastrophize events or make them worse than they are, which may generate so much anxiety that it poses a threat of relapse

FIGURE 3.1 is an example of the disputing technique as applied to "awfulizing"—the tendency to overestimate the potential seriousness or negative consequences of events, situations, or perceived threats.

IB (Irrational Belief): *It's awful when I don't drink and; therefore, I have to feel anxious.*
DC (Disputing Counselor): *Why is it awful?*
IB: *Because it is so uncomfortable.*
DC: *And you run the universe, right?*
IB: *No, but I should be able to control my own discomfort.*
DC: *That would be great. But, really, must you?*
Client: *No, I guess I do not have to have more comfort.*

FIGURE 3.1 An example of disputing.
Source: Ellis, A., J. F. McInerney, R. DiGiuseppe, and R. J. Yeager. 1988. *Rational-Emotive Therapy with Alcoholics and Substance Abusers.* Boston: Allyn and Bacon.

ACTIVITY 3.5 How do I influence people?

After reading through this activity, form groups of three. In each group, one person will play the role of the client, one the counselor, and one the observer. Role-play one of the situations listed here. The "counselor" will counsel the client, practicing active influencing skills (approximately 8 minutes). The "observer" will give feedback, noting what skills were observed and whether they were or were not used appropriately (approximately 1 minute). Remember to keep the focus on issues related to the use of drugs or alcohol. The following list suggests some situations to role play.

☐ A court-mandated client in an intake session does not agree that he needs treatment.

☐ A client who has been sober and drug free for 2 months has skipped counseling sessions and stopped attending support group meetings. The client is somewhat withdrawn and shows some of the signs of impending recurrence.

☐ A client is getting into trouble on the job, flying into rages at home, and acting sullen and brooding in the session.

☐ A client who has been sober and drug free for 4 months has not made progress on a goal in the treatment plan (e.g., finding a job, making friends, taking a vacation, repaying a debt).

Enact situations that your instructor suggests.

Discuss: After all groups have concluded their role-plays, return to the large group and discuss the effectiveness and impact of influencing skills.

☐ Identify specific influencing skills. Were they effective? Why or why not?

☐ Would you recommend handling the situation another way? How? Why?

☐ What feelings were invoked in the "counselors" and "clients"?

☐ What other counseling skills did you observe?

☐ Did the influencing skills of the counselors facilitate change in the clients? How?

Timing

The discussion of probing skills stresses being aware of the client's level of anxiety and knowing when to "advance" and "retreat." Throughout the application of all counseling skills, it is necessary to know how far to go, how to time comments well, and how to match the intensity of feelings and anxiety a counselor might arouse with the stage of treatment and the client's mood.

The "art of counseling," unlike the "science" or "technique" of counseling, depends very much on timing, which depends on the comfort level and skill of the counselor. Nevertheless, there are some ground rules. When clients come into treatment, their anxiety is usually high and they need anxiety-reducing responses (reassurance, explanation, attending, listening, and support). Later, when clients become complacent and comfortable, techniques that increase some level of anxiety (probing, confrontation) are useful to motivate a client. As Wallace points out in his classic piece, "Critical Issues in Alcoholism Psychotherapy" (1985, pp. 37–49), SUD counselors continually walk a fine line between allowing clients' denial to continue too long and pushing them prematurely toward self-disclosure.

Miscellaneous Techniques to Elicit "Change Talk"

While not exactly basic counseling skills, these techniques fit into the individual counseling toolkit:

- *Evocative questions* ask the client directly to talk about change. Examples cited by Rosengren (1999, 95) include, "If you decided to make a change, what makes you think you could do it?" and "How would things be better for you if you changed?"
- *Elaboration* asks the client to think and express him/herself more completely. If a client has made a statement about changing, the counselor asks him or her to describe such an instance. An example would be, "What was it like when you guys got along better? What went on, specifically, to help me understand?"
- *Using extremes* elicits the worst and best possible outcomes if their behavior did not change. "What's the worst that can happen?" "What do you hope for the most?" This lays out a landscape or continuum that can be filled in with the less extreme elements (Rosengren, 1999, 96).

Process Recording

Process recording is a way that counselors keep track of, look back at, reflect upon, think about, and analyze what is going on in the counseling process. It is more than a simple recording of events; it is recording and processing what is going on, leading

to an evaluation of the use of techniques and the client–counselor relationship. It allows counselors to "attend to" and "pace" themselves. It is a standard training method in social work and mental health settings, but unfortunately, it is often absent in the chemical dependency practicum (Myers, 2003). It is an invaluable tool in the fieldwork or practicum component of counselor preparation. Process recording is quite useful in supervisory sessions. **FIGURE 3.2** is an excerpt from a process recording.

Sandra Baskin (SB), a counselor at an outpatient SUD facility, wrote the following as part of her process recording of an individual counseling session with Michael Gerrity (MG). Her process comments are in parentheses. She uses the following abbreviations: Dx=diagnosis, Tx=treatment, ASP=antisocial personality, DA=district attorney.

MG entered the room.

(I was feeling exhausted and irritable since this was the fourth client in a row, the last one being very hostile. I hoped that my mood didn't show.)

MG: Hey, what's up? Mind if I duck outside on the terrace for a quick smoke?
SB: Hey, you know we can't do that!
MG: Nobody will know, come on, Ms. Baskin.

(Now I'm starting to really get annoyed at MG.)

MG (smiles broadly): Well, it could be worse! I'm alive! And with my favorite counselor!

(I felt disarmed by Michael's impish smile and smiled back. Now I remembered that Michael had a Dx of ASP and could be very charming and manipulative. I was mad at myself for being fooled, even for a moment. Got to check charts before client comes in. Maybe make red flags for important info. MG is also coming up for a court hearing...)

SB: Are you feeling ready for your hearing with Judge Madsen?
MG: Only if you are. (A teasing reference to my role in preparing the agency report on MG's cooperation, participation, and progress in Tx.)
SB: Do you feel that I'm on your side here? (MG still tends to view me as another cop; my attempts at empathic engagement must be a swindle like MG would pull.)
MG: Ummm (suddenly loses his glib repartee).
SB: I was in your position once. (Oh, crap. Why did I blurt that out? I'm so anxious to make a connection with Mike that I jumped over a boundary. Did NOT need to share that. There's that overidentification/codependency issue kicking in . . . my little brother MG is not . . . Now I'm feeling anxious and out of control.)
MG: Yeah? (smiles again, more authentically) Maybe we can be buddies after all. (An alliance or a swindle? What is the difference for him? My comment helped, but at what price later on?) Well, I'm pretty stressed about it. You know, Madsen gets into his Hanging Judge bag, get-the-dope-fiends-off-the-street thing.
SB: Maybe we should concentrate on concrete steps in your treatment plan that will help you stay clean AND out of the clutches of the DA. And an agency plan for an alternative to sentencing.
MG: I guess I can't go wrong with that. Thanks, doc. (MG calls me "doc" when he is feeling positive about our relationship. I think I rescued the situation.)

(Looking back at this section, I realize I'm spending a lot of energy on second-guessing everything I say and do and on the client's response, micromanaging myself. So much for the here and now!)

FIGURE 3.2 Excerpt from a process recording.

Process recordings, progress notes, and case presentations are different things. *A process recording* is a transcript or summary of everything that went on between the participants and the emotions evoked by their interactions. *Progress notes* (or *chart notes*) document that appropriate tasks or interventions were completed; they provide background for the next worker. The *case presentation* demonstrates the ability to muster an overview of a person with SUD's entire treatment career and comprehensive knowledge of the entire scope of treatment.

A process recording should begin with a brief description of the client and where he or she is in the "client career," a brief summary of treatment goals that are being implemented, and any other information that can provide context for the listener or reader. After this, the process recording breaks down into two tracks, the content track and the process track. The content track is a transcript of the verbal and nonverbal behavior of the client (e.g., client came in 10 minutes late, tapped his fingers rapidly while speaking, said "I hate you!" in a loud, high-pitched voice). The process track includes such items as the following, in the order that they occurred or were observed:

- Observations about a client's emotional state
- Broader inferences about how the client's expectations, transference issues, and transcultural issues affected the client's actions in the session
- The counselor's emotional reactions (e.g., "I felt . . . and this is probably related to a similar experience or relationship I had.")
- Itemization of the counseling skills applied at each point during the session
- Observations of how the counselor's use of particular approaches influenced the process.

Process recordings can alternate paragraphs or make columns (content and process) to record the tracks. Typically, the column system results in some blank spaces in the content column because the commentaries usually run longer. Cournoyer (1996, 210) uses a multicolumn analysis to prepare a transcription of an audio- or videotaped session: content, skill used, counselor's gut reaction, and counselor's analysis.

The final section of the process recording contains suggestions for treatment (improvement) based on the counselor's observations. Examples of suggestions include providing more client education on the treatment process; having further discussions of his or her expectations of treatment; focusing on the here and now; avoiding data and "war stories;" staying with more modest session goals; remembering to budget time for "patching up" the client after heavy self-disclosures; learning more about the client's ethnic background; doing something about that mental and physical exhaustion; and using attending skills more and influencing skills less.

Process recording is governed by legal and ethical guidelines. Preparation and use of the document must be done in collaboration with the agency's administrators. The agency should determine whether the sensitive document should be kept in the files because it could be subpoenaed for use in legal proceedings against the agency, its employees, or the client.

EMOTIONAL ISSUES OF THE COUNSELING RELATIONSHIP

Clients and counselors carry emotional baggage into the counseling relationship. Experiences form elements of a lens through which people view each other in distorted images, affecting perceptions, attitudes, feelings, and expectations in treatment. Traditional *psychoanalysis*—the theory and practice of psychotherapy founded by Sigmund Freud—coined the term *transference* for the effects of emotional baggage brought by the client into the counseling relationship. *Countertransference* reflects the counselor's reactions to the client through his or her own transference.

While the phenomenon of transference was originally considered outside of the awareness or conscious mind of the client, in an "unconscious"

domain, today, most schools of counseling and psychotherapy use the terms to refer to a broad range of prior issues that affect the counseling relationship (Brockett & Gleckman, 1991; Kernberg, 1975).

Clinical concern with the transference phenomena is found in therapeutic approaches that have some connection, however indirect, to a psychoanalytic perspective. SUD treatment has emerged primarily from a different historical legacy. Therefore, transference has not been a major focus of SUD treatment. In addition, the association of transference with psychoanalysis raises the fear that it is the kind of drawn-out, "long-winded" concern that might take the focus off of the immediate, life-and-death issues of SUD and recovery. Transference is actually a powerful presence in SUD treatment; it is also very useful as a clinical tool in illuminating patterns of thinking and relating. It is unlikely that the term *transference* will be used in conversations with clients, but understanding these phenomena is important in the counseling relationship.

Positive Transference

Positive transference refers to positive feelings and emotional needs being transferred from another person or relationship to the counselor. Transference of positive feelings has the advantage of helping to keep the client in treatment, even when the counselor is confronting, challenging, or pressuring the client to an uncomfortable extent.

Positive transference can be intense in early recovery. With release from anesthesia comes awareness of formerly muted emotions and needs. The "emotional rebound" includes affiliative, intimate, and affectional needs. Recovery offers relief from a lonely, often stigmatized existence. Many people with SUD who are new to treatment have been estranged from family, friends, and community. The new counseling relationship in individual and group treatments also contributes to reawakening feelings and needs, both positive and negative.

Positive transference may involve unrealistic expectations of help, love, or protection, at times involving a fantasized relationship (of which the client is not altogether aware). When taken to the extreme, the counselor is idealized and invested with the powers and qualities of some sort of omnipotent, omniscient superparent.

For the counselor, there are interrelated traps in runaway positive transference: It is flattering and ego enhancing to be a rescuer. This meets a counselor's emotional needs for validation and importance. Thus, the counselor may unwittingly "leak" cues that subtly reinforce this message. Unfortunately, in doing so, the counselor is encouraging the client's unrealistic expectations and fantasies, which are bound to be ruined at some point. This often results in extreme disappointment and devaluation of the counselor, and in some cases, of the entire counseling experience.

At the same time, the client may feel shame, guilt, anxiety, panic, or loss of control at having strong positive feelings and intense needs. Psychologist Stanley Meyers, PhD, calls this an "intimacy freak-out" (personal communication). Therefore, the client may develop denial and resistance strategies (so-called *counterdependent behavior*), leave treatment entirely, or even return to substance use.

A skilled counselor tries to handle intense emotional needs by setting limits without appearing to reject or wreak emotional devastation. One counselor asked, "How do you calm them down without sending them out (driving them away)?" Finally, transference to a variety of individuals, a group, and to the entire program, rather than mainly to the individual counselor, should always be encouraged.

A special situation is one in which the client is flirtatious or sexual. Flirtatious behavior may be the result of transferring onto a counselor the relationship with a seductive parent or a parent who demanded appeasement. Such behavior may be the only method the client knows to achieve intimacy, to manipulate people into meeting his or her needs, or a combination. It also may indicate the client's inability to distinguish between a sexual relationship and other types of close relationships.

A crucial phase in which transference occurs is termination of treatment. As termination approaches, clients may become anxious and begin anticipatory grieving for the loss they are about to experience. Some try to avoid or negate this unbearable loss by being hostile, denigrating the formerly idealized counselor, or leaving treatment and possibly returning

to substance use. Treatment planning should attempt to anticipate and plan for a healthy means of separating and moving on. Counselors should lead clients into an exploration of how they will feel when time in the program is over; they should help them weave a new emotional safety net.

Negative Transference

Clients get angry, hostile, resentful, and jealous. It is marvelous, in fact, if clients feel free and safe enough to show these feelings. Counselors must respect the clients' rights to have any feelings without risk of repercussion. Clients must learn to communicate feelings appropriately in order to maintain sobriety and prevent relapse.

In the emotional rebound of early sobriety, the rejections, resentments, abuse, and disappointments of a lifetime may be put onto the counselor. Many clients have a history of conflicts with authority, of misdiagnosis, or of punishments by the agents of authority, whom a counselor may represent. In addition, many have experienced trauma, loss, pain, and abandonment as children of people with SUD. Again, the counselor can become the target.

Of course, it is no fun to be the target. While it may be an uncomfortable situation for the counselor, it may be the first time that the client has felt safe in feeling and expressing anger or rage. In allowing this to happen, counselors provide a substitute for "drinking about it" and an opportunity to practice coping with negative feelings in a healthy way, without chemicals. Despite the discouragement, the counselor must maintain his or her professional role and not personalize the client's behavior. It is dangerous to take this anger personally and react defensively to it. It is a mistake to jump too quickly to explore, interpret, and explain the negative transference, which evades the counseling process and explains away these strong feelings.

The first task is to verify that the counselor is in fact not the cause of such anger. It is appropriate for a client to be angry with a counselor who is always late, hostile when the counselor allows other clients to cut in on his or her meeting time, or resentful of a counselor who regularly answers phone calls during sessions. Having eliminated elements in the counselor–client relationship as causes, it is necessary to explore other causes of these emotions. Is a client's anger a mask for the fear that he or she cannot be helped by this human agency? This fear may convert into rage at the counselor, even if the client has fantasized an omnipotent counselor.

There are indeed powerful sources of both positive and negative transference among clients with SUD, both sets of feelings being threatening to the client. The transference is not only strong but also marked by ambivalence, conflicts, and shifts (Wallace, 1985, 16).

Countertransference (Counselor Transference)

This somewhat awkward term was coined by Sigmund Freud in 1910. In modern parlance, *countertransference* describes those reactions to clients that stem from the counselor's own needs, relationships, or recovery issues. For the remainder of this chapter, we will substitute the term with "counselor transference." Counselors' skills in identifying personal reactions are imperative in ethical treatment. Counselors must keep clients' needs and welfare as the primary concern and avoid acting upon emotional reactions to clients in ways that are not helpful to the client or the counseling process. Examining counselor transference can also reveal important information about what messages the client is sending: A counselor may be resonating to a client's powerful feelings, which are not yet out in the open.

One of the toughest tasks facing the counselor is staying in touch with his or her feelings, especially when dealing with challenging and difficult clients. Being aware that a client is causing emotional reactions may make a counselor feel out of control, or, at least, feel a loss of self-control. However, that awareness is critical. When a counselor is not fully aware of these reactions, or how they influence his or her behavior, that counselor truly is not in control.

Positive Counselor Transference

Powerful positive reactions to clients may arise as a way of making amends for abuse or neglect suffered when he or she was actively dealing with SUD.

Another unfortunate motive is the need to be worshipped and loved by a client, which masks low self-esteem, terror of abandonment, dependency needs, and a lack of gratifying relationships in the counselor's own life.

Sorting through counselor transference is often difficult. For example, if a counselor finds the client romantically interesting, is this:

- A normal reaction to an attractive client?
- An indication of the counselor's need for intimacy or love?
- A response to the client's idealization of, or love for, the counselor, which feeds a need for praise, validation, and flattery?
- A response to a client's need for affection and intimacy being communicated via nonverbal cues, subtle flattery, or seduction?
- A romantic rescue fantasy arising from the counselor's codependency?
- A reaction to a client's skillful manipulation?
- A combination or intermediate form of two or more of the aforementioned?

Counselors must, with the aid of individual or group supervision, sort through their own feelings and needs. Exploration and evaluation of the role in the counselor–client relationship contribute to the client's progress in treatment and can help the counselor avoid the following pitfalls:

- Encouraging inappropriate levels of transference, resulting in disappointment, rage, or relapse
- Failing to maintain appropriate boundaries
- Falling into an enabling or infantalizing role
- Holding on to clients when it is time for them to move on
- Establishing a "pet" or favorite client to the disadvantage of all

Negative Counselor Transference

Being human, counselors can have angry or hostile feelings toward clients. Having negative emotions about clients is normal. Being vigilant and rigorously honest about these reactions is an ethical imperative, so as to ensure that counselors do not unwittingly act on them or send double messages to the client. Aside from simple reactions to provocation, attack, or unpleasant characteristics of a client, a wide variety of personal issues and experiences of counselors can result in negative perceptions and emotional reactions. Signals that clients may be communicating through voice quality or body language can also cause discomfort. Some negative reactions to clients occur when a counselor's reactions to a client are rooted in the counselor's own issues. A counselor may have a need to control or may expect a client to meet needs for validation, love, and so on. Unrealistic expectations may echo a counselor's negative experiences and prompt negative feelings toward a client who rejects help or who is unwilling, critical, or provocative.

Counselors may become angry and disappointed when clients have setbacks or relapse because this seems to signal their own inadequacy. Relatively new, recovering counselors may overidentify with a client and feel anxious and out of control when things do not go as planned. If a counselor identifies with a client's undesired character trait, he or she might, as the SUD saying goes, "attack in others what we faintly perceive in ourselves."

A counselor might associate the client with a negative experience or relationship in the counselor's past. What if the client is a rapist or child abuser and the counselor has suffered from similar situations? What if the counselor is parenting or has raised a problem child, like the client? Negative counselor transference can be caused by reactions to body language or voice qualities. Facial expressions, gestures, postures, and voice qualities can be inconsistent with what a person is saying, which creates tension and discomfort. Counselors also may react negatively to clients' rigid or overcontrolled body language or speech qualities, talking in a monotone, lack of affect (which suggests hidden content or difficulties), and rejection of attempts at engagement. Unexpressed strong feelings in a client who is making a valiant attempt to present a cheerful or stoic face, but whose tension and strain

"leaks through" in contradictory signals, can also make the counselor tense.

CASE IN POINT

Everything's Fine

Marge, the wife of a person with severe SUD, was enrolled in a SUD counseling training program. She maintained a controlled, cheerful, "chatterbox" persona behind which lay great tension and, probably, great pain. The internship/practicum course included a weekly seminar class in which the trainees aired their concerns, feelings, and problems, in reference to their fieldwork placements, as well as discussed clinical issues. The cheerfulness manifested by Marge was clearly forced. This "got on the nerves" of the other students, who found it difficult to deal with the façade. As often happens in a group learning to be counselors, the interactions among the group members became material to the process. The students gently and respectfully confronted Marge and encouraged her to talk about her life and problems. Through honest expression and exploration of feelings (positive and negative), the group resolved the situation—an excellent learning experience.

Unexplored negative feelings and counselor transference pose dangers. Especially a newly recovering counselor, prematurely thrust into a counseling role, may have intense reactions that could cause physical and mental exhaustion and be harmful to the client by disrupting the treatment process. A counselor in recovery may make the recovery of each client his or her personal mission and responsibility. Personal emotional investment in a client ruins the counselor's perspective and his or her ability to behave in a professional way. For example, such a counselor may be too easy on a client, or push too hard!

Unrecognized and unexplored negative counselor transferential reactions may lead a counselor to do the following:

- Subtly push away a client
- Withhold support
- Make incorrect negative interpretations
- Participate in scapegoating
- Feel guilty about hostile or negative feelings and act "nice"
- Be anxious when negative feelings threaten to surface

Before resorting to obscure or exotic interpretations of their feelings, counselors should always look at concrete things that are going on to which they may be responding. The excerpt from a student's process recording (**FIGURE 3.3**) provides a simple example of anxiety provoked by a client.

In the real world of counseling, emotional reactions are not sorted neatly into positive and negative categories. The client's reactions to the counselor are a mixture of positive and negative feelings, sometimes ambiguous and shifting. So are the counselor's reactions to the client. Ambiguity, in oneself and others, is difficult to process and often provokes anxiety. Learning to work with and tolerate ambiguity is a necessary skill in the world of relationships; a counselor is his or her own most difficult client (Ellis, 1985b).

During the course of the session, the client talked loudly and was very animated. He maintained eye contact to a point where I thought he was trying to stare me down. We were seated in a closed-door, narrow, and rectangular conference room and sat across from each other. However, even though we were seated some distance apart, the client's demeanor and behavior was so overwhelming that his presence seemed to fill the entire room. Since both doors to the conference room were closed and locked from the outside, I began to experience some feelings of claustrophobia to the point that I wanted to run out of the conference room.

FIGURE 3.3 Process recording: Anxiety.

SETTING LIMITS AND BOUNDARIES

Boundary rules provide a framework for relationships, the parts that people play in groups, and the positions that they occupy. Setting limits and establishing boundaries are important issues in counseling, as they help the client to learn appropriate, mature, sober, and successful behaviors, and in establishing the appropriate relationships between counselors and clients.

These issues frequently generate problems for counselors and clients at SUD agencies. Some clients are emerging from such personal disintegration that they seem to have a "bottomless pit" of need; others are habituated only to manipulative relationships. Counselors, especially those whose experience has been limited to participation in self-help fellowships, are not always prepared to set definite boundaries and abide by them.

Counselors must think through and establish limits, expectations, guidelines, and frameworks in advance. It is important to anticipate that clients may push beyond what is possible, realistic, ethical, or appropriate for them or their counselors. Without clearly stated boundaries, counselors can also, without realizing it, go beyond acceptable limits.

If counselors are not aware of these issues and are not aware of their own motives or attitudes that may contribute to inappropriate limit-setting, a wide range of consequences might occur for the client, the counselor, and the counseling process. Demands might be made or expectations created that are unrealistic, excessive, or inappropriate. This is a no-win situation. The counselor has the choice of allowing excessive demands or intimacy, or going along for a time and then shifting positions to reject such demands. Aligning with a client's inappropriate or unrealistic expectations can lead to resentment or burnout for the counselor, failure to help the client learn to manage his or her needs appropriately within society, and blurred roles of counselor and client. Failure to establish and respect boundaries can also lead to the counselor being drawn into manipulation, which may include finances, sexuality, housing, and other favors. Such actions, regardless of good intentions, are dangerous and violate professional ethics. A counselor who lets a client stay at his or her house, for example, might face any number of disastrous consequences. A counselor who ignores or disregards a client's behavior that pushes or exceeds limits will eventually feel stressed or resentful. The resentment may begin to show, and the double message will confuse and disturb the client. In such situations, either alone or as a result of clinical supervision, the counselor must set new limits and boundaries, which changes the nature of the counselor–client relationship. Although this is necessary, it often leaves the client feeling disappointed, rejected, or even infuriated. Honest exploration of the client–counselor relationship must lead to renegotiation of the boundaries and rebuilding of the working alliance.

PHYSICAL CONTACT

In the SUD recovery setting, hugging especially brings up the question of physical boundaries. Hugging provides support, reduces isolation, has a healing quality, and can help someone learn to trust and build toward emotional intimacy. Between counselor and client, however, and even among clients at an agency, hugs can be hidden traps. They can result in the following:

- Be used as a "quick fix" that avoids looking at some painful truths or the need to make some difficult changes in entrenched behavior patterns
- Encourage clients to look within the treatment system to have essential needs met, which may cause a termination that can be very painful and possibly even be postponed
- Prematurely open up a long-repressed "Pandora's box" of emotional needs early in sobriety, which can be threatening and result in departure or even relapse; or the client can develop a "crush" on the counselor
- Result in sexual arousal, then guilt, and possible departure
- Cause jealousy in clients who receive fewer hugs

The type of program that, to one extent or another, has a "hugging" culture that emphasizes love and acceptance may seem like heaven on Earth to many. But some individuals abuse this and become intrusive or smothering. In such a setting, people who prefer not to hug are defined as withdrawn, unfriendly, or deviant. Also, the "lovey-dovey," or affectionate technique can cover resentments or make it difficult, if not impossible, for individuals to explore anger and other uncomfortable or negative emotions within the group or program. In fact, it will cause them to feel conflicted or guilty when these feelings crop up. Finally, the real world is not always a loving environment. A counselor who fosters a client to be ill-equipped to cope with negative emotions and reactions sets him or her up for relapse.

Skills in Setting Limits

In reality, counselors all learn through error. They sometimes miss signals or clues that a client is developing expectations that cannot or should not be met; then the counselor must "back off" gracefully. There are all kinds of hidden traps that counselors cannot always anticipate. When boundaries are crossed, their renegotiation need not be a total disaster. The situation can be discussed honestly with the client, and the counselor's taking responsibility for the situation humanizes and explores the nature of this collaborative relationship. It can be reframed as an opportunity for growth in the area of relationship skills.

Although not every scenario can be anticipated, counselors should keep a number of guidelines in mind in order to negotiate the difficulties of the counseling relationship as it pertains to boundaries and limits:

- Identify the appropriate and realistic boundaries that are consistent with legal and ethical guidelines. Know your employer's standards and guidelines. Consult your supervisor about all unclear areas.
- Identify your attitudes and motives for not setting limits assertively. (Do you feel guilty or anxious? Are you confused about the role of fellowship member and the role of professional counselor? Do you need to protect or rescue clients?)
- Set limits in a manner that is assertive, direct, honest, and open as well as empathetic. Keep it simple and friendly, pertaining to a single, specific behavioral area rather than a comprehensive denunciation.

Examples of assertive statements that can be used to set limits include the following:

- "I have 10 minutes for you today."
- "I know you need more time with me today, and I wish I had it, but I have other clients who also must see me. One is waiting for me now."
- "It makes me uncomfortable when you leave your coat in my office. I'd appreciate it if you could arrange for another place to put it."

CRISIS INTERVENTION

Working with clients in making progress toward a stable recovery may be punctuated by a crisis, an event that threatens the treatment effort, and the emotional and/or social stability of the client.

A crisis may be directly related to alcohol and/or drug use:

a. Depressive episode due to discontinuance of a stimulant ("crashing")
b. A threatened relapse due to craving or mood swing
c. A minor "slip" or relapse
d. A one-time "slip" that results in an unintentional overdose

Interpersonal events that precipitate a crisis include grief at the death of a significant person, separation or divorce, or domestic abuse. Crisis-provoking external events include being arrested, convicted, parole or probation violation (even while in recovery), loss of domicile (homelessness), and loss of employment. Associating with old drug-using peers may pose a threat as they may pressure the client to discontinue treatment.

Psychologically based crises include loss, grief, and regrets.

Loss, Grief, and Regrets

Loss and grief are issues throughout the SUD and in the recovery process. Drinking can be initiated or drastically increased following a loss. This reaction is often linked to an inability to accept and integrate the experience because of an inability to go through the grieving process. SUD itself brings many losses—of relationships, self-esteem, physical health, employment, and so forth. The coming of sobriety and healing paradoxically brings a person face-to-face with these losses. Grieving losses of the pre-SUD and SUD periods is part of the work of recovery. Other situations that may trigger a crisis include:

a. Emergence of buried trauma that had been chemically numbed—the Pandora's Box mentioned earlier
b. Psychotic episodes due to discontinuance of a psychotropic medication
c. Decompensation due to psychiatric instability. Awareness of assessment and diagnosis can reveal psychological factors involved (see chapter on Case Management).
d. Fear of intimacy (the so-called "intimacy freak-out") [Stanley Meyers, Ph.D., personal communication]. We allude to the downside of a "hugging culture" at an agency.

In the immediate short term, the counselor needs to focus on resolving the crisis by helping the client turn the crisis into a solvable problem. If there is no lethality, using basic counseling skills, the counselor needs to help the client express feelings, eliminate negative beliefs, and assign specific behavioral tasks designed to help resolve the crisis. However, if there is any indication that there may be lethality (suicidal or homicidal ideation), then counselors need to be direct and involve their supervisor, psychiatrist, or get the client directly to the hospital. Review the section on duty to warn and duty to protect in the Ethics chapter of the text and in the code of ethics of your state or professional association, which spells out the legal requirements to warn of suicide.

Attention should be paid to demographics. Older Caucasian males accounted for seven of ten completed suicides in 2015 (AFSP, 2017). The next highest demographic is adolescents: suicide is the second leading cause of death in adolescents 15 to 19, and for those 10 to 14 years of age, equal to that of traffic accidents (Klass, 2017). With regard to ethnicity, Hispanic adolescent females have significantly higher rates of impulsive suicidal gestures than African American or Caucasian adolescent females (Zayas & Pilat, 2008; Zayas & Gulbas, 2010). A suicidal gesture, if not caught in time, can, of course, result in death. Deliberately driving under the influence and/or dangerously, or drinking to the point of a lethal blood alcohol level, are examples of taking risks and flirting with death.

What might be catastrophic to one person may seem like a mild concern to another. For counselors, it is important to understand that their perception of the problem is not important; it is the clients' perception that counts.

Roberts (2005, 13) lists five characteristics of a person in crisis.

1. Perceiving a precipitating event as being meaningful and threatening
2. Appearing unable to modify or lessen the impact of stressful events and traditional coping mechanisms
3. Experiencing increased fear, tension, and/or confusion
4. Exhibiting a high level of subjective discomfort
5. Rapid onset of crisis mode

Reactions to crises include shock, which can be immobilizing, and may be followed by disbelief and denial; as in *"this can't be happening to me"* There may also be bargaining, particularly in terms of relationships, as in " If you promise to ____, I will promise to _____." This is often followed by anger and a sense of helplessness and hopelessness. Sometimes, individuals feel their inability to manage a crisis as a sense of worthlessness. Counselors need to be aware of signs of lethality (expressions of harm to self or others).

A useful model for intervening in a crisis is presented by Karl Slaikeu (1990) and referred to as psychological first aid. This is a 5-step process:

1. **Make psychological contact** by listening carefully and reflecting as described earlier in this chapter. Communicating acceptance, empathy, and being nonjudgmental helps establish rapport and collaboration. Statements like, *"I can sense from the way you talk how upset you are about what's happened."* can help calm the client and establish rapport. Be aware that anxiety can be debilitating and make it difficult to find solutions.
2. **Elaborate on the dimensions and details of the problem** by determining the severity of the problem through open-ended questions. In a case of a child taken away by Child Protective Services, you might ask,*"What did they say were the reasons?" "Did they indicate that it was temporary?"* A cognitive behavioral technique that can be helpful is to operationalize the client's beliefs (Mitchesom et al., 114–115). This is done by asking questions that bring the clients' vague and generalized feelings into more concrete perspective, *"What do you mean when you say you can't cope without drugs?" "So, if you did not have your drugs, could you give me an idea of what you could not cope with?"*
3. **Examine possible solutions** by asking what the client has attempted so far. Brainstorm what can and could be done. Propose other alternatives. Help redefine or reframe the problem and seek out resources of which the client may not be aware.
4. **Assist in taking concrete action** in order to implement immediate solutions. At this point, it is critical to determine if client intentions may lead to lethality. If there is no indication of lethality, create a contract that says we will act together to resolve this crisis. However, **if there is an indication of lethality,** take a more directive stance of *"I will act on your behalf,"* which might include directly contacting family and community resources— this probably would include either assuring hospitalization or directly seeing a psychiatrist. Since the protection and safety of any client and his or her family is a major concern of any human or health service worker, including SUD counselors, successful prevention of suicide is a crucial issue. The factors listed earlier as precipitating a crisis are also risk factors for suicide. In addition, prior history of suicide attempts; family history of suicide; and a history of childhood abuse are also risk factors (CSAT, 2009).
5. **Follow up** with the client to assure that he or she has followed the contracted plan to see if the crisis has been resolved and if any difficulty that has arisen needs to be addressed. In a case of potential lethality, assure that the client receives the necessary emergency treatment.

In responding to a potential suicide, the Center for Substance Abuse Treatment (2009) recommends following the acronym GATE, which stands for gather information, access supervision, Take responsible action and extend the Action. (p.12)

Gathering information has two steps. The first involves a basic screening for all clients by asking a general question, such as, *"Have you ever thought about killing yourself?"* or *"Have you ever tried to take your own life?"* If the client answers "yes" to any of these general questions, then the second critical step is to ask follow-up questions to gather information on the seriousness of the suicide intent. These questions should first focus on the suicidal thoughts. *"What brings them on? "How strong are they?" "Have you made a plan?" "Do you have a method?"*

Counselors who are not clinical social workers or psychologists should not make a determination of the severity of suicide intentions but should immediately contact his or her supervisor. If the subject of suicide arises during treatment, supervisors should be made aware of any thoughts of suicide that the client alludes to; reports of previous suicide attempts not previously reported;

or major stressful situations that appear to raise a concern about suicide.

In discussions with the supervisor, counselors need to allow the supervisor to make a judgment about the seriousness of the suicide risk. Actions that may be taken with the counselor's supervisor's discretion may include referral to a mental health worker for an emergency evaluation; obtaining an ambulance for hospitalization; involving responsible family members; frequent contacts during crisis period; and referral to a psychiatrist for further evaluation or medication. Counselors should not assume that suicide is only an acute problem that recedes after initial intervention. Extended follow-up actions are necessary. Counselors need to confirm that appointments were made; coordinate with family, mental health workers, case managers, and any others involved or concerned with the recovery of the client. Finally, checking to see if suicidal thoughts or other behaviors may indicate a return to suicide risk. All assessments, contacts, and resolutions concerning the suicidal crisis should be documented, and counselors should be aware of the state and federal regulations on exceptions to confidentiality where a client poses a threat to themselves.

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[a]As an alternative, you can obtain or download the free SAMHSA TIP "Enhancing motivation for change in substance abuse treatment," which was prepared by a team chaired by William Miller (CSAT 1999). The document's appendices contain a variety of useful instruments for assessing readiness to change.

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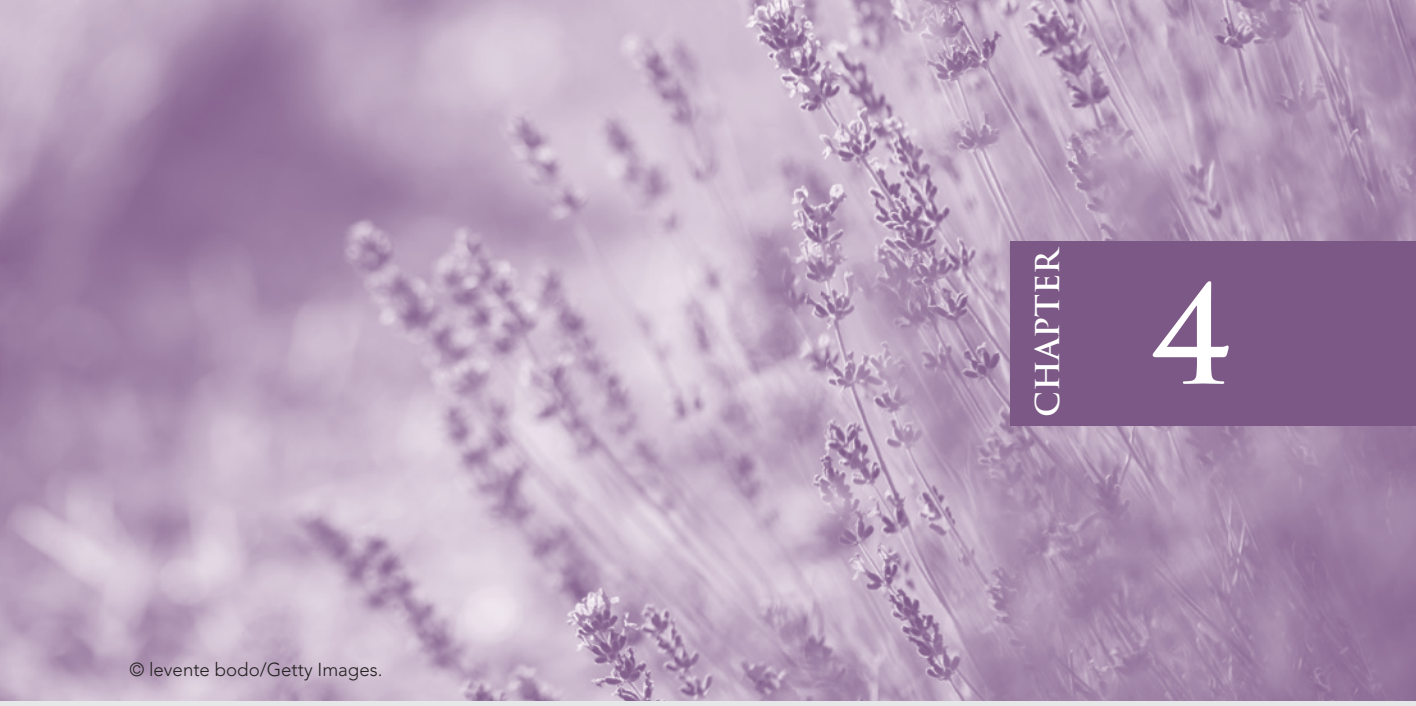

CHAPTER 4

INITIATING RECOVERY

OBJECTIVES

By the end of this chapter, students will be able to:

1. Identify and describe the dimensions involved in the initiation of recovery.
2. Describe the elements of brief interventions in substance use disorders (SUD).
3. Describe the five stages of change.
4. Provide an example of a client's response appropriate to each stage of change.
5. Describe the key elements in motivational interviewing.
6. Describe the stigma involved in SUDs: societal stigma, internalized stigma, and stigma towards people with SUDs within the treatment system.
7. Describe six motivational interviewing traps counselors need to avoid.
8. Demonstrate in role plays OARS (open-ended questions, affirmations, reflections, and summaries) responses.
9. Describe the use of an importance ruler, confidence ruler, and readiness ruler.
10. Develop in a role play a decisional balance sheet.
11. Elicit and identify in a role play the change statements made by a client.
12. Complete an appropriate change plan with a client.

There are at least three dimensions involved in the initiation of recovery: natural recovery processes, desperation, and compulsion.

NATURAL RECOVERY MOTIVES

People with substance use problems and disorders yearn for a normal and healthy life. The strength to recover may lie dormant but often awakens naturally or while in treatment. Many users do become abstinent or return to moderate use of psychoactive substances without treatment or after treatment has not appeared to achieve recovery. We hesitate to provide statistics, as natural recovery varies by level of severity and various demographic variables, and many are hidden from view and unmeasured. An overview of ten studies by Glenn Walters (2000) estimates that one half of those with SUDs attempt to abstain , but of that group, only half are successful in maintaining a clean and sober lifestyle. Nevertheless, we have a lot to learn from that one-fourth. A related concept is that of "maturing out" of substance use (Winick, 1962). For example, millions of adolescents smoke marijuana, but most of them will be nonusers decades later. Many in the treatment field do not agree with the idea that people can recover on their own (Granfield & Cloud, 1996; 1999) and it is a somewhat taboo topic.

The desire to attain normalcy is an important component of getting people with SUDs into treatment, and it is our task to bring out, facilitate, and provide hope for such yearnings, to demonstrate that "recovery works," and to outline a roadmap that can lead to recovery. It is normal and natural for people to be deeply ambivalent about substance use, the benefits of continuing vs change. This ambivalence exists before and after initiating efforts for recovery.

DESPERATION

Drug use creates a great deal of pain, yet hopeless and helpless individuals tolerate a great deal of pain on a daily basis. In early Alcoholics Anonymous (AA) groups, it was believed that the user had to sink lower and lower until he or she "hit rock bottom," that is, until he or she felt misery, illness, and pain that, for the moment, overshadowed the pleasures or perceived benefits of a using lifestyle. Early members of AA epitomized the desperate "low-bottom alcoholic" as someone who was one step from "insanity or death." Later, it became clear that earlier intervention was possible and preferable because it minimized medical and social damages and costs.

Coworkers, peers, and family members may protect and buffer the user from the consequences of his or her lifestyle. Working with significant others is important in initiating treatment. A newer model (CRAFT) of working with families is now available and it is described in the chapter on families.

COMPULSORY TREATMENT

In the majority of cases, initiation of treatment involves an element of involuntary or semivoluntary referral. Referral pathways may be as follows:

- Through the courts, as alternatives to sentencing or incarceration or as part of a child-protective action
- From an employer, through an assessment and referral program called Employee Assistance Program (EAP)
- From an educational institution with a Student Assistance Program
- From family and friends, through an organized intervention, or from child welfare systems and welfare-to-work initiatives

This compulsory element in initiating treatment is far more common in SUD counseling than in mental-health services, and has grown even more common in recent years, with the increased clientele from criminal justice systems. The client cannot disappear easily when pressure to change builds. Involuntary, or mandated, presence and other stipulations (e.g., progress reports to a child welfare agency or to an employer) are elements of "therapeutic leverage." Some people in AA call it "raising the bottom." That is, it creates initial incentive or pressure for the individual with SUD

to accept treatment before he or she sinks to a more desperate level, from which there may be no recovery. Once in a drug-free environment, clients are often engaged in treatment and may make profound changes in their lives. One of the authors worked in a therapeutic community setting in which all of his supervisors were originally residents sent as an alternative to sentencing in a court-operated program.

Recently opiod overdoses have greatly increased throughout all socioeconomic categories. Many police departments have abandoned "arresting their way out of" (the opioid epidemic) and have initiated programs that are welcoming and helpful to the desperate user. These include the Police Assisted Addiction Recovery Initiative, or Gloucester Initiative, with over 100 police departments that take users to treatment facilities, and the Law Enforcement Assisted Diversion (LEAD) Program, which diverts arrestees to treatment before booking them.

Another dimension of recovery is described in Chapter 5 and involves building recovery capital. This pertains to initiating recovery, but more importantly, to sustaining recovery.

BRIEF INTERVENTIONS

Much research has indicated that any of a variety of brief interventions and brief treatments can have a salutary impact on alcohol and drug misuse. Brief interventions are focused on immediate behavioral objectives. They focus on symptoms, not underlying causes. The acronym FRAMES, based on motivational interviewing theory, provides an overview of the components (not steps) of brief interventions (CSAT, 1999, 18–19):

F = **Feedback** is provided to the abuser about personal risk or impairment
R = **Responsibility** for change is placed on the abuser
A = **Advice** on how to proceed with change is given
M = **Menu** of self-help and/or treatment options and strategies is offered based on the specific situation of the client
E = **Empathic** style and listening (nonpunitive, nonlabeling) is used
S = **Self-efficacy**, belief in the ability of the client to change (optimistic empowerment) is instilled in the client

Typically, brief intervention includes these five steps (CSAT, 1999, 20–24):

1. Introducing the issue
2. Screening, evaluating, and assessing, as with a readiness ruler that roughly gauges readiness to change, as described later in this chapter
3. Providing feedback
4. Talking about change and setting goals
5. Summarizing and reaching closure

An important point about brief interventions is that they take the initiation of recovery out of the SUD treatment setting into a plethora of venues and "interveners": clergy, lawyers, physicians, educators, peer counselors, and residence hall personnel, in addition to clinicians. Numerous studies have shown the effectiveness of brief interventions with moderate alcohol abusers (Wutzke, Konigrave, Saunders, & Hall, 2002). A meta-analysis conducted by Moyer, Finney, Swearingen, & Vergun, (2002) underscored the effectiveness of brief interventions, excluding individuals with severe SUD, when contacted 3 to 6 months after the intervention. The authors cautioned against generalizing about the use of any particular intervention outside of the setting and population involved. The concept of brief interventions, such as stages of change, is transtheoretical and can be based on any of a number of treatment approaches. A federally-supported model of brief intervention is screening, brief intervention, and referral to treatment (SBIRT), pioneered in California. Preliminary data show a majority of alcohol abusers reduced their drinking following SBIRT interventions. Local government is following suit: New York City allocated $850,000 from 2005 to 2006 to train medical personnel at all levels in conducting brief intervention. Unfortunately, out of habit or embarrassment, many health professions do not implement routine screening, or water it down until it is virtually meaningless. An acquaintance of one of the authors recounted an incident in which a

nursing assistant entered the examining room with a clipboard and quickly filled a checklist, including the verbal statement "you don't use drugs or drink a lot, right?"

STIGMA

The MM client described in the Case in Point had many wonderful qualities that may be at variance with how many readers view this population. We described the negative attitudes that many, even those in the field, hold with regard to methadone clients. Sociologist Erving Goffman wrote over forty years ago about the concept of stigma (Goffman, 1963). *Stigma*, which is the Greek word for a mark, refers to something like an imaginary stain that sets an individual off from others. Society stigmatizes people who are different or deviant, discrediting and damaging (their identity and reputation and often dehumanizing and isolating them; this discredited person faces a rejecting world. People, who are obese, disabled, mentally ill, or of transgendered identity are stigmatized, perhaps subtly, but stigmatized nevertheless. A great deal of effort in the public health field has been devoted to destigmatizing physical and—more recently—mental illnesses. Gay and lesbian couples now appear in the *New York Times* marriage announcement sections every week, and transgender identity and transitioning is in the early stages of destigmatization. Multiple stigmata make destigmatization more difficult: for example, mothers who used crack cocaine were demonized in the 1980s, a phenomenon referred to by Stanley Cohen as "folk devils" (2000). Firsthand examination revealed that they longed to be normal parents (Myers, 2017)

CASE IN POINT

It's a Matter of Attitude

A methadone-maintenance (MM) client was known to regale the staff with hilarious interpretations of the political sexual scandals of 1997 and 1998. One day, this client showed a different side; he gave a somber account of a close friend at an MM program who had cancer. He and his friend had visited a prestigious research and treatment center, which had initially offered the friend medical attention. When they saw from his voluminous charts that the patient had an SUD and was being treated on MM, the admitting staff abruptly asked them to leave. The MM client then took in his friend and cared for him until his death.

CASE IN POINT

Wheelchair Stigma

The wife of one of the authors broke her ankle and leg and was in a wheelchair for 6 weeks, as a result. The author and wife noted that people spoke loudly to her as if she were hearing impaired, and often smiled condescendingly or nervously. It was as if they automatically attributed impaired cognition and perception to a person in the category of "disabled."

SUD is a major stigma, and people with SUD who participate in methadone programs, or who have a co-occurring psychiatric disorder and/or HIV, may have multiple stigmas, creating a huge barrier to self-esteem, successful recovery, and re-entry into society. Clients' diagnostic stigmata also add to other stigmatizing attributes: poverty, race, and social marginality.

> Stigma affects people with alcoholism in two ways: externally, through rejection by friends, family, relatives, neighbors, and employers; and internally, through aggravated feelings of rejection, loneliness, and depression. (Cosco A. Williams, at a 2000 Stigma Reduction Forum in Washington, DC. Quoted in Landry and Robinson [2001])

SUD counselors must strive to help people with SUD to overcome external and internal stigmas.

> "One of our tasks as treatment professionals is to help shift clients away from their self-stigmatizing focus on their imagined worthlessness, and to open their perceptions to the sources of strength and hope that already live inside them, their strengths and resiliencies." Pamela Woll (2001, 51)

Many people are influenced, often unwittingly, by social stigma and are predisposed to dislike or distrust those in deviant, stigmatized categories. Helpers must also honestly confront their own stigmatizing attitudes toward people with SUD. When we discussed the preceding Case in Point in class, a good proportion of the class admitted they thought of methadone clients as unredeemed "junkies" and con artists—pretty much beyond help and certainly more likely to break into your car than to care lovingly for an ill friend. These attitudes will be communicated to clients, which of course is not conducive to a therapeutic situation in which the counselor needs to treat the client with a great deal of empathy and personal regard—the basic requirements for a successful counseling relationship. Moreover, failure to recognize these attitudes will lead to an expectation of failure in treatment.

Many stigma-promoting theories about SUD are prevalent in society at large: that SUD is primarily a moral problem, a freely chosen immoral/illegal behavior; a sinful or spiritual deficit; or the result of poor willpower (Landry & Robinson, 2001, 9).

One of the things that can be done is simply to foster the use of nonstigmatizing language (**FIGURE 4.1**). Even the title of a program can promote stigma. In July of 2006, a New York City newspaper published photos of proud graduates in caps and gowns, from the Mentally Ill Chemical Abuser Program of a well-known behavioral health agency. A student remarked sarcastically, "That's screaming 'I'm crazy and a junkie and here's my diploma to prove it.'"

In the last 6 years, various state and local recovery support groups have sprung up to create pride in recovery. The Substance Abuse and Mental Health Services Administration (SAMHSA, U.S. HHS) has made stigma reduction one of its prime focus areas.

Motivation to change is essential in any effort to reduce unhealthy behaviors and initiate and sustain healthier behaviors. Working effectively with

Examples of recovery-oriented, nonstigmatizing language

Current terminology	Alternative terminology (recovery oriented, strength-based, nonstigmatizing)
Alex is an addict	Alex is a person with a substance use disorder
Kyle is noncompliant	Kyle is choosing not to, not in agreement
Mary is resistant	Mary chooses not to, prefers not to, disagrees
Jennifer is in denial	Jennifer is ambivalent about
	Jennifer hasn't internalized the seriousness of…..
Untreated Addict	Person not yet in recovery
Relapse Prevention	Recovery management
Relapse	Return to use/recurrence*
Refused	Declined
Decompensate	Experiencing an increase in symptoms
Low functioning	Has difficulty with, needs supports
Suffering from	Working to recover from, living with

(Used in training volunteers in the Chatham Cares4U program, an affiliate of the Police Addiction Assistance Recovery Initiative)

*There is debate over abandoning the word relapse. Some say that "reoccurance" would best suit a disease such as cancer.

FIGURE 4.1 Using nonstigmatizing language.

Modified From South East Addiction Technology Transfer Center "Language of Recovery" Yale University School of Medicine Program for Recovery, Tondora, et al 2009 Wisconsin Children's Mental Health Collective Impact Partners Language Guide.

clients having SUD requires skills in understanding the process of helping clients change as well as in eliciting motivation from clients.

The qualities and skills necessary to develop rapport with clients allow for deeper exploration of their presenting problems and influencing their thoughts, feelings, and behaviors. Although these skills in themselves can assist to help change unhealthy behavior to healthy behavior, research over the last 20 years has found that using the new motivational paradigm can also improve the behavioral outcomes for people needing to change unhealthy behaviors, such as smoking, chronic and/or excessive drinking problems, eating disorders, and other health issues (Rollnick, Mason, & Butler, 1999; Botelho, 2004; Rosengren, 2009).

THE NEW PARADIGM ABOUT MOTIVATION

In the past, motivation for change was placed primarily on the client; motivation was seen as more or less a permanent characteristic or trait of the client. The client who refused to consider change was perceived as "unmotivated." If a client did not adhere to the advice or confrontation by a health or counseling professional, it was assumed that he or she was not motivated, lacked will to change, was not ready, and/or had not "hit rock bottom." The new paradigm presents motivation as more about ambivalence toward change and as a product of the counselor–client collaboration. What appears to be a lack of motivation or resistance can arise from a lack of information, fear of change, inability to see any importance in changing, concerns about how change will affect one's life, or lack of confidence about one's ability to change.

In helping clients commit to behavioral change, we need to recognize the value of respecting the client's autonomy and to be sensitive to the forces that resist change. A motivational approach must allow clients to see choices, examine their concerns, and understand the forces that lead toward and away from change. Physician Rick Botello (2004, 27) states, "We must move beyond the idea of control, that is, beyond trying to control our patients or having them control themselves, to the idea of autonomy. Patients are more likely to adopt healthy behaviors if they want to change rather than if they ought to or have to change."

Motivation is also affected by the counselor's style. It either can be blocked or facilitated by how the counselor responds to the client. The desire to change and commitment to change can be elicited by emphatic understanding, meaningful feedback, nonjudgmental examining of the pros and cons of change, examining the client's self-efficacy, and other well-timed interventions. Two models of change have arisen in the last 20 years that are invaluable in eliciting positive behavioral health outcomes. The first is Prochaska and DiClemente's (1982) transtheoretical model (TTM), also known as stages of change; and the second is Miller & Rollnick's (1991, 2002, 2013) motivational interviewing (MI), sometimes referred to as motivational enhancement therapy (MET). These two models can work together to assist clients in committing to, preparing for, following through with, and maintaining healthy behavioral change.

STAGES OF CHANGE MODEL

The transtheoretical model or stages of change research done by Prochaska and DiClemente (1982) indicated that, despite the major differences in the theory and application of over 100 models of therapy, therapy seemed to work, whether it was psychoanalytic, humanistic, Gestalt, reality therapy, cognitive and behavioral therapies, or some eclectic combination of these. All of these approaches, to some degree, have some positive outcome (Luborsky & Luborsky, 2006). In an effort to understand this phenomenon, Prochaska, Norcross, and DiClemente (1994) created a transtheoretical model that proposed that different therapies worked for different problems at different times as individuals went through a process of change. They proposed that when individuals make changes in lifestyle (stopping smoking, stopping or reducing drinking or overeating,

getting a new job, or any other major change in behavior), they go through a set of incremental steps that are more or less effective in moving individuals through the process. This model is referred to as the transtheoretical model (TTM) because it borrows techniques and interventions from a wide variety of psychotherapeutic theories and approaches, including analytic, humanistic, cognitive, behavioral, and social psychology.

In researching the process of change, Prochaska et al. (1994) noted that people make changes with or without professional help, and with or without support groups, but—either with or without help—the change process requires a successful negotiation of a set of stages. These stages are precontemplation, contemplation, preparation, action, and maintenance. Successful recovery or health change requires progressive movement through these stages. Later in this chapter, we will discuss specific processes of change effective at different stages.

Precontemplation is characterized by not thinking about change, having no intention of changing or refusing to consider the idea that there is a need to change, or not being aware of any need to change. Others around the person may be concerned or urge the person to change, but that person does not see a need for change. Some people are in the precontemplation stage because they believe they cannot change, have tried but failed to change, and have given up on the idea of change and, therefore, have resigned themselves to not contemplate change. An example of a precontemplation statement is, "I don't see any reason to stop drinking. I'm sure I don't drink any more than all my friends. I feel good so I don't know why my doctor is giving me a hard time about it."

When there is sufficient awareness that change might be of some concern and; therefore, the individual is beginning to think about change, the individual is moving into the *contemplation* stage. Contemplation does not mean the person will change, only that they see a concern about their present state and are ambivalent about their feelings. They may be unsure of what to do or whether it is worth making any changes. Contemplation is characterized by ambivalence. They are weighing the pros and cons of change; they are struggling with, and perhaps confused about, whether to make any effort to change or not. They may consider the benefits of changing but may as well see problems or major concerns with changing. An example of a contemplation statement is, "I'm sure that I don't have any serious drinking problem; however, I know I have done some things that concern me when I drink."

When a person begins to decide that change may be necessary and makes some commitment to try and change, he or she is moving into the *preparation* stage. The preparation stage does not mean that the person is actually taking meaningful action to initiate or modify behavior, but only that he or she is beginning to plan how to change or to consider steps to effectively change. Preparation is characterized by an individual considering plans to change, thinking about alternative actions that he or she may take, and weighing the consequences and benefits of each alternative. Preparation is characterized by planning and is in the future tense. An example of a preparation statement is, "I will start attending an AA meeting. I will avoid hanging out at the bar."

When individuals begin to take steps to change in an active way, they are in the *action* stage. Action requires commitment and energy. It is usually characterized by implementation of plans made in the preparation stage. The individual may make others aware of his or her efforts and seek support for new behaviors. An action statement should be in the present tense, for example, "I'm attending three AA meetings a week. On Friday nights, instead of going to the bar, I'll go to the movies with the family."

When an individual sustains involvement in the action stage for some period of time (usually 6 months), he or she enters the *maintenance* stage. Maintenance is about sustaining healthy behaviors and managing barriers. Often, maintenance is supported by learning new coping skills to manage new behaviors. People with SUD must learn strategies to manage stress or resist peer pressure to avoid recurrence. An individual may return to use or have a short return to previous unhealthy behaviors but may become quickly aware of them and return to the new behaviors that he or she is trying to sustain. An example of a maintenance statement is "I've been doing well in my recovery for the last 3 months, but the holidays are coming

up, and that's when I have the toughest time. I think I could use some help in finding ways to say 'no' and mean it."

These five stages are fluid and an individual may progress through them or move back to a prior stage at his or her own individual rate. An individual may stay (get "stuck") in any of the stages for a long time. Individuals may move into the action stage or maintenance stage, have a recurrence, and need to go through the stages again. Clients may be in one stage for one problem (e.g., action stage for SUD) and in another stage (e.g., precontemplation for depression.) for another problem.

Because knowing the precise stage a client is in is important when using techniques and strategies to help the client to make a change, it is necessary to assess which stage the client is in at the time that the counselor is working with them. Activity 4.1 is designed to assist in recognizing the particular stage of change the client is in.

ACTIVITY 4.1 Assessment of readiness to change

For each statement that follows, select the most appropriate stage of change.

1. "I don't care what the doctor says. My drinking is not a problem and I don't drink any more than most of my friends."
   Precontemplation _____ Contemplation _____
   Preparation _____ Action _____ Maintenance _____
2. "I need to really think about how I'm going to plan my meals now that I'm going to diet."
   Precontemplation _____ Contemplation _____
   Preparation _____ Action _____ Maintenance _____
3. "I really don't know whether I really need to take the time to exercise, but I have put some pounds on and might need to consider doing something."
   Precontemplation _____ Contemplation _____
   Preparation _____ Action _____ Maintenance _____
4. "I do like to smoke to relieve stress, particularly after a rough day, but I know it's making my asthma worse."
   Precontemplation _____ Contemplation _____
   Preparation _____ Action _____ Maintenance _____
5. "What do I need that medication for, it only makes me fat."
   Precontemplation _____ Contemplation _____
   Preparation _____ Action _____ Maintenance _____
6. "So the stupid cop picked on me and I got arrested for DUI, but that doesn't mean I've got a drinking problem."
   Precontemplation _____ Contemplation _____
   Preparation _____ Action _____ Maintenance _____
7. "My dad died of a heart attack; I better think about finding a way to watch what I eat."
   Precontemplation _____ Contemplation _____
   Preparation_____ Action _____ Maintenance _____
8. "I've stopped smoking and feel so much better. The patch makes a difference."
   Precontemplation _____ Contemplation _____
   Preparation _____ Action _____ Maintenance _____

Processes of Change

Once a counselor defines the stage for a client, he or she can use a variety of therapeutic strategies effective for that stage (Prochaska et al., 1994). Prochaska and DiClemente have identified 10 specific processes of change that are valuable methods of intervention.

A heathcare professional may engage a client at any of these stages. Clients may move into the next stage slowly, rapidly, or not at all, depending on the strength of their motivation and how they responded to therapy by a helping professional. They also may go back to a previous stage. However, recurrence should not be seen as failure but instead examined as a learning experience and opportunity to try new strategies.

MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) is defined by William Miller and Stephen Rollnick (2013, 12) as "a collaborative conversational style for strengthening a person's own motivation and commitment to change…..the overall style of MI is that of *guiding*." MI is based on Carl Rogers' client-centered therapy: It focuses on what the client is concerned about by listening to the thoughts and feelings about whatever issues he or she expresses. However, in contrast to nondirective Rogerian therapy, the approach is a directive in exploring, eliciting, and resolving a client's ambivalence about change. MI uses reflective listening skills and open-ended questions to help clients explore their natural ambivalence about change and to elicit change statements. The counselor works in collaboration with the client in examining change options and in supporting the client's self-efficacy in any efforts to change that the client chooses.

Although many specific techniques and counselor-specific behaviors and responses can be taught, Miller and Rollnick (2013) are clear that it is the "essential spirit" and posture of counselors that matters most in successfully using MI with clients. It is an approach to the client that deemphasizes labels, avoids confrontation, avoids arguing and trying to convince clients that they must do something, and it is a willingness of the counselor to suspend an authoritarian expert role. This "spirit" includes specific attitudes concerning clients that demonstrate respect, acceptance, and affirmation, promote empathy, and provide an openness and willingness to listen. The counselor tries to avoid labeling, confrontation, arguing, and trying to convince a client that he or she must do something. Motivation is intrinsic and elicited from the client; it is not imposed. This is summed up nicely by Miller and Rollnick (1991, 51–52):

> The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative. The motivational interviewer proceeds with a strong sense of purpose, clear strategies and skills for pursuing that purpose, and a sense of timing to intervene in particular ways at incisive moments.

Resistance is a common concern in assisting clients. Resistance comes in many forms, including interrupting the counselor; arguing, saying "yes… but"; refusing to consider that there is a problem; and ignoring, minimizing, or rationalizing the continuation of an unhealthy behavior. Sometimes, a client will be compliant in words but do not seem to follow through in action. There may be many reasons for such resistance, some of which include fear of change, failure to see a need to change, concerns about the ability to change, a sense of hopelessness, and concerns about how change would affect the person's life.

Approaching and Avoiding Treatment

A typical scenario is that the individual with SUD "cuts down" on drinking or drug use, as part of an attempt to "get his act together," or enters detox and is sober for a couple of days. In either event, this alleviates some of the worst of the physical symptoms, which weakens one of the motives to approach treatment. This minor relief, coupled

with anxiety, helps people with SUD decide to "do it myself." As one SUD counselor remarked, "The client seemed to hit bottom, but he bounced."

The encounter with treatment personnel and institutions may, in fact, engender a defensive reaction. Moreover, the removal of chemical anesthesia itself in early treatment takes away the capstone of the system of defenses, which produces anxiety. Thus, the first step in ending addiction creates conditions for recurrence. It is difficult to change and grow, and the process of dealing with SUD creates yet more discomfort. The counselor walks a fine line between the individual with SUD's ambivalence and the premature unearthing of deep-seated, painful, and traumatic memories or problems (Wallace, 1985a, 1985b).

Counselor Traps

In meeting the resistance that health counselors often see in helping clients to change behaviors, Miller and Rollnick (1991) point out "traps" that counselors need to avoid. The first of these is the "question/answer trap." Asking numerous questions puts the client in a passive role and does not allow the client to explore deeply the issues that concern him or her. The second is the "confrontation/denial" trap. Confrontation usually leads to defensive behavior that leads to more confrontation and a lot of arguing and a "yes . . . but" cycle of futile attempts to convince the client to change. The third trap is the "expert role." Providing direction and advice at a time when the client is not highly motivated usually is counterproductive. The fourth trap is the "labeling" trap. Calling a client an addict, alcoholic, overeater, or any other label usually adds a stigma to the client and often makes him or her feel less empowered to change. The fifth trap is the "premature focus trap." Here, the counselor is pushing the client to make decisions and take actions before she or he is ready, willing, or able to change. The sixth and final trap is the "blaming trap." Finding fault with others or blaming the client is not helpful in building a working relationship or exploring the nature of the client's problems and helping to resolve them.

Principles of Motivational Interviewing

The motivational interviewing (MI) approach is based on several basic principles (Miller & Rollnick, 2002, 2013).

1. **Express and express empathy.** This is a client-centered focus, which emphasizes active listening and reflection of the essence of the client's content and feelings in order to enhance the understanding of the client's experience by both the counselor and the client. It demonstrates respect for the client and develops rapport. Acceptance of the client does not mean agreement with the client, but it does validate the client's understanding and belief within her or his own framework. Through empathic responses, the client is more likely to open up and explore the situation in depth. Empathy builds a therapeutic relationship and creates a sense of collaboration that reveals the innermost feelings, elicits potential thoughts and ways to change, and allows clients to feel safe in making efforts to change.
2. **Develop discrepancy.** This is done through reflecting information the client is giving that begins to increase tension to change. The counselor helps the client to identify and amplify discrepancies between the client's present situation and desired goals or values. Discrepancies that the client is free to examine and take ownership of often lead to what Festinger (1957) called *cognitive dissonance*. The concept is that individuals will be motivated to change behavior or beliefs or attitudes when there is significant contradiction between a held belief, attitude, fact, or behavior and facts that cannot be ignored. As clients begin to explore their ambivalence and examine their values and beliefs, they create their own reasons for change as opposed to having them forced upon them by the counselor. An example is a father who believes that he should be a "family man" and "a good provider" and begins to realize

that his alcohol use is financially and emotionally going against these beliefs.

3. **Roll with resistance.** This is not in the 3rd edition of Miller and Rollnick but is a favorite for trainers. Resistance to change is seen as natural, and to argue against it is counterproductive. Counselors should allow the client to express resistance and not fight with the client to make him or her accept another viewpoint. They need to respond differently by siding with the resistance in order to defuse it and increase the client's sense that he or she is being understood. The key to reducing resistance "is convincing the patient that you share the same goals, namely to improve the client's health." This comes from reflecting the client's feelings, affirming the client's strengths, and acknowledging the client's concerns. A client forced to attend a driving–under-the-influence program might say, "I don't need to be here. No one can make me do anything." It would only increase resistance to say, "Listen, you were arrested for driving under the influence and you had better learn about how alcohol affects you and avoid drinking and driving." A more effective response would be, "You are right. Nobody can make you do anything. You're strong willed and independent. Because you have to be here, maybe we can work together to prevent this from happening again."
4. **Evoke hope and confidence.** A critical factor in supporting change is the client's belief that she or he can change (Bandura, 1997). The counselor not only needs to assess the importance of changing behavior for the client and gently elicit his or her desire to change but also must continually assess and help build the confidence of the client. A willingness to make changes in behavior without a sense of confidence is not sufficient for change to occur. The client may remain in a state of ambivalence, or even give up, without feeling capable of doing what is necessary to make changes.

   Many smokers are aware of the harm that smoking is doing to them and express a desire to stop smoking, but they often believe that they just cannot stop.

To evoke hope, confidence, and self-efficacy, the counselor needs to look for and promote change talk and sustain talk, and reinforce small steps to success. More on change talk on p. 84. For instance, an individual with SUD may never have tried to stop without medication, a support group, or counseling. Providing these alternatives often gives the extra boost of confidence that the client needs.

These four principles lead into specific MI strategies and techniques that are often expressed in acronyms. OARS skills provide a foundation for the strategies that follow. They require practice, and mastering them is not easy.

MI Core Skills: OARS

- **O**pen-ended questions. These lead toward more exploration of the client's situation and respect for the client's autonomy. An example is "How would you like your life to look five years from now?"
- **A**ffirmations. These are empowerment responses that increase the client's sense of self-efficacy. An example is "The fact that you keep trying shows me how strongly you're committed to beating your addiction."
- **R**eflective listening. This is similar to paraphrasing and reflection of feeling. Reflective listening helps clients to verbalize their understanding of their experience and allows them to hear what they are saying. It helps to reduce resistance and avoid arguments with the client. Reflection can be at different levels:

  Simple reflection: Rephrasing the essence of the client's content and/or feelings in the counselor's own words

  Client: "I don't plan to quit drinking any time soon."

COUNSELOR: "You don't think abstinence would work for you right now."

Amplified reflection: Exaggeration without sarcasm, which sometimes allows the client to see the implications of their statements.

CLIENT: "I don't know why my wife is worried about this. I don't drink any more than my friends."

COUNSELOR: "So your wife is worrying needlessly."

Double-sided reflection: Highlights the ambiguity of the client's statement(s)

CLIENT: "I can't see giving up drinking now, even though the wife complains and the drunk driving fine was pretty costly."

COUNSELOR: "You're not willing to give up drinking, but you see some problems as a result of when you did drink."

- **S**ummarizing. This response ties together the main thoughts, feelings, and experiences the client has expressed in order to link or transition. "So far, we've discussed that you're not seeing a big problem with drinking at this point. You mentioned that there have been times when you and your wife were arguing over money you spent at the bar and the cost of your DWI. You like going out to the bar with your friends but you know your wife doesn't like it. Does that pretty much cover it?"

ACTIVITY 4.2 Feedback as affirmations

Choose a partner who you do not know or someone you know the least about. Face each other and choose who will go first for this exercise.

Student #1 will introduce him- or herself and share three characteristics. What are his or her best strengths and assets? Student #2 will provide positive feedback and affirmations using OARS skills. When finished, each will reverse roles and repeat the exercise.

PROCESS: Discuss how it felt to receive affirmations. Ask yourself whether the affirmations increased a sense of self-efficacy.

MERGING MOTIVATIONAL INTERVIEWING AND STAGES OF CHANGE

PRECONTEMPLATION

There is a natural blending of motivational techniques and stages of change. As noted by DiClemente and Velasquez (in Miller & Rollnick, 2002, 202), "moving through the stages of change requires effort and energy for thinking, planning, and doing. Motivational interviewing can be used to assist individuals to accomplish the various tasks required to transition from the precontemplation stage through the maintenance stage." Specific techniques are useful at each stage of change; however, many of these techniques are useful throughout the change process.

Techniques are often best done when they appear most appropriate in the process of change and in the context of a client-centered dialogue. It is important to ask the client permission to engage in a technique: "Do you mind if I ask you the following question or would you be willing to fill out the following form?"

Importance, Confidence, and Readiness Rulers

The stages of change model has been incorporated into the assessment process in SUD treatment. All innovations take decades to get into practice, and it is not possible to determine the number of agencies who have actually taken up this valuable assessment dimension. Generally, one would wish to use a decisional balance sheet to assess the ambivalence about change in a particular area or areas. Following that, one of the "rulers" would help determine if change is ready and able to occur. Several useful tools to gauge readiness for change are available as appendices to the Treatment Improvement Protocol (TIP) 35 (CSAT 1999, DHHS 1999).

The importance, confidence, and readiness rulers are simple measures of the clients' readiness

to change in particular areas. They measure clients' views of what needs to change, how they view their ability to change, and their overall estimation of their readiness to change, that is, their place on the stages of change. These rulers can be important components of assessment and of the treatment planning process. This can be done verbally or by using a form like the one shown here.

Importance Ruler
How important is it for you to change right now on a scale of 0 to10? Zero (0) would be not at all important and ten (10) would be extremely important.
0__1__2__3__4__5__6__7__8__9__10__
Because importance and confidence are two different issues and both have to be necessarily elicited from the client, you can follow up with the confidence ruler.

Confidence Ruler
How confident are you that you will change right now, on a scale of 0 to10? Zero (0) would be not at all confident and ten (10) would be extremely confident.
0__1__2__3__4__5__6__7__8__9__10__

Readiness Ruler
How ready are you to initiate change, on a scale of 0 to 10. Zero would be not at all ready and ten (10) would be totally ready.
0__1__2__3__4__5__6__7__8__9__10__

Remember the scores will vary according to each issue. For example, a person may be think it's important to change the use of crack cocaine, but not to stop drinking.

The importance ruler is a nonjudgmental way of assigning the client's stage of change. The higher the number marked, the more likely that the client is in a contemplation or even preparation stage. More importantly, it opens up dialogue concerning how the client feels about his or her health issues, fears, expectations, and/or interest about changing/not changing, and assesses the value he or she places on changing. What is most important is not where the client marks an X but the follow-up questions, such as, "Why a 3 and not a lower number?" or, "What would need to happen for you to go from a 5 to a 6?" The ruler helps elicit the client's thinking (contemplation) about change.

The confidence ruler helps clients to examine concerns and issues around the confidence and self-efficacy issues of making a change. A follow-up question to the confidence ruler is "What would help raise your confidence from a 4 to a 6?" or, "Why did you mark a 3 and not a 2?"

There are many creative ways to use the importance and confidence rulers. It may be useful to use both because sometimes it is difficult to know whether a client resists change because it is not important or because of a belief that he or she is unable to change.

ACTIVITY 4.3 The importance ruler

Think about something in your life that you are considering changing or working on. It could be going on a diet or exercising, organizing your room better, getting a job, or finding new ways to cope with a difficult roommate or significant other. Find a partner and sit together.

After completing Worksheet 4.1 (available at http://health.jbpub.com/book/addictions/4e), each person will exchange worksheets with her or his partner. With one person taking the role of "counselor" and the other "client," the counselor will ask some of the questions stated under the appropriate marking, listen to the client's response, and then follow up with other OARS-type responses. Not all of the questions listed need to be asked. After a period of time, reverse roles and repeat the process.

Process: Think about how you felt in the different roles. What responses did your partner make that seemed to help clarify or find solutions to his or her issues? Which questions were most relevant and effective?

ACTIVITY 4.4 The confidence ruler

Think about an issue in your life that you are considering changing or working on. It could be going back to school to earn an additional degree, taking up a musical instrument, or getting out of a long-term but unhealthy relationship. Anything you are willing to share. Find a partner. Face each other and choose who will role play as "counselor" and who will be the "client." Complete the importance ruler Worksheet 4.5 (available at http://health.jbpub.com/book/addictions/4e).

After completing the Worksheet 4.2 (available at http://health.jbpub.com/book/addictions/4e), exchange your worksheet with your partner's worksheet. The "counselor" will ask some of the questions stated under the appropriate heading and then follow up with other OARS-type responses. You do not need to ask all of the questions listed. Switch roles.

PROCESS: How did you feel in your role as counselor? In your role as client? What responses did your partner offer that helped you to examine your issue? Which questions were most relevant and effective?

Another version of the readiness ruler marks four spots on this continuum, corresponding to the stages of change, as follows: "not at all ready, thinking about changing, preparing to change, actively working on or maintaining a change" (Velasquez, Maurer, Crouch, & DiClemente, 2001, 30).

Stage of (readiness to) change should be noted in the client chart during the initial assessment and followed up frequently during treatment. Velasquez et al. (2001, 31) point out that a client may be in different stages of change for different substances. A dramatic example is the methadone client who is actively working on discarding a heroin use disorder yet wants and continues to drink alcohol heavily, take benzodiazepines (Valium and similar drugs), and smoke marijuana. An interesting video on the readiness ruler is available at http://www.youtube.com/watch?v=j9nHS4dyhKk.

Engaging the Precontemplative Client

In the precontemplation stage, it is valuable to begin with what led the client to see the counselor. The counselor must be empathetic with the client's reasons, whether she or he came willingly or was pressured by external motivation (e.g., to please the spouse or doctor, comply with a judge or boss, and so on). If there are specific medical or psychological tests, the results must be conveyed to the client in a nonjudgmental, matter-of-fact way without labeling or diagnosing. The client must then be asked how he or she feels about the results.

To raise consciousness in the precontemplation stage, it can be helpful to ask, "What is a typical day like for you?" Sometimes, the results of many health behaviors need to be examined over a span of time. For instance, chronic abuse of alcohol, drugs, or tobacco will cause changes in lifestyle and personal conditions that can be brought to light by asking questions like, "What were things like for you 5 years ago?" Looking ahead can also stimulate concern: "How do you imagine things will be for you 5 years from now?" Querying about extremes can be consciousness raising:

"What is the worst thing that could happen if you quit smoking? or "What is the best thing that could happen if you stop smoking?" (Miller & Rollnick, 2002).

It is often useful to examine a client's investment in his behavior. It is important to make known that all behavior serves some purpose. This can be done simply by asking, "What are the good things or benefits about (drug use; drinking; smoking, and so on)?" The counselor will probably find the client reluctant

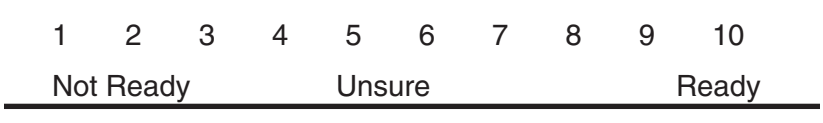

FIGURE 4.2 Readiness ruler.

to talk about the good things or benefits of what he is doing because of an assumption that only the negative "should" be discussed. A client's response might be "Well, there can't be any good things. That's why I'm here." Then the counselor should press on and say something to the effect of: "You've invested a lot of time and money into doing this, so it must have some benefits." After the client has elicited the benefits, the counselor can ask, "What are the not-so-good things or negative consequences about (smoking, eating fried foods, drinking, and so on)?"

A major benefit of these questions is that they do not push the client to change but allow the client to explore personal concerns. This builds rapport and allows the client to take responsibility for his or her own decision making.

The Decisional Balance

A very useful technique that enables clients to examine their ambivalence is called the *Decisional Balance*. This is a matrix that asks the client to describe the pros and cons of changing and not changing. The balance sheet, which was used early in the treatment encounter, provides important assessment data for continuing treatment planning. Perhaps most importantly, it provides tips for proactive relapse prevention. For example, the client lists as a benefit of drinking alcohol that it "makes me feel better after I've been fighting with my wife."

1. *Pros (or benefits) of not changing*
   What do you like about (drinking, drug use, smoking, and so on)?
2. *Cons (or consequences) of changing*
   What concerns do you have about (drinking, drug use, smoking, and so on)?
3. *Cons (or benefits) of changing*
   What concerns do you have if you tried to stop (drinking, drug use, smoking, and so on)?
4. *Pros (or benefits) of not changing*
   What benefits do you see in not quitting or reducing (drinking, drug use, smoking, and so on)?

An Example of a Decisional Balance

This is an example of what a decision matrix for cocaine would look like:

1. *Pros of continuing cocaine* It relieves my stress. I have more fun. I like to party. It makes me feel in control. It makes me feel more powerful.
2. *Pros of quitting cocaine* It would save me money. My family will approve of me. I might feel less depressed when I don't have it. I won't have to worry about getting arrested.
3. *Cons of continuing cocaine* My nose will burn out. It continues to be an expensive habit. I might get arrested. My wife might leave me.
4. *Cons of quitting cocaine* How else will I deal with stress? Will I be able to get the energy I need? I might lose some good partying friends. I might feel depressed.

Quadrant 1 and 2 focus on the client's concerns related to changing. Here, the client weighs the benefits vs the cost of continuing the behavior. Quadrants 3 and 4 focus on the client's concerns about continuing the status quo. All four quadrants are important to explore. Clients continue substance abuse behaviors not only because they see more benefits or fail to see consequences but also because they are concerned with what will happen if they can no longer continue the behavior. The behavior provides some benefit and often acts as a coping mechanism. This is particularly true with smoking, drinking, drug abuse, and overeating.

If these unhealthy ways of coping (e.g., smoking, drinking, or drug use to deal with stress) are not addressed, a situation or trigger (a stressful event) can easily create relapse recurrence. Learning new ways to

cope (e.g., stress management techniques) becomes an important action and maintenance stage strategy.

Miller and Rollnick (2013) are clear that individuals are not always conscious of their ambiguity, nor do they necessarily contemplate the weight they give to pros and cons. It is the unforced, nonjudgmental, open process of looking at the pros and cons of changing and not changing that can facilitate the awareness and potential eliciting of change statements. Miller and Rollnick (2013, 157–166) differentiate *preparatory change talk,* including desires, such as "I want to lose some weight," developing reasons such as, "*it would help me control my diabetes,"* and, *change talk* proper such as, "I am ready to….." and, "this week I didn't snack at night."

ACTIVITY 4.5 Decisional balance

Pair off with a fellow student and complete the decision balance matrix, using a personal issue that you are changing or have recently changed. In turn, each person will ask questions to the other, using each quadrant of the matrix.

PROCESS: Examine your feelings when talking about your issue from each quadrant. What responses seemed to help when discussing your partner's issues? What insights did you gain from doing this exercise?

LISTENING FOR "CHANGE TALK"

Using motivational interviewing styles and appropriate stage-based strategies, counselors need to listen for and respond to their clients' talk about personal change. Hearing clients begin to consider changing their unhealthy behaviors or establishing healthy ones is necessary when assessing readiness to change and supporting change efforts. These statements can be in various forms as described by the acronym DARN-C:

Desire: A client describes how she wants to change.

COUNSELOR: "What might you want to do to resolve your concern about your diabetes?"
CLIENT: "I want to start eating right."

Ability: A client describes specific ways to change and displays confidence in his ability to change.

COUNSELOR: "What gives you the confidence to stop drinking?"
CLIENT: "I think if I use ViVitrol with counseling, I can do it this time."

Reason: A client provides an explanation for why she needs to change.

COUNSELOR: "Why would you want to take your medications now?"
CLIENT: "Because now I know that I have to wait for the antidepressant to work."

Need: A client projects a need to change in order to achieve something or avoid an unwanted outcome.

COUNSELOR: "What makes you want to stop drinking?"
CLIENT: "I need to live long enough to enjoy my grandchildren."

Commitment: A client demonstrates a dedication to making necessary changes.

COUNSELOR: "So what are you willing to do now?"
CLIENT: "I will go to more AA meetings a week."

PREPARATION STAGE STRATEGIES

Once clients have begun to express that they have the desire and confidence to change, their counselor can support a transition to the preparation stage. This is *not* done only by focusing on the healthy side of change. If the counselor only seems to support the positive side of change, there is a natural inclination for the client to think of the negative side. Instead, the counselor should allow the client to develop his

or her own argument for change by reflecting the client's ambivalence.

As the client begins to consider changing, it is helpful to elaborate on what steps or goals the client is considering. Open questions that encourage the client to elaborate on what specific steps to take toward change will help focus the client on how he or she might accomplish each step and confront any barriers that he or she might encounter. The counselor could simply ask for a specific example: "Can you give me an example of what you will say to your friends when they ask you to go out drinking?" Or, he or she might ask for clarification: "Which medication would you use?" "What type of program are you considering?" or "What else are you considering doing to stop drinking?"

A client who is considering the steps to changing may have concerns about the confidence to actually make the change. Providing affirmations about the strengths the counselor sees in the client can be helpful.

> **Client:** "I've had a hard time trying to stop drinking in the past. I don't know if I can do it now."
>
> **Counselor:** "You've kept trying and working hard. You seem determined to do it and express a real desire to be healthy. You are willing to attend more AA meetings."

The transition from contemplation to preparation involves helping the client to develop a change plan. It is important for clients to have a plan that is self-developed rather than for the counselor to impose a plan on the client. Counselors can provide advice if it is solicited from the client or if the counselor has information the client is not aware of or has not considered. A counselor might say, "Sometimes, it has been helpful for others who are trying to do (whatever the change might be) to (whatever suggestion the counselor may have); however, the decision is yours." It is important to clearly indicate to clients that the responsibility for change is theirs. It is also helpful and appears to improve commitment, if a client's behavioral change is a choice from several options. Again, the choice is the client's to make. So, if the counselor, with the client, can develop a menu of choices, the client feels more commitment to having made the choice; the client also knows what might be best for him or her to undertake. "We've discussed various ways that you could support your efforts to quit drinking, including various medications, continued individual counseling to discuss how you might handle triggers, getting a recovery coach or mentor, and joining a support group. What do you think might work best for you?"

CREATING A CHANGE PLAN

A "change plan" can be a simple worksheet

Change Plan Worksheet

The most important reasons why I want to make this change are:

_____

My main goals for myself making this change are:

_____

I plan these specific things in order to accomplish my goals …

Specific action	When?
_____	_____
_____	_____
_____	_____

These people can help me with change in these ways:

Name of person	Possible ways to help
_____	_____
_____	_____
_____	_____

These are some possible obstacles to change and how I might handle them:

Possible obstacles to change	How to respond
_____	_____
_____	_____
_____	_____

I will know my plan is working when I see these results:

_____

_____

_____

ACTION AND MAINTENANCE STAGE STRATEGIES

The action stage occurs when clients begin to implement a plan. They are actively engaging in new behaviors or quitting old behaviors. They consciously change behaviors, such as getting rid of cigarettes or removing all alcoholic beverages from their living space, or they develop a new regimen of attending group meetings, taking medications as prescribed, checking in with a sponsor, getting more rest, eating better, and actively learning new skills, like assertiveness or anger management, and so on.

In both the action and maintenance stages, vigilance is necessary. A return to old behaviors can and often does occur. Clients will miss old behaviors. Ambivalence about change still exists. Counselors need to be supportive of change and help clients work through concerns, barriers, and recurrences.

Clients often see relapse as a weakness or failure, or they view themselves as incapable of changing. They may feel frustrated and confused and may want to give up. It is helpful for the client to view relapse as a learning experience, a natural part of the recovery and change process, and an opportunity to re-establish a new plan that may incorporate additional methods. Clients often benefit from group therapy or self-help support groups.

Throughout all of the stages of change, it is important for the counselor to continue the "spirit of motivational interviewing." This would include being empathetic, listening carefully, using open-ended and evocative questions, respecting the client's autonomy and abilities, supporting self-efficacy, and being collaborative with the client by drawing out his or her concerns, desires, and viewpoints (Manuel & Moyers, n.d.).

SHORTCOMINGS OF MOTIVATIONAL INTERVIEWING

Motivational interviewing is an effective rational approach to evaluating motives, attitudes, and behaviors. A shortcoming of this approach, acknowledged by Miller and Rollnick (1991, 24), is that many of the forces driving addictive behavior are not enumerated easily by rational reflection or introspection. These include community and peer influences, enabling behaviors and sociocultural factors, as well as short-term forces, such as psychological discomforts of hangover or withdrawal, which "fall off the chart." Also, one cannot simply measure pain, grief, love, and other emotional associations against motives, habits, consequences, or memories. If a person is emotionally devastated by, say, the loss of a child or spouse, decisional balance sheets or readiness rulers are not what he or she would need. This does not diminish the successes of MI in eliciting change, even in the most recalcitrant clients.

SUMMARY

Helping clients with SUD begins with their making lifestyle changes. Change for individuals is a process comprising a series of stages. These stages are the precontemplation stage (not considering change or seeing a need to change), contemplation stage (feeling ambivalent about change), preparation stage (planning to change), action stage (actually making changes by implementing plans to change), and maintenance stage (reinforcing efforts and continuing with the change). Assessing the point at which a client is on the continuum of his or her process of change is important. Different counselor responses and interventions have been found to

be more effective than others, depending on the client's progress in the process of change.

Behavioral change, necessary to improve an individual's health, is dependent on motivation. Motivation is the engine that moves clients through the stages of change. Motivation to change depends on an individual's sense of the importance, confidence, and readiness to change. Motivation also requires that individuals work through their ambivalence concerning changing. Motivational interviewing (MI) is an evidence-based strategy that involves both a counselor style and various techniques to assist clients through the change process.

Some of the most important elements of MI can be summed up in the acronym *FRAMES* (Rollnick & Miller, 1995):

- **F**eedback. Nonjudgmental assessment of relevant client information delivered in a nonthreatening, matter-of-fact manner is essential.
- **R**esponsibility. Change is the client's responsibility. The decisions and the choices the client makes are always his or hers.
- **A**dvice. The counselor provides information and suggestions that the client may choose to use or not use.
- **M**enu. Developing options on change from which the client can choose gives the client ownership of each choice.
- **E**mpathy. Use a counseling style that accurately reflects the feelings, thoughts, and experiences of the client from his or her frame of reference.
- **S**elf-efficacy. Promote and affirm the client's self-confidence concerning the changes he or she is endeavoring to make.

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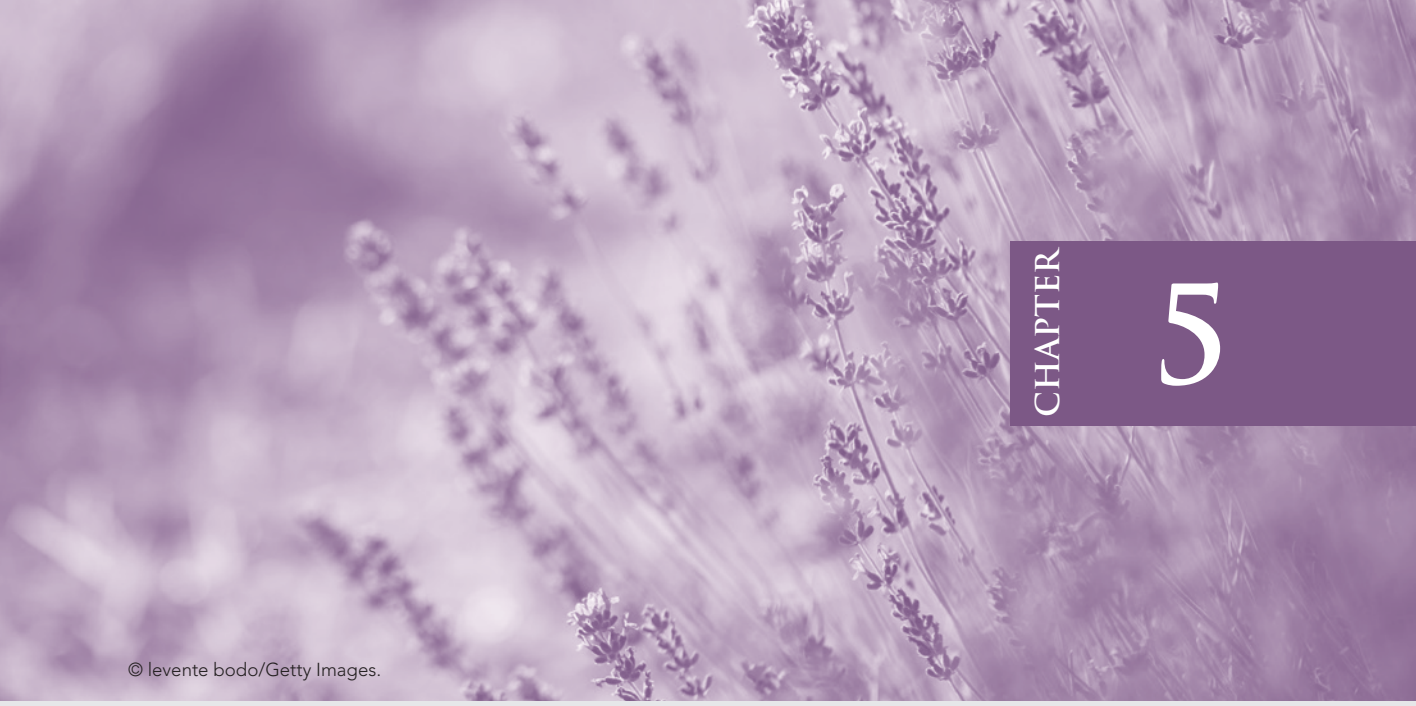
ANSWER KEYS

ACTIVITY 4.1 ANSWERS

1. precontemplation
2. Preparation
3. Contemplation
4. Contemplation
5. Precontemplation
6. Precontemplation
7. Contemplation
8. Action

ACTIVITY 4.2 ANSWERS

1. I
2. D
3. B
4. C
5. A
6. E
7. F
8. G
9. H
10. J



CHAPTER 5

SUSTAINING RECOVERY

OBJECTIVES

By the end of this chapter, students will be able to:

1. Describe the new recovery paradigms and how they differ from older approaches to substance use disorder (SUD) treatment and recovery.
2. Describe four elements of lasting behavioral change.
3. Identify categories of erroneous automatic thoughts that clients often generate in response to certain situations, as they apply to facilitating and sustaining recovery.
4. Describe tasks in managing emotional states in order to facilitate and sustain recovery from SUD.
5. Describe cognitive behavioral therapy (CBT) core concepts.
6. Describe Marlatt and Donovan's (1995) model of relapse.
7. Describe at least two methods to help clients reduce stress.
8. Outline the main concepts of mindfulness-based relapse prevention.
9. Describe the interaction of trauma and SUD.

OVERVIEW OF RECOVERY CONCEPTS

Distinguishing Recovery from Treatment

Recovery is an ongoing process by which individuals suffering from substance abuse, gambling, or other compulsive behavior disorders achieve sobriety, get their lives under control, and move in the direction of health and wellness. Abstaining from alcohol, drugs, gambling, or other unwanted behaviors is necessary but not sufficient for a full recovery. Recovery also implies attaining healthy emotional, behavioral, and cognitive states, healthy relationships, and positive social involvements.

Recovery often, but not always, involves episodes of professional treatment and/or involvement in mutual-aid groups. People in recovery often keep this as a major component of their identity for decades or on a lifelong basis (what sociologists call their *master status*), while others move on from that stance and define themselves more in terms of other involvements.

NEW RECOVERY PARADIGMS

Over the past decade, new recovery paradigms have emerged in the treatment field that we summarize here. Programs that emphasize these new paradigms are called *recovery oriented systems of care (ROSC)*, and, as a cultural shift, they are referred to as a "new recovery movement," largely led by William L. White (2000a, 2000b).

The new paradigms of recovery in the 21st century are as follows:

1. Strengths and resiliencies within people with SUD and how we can build upon and strengthen them. These approaches were developed in social work and counseling psychology decades before they were imported into SUD counseling. According to this view, even in the depths of the disorder, part of the individual with SUD yearns to get better. The power and potential to get better lie within all of us. This approach reverses the view of substance-abusing people as "sick," de-emphasizes pathologizing and labeling of clients, and radically changes the view of recovery as driven by external, coercive professional authorities. It also ends the taboo on discussing or recognizing "natural recovery" without treatment, but stresses harnessing and facilitating natural recovery motives and powers within us as the essence of treatment.

   ROSC emphasizes the development of a personal recovery plan in addition to an externally directed treatment plan (Loveland & Boyle, 2005).
2. ROSC seeks to build "recovery capital"—the quantity and quality of both internal and external resources that a person can bring to bear on the initiation and maintenance of recovery (White, 2009; White & Cloud, 2008; Cloud & Granfield, 2009 Szalavitz, 2017).
3. ROSC recognizes the need for long-term recovery support through low-impact case management (recovery management) via peer-to-peer "recovery mentor" or "recovery coach" services. This is a long-overdue implementation of recognizing SUD as a chronic, recurring disease rather than as an acute episode (White, 2005). Treating severe SUD as an acute care disorder creates a cycle of treatment and a crisis-oriented treatment approach that is inappropriate to the realities of SUD. In fact, providing long-term support is more important than the barrage of services one may offer during a short stay in treatment. Some SUD professionals fear that nonprofessional or minimally credentialed recovery coaches will replace them as treatment funds diminish at the federal and state levels. It is important to understand the differences between the role of a sponsor in

a recovery fellowship and the role of a recovery mentor. An essay on this distinction is in White (2006, 2007).

4. A new, proud recovery community celebrates and advocates for recovery through such groups as Faces and Voices of Recovery, which plays a big role in reducing stigma associated with alcohol and drug disorders (http://www.facesandvoicesofrecovery.org).

Recovery community organizations (RCO) are flourishing nationally. RCOs are led by people in recovery, families affected by SUD, and allies in the community. Many RCOs belong to ARCO, the Association of Recovery Community Organizations. They provide recovery support, information and education, and help individuals develop pathways to recovery. Another national group is Young People In Recovery.

CASE IN POINT

Young People in Recovery Collaborating

An RCO in Chatham, NY (upstate), has two members of Young People in Recovery on its Board of Directors, and a leader of the African-American church. This RCO, Columbia Pathways to Recovery (CPR), works closely with the local police department, which is affiliated with the (PAARI) Police Assisted Addiction and Recovery Initiative, or Gloucester Initiative, and staffs a helpline that provides intake to the police initiative prior to handing over the caller to an officer for transport to treatment with a civilian volunteer known as an "angel." With the advent of the opioid epidemic, both the police and the helpline are overwhelmed with people asking for help and who are reaching out to political and private entities for more resources.

There has been a cultural shift over the last few decades whereas a larger proportion of people, even those in Alcoholics Anonymous (AA), now openly disclose their personal recovery status (Colman, 2011).

A wide variety of monographs and resources pertaining to the new recovery paradigm and recovery movement is available at http://www.facesandvoicesofrecovery.org/resources/publications_white.php.

Aside from Faces and Voices of Recovery, 2010 to 2011 saw the founding of a group of treatment professionals working with alumni groups that provide extended recovery support (Treatment Professionals in Alumni Services; TPAS) and an organization (National Association of Recovery Residences; NARR) working to certify sober living facilities.

Introducing the Dimensions of Recovery

The *whole person recovery* approach involves changes in many interconnected realms of human functioning. Important dimensions of recovery, which we will describe in greater detail in the second section of this chapter, include emotions (sometimes called *affects* by clinicians) and behavior.

- *Cognition* (thinking, problem solving, processing of information), interpersonal functioning, skills, relationships, reduction of isolation
- Physiological improvements: Improvement in cerebral function, nutrition, substance-related illness, exercise, moving from a culture of substance abuse to one of sobriety and wellness. This may incorporate spiritual awakening, development, and affiliation with sober networks, or what Granfield and Cloud (1999) call *cultural capital*, the local availability of culturally prescribed pathways to recovery, such as AA in a language other than English or indigenous healing methods, such as the Red Road (Coyhis & White, 2006, White Bison, 2002).
- Improvement in the social and economic aspects of *recovery capital*: Stable employment; housing; a support network, including family, peers, and colleagues; educational attainment or returning to school. A few state programs, such as the one in

Connecticut, have even paid for textbooks so that a recovering individual can obtain an educational and career position successfully.

The Substance Abuse and Mental Health Administration had presented 10 pillars of mental health recovery in 2006 (SAMHSA, 2006) but then unified the definitions of mental health and substance abuse recovery in 2011 (SAMHSA, 2011). The overarching definition is that "Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential."

The SAMHSA principles of recovery are identified as being:

- Person-driven
- Occurring via many pathways
- Holistic
- Supported by peers
- Supported through relationships
- Culturally based and influenced
- Supported by addressing trauma
- Involves individual, family, and community strengths and responsibility
- Based on respect
- Emerges from hope

Furthermore, they identify domains that support recovery as follows:

- *Health*: Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way
- *Home*: A stable and safe place to live that supports recovery
- *Purpose*: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- *Community*: Relationships and social networks that provide support, friendship, love, and hope

The following sections describe methods and issues in the quartet of emotion, behavior, thought (cognition), and interpersonal skills.

Emotion (Affect) Management

When someone has lived for some time, perhaps during crucial developmental years, under the influence of an emotional anesthetic, he or she often suffers from *emotional illiteracy*. This term refers to the fact that many people are simply naïve about feelings—they have neither the tools nor the habit of "reading" their emotional states; no words to describe them; and little practice in describing or communicating them. It is better to describe this as a deficit of learnable skills rather than a pathology. However, some people are also terrified or anxious about their feelings; they feel guilty for having feelings that they believe are wrong or dangerous. Some tasks of counseling in the realm of emotion are to help the client:

- Identify emotions
- Differentiate emotions from thoughts and actions
- Accept emotions, be nonjudgmental and compassionate to self
- Communicate emotions appropriately

Becoming emotionally literate offers relief from the following:

- Having to spend sizable energy fighting emotions
- Fearing buried or misunderstood emotions
- Getting stuck in cycles of self-stimulating anxiety
- Getting flustered by the experience of emotion
- Fearing the outcomes of having emotion
- Having panic or "self-hate" attacks when "forbidden" emotions occur

It also is important to help clients identify feeling states just prior to the use of alcohol or other drugs. People often confabulate or distort how they were feeling prior to or during use, so-called *euphoric recall*. Keeping a log of feelings and substance use can uncover the fact that the individual was angry, lonely, bored, or anxious before using. This technique is often associated with adolescent treatment, where substance use is defined as a "fun" activity.

Clients should learn that emotions are not catastrophes: "If you can think about it and talk about it, you don't have to drink about it." Cummings, Gordon, and Marlatt (1980) reported that three-quarters of alcohol use relapses involved either "unpleasant" emotions, interpersonal conflict (which arouses uncomfortable emotional states), and/or social pressure. Affect management addresses at least two of these high-risk situations. Much of this work takes place in group settings. Loss and grief are also major issues that emerge in recovery, from the loss of alcohol itself and all that it entails (e.g., friends, places to go, some activities, emotional numbness) to the losses sustained while actively with SUD (e.g., marriage, job, self-respect; Goldberg, 1985). AA tells the newly recovering person not to get too hungry, angry, lonely, or tired (HALT); in other words, he or she must remain aware of relapse-triggering affects and physical states. Other individuals are numb to feelings due to a schizoid or antisocial personality disorder, and so it is important for the counselor to obtain a medical history before attempting to put emotional objectives into a treatment plan. Appropriate consultation with medical professionals should not be neglected if there is a suggestion that a psychiatric or neuropsychiatric issue is involved.

For some clients, a specialized anger management plan is necessary, or anger management sessions can be built right into a schedule of group sessions. A cognitive behavioral therapy manual is available online (SAMHSA, 2002). While we are concerned with out-of-control anger and anger that triggers relapse, there also is the opposite tendency of being terrified of negativity because, in individuals with SUD, these emotions are acted out in a destructive manner and are thus labeled as "bad."

Behavioral Change

Behavior associated with SUD is often defeated, self-defeating, and disorganized. Research shows that the outcome of treatment often depends on an increased sense of *self-efficacy* (Bandura, 1997), a sense that what one does will make a difference. Meaningful recovery necessitates learning modes of behavior that help meet personal needs, or in popular terms, *self-empowerment*. In the self-efficacy theory of Bandura (1987), clients change negative thinking by learning behaviors, performance, and coping responses via "homework" assignments.

When persons with SUDs are using drugs and alcohol, they begin to develop unconscious associations with the experiences and situations (the people, the places, the things) in which they routinely used their drug of choice. Re-experiencing these situations becomes a subliminal stimulus (sometimes referred to as an environmental *cue* or *trigger*), which then creates the cravings, the compulsions, and the desire to use. This is why in AA and Narcotics Anonymous (NA), it is often stated that it is best to avoid "people, places, and things" associated with the individual's alcohol and/or drug use. An example is smoking while drinking morning coffee. When someone is attempting to stop smoking and they have their morning coffee, often, the craving to smoke will be strongest. Specific associations need to be identified and avoided, or the client needs to find coping mechanisms when they arise.

Contingency management (*CM*) is a system of reinforcing client behaviors, such as abstinence from drugs or alcohol (as monitored by blood or urine samples) or attendance at sessions at the facility. The use of blatant rewards for behaving well is, of course, the subject of much controversy. One of the major forms of contingency management is a voucher system, voucher based reinforcement therapy, whereby the clients collect tokens or vouchers that add up to an amount of money, a trip, a gift, or another reward. Despite recovering counselors being wary of contingency management, two major meta-analyses (Prendergast, Podus, Finnery, Greenwell, & Roll, 2006; Lussier, Heil, Mongeon, Badger, & Higgins, 2006) show that it can have a positive result, especially in early recovery, where there is not much investment in change, and in people with low social capital to begin with. Despite the

efficacy of CM, about one-third of counselors are not aware of it (Bride, Abraham, & Roman, 2010).

Changing Ways of Thinking (Cognition)

Beliefs, attitudes, thoughts, categories, and self-statements act as lenses through which to view and interpret the world. Cognition plays a large role in emotional responses by determining reactions to stimuli and providing labels for psychological states. According to rational–emotive–behavioral therapy, people with SUD indulge in negative thinking that includes many irrational beliefs and negative self-statements; this negative thinking can preclude positive action, force people to drive themselves unmercifully, and lead to chemical use.

1. *Demandingness* results from unfounded assumptions about requirements, usually expressed in terms of "should," "must," "ought to," "have to," and "need to." Typical statements are "I can't tolerate anxiety" and "I must drink to get through the day."
2. *Awfulizing* or *catastrophizing* is magnifying or exaggerating the badness of an event, "making a mountain out of a molehill." Catastrophizing, panicky thinking styles, and cognition that follows, what some professionals refer to as a *negative extrapolatory expectation pathway*, are found among a large subset of people with SUD. Catastrophizing or awfulizing can be a self-stimulating thinking cycle that creates paralyzing anxiety and easily contributes to relapse.
3. *Low frustration tolerance*, according to rational–emotive–behavioral therapy, is not a neurologically based behavior, such as in attention-deficit hyperactivity disorder (ADHD), nor is it a personality dynamic. It is an irrational belief that a person cannot tolerate discomfort, frustration, or other unpleasant feelings, and thus must drink or take drugs to cope or become numb.
4. *Overgeneralizing* is making broad conclusions from limited information. Persons who overgeneralize use words like "never," "always," "everybody," or "nobody." This often applies to the future: "I will always be alone." "I will always fail." Overgeneralization also can apply to the past and present: "He always hated me." "Good things never happen to me." "She never once said a decent thing." "I screw up everything." "Everyone I ever knew believed in cheating on taxes."
5. *Dichotomous thinking or polarized thinking* is an all or nothing, black or white, statement. "I have to be perfect or I'm a failure." "I had a slip. I've completely blown it. I'm weak."
6. *Mind reading or projection* is believing one knows what others are thinking about oneself. "They're talking about how fat I am." "She's awfully quiet; she must be mad at me."
7. *Emotional reasoning and magnifying* comprises reasoning from feeling and not the reality of the situation. "Because I'm anxious, the situation must be dangerous." "I feel down today; nothing is going to work out for me." Also, there is exaggeration out of proportion based on emotions. "I couldn't go for that job interview without having a few drinks; it's impossible!"
8. *Personalization* is taking responsibility for things that are not one's fault or making comparisons that are not reasonable to make. "She passed right by me on the street and said nothing. She must be very upset with me," or "He can stop smoking because he doesn't have the stress I have."
9. *Should statements*—"shoulda, coulda, wouldas"—are ways people continually feel regret and obsess over what might have been. "Shoulds" can be rigid rules about how one must behave or how others must act toward one. "I should never have started smoking." "She could have been a better mother." "I should be witty and more interesting."
10. *Selective abstractions or filtering* is seeing only a portion of personal experience to justify a belief or belief system. This involves ignoring or filtering out any information that

> does not support one's negative interpretation of a situation. "It's not important that I stayed sober for three weeks; the fact is I drank last night" (Freedman & Reinecke, 1995, 192).

According to Marlatt and Gordon (1985), decisions about when and how much people drink are shaped by the expected outcomes of their behavior. One type of expectation is *alcohol-efficacy expectation*, which holds that people are more likely to drink if they feel a lack of power (self-efficacy). In such a situation, they attribute power to alcohol (alcohol efficacy) and believe it can help them get their desired outcomes (e.g., making friends, being relaxed at parties, calmly delivering a speech, enjoying a vacation).

Although there are apparent divergences between 12-step and professional approaches, there are actually examples where the 12-step approach and cognitive psychology have *parallel* approaches to the kind of thinking that precedes initial recurrence. Cognitive psychology (Beck et al., 1993) describes anticipatory beliefs that are triggered by internal states (boredom, sadness) or external stimuli (a bar, holidays). They include self-statements like, "I can't have fun without pot" and "I won't be able to make it through the day without a drink." This, in turn, triggers substance craving, which triggers a permission-giving belief (stinking thinking), such as "One drink won't hurt," "I'll stop after one drink this time," and "I deserve it this one time."

ACTIVITY 5.1 Identifying thinking distortions or patterns

Complete **Worksheet 5.1** *(available at http://health.jbpub.com/book/addictions/4e), identifying the specific type of thinking distortion for each statement.*

Volunteer to answer each statement during class. Could the labels for various types of distorted or faulty thinking be somewhat arbitrary? Which of the statements fall into several categories? The important thing is to begin to pick up on how clients think in ways that sabotage their efforts at behavioral change.

It should be noted that when it comes to core beliefs, individuals who are struggling with SUD or other compulsive, unhealthy lifestyle behaviors tend to hold three critical beliefs that occur before, during, and after indulging in the unhealthy behavior. These are *anticipatory beliefs* that provide powerful and almost magical quality to the drug or behavior. "It would feel great to do this (get high, engage in unprotected sex, have a few drinks at the bar, and so on)." This is followed by *relief-oriented beliefs*. "I need to have this drink, use drugs, gamble, and so on" "I will feel well again." And this is followed by *permissive beliefs* that provide a rationale for continued use or engagement in the activity. "I deserve it this one time." "I can handle it." "This is a special occasion" (Beck et al., 1993).

COGNITIVE RESTRUCTURING

As the counselor and client begin to review situations and conditions under which certain automatic thoughts emerge, it can be helpful to develop a record. This document would record situations that the client has encountered, the automatic thoughts the situations have generated, the corresponding emotions, and the behaviors or actions that have resulted. Next to this list can be alternative and more rational ways of thinking and their subsequent emotional response and behavioral outcome. This basic process is known as *cognitive restructuring*. It allows clients to identify the thoughts that specific situations automatically engender and the negative experience that such thoughts create. When these errors in thinking can be recognized by the client, they can reevaluate their meaning and respond more appropriately and with less stress and dysfunctional behavior. Cognitive restructuring as a strategy for dealing with negative emotions is to convey the message that feelings are, to some extent, generated by patterns of thought, that such thoughts are often inaccurate, and that people can learn to change irrational and unhelpful patterns of thinking.

ACTIVITY 5.2 Cognitive behavioral therapy model practice

Write the following words as columns on your paper:

- Situation
- Automatic thoughts
- Emotions
- Response
- Outcome
- Rational response

Now, think of a situation that might endanger the recovery of a client. Then list what automatic thoughts your client may have and what emotions he or she might be experiencing. Assign a percentage of level of intensity for each emotion. Without counseling, what do you believe the outcome would be for your client? What could be more rational ways to consider your client's situation? Write down your answer.

PROCESS: Consider your rational response to your client's situation. How might it change your client's feelings about the situation? What would be his or her behavior response?

INTERPERSONAL SKILLS

Interpersonal skills allow for individuals to benefit from social support, get what they need from relationships, reduce conflict, improve a sense of self-efficacy and self-esteem, and reduce the pain of isolation. Developing skills, such as active listening, interacting with groups appropriately, and coping with the ever-changing roles in families is important. Assertiveness is a foundation strategy that can prevent relapse.

Karl Albrecht (2006) and Joseph DeVito (2008) have written books on interpersonal coping styles and skills (what Albrecht calls *social intelligence*) that can supplement what is by necessity a short coverage of this area within this text.

INTERPERSONAL STYLES

Assertive behavior means communicating your needs, thoughts, and feelings in a clear, direct, and appropriate manner without disrespecting the needs and feelings of others or denying them their rights. Assertiveness builds self-esteem and self-efficacy, meets goals, and gains the respect of others (I win—you win). Thus, assertiveness can be a component in a suite of recurrence-prevention strategies for people with SUD. Assertiveness skills are important for counselors who need to set limits with needy or demanding clients.

Passive behavior (submissiveness) does not meet goals or needs, results in a negative self-image, and leads to low self-esteem, low self-efficacy, and helpless and hopeless thinking. It also lowers the respect of others toward a person and will encourage others to take advantage of that person. Passive people are chronically anxious, but they also eventually feel resentful and cheated, like a "doormat" (I lose—you win). Getting rid of resentments is a cornerstone of the AA recovery strategy because fuming about resentments will cause people with SUD to relapse.

Aggressive behavior meets goals at the expense of others, and it gains their resentment. Others will either give in resentfully or return the hostility. It either destroys relationships or creates a relationship from a superior vantage point toward a subordinate who is demeaned, based on fear (I win—you lose). Developing an assertive behavioral style also means dropping a defensive "street" persona that stands in the way of starting or maintaining healthy relationships.

Indirect (passive–aggressive) behavior is manipulative and dishonest. It creates suspiciousness and resentment.

ASSERTIVE THINKING

1. Assertion, rather than hostility, submissiveness, or manipulativeness, leads to a happier life and better relationships with others.

2. Standing up for ourselves and allowing others to know us earns their respect and our self-respect.
3. Demeaning others demeans ourselves.
4. Personal relationships are more satisfying when we show our honest reactions to others and do not block their honest reactions to us.
5. Being assertive gives others the opportunity to change their behavior.
6. We are entitled to express ourselves and our needs, feelings, and thoughts.
7. Being assertive does not mean we deny the needs and feelings of others or violate their rights.
8. We have the right to set limits and to refuse to meet the expectations of others that are painful or difficult for us to meet.

Elements of Assertive Skills

1. **Escalating assertion.** Always start with the minimum amount of assertiveness, and then increase forcefulness gradually as needed, including leading to stipulation of consequences.
2. **Consequences.** "I need that item changed. If you won't do it, I'll have to take it up with your supervisor" (then, "with my lawyer," "with the police," and so on).
3. **Empathetic assertion.** Recognize the needs and feelings of others. "I realize you need me to help move furniture, but I absolutely must study for tomorrow's exam." "I know you are busy, but I need to ask you for a favor."
4. **Discrepancy assertion.** "Bob, you say you want our departments to work together cooperatively, but you issue memos that are critical of our performance. I'd like to talk about that and work something out."
5. **Emotional assertion in behavioral context.** "When you don't help clean up, it really irritates me, so I'm asking you to make more of an effort to help clean up. This starts with hanging up your wet towels instead of dropping them outside of the shower."

Practice in role-play situations will give the client an opportunity to improve his or her skills in a safe place before using them in the real world outside of therapy. Next, the counselor needs to explore what might be a real-life situation that the client believes may arise or has happened in the past and has sabotaged his or her efforts to change. The counselor can take on the role of the person who is making it difficult for the client. Sometimes, it is helpful to reverse roles, and the client can play the counselor or the other person. This role reversal often provides insight for the counselor and the client, which can be useful in examining the emotional issues related to the situation. Here is a short dialogue with someone in recovery from alcohol dependency.

Counselor: Tell me about a situation that might threaten your recovery.

Client: Well, my uncle Bill comes by every weekend and we go bowling. He drinks quite a bit. He is always trying to buy me a drink. If I say "no," he gets upset and tells me that I can handle it and he'll make sure I only have few.

Counselor: Does that work for you?

Client: No, I always wind up getting drunk and in trouble.

Counselor: What would you like to do about it?

Client: I think for now I need to say "no" to him about going bowling at all.

Counselor: Have you tried that?

Client: Yes, but somehow, I always give in.

Counselor: Let's practice trying to say "no" to going out. First, I'll be Uncle Bill and you play yourself. (Being Uncle Bill) Hey Johnny, it's Friday night. Let's go bowling.

Client: No, I can't go tonight.

Counselor: Why not? You know we always have a great time. I guess you're afraid I'll beat you again.

Client: I guess I just don't feel well tonight.

Counselor: Oh you'll be fine as soon as we get to the lanes.

Client: Oh! Ah! I just don't know.

COUNSELOR: (Stepping out of character) Excuses usually don't work when you're trying to say no. What would you like to say?
CLIENT: I'd like to say, "Uncle Bill, it's just not good for me to go there."
COUNSELOR: OK, say it.
CLIENT: Uncle Bill, it's just not good for me to go there.
COUNSELOR: How did that feel?
CLIENT: Wow. It feels kind of good. OK, I think I can do it.

ACTIVITY 5.3 Behavioral rehearsal

To practice a role play using an assertiveness skill, select a partner. Choose which one will play the role of "counselor" and which will be the "client." Using the scenarios from the following list, demonstrate aggressive, passive, and assertive responses to each situation. Pick one scenario and then develop a role play where the "counselor" helps the "client" develop appropriate assertiveness skills to cope with that situation effectively. Switch roles and repeat this exercise.

1. Laura approaches a sales counter and should be first to be served. Another woman edges in front of her. When the salesperson asks who is first, the interloper says, "I am!"
2. Ms. Jones is a retired widow living in a senior colony in Florida. She is independent and creative and enjoys her privacy and solitary pursuits, which include painting, ceramics, and gardening. She earns some spending money from selling her artwork at the local flea market. Another resident of the colony, Ms. Phillips, has been dropping in for tea and small talk about twice a week. Lately, however, Ms. Phillips has been arriving almost daily, spending two or more hours visiting. This is more than Ms. Jones can stand, and she is not producing enough work to sell at the flea market.
3. You are in a physics lecture with 250 other students. The instructor speaks so softly that the people in the outer rows cannot hear.
4. John borrowed $250 dollars from Ken a year ago. At the time, John was out of work and taking care of an ill parent. Now John is back at work at a good job, but he has made no effort to repay Ken or explain his behavior. Ken is getting more resentful every week.
5. You purchased an item, but when you got home you didn't want it anymore. Now you are returning the product to the store.
6. At a party, your friend lights up a joint, inhales deeply, and holds it out to you. How do you say "no" to the offer of a hit of marijuana?
7. How do you tell a family member not to keep offering you a piece of cake?

PROCESS: How did you feel during the role-play? When was the "counselor" most effective in helping the "client" develop assertiveness skills? How did the "client" act in ways that the "counselor" knew the "client" had problems with getting needs/wants met?

The counselor needs to follow up on how the client used the skills they practiced in the behavioral rehearsal and ask if the skills are used in real-life situations. It is helpful for the client to keep a daily record and note the events when they try out a new behavior. They also should examine the consequences of the new behavior because, if it is beneficial, it reinforces the new behavior.

It is important to know both the psychiatric diagnosis per the DSM-5 (see the chapter on co-occurring disorder) as well as the level of functioning as measured by the *World Health Organization (WHO)* [This replaces the Global Assessment of Functioning Scale, which appeared in the DSM IV–TR]

WHO Domains of Functioning:

- Cognition—understanding and communicating
- Mobility—moving and getting around
- Self-care—hygiene, dressing, eating, and staying alone
- Getting along—interacting with other people

- Life activities—domestic responsibilities, leisure, work, and school
- Participation—joining in community activities

Integration of Affect, Behavior, and Cognition

Affect, behavior, and cognition are clearly interwoven. For example, a young man meets a young woman in his college class. They sit next to each other for much of the semester. He likes her very much but avoids initiating any extracurricular recreation (i.e., dating). His thoughts (cognition) might include, "She will reject me" or "Even if she goes out with me, she won't like me." "I will feel worse when she rejects me than I would if I had never asked her out." "I cannot tolerate the horrible feelings I will have." "It is hopeless to try." "I am not good enough for her." "I am too ugly to interest her." He feels (*affect*) ashamed, depressed, sad, lonely, and helpless. He acts (*behavior*) helpless and passive, or, rather, he takes no action. The consequences of his failure to act are feeling worse, reinforced negative beliefs, lost opportunities, and so forth. This *learned helplessness* model of depression was introduced by Martin Seligman, who experimentally induced depression in animals (1972). Insights from the learned helplessness model have led to some of the keys for understanding depression (Abramson, Seligman, & Teasdale, 1978; Costello, 1978; Depue & Monroe, 1978; Seligman & Maier, 1967). The major treatments for depression are psychotherapy, medication, or a combination of both (Beck et al., 1993).

Several clinicians have formulated integrated strategies and applied them to SUDs. The best-known integrative counseling model is rational–emotive therapy (RET), now known as rational–emotive–behavioral therapy (REBT). It was expounded in the 1950s by Albert Ellis (Ellis, 1962), who applied it to SUDs during the 1970s (Ellis et al., 1988). It is the basis of smart recovery, a self-help network founded in 1996 as rational recovery. The other major school of thought is cognitive behavioral therapy (CBT), an approach associated with the psychologists Alan Marlatt (Marlatt & Gordon, 1985), Peter Monti (Monti, Rohsenow, Colby, & Abrams, 1989), and others. It is especially applied to recurrence-prevention strategies. Rational–emotive and cognitive behavioral approaches dissect the cascade of effects involved in triggers to drinking and taking drugs, ways of identifying and managing triggers to recurrence, and ways of coping with cravings and maladaptive beliefs. It teaches behavioral and cognitive problem-solving strategies and behavioral and cognitive skills, such as assertiveness, that counter helpless and hopeless behavior, thinking, and feeling. More recently, a so-called "third wave" of cognitive behavioral models has emphasized acceptance, compassion, and mindfulness. Mindfulness will be discussed later in this chapter.

RELAPSE PREVENTION MANAGEMENT

> "Ever tried. Ever failed. No matter.
> Try again. Fail again. Fail better."
>
> Samuel Beckett
> Worstward Ho, 1983

Two-thirds of all participants in treatment research return to use within 90 days (Dimeff & Marlatt, 1995, 176). Although this may seem foreboding, clients often enter stable recovery after a number of relapses; thus, returning briefly to use can be considered more the rule than the exception. Using the stages of change model, relapsing is a normal, temporary recycling on the upward spiral of recovery. Rather than being considered a sign of failure, relapse should be viewed as an opportunity to learn new strategies to solidify recovery. Carlo Di Clemente and colleagues pointed out that "relapse" has never been objectively defined (Connors, DiClemente, Velazquez, & Donovan, 2016) They postulated that a real relapse is when a person gives up and returns to the precontemplation stage . All other relapses are lapses. We use the term "relapse" and the less-stigmatizing "reoccurance" or "return to use" interchangeably in this edition as many counselors

and others in the workforce still use "relapse" and are not familiar with the new language (a table of nonstigmatizing language appears in Chapter 4)

Prevention of use recurrence (relapse) should be a proactive affair, discussed frankly and openly. Some counselors fear that talking about relapse would give permission for returning to use. However, discussion about recurrence is more likely to prevent it than avoiding the subject. It allows clients to feel less shame about their ambivalence about using and about their "slips" along the way; and it allows them to identify and examine potential roadblocks to recovery. Relapse prevention must be grounded in understanding of the process of change: deciding to change; taking the actual, initial steps to change; and then finally maintaining change. Each requires different sets of knowledge, skills, and attitudes (Velicer, Prochaska, Fava, Norman, & Reading, 1998).

Often, clients are willing to change, have the ability to change, and are ready to change; however, as counselors, we are unwilling or unable to allow the client to change in his or her own unique way. In other words, rigidity, formulaic approaches, and dogma are counselor attitudes that are impediments to change.

Once the client is stable, it is important to obtain a thorough biopsychosocial history with specific focus on the people, places, situations, events, feelings, and thoughts that appear to have precipitated relapse in the past or that appear to be major contributing factors to using. Clients may be vague about how or why they relapsed, so it is important to note that some situation or event triggered thinking and feelings that led to the relapse. High-risk situations for relapse include the following:

1. **Negative emotions**—particularly anger and frustration
2. **Social pressure**—being in social situations where people are using or encouraging use
3. **Interpersonal conflict**—with parent, spouse, child, boss, friend, and so on
4. **Positive emotions**—celebration associated with use

(Note that not all risky experiences and feelings a client has are negative. One author had a recovering friend who noted that he never drank when unhappy or stressed. His relapses always occurred when he had success and wanted to celebrate.)

Risky Situations

Counselors need to thoroughly examine with their clients what appear to be high-risk situations for relapse. These include times, situations, people, places, and things that brought on the urge to use and set up past relapses. Knowledge of what the high-risk situations are for any specific client allows for planning strategies to avoid or cope with temptation and potential relapse. These often include being in the presence of the drug, seeing others use the drug, being in places where the client used the substance, experiencing both negative and positive moods, recalling memories associated with use, experiencing sounds and smells associated with use, and suddenly coming into money (Washton & Boundy, 1989).

Warning Signs

Much of the literature on relapse prevention focuses on identifying warning signs that predate relapse and/or potential triggers or cues to use, looking at how clients have responded to situations and conditions in terms of how they thought about the situation, the feelings that these thoughts generated, and the subsequent behavioral response. This cognitive behavioral model is useful in assisting clients to plan effectively for preventing relapse (Annis, Herie, & Walkin-Merek, 1996; Marlatt & Gordon, 1985; Marlatt & Donovan, 1995). The counselor assists clients in identifying these warning signs. Major signs (adapted from "37 warning symptoms," Gorski & Miller, 1982) include the following:

- Return to denial or minimization of their problem
- Getting too lonely, hungry, or tired
- "Tunnel vision"
- Not planning or developing a strategy to deal with difficult situations
- Wishful or magical thinking about resolving problems

- Poor self-care, including lack of sleep, poor eating habits, and not exercising
- Harboring resentments about past life
- Indulging in self-pity about one's situation
- Desiring and returning to risky people, places, and things
- Becoming easily testy and angered by others
- Not having any daily structure, program, or support group (i.e., AA, NA, or RR)
- Having an "I don't give a damn" attitude

Once a list of specific thoughts, feelings, and behaviors can be identified, the counselor needs to work with the client to develop an action plan to manage the thoughts, examine the feelings and responses, and modify the behaviors to minimize risk of relapse. This is best done before discharging a client and as part of the discharge plan. However, if a client returns because of a relapse or the fear of a relapse, it also can be an opportune time to frame the experience as a learning opportunity and to do a *postmortem* analysis of the situation, feelings, and experience that led to the relapse.

Exploring when the client is most tempted to use is quite useful in developing a plan. One way in which to do this is to have the client complete a form.

Creating a written plan helps reinforce commitment to assist the recovery process and assist in avoiding relapse. The plan would involve identifying situations that the client realizes put him or her at risk. In assembling such a plan, the client should complete the following statements:

- I plan to make these changes (name specifics).
- The most important reasons to make these changes are (what).
- Steps I plan to take are (what).
- People who can help me are (names of persons), and the possible ways they can help me are (what).
- I will know my plan is working if (e.g., what events occur, belief system changes).
- Some things that will interfere with my plans are (beliefs, people, places, events).

Dealing with sudden urges to use is also important in helping a client to avoid relapse. Clients need to understand that cravings and urges will dissipate given time. Having a strategy to delay the urge is important. Clients can be encouraged to do some of the following:

1. Things I can say to help me wait it out.
   I can tell myself the urge will go away.
   I can wait it out.
2. Think of negative results if I start to use.
   My marriage will be in trouble.
   My housing will be in trouble.
   My job will be in trouble.
   My quality of life will be zero.
3. Think of positive results if I do not start.
   My marriage will be better.
   My health would be better.
   I will increase my self-esteem and self-confidence.
   I will do things better.
   I will be able to continue living in the same house.
4. Eat or drink something else.
   I can eat an apple rather than indulging in a café mocha or ice cream.
5. Do something else.
   I can pray.
   I can take a walk.
   I can read.
   I can call a supportive person.
   I can listen to music.

Even if a client returns to use after learning recurrence-prevention skills, he or she stands a much better chance of returning to a full and healthy recovery.

Don't Pick Up the Second Drink

An often-neglected component of recurrence-prevention management is having a plan for minor recurrences ("slips"). Again, counselors may be loath to even entertain such a possibility, but alcohol and drug abuse syndromes are chronic and relapsing conditions, and it is not realistic to avoid discussing all contingencies. According to Marlatt and Donovan's (1995) concept of the Abstinence Violation Effect, a "slip" or minor relapse can lead to greater relapse if the client believes that he or she has failed, has lost all of the progress he or she has made, and feels that he or she has let significant others down. Therefore,

there should be a very concrete, specific set of steps to follow in the eventuality that the client "picks up" or uses. AA tells us, "Don't pick up that first drink." Relapse prevention tells us, "If you do pick up that first drink, what are you going to do to not pick up the second drink?" Usually, this plan involves making immediate contact with a counselor, buddy, or AA/NA sponsor, going to a neutral place, or engaging in some of the strategies outlined previously that were designed to prevent the initial lapse.

Mindfulness

Many modern therapies and recovery management models emphasize "mindfulness" and meditation, which is based in part on Buddhist psychology. These models, which overlap a great deal, merge mindfulness with cognitive behavioral concepts. We stress that this brief introduction to mindfulness practices does not prepare the reader for practicing them. Facilitators need formal training in mindful-based stress and recurrence reduction (Bowen, Chawla, & Marlatt, 2011, 25)

A common misconception is that meditation induces a trance-like state, whereas the opposite is true: it is about waking up and becoming more aware of our experiences, internal and external. (Bowen et al, 2011, 82)

1. Suffering, grief, and loss are unavoidable in life. We cannot eliminate all suffering. We can, however, learn to live with it and not let it dominate our lives, feelings, and thoughts.
2. Mindfulness involves becoming aware of thoughts and feelings (often through meditative practices). Many thoughts and feelings are outside of our awareness, including those that might lead to relapse. (Helig, 2015, 204–205). Kabat-Zinn (2013, lxv) quotes legendary Yankees catcher Yogi Berra, "you can observe a lot by just watching."
3. Mindfulness involves exposing false (and often unspoken or unconscious) beliefs about emotions. Some examples are as follows:

    - If I let myself grieve, I will be sad forever.
    - If I let myself grieve, I will fall apart.
    - Other people don't feel this way; there must be something wrong with me.
    - If I tell others how I feel, they will think I am weak.
    - Only an immature (or weak) person would get so emotional.
    - If I feel this emotion, I will lose control over my behavior.

    (Adapted from Williams and Kraft 2012, 12)

    In contrast to these beliefs, if one tries to repress the natural emotions, one is more likely to "fall apart" or reach for substance abuse behaviors (ibid, 13)

4. Mindfulness involves moving away from being entangled/fused/caught up/hooked into negative feelings and thoughts. Fighting with negative thoughts/feelings uses up energy and makes the negatives worse.

    As Jon Kabat-Zinn, perhaps the most major figure in the founding of mindfulness psychology, notes (2013, li)

    > "…at those times when you are feeling completely overwhelmed by the pressures in your life and see your own efforts as ineffectual, it is very easy to fall into patterns of what is called *depressive rumination*, in which your own unexamined thought processes wind up generating increasingly persistent feelings of inadequacy, depression and helplessness."

    We can add to Kabat-Zinn's comments that "anxious rumination" is a similar, overlapping, linked process.

    As an alternative, one must work on acceptance of all of one's thoughts and feelings and observe them nonjudgmentally, like leaves floating down a stream, which will come and go. Paradoxically, if one lets go of this struggle, the negative thoughts and feelings will abate somewhat. Note that many of the automatic thoughts associated with stress, depression, and relapse are outlined earlier in this chapter in the sections dealing with cognitive

behavioral psychology. The mindful models stress compassion and acceptance for oneself and one's thoughts and feelings, rather than endlessly running away from them, feeling shame or guilt about them, or fearing them (A. Marlatt in Bowen et al., 2011, viii).

One of the hardest emotional conundrums is ambivalence toward friends and relatives. Such ambivalence generates anxiety and guilt.

5. One of the mindfulness-based relapse-prevention exercises is called "urge surfing" (Bowen et al., 2011, 60–61). This approach compares urges to ocean waves that arrive, crest, and subside. There are several exercises and videos available on the Internet on urge surfing.

Breathing

Although it may seem simplistic or glib, breathing exercises are a part of all approaches to the treatment of anxiety. We offer a few common elements to give the reader an idea of what this entails:

1. Before beginning, find a quiet setting that feels safe. Turn off phones. Make yourself comfortable, and move your shoulders and neck to work out the tightness or kinks.
2. Although this is optional, it can be helpful to put one hand on the abdomen (belly) and the other on the chest. As you breathe, you might note that the chest rises more than the belly. Visualize filling the abdomen.
3. Take an initial deep, cleansing breath, perhaps counting from 1 to 4, in and out similarly.
4. Focus on breathing deeply and slowly. Observe thoughts and feelings that come and go. Do not pass judgment on them; remember that the mind will wander. Return to focusing on the breath.
5. Discuss with the facilitator or write down what feelings and thoughts emerged during the exercise. Note the level of anxiety before and after the breathing exercise, say, on a scale of 1 to 10.
6. It takes time to develop the ability to meditate. Do not blame yourself if you cannot master this ability for a long time. Finally, some people are just not cut out for meditative practice and should not be judged or self-judged, nor considered a "treatment failure."

There are many free meditation apps available on the Internet and meditation videos on YouTube.

TRAUMA-INFORMED CARE

Trauma is the emotional and physical shock felt following an extremely stressful event.

A majority of people with SUDs have suffered from trauma:

- Early childhood abuse, witness to violence, sexual abuse, neglect, emotional abuse and cruelty, often when parents had SUDs
- Partner violence and verbal abuse
- Combat
- Sex workers abused by pimps and clients
- Being in prison, prison camp, concentration camp
- Unexpected loss of a loved one
- Growing up in neighborhoods with gun and gang violence
- Trauma of loss of control due to SUDs
- Traffic and other accidents
- Experiencing terror attacks or watching media representation of such attacks; watching such representation sometime after the attack can rekindle the trauma symptomology
- Forced removal from one's language and culture, such as was experienced by First Nations (Canadian indigenous people) children who were sent to residential schools by the government until 1966, where they were not even allowed to speak in their tribal languages (Porter, 2017)

What makes these different from other major life events is the magnitude and unexpectedness of the shock, and the intense fear and helplessness engendered (Lee & James, 2011, 3)

Substance use in this context enables an emotional encapsulation whereby the terrors of repressed trauma may be held at bay. This can create resistance to efforts to treat substance use disorders. We walk a fine line between opening a compartmentalized section of intense feelings and allowing the system of encapsulation to continue premature occurrence of an unpredictable event or fearful anticipation of that event potentially causing some people to avoid treatment or resist involvement in the therapeutic process. Trauma has often been cited as the single most common complicating factor in treatment and recovery (Carruth, 2006 xix).

There are several forms of trauma disorder.

- Full blown post-traumatic stress disorder (PTSD; delayed reaction to trauma)
- Acute stress disorder (recent trauma) down to mild trauma reactions
- Chronic traumatic situations are considered complex trauma; one theory proposes that borderline personality organization is a form of complex PTSD (Herman, 1992) because trauma results in attachment difficulties and mood swings. It is important to recognize personality and other disorders that co-occur with PTSD.

Diagnosis of PTSD or related disorders must be completed by a health professional licensed to perform psychiatric diagnoses. Recently, medical researchers, especially neuropathologist Daniel Perl, have found evidence that many veterans of combat diagnosed with PTSD, and who have experienced explosive blasts at close proximity, have a unique type of injury to the brain, called astroglial scarring (Worth, 2016; Shively et al., 2016). This research is in its infancy, and it is important for treatment providers to follow up on the latest developments. Finally, PTSD is a popular diagnosis and is often the subject of news coverage. There is a tendency to self-diagnose and the counselor may erroneously assume that a client has, in fact, been professionally diagnosed. For the minority, the motivation might be to qualify for benefits or simply to explain the frightening symptoms that they are experiencing (the same can be said of any client who arrives with a diagnosis that he or she has come up with by reading popular literature or Internet sites.)

Case vignettes illustrating the complexity and uniqueness of each person with trauma issues

a. A young man was in therapy and described to his new therapist the emotional cruelty of his father, something he had discussed with prior therapists. Suddenly, an aspect of his experience that he had not processed brought strong feelings to the surface and caused tears.

b. A 9/ll survivor who had an acute trauma reaction at the time was under stress a decade later due to exhaustion, family problems and illneses The noon fire siren sounded and he burst into tears, remembering both the 1950s practice of going under school desks when the siren sounded, warning of nuclear attack, and left over trauma from the 9/ll attacks that he had not fully processed at the time.

c. A former victim of partner violence had difficulty enjoying sex and held partners at an emotional distance due to underlying fears of further abuse/trauma—one of many forms of attachment disorder due to trauma

d. Elderly members of the Haida culture of the Northwest Coast of the US and Canada are relearning their language, which is in danger of becoming extinct. They reported that the hardest part was processing the trauma of having their language and culture forcibly taken from them in residential schools, which also features physical and sexual abuse (Porter, 2017). Another First Nations cultural group, the Innu of Labrador, experienced multi-generational problems. Adults who were abused and had their culture taken away became alcoholics and had astronomical rates of suicide. Their children, in turn, became inhalant abusers, sniffing gasoline fumes concentrated in plastic bags (Samson, WIlson, & Mazower, 1999).

e. John, a thirty-year-old army veteran, had been deployed three times to combat zones abroad in both the Iraq and Afghan combat theatres. His good friend and combat buddy was shot

and killed by a sniper while he rode with him in the same truck. Upon separation from the Army, John suffered from nightmares, which awakened him in sweats; he was jittery and jumpy when there were loud noises; and he had "fight preparation" reactions when people walked near him. Media coverage of battle scenes triggered flashbacks, confusion, shaking, and crying. In addition to the full blown symptoms of PTSD, John ruminated over how he could have saved his friend, experiencing survivor guilt and depression.

The main symptoms of PTSD are the following:

a. Flashbacks: Upsetting memories coming to mind; feeling as if it is happening again; and/or nightmares
b. Avoidance: Staying away from reminders or memories; staying in an emotional fog or numbness; staying away from family and friends; disassociating (spacing out, memory lapses)
c. Hypervigilance: Being on guard; having problems sleeping, expecting danger

For a full list of criteria that psychiatrists and psychologists use to diagnose PTSD, one needs to consult the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* or DSM-5 (APA, 2013)

A vicious cycle of trauma, as described by Sheela Raja (2012, 5) involves childhood and young adult trauma, leading to loneliness, boundary uncertainty, trust issues, isolation, and vulnerability. This is often compounded by adult trauma, and both may lead to unhealthy coping, such as drug and alcohol use, risky sexual behavior, and avoidance of emotions. Finally, these latter behaviors cause more adult trauma, and so forth.

Frequently, people struggling with past trauma feel helpless and alone, and even ashamed. Providing a framework where trauma can be shared and explored is itself curative and allows the individual to feel cared for, supported, and part of the human race. Consider the following from the Center for Substance Abuse Treatment in 2014.

Advice to Counselors: Helping Clients With Delayed Trauma Responses:

Create an environment that allows acknowledgement of the traumatic event(s).

Discuss their initial recall or first suspicion that they were having a traumatic response.

Become educated on delayed traumatic responses.

Draw a connection between the trauma and presenting trauma-related symptoms.

Create a safe environment.

Explore support and fortify them as needed.

Understand the triggers that can precede traumatic stress reactions, including delayed responses to trauma.

Identify their triggers.

Develop coping mechanisms to navigate and manage symptoms.

(SAMSHA 2014, 84)

Many of the methods for helping individuals with trauma are the same as those outlined in the sections of this chapter on affect management, behavioral change, cognitive change, and mindfulness. The placement of trauma-informed care in this chapter was, in fact, largely dictated by this circumstance. Specific trauma-informed care other than these includes:

a. A medical workup to determine whether traumatic brain injury plays a role in the symptoms one may be ascribing to purely psychological processes. As mentioned earlier, research on this is in its infancy.
b. Exposure-based techniques, which can take the form of talking about the trauma, writing or journaling, and confronting situations that are reminiscent of trigger trauma

symptoms, are best done in small steps in order to avoid overwhelming or "flooding" the client with terrifying feelings. (Raja, 2012, 43)

c. Although mentioned earlier in the section on mindfulness, it bears repeating that breathing exercises are calming, even while driving.

d. When working with a client who is experiencing flashbacks, it is important to respect the client's need for considerable personal space. This can help to "de-escalate" the situation.

e. Medications approved by the U.S. Food and Drug Administration to alleviate symptoms of PTSD are the selective serotonin reuptake inhibitor (SSRI) antidepressants sertraline (Zoloft) and paroxetine (Paxil). Tranquilizers, such as the benzodiazepines Clonazepam (Klonopin) and other Valium-like medications, are not recommended as they only temporarily blunt symptoms; they do not allow patients to work through trauma. As is well known, tolerance and dependence to "benzos" easily develop, and withdrawal symptoms can be staggering.

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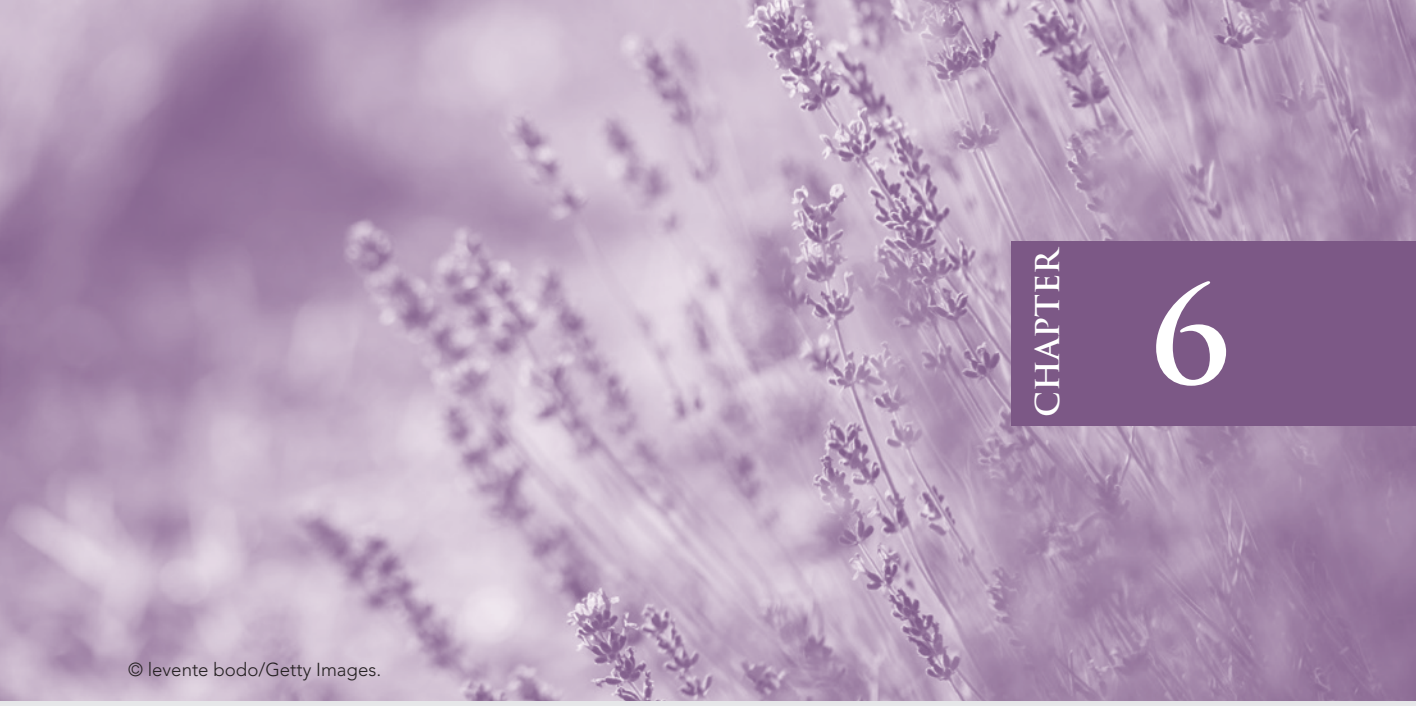

CHAPTER 6

GROUP TREATMENT

OBJECTIVES

By the end of this chapter, students will be able to:

1. Describe at least three benefits of group treatment.
2. List at least four differences between interpersonal groups and other types of groups, such as self-help groups.
3. Describe process vs content issues in group treatment
4. List four or more process behaviors to observe in group treatment
5. List four or more patterns to observe in group treatment.
6. List four or more self-oriented roles played by members in group treatment
7. List four or more facilitated roles played by members of a treatment group
8. List three or more ways leaders can choose to intervene in the group process.

INTRODUCTION

While many client gatherings are liable to be called a "group" or "group therapy," in this chapter, the term *group treatment* or *group therapy* applies to interactive groups in which the clients' discussions with each other is the major activity, directly or indirectly facilitating personal growth and recovery from substance use disorder (SUD). A variety of didactic and educational groups can also have important roles in SUD treatment, but in such settings, interaction among members is not a central or defining characteristic.

Most alcohol and drug treatment occurs in group settings, which are well suited to the needs of people recovering from SUD. Groups break down isolation and encourage relatedness, social reemergence, and the identity of the "individual recovering from SUD." They provide hope, motivation, positive peer pressure, and support on recovery issues. Tension, shame, and guilt are reduced greatly when members bring out concealed feelings, thoughts, and behaviors that are often shared by others in the group. Clients can form attachments and loyalties to something larger than the one-to-one, sometimes overdependent, counseling relationship, thus forming a counterbalance to the user/abuser milieu. Groups allow observation and reflection of real behavior patterns and replaying of roles. They are tremendously cost-effective and "are also great fun" (Blume, 1985, 75).

Groups work well at the individual, intrapsychic level because they activate so many therapeutic forces. They teach social skills and facilitate interpersonal bonding. Groups also help bond clients to the treatment program itself, its values and norms, and to a culture of recovery and responsibility.

Group counseling methods are as diverse as those of individual counseling. Groups vary tremendously in focus, content, intensity, client characteristics, stage of treatment, format, and philosophy. Emotions may be expressed in outbursts or politely discussed; behavioral changes may be harshly mandated or merely suggested; clients may interact freely or be discouraged from "cross-talk." The way in which a group is conducted is often based on a hallowed tradition within the agency milieu. However, rigidly following tradition may clash with the individual needs of clients.

INTERPERSONAL (INTERACTIVE) VS OTHER KINDS OF GROUPS

Psychoeducational (*didactic*) groups educate clients new to and ambivalent about recovery from chemical abuse, dependency, and recurrence issues. They provide a low-intensity introduction to being in groups. The group leader is more of a teacher than a facilitator of group process, and he or she needs to have basic teaching skills (CSAT, 2005, 14) so that he or she can deliver information in an organized, engaging, and culturally relevant manner. The group leader must manifest basic helper qualities, such as caring, warmth, genuineness, and positive regard.

Groups modeled after Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are a "round-robin" of storytelling, perhaps with feedback. Members do not engage in "cross-talk" or bounce from member to member. (Format is described later in the chapter.) Spitz (2001) compared self-help (AA style) groups with interpersonal group therapy. Interpersonal groups differ from self-help groups in that they:

- Occur in a professional context with professional leadership
- Have members who are screened
- Emphasize group process
- Emphasize differences among members (self-help emphasizes similarities)
- Meet less frequently
- Are much more time limited, especially in the current managed-care climate, as opposed to the "lifelong fellowship" of AA and NA

This chapter pertains to interpersonal group treatment. For people with SUD, who

often have grown up in families with distorted communication patterns, chaotic organization, abandonment, and aggression, interpersonal group therapy based on the work of Yalom (1995) is a laboratory for learning, growth, and healing in the realm of relationships and for being part of healthy social systems.

According to the interpersonal group therapy theory, the three levels of intervention in groups are the *intrapsychic* (what is going on in the "unconscious mind" of the individual client), the *interpersonal* (roles and relationships and interpersonal styles), and the *group as a whole* (how the group is functioning as a system; whether members are resisting treatment, staying away from difficult topics, or scapegoating certain individuals).

Kraus and Carroll (2007) point out that while one sees a great deal of research on treatment efficacy, there is little evaluation of group treatment *per se*. This is partially due to the fact that it is hard to separate the effect of the group from the other interventions that the client is exposed to, such as the quality of the case management, treatment planning, and individual counseling. It also is due to the fact that there is no standard set of outcomes, aside from sobriety.

Phases of Treatment and Placement in Groups

In the early phase of treatment, clients are most ambivalent about ending chemical use; they decline treatment and have adversarial relationships with authority (CSAT, 2005, xix). In the middle phase of treatment, clients are more acclimated to the group culture and have made gains that facilitators can point out. In the late phase of treatment, clients can more readily deal with conflict or deep emotion. Early-stage patients might avoid displays of overwhelming emotion and intimacy.

As a general rule of thumb, putting someone with a severe personality disorder (such as severe borderline or antisocial personality disorder with poor impulse control) in a general population group can be a disaster (CSAT, 2005, 39). Women who have suffered from trauma and abuse are served best in homogeneous groups. Men's groups are also indicated in some cases.

GROUP CULTURE

Societies and groups have systems of behavior, values, and ideas that professionals refer to as their *culture*. The culture of a counseling group includes theme, content, group process, lore, format, and often a philosophy of human nature. A group's culture may derive from a particular tradition, such as 12-step, psychoanalytic, confrontational encounter group, and Gestalt psychology, or it may be a synthesis of styles. Agency and group culture is often summarized and transmitted in the form of colloquialisms, mottoes, and aphorisms. (Some examples include: "When you think you're looking bad, you're looking good!" "You're as sick as your secrets." "It gets better." "Keep it simple." "Bad feelings get in the way of good feelings.") As happens in any culture, therapeutic culture engenders many concise descriptions of, among other things, the group dynamics and process. For example, protection from confrontation is described at Daytop Village (New York) as "red-crossing" and at Integrity House (Newark, NJ) as "band-aiding."

Group cultures vary in the ways they map out personality dynamics. Models of personality, although not always directly stated, are crucial influences on clinical approaches and should be recognized and critically evaluated. For example, anger is handled differently in different group cultures. The 12-step model in a group setting may influence the identification of anger as a relapse trigger; members might then be encouraged to "turn it over to a higher power" or put it aside. In contrast, the therapeutic community model, which also sees anger as a sign of potential relapse, recommends that such emotions be forcefully purged from the system in the group. Some clinicians (Brown & Yalom, 1977, 452; Wallace, 1985a, 1985b) caution against pressuring clients to engage in extreme emotional outbursts in

SUDs groups because they are far too threatening and overwhelming and result in premature self-disclosure by clients.

SUDs agencies often have formal orientation to group rules and group culture. Group orientation facilitates the group process. For example, the almost universal rules of "No violence or threats of violence" and "Everyone stays in his or her seat except for a group exercise" reassure the members that this is a safe place where, unlike some family and community environments, expressions of opinion or anger will not meet with physical retaliation or abuse. Orientation and ground rules also provide structure and reassurance for the individual who has recently recovered from SUD and who may retain some fear of losing self-control and physically acting out when angered. Other group norms that are commonly introduced in an orientation include the importance of regular attendance and punctuality, the rule against sexual contact among group members, and strict confidentiality. While it is tempting to gossip, "Everything stays in this room."

ACTIVITY 6.1 Are you all together?

Sometimes, it is difficult to assess "groupness." For instance, is a rock band a group? Is a baseball team? A family? The audience at a concert? Usually, a group has some shared goals, some development of trust, norms of how to behave toward each other, some sense of leadership, and methods for making decisions. Probably, most important of all is that members think of themselves as part of a group.

Form groups of six to eight and draw a picture of "a group" and of "a collection of people." How do your pictures differ? Small groups can post their pictures and describe them, differentiating the qualities of "group" and "collection of people."

PROCESS: *Did all of the small groups come up with similar definitions? What processes took place in the small groups during the assigned task? Did some people push for completion, take over leadership, or bring up other topics?*

DEVELOPING AWARENESS OF THE GROUP PROCESS

Group process refers to all patterns and styles of interaction in the group. Content is what a group is discussing. It may be the problems or concerns of members or perhaps the tasks they are trying to accomplish. Although content should always be relevant to group objectives, even more important is the healing that goes on.

To help the group facilitate healthy behaviors, healing, and recovery from SUD, the counselor must be skilled in observing and evaluating the dynamics at work in the group.

First of all, counselors should think about how people present themselves. From these behaviors alone, none of which would be discernible in a transcription of the group, counselors can deduce the tone or atmosphere of the group (e.g., accepting, supportive, rejecting, tense or edgy, repressed, avoidant, overly polite) and the level of participation by each member. Behaviors to observe include the following:

- *Voice*: How do people sound? Listen to the voice qualities that members use.
- *Expression*: What are the facial expressions—smiles, frowns, raised eyebrows, sneers? If a person smiles, is it spontaneous, tight-lipped, fixed?
- *Posture*: What postures are adopted—bunched up, tipped back in the chair, close or distant from the speaker or the next person in the circle?
- *Contribution*: Who talks a lot? Who seldom talks? Who talks only when probed?
- *Visual focus*: Where do people look when they talk? At others? At one person? At the leader? At the floor or ceiling? Out the window? Eyes closed?

Second, counselors should observe regular patterns of social interaction: how decisions are made and tasks are accomplished, agreements made

and kept, roles developed and enacted. Patterns to observe include the following:

- *Influence*: Who influences whom in the group? How? What is their style of influence?
- *Rivalry and conflict*: Is there animosity or conflict among members? Is it open? Covert? Passive–aggressive? Aggressive? Constant or intermittent?
- *Level of participation*: Who takes part? Always the same people? How much? How often? Is participation encouraged or discouraged? How do members respond to nonparticipation by other members?
- *Decision making*: How are decisions made? Does one person dominate or take the lead? Does everyone have something to say or a chance to say it? Do decisions in the group come easily or with conflict?
- *Teamwork and productivity*: How are tasks accomplished, or not? Is the group following up on crises that have been mentioned? Are commitments being kept? Does everyone show up? Is everyone on time?
- *Roles*: What roles are developed? Why and how do people play parts, such as "scapegoat" and "hero"? Who is "in trouble"? Examples of members who are in trouble include those who cannot get a turn to speak, are interrupted before they finish speaking, are distressed at events taking place in the group prompting them to leave, or are the target of derision or disrespect and cannot respond adequately.
- *Covert agreements*: Are there unspoken understandings, such as taboo topics, nonconfrontation, and resistance to progress? Does this occur in subgroups or cliques, or on the part of the entire group?

Group process is a powerful tool; it can be healing and facilitate growth, or it can be detrimental. Knowledge of group processes and continuous attention to process enable counselors to fulfill the ethical responsibility of promoting and safeguarding clients' welfare, emotional safety, and progress in recovery. The major role of a SUD group leader is not to give information, advice, or counseling but to facilitate the group process.

Group development is complex and slow and should not be rushed or mandated. Tension, conflict, resistance, and regression are expected; they provide important learning opportunities for the members. When members do not feel that they are being helped or feel stymied in their attempts to progress, they may make the leader their scapegoat. Anger at the leader is a normal stage in group development, and the ability to express such feelings can be a growth experience for members (Ormont & Strean, 1978; Stokes, Tait, & Miller, 1980, 124–125; Yalom, 1995, 306–311).

ACTIVITY 6.2 Process or content?

Decide whether each statement in the following group conversation is focused on process or content. Take about 10 minutes to read over the items and make notes where appropriate. Then discuss responses to the items.

Mary: Let me tell you about my last slip.
Tom: How does everyone feel about talking about this?
John: I don't like the word "slip." I prefer "relapse."
Mary: It happened when I ran into my old girlfriend.
Susan: I had a similar experience with my boyfriend.
Bill: How does Terry feel about our discussion?
Tom: I noticed Mary back off when you asked Terry to talk about it.
Mary: He's always criticizing my decisions.
Terry: Tell us more about your reactions to Bill.
Susan: I'd get a lot out of more discussion on resentment.

INTERVENING IN THE GROUP PROCESS

It is important to realize that group process is always taking place. The counselor or anyone designated as the leader or facilitator must decide

when—if at all—to intervene in the group process. This decision depends on what the group leader sees as necessary to make the group interaction healthier and more productive; to encourage more interaction, remind the group of its goals and rules, and focus the group on process or recovery issues. Group leaders can choose to intervene in many ways and at various levels. They can choose between content (e.g., adding information to the discussion) or process (e.g., commenting on the silence, anger, or lack of involvement). They also can choose to address one, several, or all of the group members or encourage members to respond to one another.

Involving Marginal Members

Group membership is an important issue for each member. Members, particularly new members, are always struggling with the idea of whether they belong. To what extent they should or could share about themselves is a critical concern. Sharing of self is risky and requires trust of other group members and a belief that the benefits from the group outweigh the risks. Although new members of a group should not be forced to rush directly into interaction, counselors must try to phase in their involvement. Waiting more than two group meetings to interact sets a precedent that can dilute the group process below therapeutic levels. Moreover, marginalized members receive less help than they could, feel no investment in the group, and are in danger of leaving treatment or of relapse. Although they may not have articulated it, even to themselves, they feel extremely lonely and isolated. In many cases, it is a relatively simple task for the counselor to help them initiate some contact with the group. One can, if no major pathology or other serious problem is suspected, gently force the issue. Subtle promptings include noting shared problems among members and asking the isolates to comment on their reactions to particular disclosures. At the very least, a counselor can note a group member's silence so that the client does not feel invisible. Although many new members are overwhelmed by the self-disclosures and open exchange of emotions in the group, it is important to identify other reasons for marginality and isolation. Possible reasons include fear of self-disclosure in a sensitive area such as sexual orientation, violence committed while intoxicated, or concomitant psychiatric diagnosis. These issues may be determined best in individual counseling. If an individual stays isolated and sees no way out of isolation and feeling unwanted, he or she will eventually leave unless compelled to stay.

CASE IN POINT

Countering Isolation

At an agency that employed one of the authors, clients filled out confidential questionnaires asking with whom they preferred to associate. These connections were charted, and those who were not "on the chart" (called *sociometric isolates* by social psychologists) were rightly gauged as at risk of being "splittees" (individuals who leave treatment). Remedial interventions, such as those discussed in this book, were conducted to bring them into contact with other members.

Encouraging Peer Leadership in the Group

Counselors need to encourage a greater proportion of member-to-member interactions at the expense of leader-to-member interactions. This applies both to content (e.g., advice, confrontation, feedback) and to facilitation of group process.

If clients are still embedded in the drug culture, it may predominate over identification with a recovery program. Simply putting them in a room and expecting group therapy to occur is unrealistic, and, in fact, may cause more trouble. If clients have developed some measure of therapeutic alliance with counselors, the group is much less likely to get out of control. However, a large proportion

of senior, committed clients is less often found in the current world of short-term and mandated treatment. The situation faced by the counselor whose client boasted of "skin-popping" (see the next Case in Point, "Peer Leadership") may be more typical. Fortunately, the counselor in that situation was assisted by a senior staff member who developed a positive, healing group process by focusing on issues of common concern, such as teen parenting and parental abuse.

CASE IN POINT

Peer Leadership

The importance of peer leadership and positive peer culture was made clear early in the career of one SUD counselor, who was trained at a branch of an adolescent intensive outpatient program where senior group members trained, confronted, and helped new members. The leader, in fact, had little to do. Interventions by peers were much more effective than interventions by authority figures. The following month, the counselor was placed at a new branch where he and another staff members had to oversee a large group of teenagers who were not socialized to group culture and process or to drug-free norms and goals. They were unable to intervene as a member boasted to a receptive audience of having "graduated" from sniffing heroin to subcutaneous injection ("skin-popping").

It is important for counselors to examine whether they behave in ways that focus the group around themselves, and, if so, why. For example, a counselor may fear that silences signal that the group is not functioning and will fail, that time will be wasted, or that a point will be missed unless he or she makes it in the (theoretically) correct and most articulate way. A counselor may be afraid of losing control of the group or feel gratified by playing the role of revered leader, wise oracle, or healer. Of course, clinical or legal emergencies that require quick decisions by the staff override preferences for letting the group process develop at a natural rate.

Helping the Group Understand the Group Process

Group members are primed during orientation to focus on what is going on in the room. During orientation as well as during the first few group sessions, clients learn mottoes and terms that describe group processes. In order to encourage the group's reflection on its process, the counselor must be aware of his or her own feelings in the group and how they reflect the prevailing atmosphere. The leader can and should comment on his or her observations of group processes, but it is more powerful for members to have and communicate these insights. The best facilitative interventions are those that encourage the group to observe itself and discuss the group process, which is often called a *here-and-now focus*. Such observations offer growth experiences for people with SUD; they provide insight as to how one actually behaves and how others react; and they reveal or highlight the consequences for one's identity, SUD, or recovery. Such a focus creates involvement, relevancy, and excitement. It is the basis for many group benefits listed in the introduction to this chapter.

The group leader has a major ethical burden. The group can unleash powerful forces, such as memories of abuse, a need to share painful secrets, overwhelming emotions that can lead to a desire to leave the program, or—worse—suicidal intent. Proper clinical supervision is needed to help the novice counselor deal with the potential "Pandora's box" situation.

Failure to prevent suicide has resulted in many medical malpractice claims made against behavioral health systems. One-shot "sensitivity groups" held outside of an agency's purview, where participants are not screened, and for which the participant is not protected by any follow-up, pose a grave risk in terms of precipitating a psychiatric and/or suicidal crisis. Leaders need to protect individuals who do not wish to, or cannot,

participate in cathartic and intense emotional outbursts. Rather than let emotions get totally out of control, the leader should limit conflict, step back to discuss what is going on, and try to determine where the powerful feelings are coming from (Yalom, 1995, 350). Whereas "emotional contagion" is useful in groups, the domino effect of a crescendo of feelings can build to a level that can potentially terrify some clients, or at least create a climate of discomfort.

DEVELOPING GROUP INTIMACY

An atmosphere of intimacy is necessary for individuals to feel trust, which is a precondition for taking the risks involved in curative self-disclosure of information and emotion. Under ideal conditions, it happens this way: orientation, developing trust, calling members on violations of rules, promptings by the counselor, reminders, and so on. Unfortunately, most groups, especially SUD groups, operate under restraints. Groups are most often limited by financial issues, such as a member's number of group sessions or the reimbursable fee being limited by his or her insurance company. Therefore, structured ice-breaking activities can accelerate the process in the early stages of a group.

Activity 6.3 and others have been developed (Napier & Gershenfeld, 1973; Stokes et al., 1980) and used successfully for decades to help a group move quickly to intimacy. Activity 6.4 was developed in the late 1960s at Daytop Village, Inc., to help people with SUD discard their street or "dope fiend" images, which were thought to impede recovery. It allows people to discard stereotyped perceptions of themselves, known as their *jackets* (a term based on the manila file folder of information that follows the person in the criminal-justice system). This type of sharing allows people to explore intimacy in a nonthreatening manner, lessens group defensiveness, and establishes an atmosphere of trust.

ACTIVITY 6.3 It made me who I am

Form pairs based on differences that you perceive in the other. First, discuss the criteria you chose to define "difference," and then discuss a pivotal or critical event in the formation of your personalities or lifestyles, regardless of whether it was positive or negative.

PROCESS:

- Was it hard to share the critical event with your partner?
- Did you quickly censure your choice of events and settle on an easy one?
- Do you feel closer to your partner now? If you do feel closer, how does that closeness or intimacy affect you?
- Does it make you feel vulnerable, embarrassed, or anxious to have disclosed personal information to your partner?

ACTIVITY 6.4 Blowing my image

"The Philosophy," by Richard Beauvais (1965), was read at the morning meeting of Daytop Village. Read "The Philosophy" or ask someone to read it aloud.

The Philosophy

We are here because there is no refuge, finally, from ourselves.
Until a person confronts himself in the eyes and hearts of others,
He is running.
Until he suffers them to share in his secrets,
He has no safety from them.
Here, together, a person can appear clearly to himself,
Not as the giant of his dreams, nor the dwarf of his fears,
But as a person, part of a whole with a share in its purposes.
Here, together, we can at last take root and grow,
Not alone anymore as in death, but alive in ourselves and others.

Discuss: What does "the dwarf of our fears" represent? Some answers might be that we are afraid that what we have to offer is insufficient or not good enough, that we cannot measure up in the eyes of others. Some counselors humorously refer to an unrealistically poor self-image as *delusions of inferiority*.

Can low self-esteem, poor self-efficacy, or fear of being attacked make a person feel as if he or she needs to put on a mask, present a false image, or maintain a grandiose or tough exterior? Can this, in turn, make a person feel unknown, dishonest, or not liked for who he or she truly is? Do you think people can see through images to know what people really need?

What does "the giant of our dreams" represent? Here, the giant symbolizes what we would like to be; it is a wish-fulfillment image.

Process:

1. Each member receives feedback from the group on the image he or she presents to the world.
2. Each member then honestly recounts his or her self-image and secret and wish-fulfillment image.
3. Each member performs a simple task that changes his or her image in the eyes of others. For example, a person perceived as very serious tells a joke or does something silly, a "good guy" admits to a nasty impulse, or a "tough guy" admits to vulnerability or fear.
4. Each member briefly explores how the self-disclosure and having his or her image exposed made him or her feel. Others may offer brief reactions.

KEEPING THE GROUP ON TASK

Staying on the Issue

A goal in the development of a well-functioning group is that the group members themselves realize when the discussion has gone astray and point it out. Until the group can do this; however, the counselor needs to refocus the group on recovery issues. This is particularly a task in groups composed primarily of beginners, such as those in detox units.

Many groups emphasize feelings in the here and now. This helps the clients become aware of their emotions, identify them, differentiate them from thoughts and attitudes, learn to communicate them assertively and appropriately, feel comfortable with them, and learn to air and share them rather than chemically anesthetize them. Feelings are hard work; they are also threatening. It is natural to drift into an easygoing discussion about sports, clothes, or even drugs. Counselors monitor this so that every moment of the group is used in a productive way, maximizing the gains each client can achieve. Effective group counselors do not stamp out all utterances referring to past events; however, they help to distinguish between war stories of SUD, which are not productive for interactive groups, and accounts that evoke emotion in the speaker and other members of the group.

Staying in Routine

The counselor has the task of gently assuring the group that the group format, to the extent that there is one, is followed. *Format* refers to the way the group's time is structured. There are an almost unlimited variety of formats, including the following examples:

- *Open discussion*: Members take random turns as they wish, without cross-talk—a format found in 12-step fellowships.
- *Rigidly timed segments*: Each member has the same amount of uninterrupted time to speak.
- *Loosely timed segments*: The length of time each member speaks shifts from client to client according to the issues and emotions that arise.
- *Unstructured interaction*: Within the overall group format, the individual client's turn in groups also may follow a predictable routine, as does the personal "story" or "drunkalogue" in AA. There are various approaches to how

a client should use the time in a group. Aside from attempts to help a client focus on relevant issues, there may be some attempt to structure the turn taken by a client. For example, it may be considered important to ensure that the client gains insight into his or her behavior, thinking, and emotions, or that the client sees the connections among these areas. Years before formal schools of psychotherapy and counseling attempted such a broad synthesis, some SUD programs staffed by people recovering from SUD structured groups so as to "cover all the bases." In one such format, clients took their turns to be helped by focusing first on a specific problem, then on feelings related to the problem, then on positive behavioral changes they could attempt, and finally on identification and feedback from group members. This cycle could be repeated for each client who took a turn "on the hot seat."

In the format just described, the *problem* segment could address an issue raised by a client or an observation by another group member of behavior seen as problematic, in a concerned inquiry or confrontation. The *feeling* segment could involve helping the client identify, evoke, communicate, and accept her or his emotions concerning the issue. It may entail the following:

- Simple questions, such as, "How did you feel about that?"
- Focusing and clarifying questions
- Going around the room and expressing the feeling to everyone present, speaking to someone not present,[a] or speaking to a person playing the role of the absent subject[b]
- Venting an emotion by shouting or crying

The third segment of this format is commitment to a plan for behavioral change or experimentation broken down into specific behavioral steps, as well as contingency planning. These are written down so that the group can follow up on them in the next meeting. The commitment may be as simple as getting phone numbers of two group members and calling them during the week.

Identification and feedback come through supportive comments from others. Group behaviors in one segment may provide material for the next member's turn. There are two functions to such a segment:

1. In one study (Feeney & Dranger, 1976), people with SUD rated identification with others as the most helpful element of group therapy. It is a tremendous relief for a client to realize that his or her problems and feelings are shared by many others, that others have "been there, done that," and that they can empathize with what the client is going through.
2. A "cooling-down" phase involves closure and summation of the segment. If the client is in distress, an attempt is made to sooth ("patch up") him or her prior to the end of his or her segment. Cooling off and closure segments are found in many group counseling approaches; they provide a transitional period from the vulnerability of deep emotion to the outside world.

In formatting the entire group meeting, time should be budgeted for possible crises, a cooling-down phase, and at least a moment for each member to be noticed and acknowledged.

The cognitive therapy format of Liese, Beck, & Seaton, (2002) for a SUD group is as follows:

1. *Facilitator introductions* (5 minutes). Introduce self, the group, and the cognitive model
2. *Group member introductions* (20–40 minutes). Facilitator may relate problems to cognitive model
3. *Challenging thoughts and beliefs that lead to (trigger) SUD behaviors* (20–40 minutes). Examples are "I need some drinks before

[a] This is the "empty chair" technique (Perls, 1992).

[b] This activity has roots in psychodrama; some grounding in the essentials of psychodrama would improve its effectiveness.

bed so I can sleep," "Just one drink won't hurt me," and "I'll stop tomorrow."

4. *Coping skills training* (10–20 minutes). These include developing healthy relationships, mood control, motivation and readiness to change, crisis management
5. *Goal setting and homework commitments.* These include envisioning the future, setting specific and achievable goals, identifying resources, committing to specific behavioral steps
6. *Closure*. Reflecting on what members have learned

Finally, formats of groups for specific stages of change and for identifying triggers for relapse; managing stress, effective communication and refusals; managing criticism, thoughts, cravings and urges; and developing an action plan, are presented in the *Group Therapy Stages of Change Manual* developed by Velasquez et al. (2012).

HELPING GROUP MEMBERS EXPLORE ROLES

Roles are patterns of behavior, sets of expectations, and parts played in a social system. As in physical systems (such as the solar system), the parts interact and resonate with each other. Members of SUD groups can benefit tremendously by reflecting on how their behavior in group replays, repeats, or transfers from another situation, past or present. The counselor needs the skill of facilitating this self-reflection. When counselors attempt to analyze a system of roles, they look for motives that the individual members of the group may have for each person to play an assigned part. The benefits accrued to one or more members may be obvious, indirect, or even based on false perceptions. However, the group leader should take care not to fall into simplistic formulae that interpret behavior in terms of simple transference from other roles. A group member's behavior may be a situational adaptation not typical of other settings.

CASE IN POINT

Different Faces for Different Places

People play various roles. Some can loom larger than life in one setting and then fade into meekness in another. One example is an assistant principal who is the terror of the classroom but is timid in the presence of peers at the faculty lunch table. Another example is the camp director whom all acclaim as "easy to work with and wonderful with the kids" but who has no time, energy, patience, or understanding for her husband and children.

Groups offer the possibility of learning to be accepted based on authentic feelings and reactions, not on some image someone thinks he or she needs to build. This has a humanizing effect, lowers anxiety, and reduces the need to self-medicate with psychoactive substances.

Personal Roles Enacted in Groups

The role a member takes in a group has roots in his or her emotional history. The following roles are often cited as parts played in families, which can be transferred into other group settings. Again, it may be simplistic and deceptive to interpret all such behaviors as transferential of family issues or patterns. In the following sampling of roles typically found in SUD groups, it is important to note the variety of motivations that generate or maintain such behaviors.

The term *scapegoat* is perhaps the most common example of a group role. The term comes from the Biblical book of Leviticus and refers to the goat driven out into wilderness bearing the sins of the tribe. As originally described by Jackson and Bateson of the "Palo Alto group" in family therapy (Satir, 1984), an individual brought into therapy as the identified patient may be the scapegoat in a dysfunctional family.[c] Both professional and folk psychotherapy systems

[c] The group of researchers that has become well known as the Palo Alto group is officially from the Western Behavioral Science Institute.

have long recognized the advantages of scapegoating for group members, such as the following.

- Deflecting attention from their own behaviors
- Forestalling possible attacks on themselves
- Creating a convenient, cathartic whipping boy

People commonly chosen as scapegoats include different, weaker people or those who are new to the system. Although one would not expect an individual to seek out such a role, some might find it convenient to justify leaving the program in order to return to substance. Orientation sessions and written rules for groups in various programs may include injunctions against scapegoating. Groups use many terms to identify destructive scapegoating behavior. In its most egregious forms, when a group "jumps on" a person and overwhelms him or her with criticism, it can be called "rat-packing," "rat-raging," or "piling on." There is also a more subtle holier-than-thou form of criticism, which serves to scapegoat other members. The latter is identified and thwarted by the slogan, "If you can spot it, you've got it."

The *leader*, *protector*, or *pseudotherapist* role involves taking responsibility for the problems of others. It also sets the individual apart from and above the ranks of the group members. There are many motivations behind adopting such a role. It might stem from the following:

- A recapitulation of the super-responsible or family hero role in the addictive or other type of dysfunctional family
- A fear of intimacy (i.e., a way of holding people at arm's length)
- A wish to avoid confrontation and direct the focus away from self
- A feeling of not being entitled to acceptance and attention as an ordinary group member, but only in this special, exalted position
- Faulty thinking, such as, "If I'm not on top, I'm a flop"

Approaches by the facilitator to the member who consistently adopts this type of role should start with encouraging the member to take time for him- or herself, to ask for help with problems, and to make statements that include "I feel …" or "I need …" Once the member has gained that skill, the group can explore which motivation might apply in this case. Another type of approach is for the facilitator to encourage members to reverse positions with the "leaders," confront them, and strip them of their carefully constructed images.

The *provocative*, *hostile*, or *resentful* role may represent, to some extent, recapitulation of a scapegoat role in the family of origin. Other motives that bear exploration include the following:

- A "counterdependent" defense, fear of intimacy, or vulnerability
- Testing of limits and quest for imposition of structure
- Wishing others to really prove their concern despite the unpleasantness
- Wishing to be ejected—an excuse for avoidance or recurrence
- Lack of skill in aoorioruate ways of getting attention

The group should not respond to the challenge of the provocative member but should defuse the situation by asking what the provocateur really needs from the group or from specific members of the group. The group can help a hostile member understand that he or she is actually placing him- or herself in a situation where he or she would be isolated.

The *class clown* or *joker* role may be generated by:

- Anxiety
- Fear of intimacy
- Boredom
- Fear of confrontation
- A need for attention, lack of skill in better methods of getting it
- Hostility, a wish to provoke
- Unrecognized attention-deficit hyper-activity disorder (ADHD)
- A need to compete with the leader

The class clown often attempts to involve others in his or her act and searches for an audience, a "sidekick," or an associate. Again, the group can defuse this role by asking the joker what he or she really needs or wants from the group or from

specific members of the group and by encouraging statements that begin with, "I feel" or "I need." Finally, every attempt to provide a bit of humor need not be denounced as a pathologic role.

The "weakest" group member, or the "sickest" one, may be pathologically dependent and may have come to this role through the following:

- The feeling that he or she is entitled to attention only if very sick or in crisis
- The need to regress, be babied, or get permission to not be responsible
- The fear of termination; if one gets healthy or grows up, one has to leave the group and be independent
- Hoping to find an enabler in the group to feed, promote, encourage, and justify weakness
- Identification with parents having SUD in the family of origin, who modeled the sick behavior
- Hope that less will be expected of him or her in the group, which may come from fear that he or she cannot do what is expected and cannot measure up

Roles That Facilitate the Group's Work

Another approach to analyzing and categorizing roles in groups has to do with how members focus on facilitating the accomplishment of group tasks or on satisfying their own needs. Such an approach is less personal and clinical; rather, it focuses on the needs of the group as a "living organism." This approach to categorizing roles was developed by early group dynamics theorists (Benne & Sheats, 1948; Deutch, 1953). It became the basis for human relations training (Nylen, Mitchell, & Stout, 1967) and was later used for group counselor training adapted for SUD counselors (Stokes et al., 1980, 78–80).

Group facilitators or group maintainers typically engage in the following activities.

- *Harmonizing* to reconcile differences and reduce tensions (usually associated with the placater or peacemaker role in a family whose members may have SUD)
- *Gatekeeping* to keep communication channels open and facilitate communication by others
- *Compromising* to reconcile conflicts and help people admit errors

In contrast, self-oriented roles tend to interfere with the group's mutual efforts. These behaviors include the following:

- *Dominating* by monopolizing the group, not listening to others, and trying to make all the decisions
- *Withdrawing* and making no contributions, appearing apathetic or afraid or having no affect
- *Blocking*, usually by being aggressively critical, attacking others' opinions, and being hostile
- *Seeking recognition* and trying to be the center of attention, the entertainer, and by frequently straying off task and topic (perhaps related to the class clown)
- *Monopolizing the group*: The counselor can bring the group's attention to such behavior by stating, "What do you want from the group now that you've said all this?" "How do you perceive the group members responding to you?" "Could you contribute to the group in less than 20 words?

  Member: "Carol's impossible to stop."
  Leader: "Is that right, Carol—are you really impossible to stop?"
  Leader: "My hunch is, Carol, that when you go on and on, you don't feel quite connected here; we need to find a way for you to share that will make you feel connected to others, and they to you … just using a lot of words isn't getting you what you need" (Vannicelli, 1992, 166–169).

- *Being verbally aggressive/abusive*: It is the counselor's role to provide a safe environment in which interactions can be processed and understood. For example, a leader can placate a verbally aggressive member by stating, "What

was going on for the group as John was talking just then?" "You have a lot of feelings, and you express them very forthrightly. When you get upset, can you try communicating in a way that doesn't push people away? Let's try right now."(Vannicelli, 1992, 165). In other words, the counselor must maintain an empathetic attitude toward the aggressive member.

- *Opposing group goals*: This is a behavior often seen in the mandated, involuntary client who does not want to be in the group. He or she will show strong opposition to group goals. Vannicelli (2001, 54–55) suggests incorporating noncompliance into treatment by inviting clients to discuss their anger at having been made to come and then praising their honesty.

It is more difficult to get members to appreciate the importance of focusing on tasks in groups than on emotions, behavior, and lives of the individual members. Obviously, tasks do not have the personal impact of, for example, realizing that one is being scapegoated or recapitulating a family role. Approaches to educating members on healthy approaches to the work of the group need to be reduced to basic questions, such as, "What are we trying to do right now?" and "Is this helping?" Such questions encourage direct and assertive communication of needs and feelings and help to short-circuit manipulative or self-serving behaviors.

According to Kraus and Carroll (2007), the dominator or monopolist is the most troublesome role for novice facilitators to change. The usual alternatives are letting the monopolist get his or her way or allowing resentment to develop into angry confrontation. Asking the monopolist what he or she wants or needs from the group, or how he or she perceives the group's responses to him or her, is a better strategy.

ACTIVITY 6.5 How do I see this group?

Form a group of six to eight volunteers and play roles that facilitate the group's work (approximately 15 to 20 minutes). As observers, other members of the class identify the roles. Observe the levels of trust and self-disclosure, the levels of participation, the decision-making process, the levels of loyalty, and the sense of belonging. Then, six new volunteers form a group and play roles from the list of self-oriented or so-called negative roles. Again, the rest of the class can offer observations. Discuss what was different. Questions for discussions can include the following:

- What roles are being played or enacted here?
- What levels of trust or self-disclosure were displayed?
- What was the level of participation?
- What was the level of loyalty, sense of belonging?
- What was the decision-making process?
- How did other members react to a member blocking the group process? Did they adopt a unified reaction, did they overcome it, or did it lead to chaos?
- What feelings were evoked during the enactments by actors and observers?
- How might the group facilitate the adoption of productive roles for themselves and group members?

ACTIVITY 6.6 In my family …

Use the same format as in Activity 6.5; however, use family-style roles. By drawing slips of paper, you can be assigned one of the broad roles, such as scapegoat or clown. Other members or observers identify the role or defense being enacted.

HELPING GROUP MEMBERS TRANSLATE WHAT THEY HAVE LEARNED IN GROUP INTO LIFE

Social skills learned in groups will not automatically translate into a repertoire of behaviors practiced in the outside world. People are habituated to certain

modes of interaction with others and will regress to the old norm when confronted, say, with family and friends. A process needs to be built in to check on this "translation" effect, which is often seen in the "homework" segment in groups and in the follow-ups in weeks to come.

Some people come to groups more engaged and outgoing, whereas others are more shy, reticent, and fearful. They may have a history of emotional or physical abuse, abandonment, or other attachment and trust issues. The danger is in letting those who take longer in mastering social skill sets feel like failures, become marginalized, or even be scapegoated. Positive feedback for the less sociable group members, and care to involve them from time to time, is a must.

CASE IN POINT

Coming from a Different Place

In a high-energy encounter group for volunteers at a SUD program on Staten Island, New York, in which some people recovering from SUD participated, a young Scandinavian woman had difficulty convincing the other members that she was upset. Time and again, they challenged her statements by observing that she "acted like she had no feelings," "acted like a zombie," and "seemed stoned." Finally, the psychotherapist who was facilitating the group stated that one would not expect the nonverbal cues of "upset" Scandinavians to be as dramatic, on average, as those of the Mediterranean, Latino, and Jewish people who formed a majority of the group members.

DEFENSE AGAINST EMOTION

It is often difficult to be vulnerable, trusting, and emotionally open to a group of relative strangers. It is also hard work. Labeling a new member as defensive may not be helpful. Participation in the group process and natural reaffirmations to the expressed emotions of others should gradually help the new member share his or her emotions.

Groups help to build emotional literacy, which is the ability to identify, acknowledge, experience, and communicate emotions (Goleman, 2005). A large proportion of group norms, mottoes, and exercises concern emotion; treatment groups tend to be charged with emotion. Yet, individuals invest a lot of energy in defending against emotion, for a wide variety of reasons.

Blunting or Negating Feelings

A variety of mechanisms can be employed to blunt or negate threatening or painful feelings. It is important to distinguish such defenses from unfamiliarity with the vocabulary of emotion and from the blunting of affect that may be symptomatic of depressant abuse or schizophrenia. Emotions can be negated by

- Denying emotion
- Withdrawing and isolating
- Staying vague or confused
- Using program jargon and clichés

Staying in a Cognitive or Informational Channel

By providing only cognitive and informational content, a group member can avoid his or her emotions. Varieties of this defense include

- Intellectualizing
- Barraging the group with data
- Not venturing beyond the ritualized AA drunkalogue or "story"
- Storytelling (war stories)

Storytelling (in some programs, this is called telling "war stories") can be seen as the lack of client orientation away from the AA/NA model, where the "story" is the centerpiece of a member's utterances. On the other hand, it can be a sign of resistance. A third possibility is that the person is holding on to the old group culture out of fear of intimacy, although he or she knows the group norm is one of interaction.

FORMULATING TREATMENT PLANS FOR GROUP MEMBERS

One of the major tasks in planning group treatment is to make sure that issues and individual clients' concerns are addressed in the group, including issues emerging in individual counseling that warrant group attention (making sure to observe confidentiality). Similarly, information, issues, and problems that emerge in the group need to be forwarded to individual counseling, when necessary. Clearly, staff need to function as a treatment team. There are three canons of long-range treatment planning in groups:

1. Phase goals appropriate to each stage of treatment.
2. Anticipate feelings that are likely to be evoked at each stage.
3. Make sure the approach is congruent with or appropriate to the setting or modality (e.g., an intensive outpatient treatment program, a residential program, a halfway house).

One example of rather predictable feelings is "the terrible twos." This phrase refers to the second year of recovery. In recovery milieu, it is a humorous analogy to the difficulties parents often have when their "little angels" exhibit stubborn behavior or tantrums when they are two years old. In early recovery, the individual with SUD is often on a "pink cloud," having ascribed all problems to the former SUD. When problems (inevitably) reassert themselves and result in cognitive dissonance or some attempt to set the blame on some lingering aspect of SUD, the client must begin to face his or her disappointment that recovery is not all joy. These issues can be brought out and shared in the group setting. Another example of predictable feelings is the approach of termination. When a member is preparing to leave the group, he or she may have anxieties that are manifested in regression, threat of recurrence, or behavior that covers up needy feelings (such as a show of independence or denigration of the group or leader). In addition to monitoring the departing member, the counselor should observe the group's reactions to the impending departure of the member in order to determine whether the group is motivated to undermine growth, emphasize weakness or danger, or "break the wings" of the client.

Planning Formats

The formats for planning treatment for groups that appear in **FIGURES 6.1**, **6.2**, and **6.3** are based on some of the most important sets of goals for SUD groups. It is not realistic to expect counselors

Goals *(apply to early treatment)*

- *Manage uncomfortable physical and psychological states of early sobriety.*
- *Manage the desire to drink or use drugs.*
- *Manage the anxiety and stress of being in an institutional setting, in a hospital unit, or in the group.*

Strategies

- *Establish group norms of sharing.*
- *Use role models by pointing to more senior clients who have moved beyond acute withdrawal.*
- *Provide information about withdrawal and abstinence.*

Trouble-Shooting Areas

Problems: *Denial of desire to drink, use drugs,*

Resolution: *Identification given by others more experienced, sticking with first-stage issues, reiteration that feelings are normal and natural.*

FIGURE 6.1 Plan 1 for group treatment.

Goals *(appropriate to later treatment)*

- *Develop the ability to engage in conflict and resolving conflict without withdrawing, drinking or drugging, or becoming violent.*
- *Related Objective: Learn to be angry in a socially appropriate way, without anxiety, guilt, or acting out.*

Strategies

- *Orient to the group norm: No violence or threats of violence. Stay in your seat. One person talks at a time.*
- *Orient to group culture, including the mottoes: Bad feelings get in the way of good feelings. You are entitled to all of your feelings. If you talk about it, you won't drink about it. It's not that you're not good enough, only you are good enough!*
- *Discuss old ways of dealing with resentments and triggers for violence.*
- *Orient to a simplified version of assertiveness concepts: It is not hostile or aggressive behavior, passive behavior, or indirectly hostile (passive–aggressive) behavior.*
- *Encourage "I" statements: "I need ...," "I feel ..."*
- *Reward direct expressions of anger. Show the positive aftermath.*

Trouble-Shooting Areas

- *Fear of rejection*
- *Conflict defined as part of "old, bad" ways*
- *Passivity, depression, and learned helplessness*
- *The low-conflict style of Alcoholics Anonymous*
- *Fear of own feelings, panic at premature self-disclosure*
- *Denial of feelings*

FIGURE 6.2 Plan 2 for group treatment.

Goals *(appropriate throughout treatment)*

- *Stability and responsibility, which are the broad behavioral objectives*

Strategies

- *Use punctuality and attendance as group material.*
- *Explore reasons for difficulty in establishing responsible behavior patterns. Link to chemical intoxication, SUD lifestyle, and hopelessness.*
- *Discuss difference between being "dry" and real recovery. Use the AA concept of the dry drunk.*
- *Discuss behavioral problems and specific commitments made to group for follow-up.*
- *Prioritize goals and objectives, breaking down behavioral changes into simple, nonthreatening, concrete steps to be taken, one at a time.*

Trouble-Shooting Areas

- *Explore the impediments to changing behavior—habitual roles, process variables, and client mix.*

FIGURE 6.3 Plan 3 for group treatment.

to chart all of their group goals, strategies, and impediments, especially in a short-term treatment setting, nor to follow any chart very closely in an interactive, unpredictable group. However, counselors should be prepared with appropriate interventions at each stage of treatment and anticipate the obstacles that inevitably crop up when traveling these paths.

Interventions should be keyed to readiness to change. The stage of change (i.e., precontemplative,

contemplative, planning, action, maintenance) that has been noted in clients should be available in the most current psychosocial assessment. It would be inappropriate for the precontemplative client (often a mandated or involuntary client) to be involved in advanced issues, such as exploration of early abuse. A valuable group therapy manual based on the stages of change model promulgated by Prochaska and DiClemente is the work by Velasquez et al. (2016). Most of the motivational interviewing strategies and techniques can be successfully translated into a group format (Mitcheson & Greller, 2011). A five-session motivational interviewing-based group curriculum was developed by Ann Fields (2004), complete with handouts and worksheets, which the purchaser may use without violating copyright.

Impediments to Change

Regardless of the planning format, counselors must observe, assess, and monitor the enormous variety of impediments to changing behavior. These include habitual roles, process variables, and the mix of clients in the group.

Roles

Almost any of the roles adopted by group members can create impediments to behavioral change. For example, some may be afraid to relinquish a "sick" role that offers some comfort. Others may engage in "rescuing." Rescuing enables the avoidance of confrontation or other uncomfortable situations. Such "red-crossing" or "band-aiding" in drug rehabilitation programs is often a problem with new members who identify with people "on the hot seat" and become anxious when others are pressured. It can also be a form of "flag-waving" (i.e., signaling that the rescuer needs help), presentation of a nice-guy image in order to be liked, or the habitual reprise of codependent and enabling behavior of a family whose members may have SUD. Crying, in particular, is certain to bring out rescuing behavior. It is good material for group discussion when it occurs. A useful tool is the therapeutic community concept of responsible concern (similar to the tough-love concept), which is that rescuing is not helpful to the individual or to the group. In behavioral confrontation, counselors always need to steer a course between scapegoating and rescuing.

Process

Aspects of group process that can impede behavioral change include mutually protective, tacit agreements among members not to "make waves" or reveal certain information ("pulling covers"). Some programs call these negative contracts. They often reflect a relationship outside of the group. Entire groups also can develop a tacit understanding to avoid uncomfortable or pressuring areas and topics. So-called higher-level groups of experienced members are prone to this. While it may appear that the group process is well developed and group affiliation and solidarity are optimal, it is important to examine whether, on a deeper level, the group is being complacent and refusing the difficult, anxiety-provoking work necessary to progress further. Scapegoating and pressuring of a weaker, newer, annoying, or different member is another example of a group contract.

At some old-style therapeutic communities, members link the two concepts: It is sometimes thought that "red-crossers" were "hustling for a contract." In more familiar language, people may do favors, such as rescuing and protecting others in the vague or explicit hope that this will be reciprocated. Assertiveness skills training (Lange & Jakubowski, 1976, 23–24) refers to this as the *hidden bargain*[d].

Defenses

Any of the defenses may come into play, such as overwhelming the group with data; offering a fierce, hostile image (one who will retaliate); and presenting a weak, fragile, and guilt-evoking image (which Al-Anon groups have aptly labeled "the poor

[d] Assertiveness skills training is a long-established system of learning appropriate, nonthreatening, and effective approaches to dealing with conflict, potential conflict, and communication of negative emotion. See Lange and Jakubowski (1976) for training options for this area.

me," or "throwing a pity party"). A seductive or flattering member may also succeed in downplaying confrontation. Experienced group members may present a super-honest, super-confessing image. The counselor should consider whether this is a subtle form of resistance, especially when real and difficult behavioral changes should be on the agenda. Another defense is the raising of distracting information or side issues, sometimes called "throwing a bone." This phrase also can refer to presenting real information in a skewed way in order to have something to say. (See the Case in Point, "Throwing a Bone.") In such a case, the group's response could help the client overcome his or her timidity and reticence in interpersonal, dating, and sexual matters, or it could make him or her feel more inadequate and alone. Group process in a confrontational-style group can set up a self-fulfilling prophecy: When the group enjoys attacking defenses, participants may feel anxious and evasive and become more defensive. Much of the behavior that is called denial is simply a reaction to anxiety.

CASE IN POINT

Throwing a Bone

At a SUD group in a young adult intensive outpatient clinic based on the therapeutic community model, a young man who had problems initiating romantic relationships had not spoken in weeks and was urged to provide an update. He sadly recounted a sexual encounter that culminated in a frustrating rejection. Then a friend remembered that this incident had taken place two years earlier. It was revealed that he had not, in fact, been dating for some time and in anticipation of "flack" on this score was "throwing a bone" to the group. The group met the discovery with derision, ridicule, and laughter.

GROUP RECORDING

Recording a group process is more difficult than recording an individual process. There are several participants and a multiplicity of relationships. Moreover, note-taking during group sessions is rarely allowed. Notations on the content of sessions and on the process taking place in the group are often a summary of what the counselor recalls with detailed descriptions of events that were particularly dramatic or especially illustrative of the process. Like individual process recording, a group process recording can be laid out in two columns (content and process) or it can be written in alternative paragraphs for the same purpose.

ACTIVITY 6.7 How was group today?

To practice recording the content and process of a group, you can use the processes at work in a real treatment group or in a "fishbowl" group set up in the classroom. In the latter situation, a circle of students observes either a smaller group that is conducting a scripted role play or a group that is simply discussing their feelings in the here and now. Do not take notes during the role play. Later in the day, write your process recording of the group. When the class meets next, compare the perceptions and descriptions you wrote with those of your classmates. How do your descriptions of each component agree and disagree? What accounts for the differences in perception of group processes?

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CHAPTER 7

FAMILY

OBJECTIVES

At the end of this chapter, students will be able to:

1. Describe the roles of status, power, and authority in a family system.
2. Define the terms *enmeshment* and *disengagement* as used in family therapy.
3. Describe the dysfunctional patterns of communication found in addicted families.
4. Describe at least four irrational belief systems in families having a member with substance use disorder (SUD).
5. Describe the roles played by children and spouses of people with SUD.
6. Describe a minimum of four major sober living tasks of a family in recovery.
7. Contrast the three major approaches to intervening with a family with a substance abuser: Al-Anon/Nar-Anon, the Vernon Johnson intervention model, and CRAFT.

FAMILY TREATMENT

Readers should be aware that family therapy is a separate field from SUD treatment, with its own professional organizations, vocabulary, and licensing requirements. SUDs agencies may conduct family interventions and family education but must be careful not to declare that they perform "family therapy" without properly credentialed staff in that area (as licensed marriage and family counselors). Also, please note that third-party payers are increasingly more unlikely to reimburse for both substance abuse and family treatment. The inability of agencies to get payments for hours spent with families has become so severe, in fact, that a colleague suggested that this chapter be omitted from this text.

Involvement with families, where possible, is usually helpful, and provides an opportunity to note negative patterns, such as being controlling, bullying, and domineering; it also prevents importing such patterns into family meetings. Conversely, counselors must ensure that what goes on in a family session will not trigger family violence once the members go home. One does not try to initiate treatment with a threatened, terrorized family member and their persecutor; instead, one gets them into a domestic violence program.

Some important reasons for attempting to work with families are the following: (1) family members can increase the motivation for treatment; (2) families understand that the "whole family" is affected by substance use disorders; (3) working with families can change patterns of behavior that interfere with or work against recovery; (4) it is useful to help families prepare for what often occurs in early recovery; and (5) "and to encourage family members to support long time recovery." (Edwards, 1990, 25–41.)

FAMILY DEFINITIONS

Although "family" may connote to some a configuration such as mother, father, and children, that is only one type; in fact, it is a fairly rare type of family (the so-called *nuclear family*). Far more typical among the countries across the world, and even in the United States a hundred years ago, is the *extended family* involving either three generations in a household, an uncle or aunt, cousins, or all of the above. It is not within the scope of this text to begin to describe the incredible diversity of family and kinship systems, which may include first- or second-cousin marriage, blended families, and/or homosexual families. Counseling trainees can benefit from an introductory course in cultural anthropology and/or marriage and the family. Family and kinship are a major focus of cultural anthropology (McGoldrick, Gerson, & Petry, 2005).

THE FAMILY AS A SYSTEM

Families are social systems. There are three general principles of systems.

- Each element (in this case, person) plays a part or role in the system.
- The elements of systems (here, people) influence each other
- Systems tend to strive for balance and to maintain the status quo

Like group counseling, family counseling focuses on process. Unlike a group of strangers together in a room, however, a family has a long-established system of rules, traditions, rituals, and modes of communication. Every family member knows the rules and plays his or her role. A good metaphor for the difference between individual and family counseling is the choice of a seat at a football game. You can sit up close and see individual players or sit farther back in the bleachers and see the entire team play as a unit. In family counseling, the counselor focuses on the way the "team" plays as a unit rather than on each individual's actions.

ACTIVITY 7.1
In my family …

Form groups that correspond to your family's size (only child, two children, three to five children, and so on). Discuss the rules, taboos, and family rituals of your childhoods. Consider issues of drinking, sex,

and secrets. Discuss who had power in the family, who drank or took drugs, who supported whom, how you were disciplined and by whom, who came into conflict with whom, and how conflict was handled. Were there family secrets, things kept within the family? What happened on special occasions like birthdays, holidays, and anniversaries? Share only what you wish to share!

To help a family with a member living with SUD, counselors need skills in assessing, understanding, and facilitating change in a number of areas.

STATUS, POWER, AND AUTHORITY

It is important to determine who has power and authority in the family. Observations of who makes decisions are necessary but not always sufficient. Who determines whether a referral will be implemented or aftercare recommendations followed? It may be the oldest child, an uncle, a grandparent, a grandaunt, or even someone not living in the continental United States. In some urban communities, teenagers who are dealing drugs acquire unusual power in the family. If there are two languages or cultures involved, the use of a child to translate for parents may transform the child into a "family hero" or "cultural broker" on whom the family depends for information and representation. Even a counselor's intervention can play a role in the family's power system. The counselor can play a part in reinforcing the status and power of individuals who are neglected or suppressed within the family system by looking to them for responses and comments and by encouraging and rewarding their participation.

Elements of the System

Minuchin and Fishman (1981) developed special terms to characterize family relationships. *Enmeshment* describes excessive or intrusive involvement where there is no personal space, autonomy, or sense of personal competence. The term *fused* is almost synonymous. Enmeshment may be a reaction to trauma or loss, a "circling of the wagons," or coalescing against a perceived threat. Quite typical in the family with a parent with SUD is a pattern of enmeshment between the nonusing spouse and the children (Edwards, 1990, 17). Enmeshed and fused relationships go beyond mere coalitions or alliances; people intertwine to the point of losing their autonomy, a condition that is necessary for personal growth. Keeping up appearances in the family with a member with SUD or a disabled person can involve an adaptation in which everything revolves around the SUD of another person. To be enmeshed is also to be *dependent*. Enmeshment, then, comes close to the popular, if overused, concept of *codependency*.

The opposite of enmeshment is *disengagement*, an abnormal lack of involvement, communication, loyalty, and sense of belonging (Minuchin, 1974). Many family members disengage from a problematic, untrustworthy, or troublesome member (living at home or not). An individual with SUD may drift y into a SUD netherworld and become disengaged, or he or she may pop in and out of a family or other social system when he or she needs help or wants to resume a normal role. In between the extremes of enmeshment and detachment is a healthy zone that nurtures but allows growth.

The degree of disengagement from SUD varies considerably by ethnicity. Fitzpatrick's study of Puerto Ricans with SUD (1990) found that their families did not reject members with SUD, or, if the individual with SUD was isolated from the family and later went into recovery, he or she could re-enter with relative ease (p. 119). However, the family of the person with SUD may have to put up with a great deal of exploitation (p. 120). This acceptance may not extend to the disgraced or degraded female user, particularly one who exchanges sex for drugs (Williams, 1989).

Definitions of Relationships

A family system with one or more member living with SUD often has its own definitions of the way families are supposed to be, such as what constitutes a

"good child" or a "normal marriage." Families may hold sharply contrasting views of what constitutes "good" and "normal." A "good" child may be a passive or quiet child, one who attends to the parents' every need or one who excels in sports or academics. For some families, "talking back" to parents is a sign of courage, spirit, and intelligence; for others, it is a sign of disrespect. Cultural norms shape many of these definitions. For example, in the film *Lovers and Other Strangers*, a young man complains that he and his wife do not love each other anymore and are planning to divorce. In response, his father explains that romantic love is not necessary in a marriage, that he and the mother were "content" with each other. Not only do family patterns vary among ethnic groups but also historic changes in all societies affect concepts of love and family.

Conflict

There are innumerable sources of conflict, hidden or open, in a family, as well as various methods of resolution. Reactions to conflict are based both on norms of appropriate emotional expression and on the propriety of conflict. There may be interminable "cranky" verbal recrimination and accusations, "cut offs" of family members (McGoldrick, 1982), or fused and enmeshed but conflicted relationships. Conflict may take the form of verbal violence, physical violence, indirect sarcasm, nonverbal signals, or attempts to manipulate (by guilt, loyalty, or fear). It may be expressed in the form of verbal battering by a man who resents his wife for earning more money than he does. If an adolescent is the focus of conflict, he or she might be "sent back" to his or her country of origin, if it is feasible. This might be a combination of a "geographic cure" and a way to minimize conflict. It also functions to remove the "problem teen" from the family and from peer groups that may be perceived as negatively influencing himand, perhaps, to transport him to a stricter environment to "straighten him out." A family that has migrated may experience *transgenerational stress*, when members of the family do not adhere to traditional norms of deference and respect.

Styles of Communication

Families have many methods and styles of communication, which vary on many axes and dimensions: the degree to which communication is direct or indirect; the attitude such as assertive, playful, passive, hostile, or passive–aggressive; the "channels" employed (words, voice qualities, gesture, posture, and facial expression); and the degree to which emotion is displayed or shared. Some families air important issues at the dinner table; some post notes on the refrigerator; others ignore issues until a crisis erupts. Certain family members may have "permission" to communicate emotion (e.g., only Dad can get angry).

SUD superimposes dysfunctional patterns onto an existing cultural pattern. To cope with pain and anxiety, denial among family members is practiced, resulting in an emotional climate where, as described in detail by Claudia Black (1981, 24–48), the unspoken rules are "Don't talk. Don't trust. Don't feel." Thus, there is noncommunication, incongruent communication (double messages), or destructive communication, and family secrets.

It is important to distinguish between cultural patterns and patterns influenced by SUD, or their interaction. One common clinical situation is that a wife objects to confronting a husband or refuses to confirm what is evident to the counselor about the family's dismal state. This might be a manifestation of required family loyalty/secrecy found in their culture, the exaggeration of a tendency toward that behavior, or an adaptation caused by SUD.

Family Belief System

The family having a member with SUD constructs an account of its functioning that family members believe and present to others. The SUD and codependency in the family are often denied, rationalized, excused, or blamed on others. Families in general think of their own behavioral patterns as the norm, a kind of micro-ethnocentrism. This is also true of the dysfunctional family: The abnormal is perceived as normal. Its thinking patterns are also typically helpless and hopeless. **TABLE 7.1** shows some irrational statements or internal dialogues,

TABLE 7.1 Irrational Thoughts of Families Having a Member with SUD

- The user's SUD is the most important thing in family life.
- Use of alcohol or drugs is not the cause of our family's problems.
- Someone or something else caused the problems; the individual with SUD is not responsible.
- Keep the status quo at all costs.
- Everyone pitch in and enable the individual with SUD.
- Don't discuss what's going on with one another or with outsiders.
- Don't say what you feel.
- If we stop enabling, something terrible will happen.
- Things will get better when …

which may not be consciously realized. Some of the items are adapted from the "alcoholic family rules" summarized by Wegscheider (1989, 80–84).

Harm to Family Members Not Having SUD

The family having a member with SUD has many problems growing out of SUD and codependency. These problems affect all members of the family, including the members without SUD and extended family members. The harm—which may be short term, long term, or both—includes sexual dysfunction, marital paranoia, emotional and physical neglect, and nutritional problems. Family life is traumatic and inconsistent: After an outbreak of violence to which the children and other family members bear witness, there may be a brief "honeymoon period" where the perpetrator feels remorse, and then the SUD resumes. Chaotic functioning and not knowing what trauma is about to occur generate a great deal of anxiety. Family alliances shift as the system frantically attempts to cope with SUD loss of control. Other aspects of trauma to children include witnessing sex, being molested themselves, and being witnesses to police intervention in the home. Another harmful effect on families is that out of isolation or preoccupation with the family itself, or a subsystem within it, an individual member often gets "stuck" in the normal process of development (Edwards, 1990, 59; Sweet, 1990).

Expectations of Treatment

Family members coming into recovery hold many myths and unrealistic expectations. Among many working-class and poor populations, for example, the concept of family therapy is alien. They expect individual SUD treatment to be short term, as in a detox unit. Family counseling, to the extent that this concept is accepted, is also expected to be very short term. The family may expect primarily concrete instructions and advice. They may believe that "everything will be OK now that he or she has stopped." They need orientation about the process of family therapy. They need to know that all of the family members will have to work hard to avoid enabling and to communicate honestly and directly, both in treatment and at home.

Engaging the Family

When engaging with family members, it can be useful to establish basic rules for the initial meeting because emotions run high and can sabotage the meeting. These include the following:

1. Requesting that each family member shows respect. Indicate that each member should tell his or her view of the problem without interruption or using derogatory names or being sarcastic. Each person should be given time to speak uninterrupted.
2. No one should speak for another member. They can say what they saw or experienced with another member but not for the other person.
3. Each member should agree to participate in helping each other.

4. Each member can ask for reasons and explanations and expect honest answers.
5. All family members should agree to remain throughout the information meeting and try and commit to attending future meetings (Juhnke and Hagedorn, 2006, 152–3).

Privacy and Boundaries

Concepts of boundaries around the family vary greatly. Discussion of intimate relationships with people outside of the family and public expressions of anger or discord may not be permissible. Families act as units, putting up boundaries around themselves. Concepts of privacy vary among families as well as among groups in society to which families belong. The degree to which privacy about a topic is an issue varies and is expressed by reactions ranging from discomfort to absolute secrecy. Further, information may not be shared even with individuals in the family, such as children and adolescents. Again, SUD dysfunction is superimposed on regular cultural norms: In the family having a member with SUD, there is a great discrepancy between what goes on "backstage" and what is presented "frontstage" in order to "keep up appearances." The family tends to encapsulate, putting up thick boundaries.

The need to use a child to translate, mentioned earlier, can make certain topics even more taboo, and, in general, may seem disrespectful. Counselors must find out about these customs and attitudes before initializing family therapy.

Counselors need to gather information in the aforementioned areas in order to help family members develop self-understanding of their work together as a system and to help facilitate a healthier, recovery-oriented system. There is a wide variety of "normal" families, and the counselor may find that he or she must balance between respecting the cultural norms of families (and not alienating the clients) and encouraging changes out of the need to facilitate honest communication, individual autonomy, and growth.

SUBSTANCE ABUSERS AND THEIR SATELLITES

Family systems tend to adjust themselves around a member's dysfunction. If this happens during caretaking for a cancer victim, it may be beneficial for the sufferer. In the case of chemical abuse, however, it perpetuates the substance abuse or even makes it easier to progress onward in severity. In treatment of families with substance abusers, behavior that contributes to continuance and progression of chemical abuse is called *enabling*. It may include cleaning up the mess made by an individual with SUD, cleaning him or her up, bailing individual with SUD out of jail, paying his or her debts, getting out of dinner invitations, or calling in sick to an employer. The family often does not see how its "helping" is injurious. A closely related term in the SUD self-help vocabulary is codependency. *Codependency* refers not only to the enabling role played by a significant other or family member of an individual with a SUD but also to the overinvolved investment in playing that role and in making the individual with a SUD and/or SUD the center of his or her life, like a small satellite circling a planet. Prominent examples of such codependent roles are the rescuer, the caretaker, and the eldest child who takes on parental functions.

The term *codependency* has gained acceptance with those who came to believe that their lives were overly circumscribed and defined by the needs of others, and the concept has spread to encompass or explain a multitude of phenomena in society, although rarely grounded in clinical observation or research. In this text, we limit the use of codependency to those who adjust their lives around SUD and who receive gain or benefit to themselves or to the system as a whole, although this gain may seem very indirect and, in fact, be injurious in the long run.

Edwards (1990, 196–197) remarks that he never ceases to be amazed at the "sincere and abysmal ignorance" he encounters in family members who, for example, greet the returning, newly dried-out member with a drink. Moreover, telling family

members *not* to allow the member with SUD back into the house or clean him or her up may run against family norms of loyalty and protectiveness that are almost sacred in its culture.

Family Roles

It is normal for families to assign roles to members, often predicated on birth order. The birth-order effect was discussed in detail as early as 1931 by Alfred Adler (Adler, 1998). Often an eldest child, particularly in a family where there do not seem to be many achievements, goes on to relative success and is pointed to as a family hero. Often a youngest child is the beloved baby or mascot. The middle child may have no special part to play, being neither the first born nor the baby, and may become invisible and/or depressed, misbehave to get attention, and become the identified patient or the scapegoat (Adler, 2008).

Whatever the combination of factors, trauma or increased stress may cause even more need for a hero, a mascot, or one fewer person to bother about. In addition, the family frequently needs someone to "take up the slack"—one person must then do more than necessary and usually takes on more decision-making authority, often at the expense of his or her own needs. Salvador Minuchin (1974) describes a "parental child" who carries decision-making authority in a family whose parent is unavailable (absent or unable to function). Virginia Satir (1964) describes a similar concept, the "super-responsible one." All of these adaptations need to be seen against the backdrop of family relationships typical of the culture of which this family is a part.

Scapegoating

Families, like other groups, may actually need someone to draw fire, to be a tension-reducer, to take the blame. The "Palo Alto group" of family therapy systems researchers (Don Jackson, Jay Haley, Virginia Satir, and Gregory Bateson), as early as 1959, described the way the family often acts as a unit, the communication disturbances, and the process by which the family creates a *scapegoat*, often a child who is identified as the patient (Kolevzon & Green, 1985; Satir, 1964; Vogel & Bell, 1960). In one respect, however, the Palo Alto group came to a conclusion that was not borne out by later medical research. They reasoned that scapegoating caused childhood psychiatric illness. This hypothesis has been proven false. We know now, however, that schizophrenia and other brain diseases are not caused by poor parenting. A family with a member having SUD often directs its anger and frustration at the weakest, most deviant, or problematic member. The hyperactive child may be scapegoated, even abused. The chemically dependent member of a family may become the scapegoat for problems not of his or her creation. By scapegoating, the family is telling itself (Edwards, 1990, 31), "If he didn't use, we'd be fine."

Parental children, scapegoats, and other such roles are especially typical of enmeshed families, whose members are overinvolved with each other and underinvolved with their own identities and outside relationships. However, many family systems beset by SUDs do not fit any sort of enmeshed pattern; in the extreme, the caregiver is a mentally and physically exhausted grandparent or it may even be a no-parent family.

Popular Views

During the 1980s, popular writing on SUD in the family and on the roles of children that are carried into adulthood, these roles, described by family systems experts, such as Adler, Minuchin, and Satir, are depicted as especially characteristic of families having a member with SUD (Wegscheider, 1989). There is usually no citation of the earlier researchers and clinicians who observed these roles in families not affected by SUD (Myers, 2002; 2011). Moreover, the cultural context that determines family roles is also overlooked, as if there were one type of family affected by SUD that transcended culture. These writings were venerated by the Adult Children of Alcoholics movement. Because such roles are so common, many individuals identify with them and ascribe a variety of ills to their being the offspring of an individual with a particular variety of SUD.

To be sure, many individuals suffer tremendously from the legacy of belonging to a family battling with SUD, and some have indeed been cast in one of these roles as a by-product of SUD in the family. Still, there is the real danger that a counselor may identify behavior as that of a role of an adult child of an individual with SUD or a codependent when the behavior is actually grounded in mood disorders, birth order, cultural patterns, or acculturative stress.

Other Disorders

The chaos in families contending with SUD is sometimes the result of family members who have attention-deficit hyperactivity disorder (ADHD), some of whom self-medicate. Because ADHD has a genetic component, there may be a parent and a child who both suffer from problems of hyperactivity, organization, staying on task, and losing and forgetting things, and who also may serve as role models for other children. Yet, some SUD specialists tend to look only at the substance abuse as the cause of the problems.

Cultural Patterns

A counselor who is familiar with a client's regular cultural patterns might be guilty of *ethnocentrism*, that is, looking through cultural blinders and evaluating another culture by the standards of one's cultural rules. For example, McGoldrick's description of the Irish family roles also sounds like the roles that have been described as typical of families contending with SUD. She says that the typical Irish family (not necessarily that with SUD) as described by the mother, contains "My Denny, Poor Mary, and That Kathleen"—a family hero, lost child, and scapegoat (McGoldrick, 1982). Scheper-Hughes (1979) provides many examples of the Irish family's "pattern of mythmaking whereby each family in the village seemed to have its successful, high-achieving (usually first-born) 'pet son' as well as its black-sheep alcoholic or its shy, incompetent (often last-born) bachelor son" (Scheper-Hughes, 1979, 179). These patterns are rooted in both birth order and economics; they are not results of SUD in the family system.

As another example, the partially assimilated Mexican-American family "retains" and infantalizes the youngest child as a defense against assimilation that has claimed other children. This role is similar to the mascot described by Wegscheider et al. (Falicov & Karrer, 1980).

Assessment of Family Roles in a Family Living with SUD

Children of members with SUD describe their father's vacillation between a drunken, violent person one night and a benign parent the following day. Living with such inconsistency generates tremendous cognitive dissonance and anxiety, which necessitates considerable denial to self and others. On a less catastrophic (nonetheless disruptive) level, the member with SUD may simply drift in and out of people's lives. The binge-drinking or chronically recurring single parent with SUD may vacillate between a "normal" parental role and an infantalized childlike role (Edwards, 1990, 76–78).

When assessing a family's roles, counselors must take into consideration its community and culture. If counselors are not familiar with them, they should consult someone who is. It is wrong to assume that a role derives from SUD or dysfunctional adaptation.

ACTIVITY 7.2 Assessing the role of the spouse/significant other

The left-hand column is a list of roles played by spouses or significant others of individuals with SUD. The right-hand column represents the thinking patterns or rationale for these behaviors but shows them in random order. In the first part of this activity, please match up the roles with the thinking associated with each role. You may wish to photocopy the page to draw lines across the columns to match up the items. In the second part of this activity, students can discuss how any of these roles apply to a case in which they are involved. In addition, they should consider whether the spouse or significant other vacillates between

two of these roles or is transitioning from one to another. They also should consider if and how this role deviates from the traditional role of spouse or significant other in their culture of origin.

Role	Thinking
Rescuer	"It wasn't that bad. He didn't really mean it."
Caretaker	"Don't drink more than one drink tonight."
Long-suffering martyr and saint	"I just don't feel well at all."
Overextended super-responsible one	"Love conquers all."
Chief enabler	"Poor me, I do it all myself for their sake."
Scapegoat	"You're ruining our lives!"
Hypochondriac, somaticizing	"The poor man, he needs my help."
Joiner in use	"We'd all be better off if she'd just give up the booze."
Placater or peacemaker	"I don't care. After that last fiasco, I'm not having any more to do with my family."
Blamer, conscience	"I love you, but I can't be with you until you start getting better."
Battler, limiter	"Let's get high and stay together."
Disengaged and hostile	"I'll take care of it."
Recovering from codependency, lovingly disengaged from SUD, and/or attempting to achieve referral into treatment	"I'm just trying to help."

ACTIVITY 7.3 Role of the individual with SUD

Each student should consider the case of a person with or who has recovered from SUD. A student volunteer or the instructor may offer a description to help start this discussion. Check one or more of the following descriptions if they apply to the individual with SUD. If the individual with SUD, as is often the case, cycles between two behavior patterns, depending on his or her state of intoxication, it is important to indicate this. This can be done by drawing a two-headed arrow between the two roles.

_____ *Absent, disengaged*

_____ *Infantilized and/or sick role—may or may not be kept out of sight*

_____ *Scapegoat*

_____*Good, depressed provider*

_____ *Out of control, but not particularly threatening*

_____ *Out of control and threatening or abusive*

_____ *Attempting relapse*

_____ *Other* _____

ACTIVITY 7.4 Role of the children of individual with SUD

Each student should consider a family with whom they are familiar, in which there is a parent with SUD. A student volunteer or the instructor may help start this activity by describing such a family. Indicate which children play which role, by birth order and gender. A simpler technique is to enter the children's names and ages next to their roles. You also can draw an arrow to indicate transition or growth from one role to another, or draw a double-headed arrow to indicate vacillation. The binging or recurring parent, for example, may propel a child repeatedly into "pseudoparent to parent" status and back out again. An individual can play one or more of the following roles:

_____ *Pseudoparent to other children*

_____ *Pseudoparent to parent*

_____ *Pseudospouse to spouse of individual with SUD*

_____ *Family hero*

_____ *Scapegoat, rebel who acts out*

_____ *Scapegoated child (some are colicky, hyperactive, or have fetal alcohol syndrome)*

_____ *Invisible one*

_____ *Placater*

_____ *Coabuser who joins the parent in abuse*

_____ *Battler with SUD who attempts to limit someone's use*

_____ *Codependent in recovery, lovingly detached*

_____ *Other* _____

ACTIVITY 7.5 How do I describe this family?

Solicit volunteers to play family members in a mini-drama, taking roles from the assessment schedules. Identify a situation or a theme for enactment. One approach to implementing this activity is to set up a situation such as, "Dad with SUD shows up drunk at Christmas celebration" or "Dad is downstairs drunk and is about to crash the Christmas celebration." Have students act out the typical responses of children in their roles as listed earlier in either situation and have other class members then guess which roles are being played.

Addiction or Cultural Norm?

Counselors must take care not to confuse codependency with normal cultural roles, ADHD, bipolar disorder, or birth-order roles. For example, in many African-American families, the so-called executive authority over younger children can be the normal role of an eldest daughter as part of a broader pattern of role flexibility (Brisbane, 1985a; Brisbane & Womble 1985). Literature on families contending SUD and codependency has patented this role, the family hero, as typical of this kind of family. Such a role may not flow from a framework of SUD. When a counselor sees an older child playing a parental part in the family, he or she must be careful to determine, as much as possible, whether this is culturally routine behavior or indicative of a response to SUD in the family.

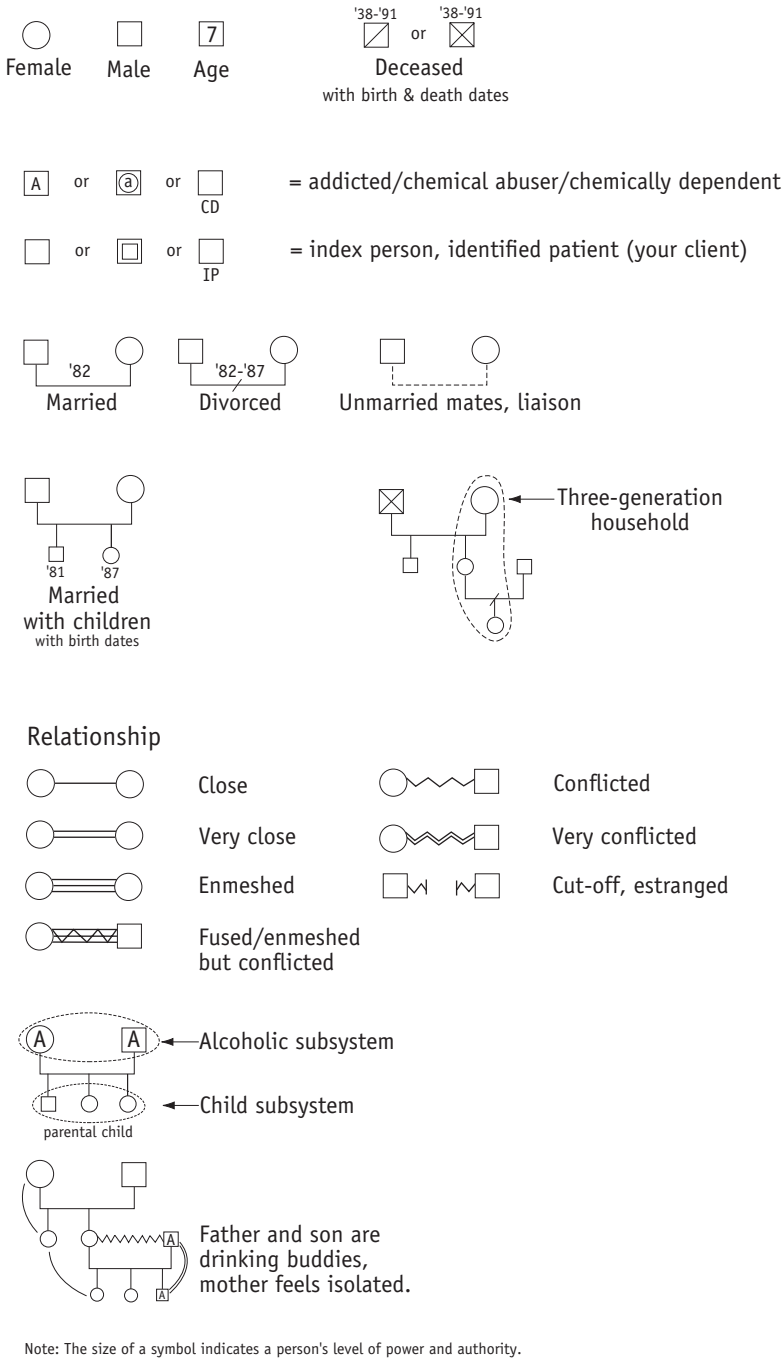
According to Brisbane (1985b), the African-American female family hero elaborates upon a normal second-mother role, one who is in charge and is preparing for her (assumed) adult role. Unfortunately, in the family contending with SUD, the executive/parental child has no adequately functioning mother figure to emulate. The codependent mother or the one with SUD can, perhaps, provide concrete needs, but she is less likely to be capable of fulfilling psychological needs. The African-American female family hero may not complain about her plight. She is proud of her tenacity and ability; SUD is but one more problem to cope with, not to correct (Brisbane & Womble, 1985). She is likely to leave home early, via a job or marriage, although she continues to be a source of emotional support for younger siblings and may provide a refuge or safe place for them. These pseudoparents are themselves victimized by not having the opportunity for nurturance, play, and age-appropriate dependence.

CHARTING THE FAMILY

Sometimes, people need help conceptualizing patterns and structures, especially their own. Genograms and family maps help counselors and clients see the patterns in their behavior. **FIGURE 7.1** shows the symbols used in family charts to indicate relationships. In addition, the following link provides the basic symbols used in genograms and family maps: http://dhhs.ne.gov/children_family_services/Documents/a1FGenSym.pdf.

Edwards points out that family charts (genograms and maps) are no more than working hypotheses, ones that may need correction or amplification, or that may change (1990, 50). They are a model of the family, which counselors may embellish with meanings that are not there, based on ethnocentric assumption.

Culturally competent family assessment must also identify the generations since immigration,



Note: The size of a symbol indicates a person's level of power and authority.

FIGURE 7.1 Symbol for family systems charts.

Adapted from the work of Murray Bowen, Monica McGoldrick, and Randy Gerson (McGoldrick and Gerson 2008).

if appropriate: bicultural behaviors of the family as manifested in their identity, language, healthcare, and other areas; transgenerational gaps, if any; and the economic and educational status of family members.

The Genogram

A genogram is a family tree that include data on the relationships among family members across the span of several generations. It is an efficient way to assess a family by recording information and gaining an overview and summary of relationships that reveal patterns of functioning. Students may enter "genogram" in a search engine to see samples (or, narrow it down to famous families by entering "Kennedy genogram," for example. Students who have taken a course in cultural anthropology will notice that the symbols and the method of linking them is different.

The genogram should include all significant kin, informally adopted kin, stepkin, and people referred to or treated as kin who are not legally or biologically related. To elicit information, counselors ask these kinds of questions (Garrison & Podell, 1981; McGoldrick et al., 2008):

- Who raised you?
- Who was significant to you when you were growing up?
- Who is important to you?
- Have you gotten help from the community?
- Has anyone else ever lived with your family? Where are they now?
- On whom do you rely?
- To whom can you go for help?
- Who listens to you?

The nuclear family, defined as the normal family in the dominant culture of the United States, is really not ordinary. In more societies than not, the unit of family organization is some form of extended family; that is, it contains more than two generations or other relatives such as nieces, nephews, unmarried or widowed uncles or aunts, and so on. In the United States, it is difficult to maintain common residence for all of these individuals because of the vicissitudes of employment as well as the size of apartments in cities.

While assessing the family, the counselor must take care to identify significant relatives who are not in the immediate household, in the vicinity, or in the same country. Absent relatives might play a large part in making decisions for the family, which may include encouragement of a referral into treatment or to an alternative, folk healing system.

CASE IN POINT

Extended Families

One of the authors (PM) grew up in a largely Irish and Italian neighborhood where extended families continued to exist but were spread out over several blocks. Many adult men worked on the nearby waterfront and congregated in the neighborhood bars after work. Their wives, wives' unmarried sisters, and mothers spent many daytime hours working together and visiting without having to walk more than a block or two. Later, while working in a tenant-organizing program in the 1960s on the Lower East Side of New York City, PM found members of extended Puerto Rican families occupying two or more apartments in the same or adjacent buildings. Members of the extended family walked in and out of any of the apartments as if they were contiguous. Babies and young children were watched by mothers, aunts, or grandmothers so that their mothers could work or complete high school.

The genogram can bring out powerful repetitive patterns within family lineages. One student, reporting on the book *Genograms and Family Assessment in 2002* (McGoldrick & Gerson, 1985), read a genogram and accompanying text stating that the Kennedy family males had a pattern of taking risks, violent accidents, sexual impulsivity, and substance abuse. Students raised four more such incidents that had occurred in the Kennedy "clan" since the book had been published in 1985.

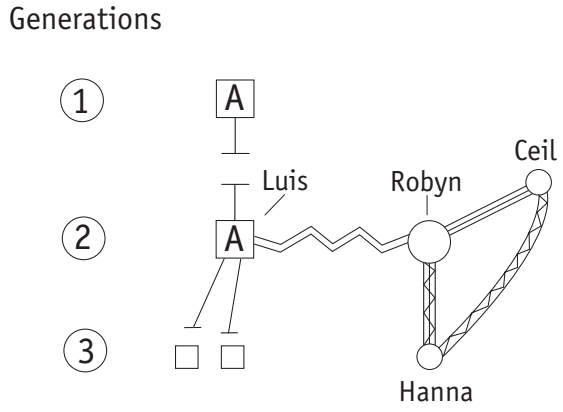


FIGURE 7.2 Hanna's family map.

THE FAMILY MAP

Mapping a family is simpler than constructing its genogram. It takes a few key family members and indicates their relationships. It may be an alternative or ancillary tool to the genogram of a large family system for which the number of lines necessary to indicate biologic relations and the quality of relationships grow out of control. A family map is certainly quicker and easier to draw than a genogram. To create a family map, simply put down male and female symbols separated by a line to show who are the parents and who are the children, and do all of the relationship chart symbols between them. A square or circle can be bigger or smaller to show power and influence. **FIGURE 7.2** is a chart of the immediate family of client Hanna, showing her absent, disengaged father, himself the son of an individual with SUD, and the enmeshed and fused, yet conflicted relationships with mother and grandmother.

HELPING FAMILIES

There are three major approaches to helping family members (concerned significant others [CSOs]) cope with SUD in the family.

Al-Anon was founded in 1951 by Lois W. and Anne B., out of clusters of Alcohol Anonymous (AA) wives. Nar-Anon, composed of family and friends of substance users, was founded in 1968. They are modeled on the 12 steps of AA and NA (Narcotics Anonymous), and are anonymous, confidential fellowships.

Al-Anon and Nar-Anon recommend that members do not try to influence or force the member with SUD to stop drinking, taking drugs, or enter treatment but focus on not letting the member with SUD be the center of the CSO's life; stop enabling behaviors, such as cleaning up after them and, where continued involvement is destructive to the member with SUD or the CSO and prevents personal growth; to "lovingly detach." They are a supportive fellowship, provide role models, and show how recovery is possible. Al-Anon teaches that in a family where a member is actively dealing with SUD, one needs to avoid enabling and maintain some autonomy and individual identity. Note that Narconon is totally different; it is based on the teachings of the Church of Scientology.

At the other extreme is the Vernon Johnson model associated with the "formal intervention." Note that the term *intervention* is used in two ways in the human-services field: (1) as a general term to refer to any remark, technique, confrontation, or helping effort, and (2) to refer to a specialized technique of group confrontation by friends or loved ones to convince an individual with SUD to go into treatment). In this section, we are referring to the prepared, structured Johnson model intervention.

Johnson (1998) describes the steps in preparing a formal intervention:

1. *Gather the intervention team*, which consists of meaningful people who surround the chemically dependent person. They can be family, friends, or colleagues.
2. *Form and inform the intervention team*. Each person must be willing to risk his or her relationship with the individual with SUD, be knowledgeable about the nature of SUD, and be emotionally strong enough to perform as interveners. Part of this step may be SUD education for team members.
3. *Gather the data*. Each person writes a list of incidents or conditions related to the victim's

use that illustrates his or her concerns. The counselor may need to guide the team to write concrete, first-hand incidents, not general gripes or statements. Johnson suggests using a video of the client while intoxicated. At this time, local treatment options must be explored. The intervention cannot proceed without this information because there will be a short window of opportunity to refer the person with SUD to appropriate treatment.

4. *Rehearse the intervention*. Prepare an agenda and practice the scenario over and over, with someone designated as the client, and plan how to deal with the likely or probable reactions of the member with SUD during the intervention. Also think of realistic yet firm statements of future nonenabling stands by associates of the individual with SUD.

The tone of the intervention must be objective, unequivocal, nonjudgmental, and caring. It is *not* a therapeutic community confrontation or "haircut." Significant others who cannot control their anger should be excluded and the reasons should be explained to them in an empathetic, nonblaming manner. Some studies have shown that while trained families conducting the intervention and following through with consequences have good results in terms of engaging subjects in treatment, many groups balk at carrying out this rigorous procedure and/or do not follow up with setting limits or establishing consequences (Miller, Meyers, &Tonigan, 1999,689)

A third, and more recent approach is CRAFT (community reinforcement and family training). CRAFT works with concerned significant others (CSOs) of substance abusers to solve problems. Briefly, the goals of CRAFT are to influence the abuser to engage in treatment, but, in the meantime, to reduce their use, and to help the concerned family member to make positive lifestyle changes that will improve their psychological functioning regardless of the outcome (Meyers et al, 2011)

In the initial session, the CSO describes the abuse problem and the repercussions to the family. They are encouraged to identify and explore their feelings beyond what they have conveyed to the counselor initially. The CSO is asked to described prior attempts at influencing the abusing subject. Confidentiality is addressed, and an overview of the CRAFT program is provided (Smith & Meyers, 2004, 12).

The major areas and skills developed with the CSO include the following.

- Domestic violence precautions
- Communication training (similar to assertiveness skills) via role playing
- Positive reinforcement training (identifying small rewards for the abuser and showing the CSO how to use these to reinforce clean and sober behaviors). Example: "I enjoy watching television with you but only when you are sober."
- Discouragement of using behavior (by stopping positive reinforcements and allowing using behavior to have its consequences) (Smith & Meyers, 2004, 5).

Ambivalence is shown as normal, and the exploration of this with the abuser by the CSO is not dissimilar to motivational interviewing, its motivational balance sheet, and other instruments.

A comprehensive description of CRAFT is book-length, and thus, is not within the scope of this text. If the agency and/or its staff wish to employ CRAFT as a strategy, it should consult both the text meant for the CSO (Meyers & Wolfe, 2004) and the manual for clinicians (Smith and Meyers (2004)) and arrange for training and supervision by a seasoned CRAFT practitioner. As an alternative to purchasing the CRAFT texts, a brief introduction to the practices is available on websites the reader can locate by doing an internet search.

Finally, we have begun this chapter by noting that actual family therapy is generally not practiced in SUD treatment agencies. It is also a separate subfield in counseling, often practiced by licensed marriage and family therapists. However, we will outline a few basic principles in working with family members and friends (CSOs).

1. Help the clients become aware of family dynamics and learn to recognize the roles and patterns in their family system.

2. Help CSOs develop autonomy and self-care.
3. Help CSOs stop enabling; the "help that hurts." Reasons for enabling by CSOs may include guilt, shame, fear of hurting the individual with SUD, fear of losing his or her love, a misguided sense of loyalty, fear of humiliation, need to feel important or have a meaningful role as protector, and fear of change. Ask questions such as, "Do you think it helps Don face the consequences of his behavior when you bail him out of jail every time he is arrested for public intoxication?" or " when you bathe, change clothes, and put Don to bed when he is dead drunk on the street, what message does that send?" Help CSOs to set limits, examples being refusing to cook at midnight, not giving money that will go for alcohol or drugs.
4. Help CSOs become aware of communication patterns in the family or the lack of communication. Encourage "I" statements and sentences such as "When you _____ it makes me feel _____" (train CSOs in basic assertiveness skills of directly and honestly communicating feelings and needs while remaining empathetic to others' feelings and needs).
5. Bring silent members into the conversation. Do not let the invisible "lost child" hide and be isolated.
6. Help the overextended, protective member (parentified) to surrender some of his or her tasks, while acknowledging that they take on too much out of guilt or desire to rescue the member with SUD.
7. Do not use labels like "codependency" or "chief enabler," or, worse, tell distressed CSOs that they are as sick as the member with SUD.
8. Do not directly or indirectly blame family for the member with SUD in their midst.
9. Provide educational materials on SUD and recovery, and materials that reduce the stigma of being the family member of a person with SUD. The spread of recovery oriented systems of care, groups such as Faces and Voices of Recovery and the spread of recovery community organizations (RCOs) is contributing to removing the stigma of being a CSO. Some RCOs were, in fact, started by CSOs.
10. Keep in mind that there is often a danger of violence in substance using families and safety and protection of family members must be a priority. Have a "safety plan," which includes what steps to take if a family member feels threatened. These might include quick contact with the police, contacting a shelter, having friends or family you can trust to go to, hiding an extra set of keys, or learning to deescalate an angry situation (McCollum & Trepper, 2001).

Sober Family Living Skills

The rules of engagement change as the family moves from "wet" to "dry"; there is a different set of tasks and dilemmas. Roles and rules change. Some of the areas that need to be addressed include the following:

Building Healthy Communication

Reestablish channels of communication and teach healthy communications skills that are assertive rather than passive, hostile, or aggressive. Assertiveness skills (sometimes known as *say-it-straight skills*) are important in all types of families. In the "wet" family, they help people survive as individuals, set limits, and undermine the conspiracy of silence. In the "dry" family, they further and strengthen the recovery process and help to explore options for a new "family mobile."

Develop Sober Relationships

If a member of a couple was actively contending with SUD when the two became involved and is now sober, it is almost as if they never were introduced.

If one of them has been living with SUD for a long time and gets clean and sober, it is like starting over. If we are engaging with couples, one technique is to assign a "date" as homework. This provides the opportunity to fashion a relationship, to process the changes they are going through, and, if there are children, to allow some space and intimacy for themselves as a couple outside of the larger family system.

Stay In the Here and Now

Concentrate on family processes and feelings in the here and now, not content or details of arguments. Group therapy skills of staying in the here and now can be generalized successfully into work with the family systems. If a member can reflect on what he or she is feeling, and to what underlying issues these feelings pertain, he or she is less likely to pour it all into an argument over who was responsible for letting the toast burn.

Learn Appropriate Parenting Skills

Parents need to take back the responsibility and authority from whomever they gave it to, whoever took it from them, or whoever took over for them: parental child, grandparents, aunts, neighbors, teachers, and so on. They need to set boundaries, get help, distinguish themselves from their children, and distinguish their children from friends or other adults. Parents must support their children's growth through their understandable resistance, anger, built-up hostility, and fears. They must be patient as children develop trust of a parent who betrayed and abandoned them by not being a parent and being unavailable. Parents also must learn that children will test to see whether it is really safe to express their feelings. They should not respond to their children's challenges the same way they would to being challenged by another adult.

Children Learn or Relearn to Be Children

They must relinquish pseudoparental or pseudo-spousal roles and acknowledge how that feels. They may have to grieve the loss of the old role with which they felt comfortable. They also may have to redefine relationships with siblings and learn to make friends with peers.

Adapt to the New Personality of a Recovering Member

Relating to the new personality of a recovering member is often very difficult for his or her family. Out from under a chemical haze, the sober member may be unexpectedly assertive, argumentative, irritable, demanding, or needy. People in recovery have to try out new ways of being and dealing with other family members. Often, when the family resents the changes and wants to return to its old ways, someone may say, "We like you better drunk!" They may sabotage or undermine the real changes that go with recovery, or they may even go from blaming all problems on the person with SUD for being a user to blaming all problems on him or her for his new qualities in sobriety and recovery.

Adapt to the New Personality of the Significant Other of the Newly Recovering Family Member

Family members of people newly in recovery often develop a more assertive and less controlled style, discovering that they have feelings, opinions, and the right to express them. They may feel guilty at first. Another possibility is that their feelings, having been held in or repressed for a long time, are likely to be extreme to the point of hostility and being verbally aggressive.

Adapt to a New Family Structure

Resolve arguments about child rearing and finances: "I was used to doing the checkbook alone." "I can't believe you let him watch so much television." The counselor can help clients turn arguments into discussions about the possibilities of handling these things, helping them brainstorm new and different strategies, and saying, "Why not at least try it? The old ways were not working in healthy or satisfactory ways, were they?"

Adapt to New Activities and Relationships of Family Members

"All those damn meetings." "Some of your new friends sure look seedy." Loved ones of people in recovery have to deal with feelings about 12-step or other support groups, fears of infidelity, unfamiliar beliefs and rituals, unavailability of the recovering member of AA/NA who is attending the recommended 90 meetings in 90 days, and resentment of the counselor, for example. "Now that

you have your new friends, I suppose you don't need us anymore" or "I guess we're not good enough anymore" or "So, now you just do everything she says?" Friends or extended relatives often interpret recovery-milieu involvements as dangerous or strange: "If she keeps going to those meetings, you're gonna lose her for sure. All those feminists giving her ideas. She'll leave you and take you for all you're worth—and you'll never see those kids again," or "She'll take off and leave you with the kids."

Learn to Express Anger and Sexuality in Healthy Ways

Some clients have difficulties expressing anger or sexuality because in the past these were associated with alcohol, drugs, or violence. Some fear that the loss of control over feelings will precipitate a relapse. In fact, trying to control all of one's feelings all of the time, or any form of obsessive perfectionism, is so exhausting and anxiety-producing that it could threaten a relapse.

Deal with the Emergence of Masked Problems

For example, some people with SUD have never indulged in sexual activity when sober. Others did not think much about sex when they were using. Learning to come to terms with this as an adult can be terrifying. Therefore, although some experience sexual dysfunction while contending with SUD, others experience it when clean and sober.

Build Trust

Having had good reasons to mistrust the individual recovering from SUD, the family finds it hard to shed the stigma and fear associated with SUD. On some level, family members may be saying to themselves, "We can never trust him or her again." The member recovering from SUD may sense this mistrust and think, "They should recognize my recovery and treat me differently."

Abandon Unrealistic Expectations

People with SUD and their families may think that the end of drinking/taking drugs means the end of problems when actually the journey has just begun. There are still problems with children, layoffs and downsizing, health problems, crime, pollution, and all of the emotional problems that people have who never had a drink or put a needle into their arms.

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Weblinks to be uploaded to our website:

Genogram and family mapping symbols:

http://dhhs.ne.gov/children_family_services/Documents/a1FGenSym.pdf

CRAFT
https://www.robertjmeyersphd.com/craft.html

http://www.soberfamilies.com/about-craft/

Al-Anon
www.al-anon.org

Nar-Anon
www.nar-anon.org

CHAPTER 8

CASE MANAGEMENT: FROM SCREENING TO DISCHARGE

OBJECTIVES

At the end of this chapter, students will be able to:

1. Describe the seven steps in managing a case.
2. Define case management according to the International Certification Reciprocity Consortium (ICRC).
3. Define the purpose of screening and list at least one screening tool.
4. Describe the symptoms outlined for substance use disorders (SUD) in the DSM-5.
5. List at least two valid assessment tools used in SUD treatment.
6. Describe the purpose of a biopsychosocial assessment.
7. List at least six major life areas to be assessed in a biopsychosocial assessment.
8. Describe the six American Society for Addiction Medicine (ASAM) Levels of Care
9. List at least three variables to determine the severity of dependency.
10. Write a treatment plan based on needs and resources developed in collaboration with the client.
11. Write a treatment objective using SMART (specific, measurable, attainable, realistic, and time limited) criteria.
12. Use the SOAP (subjective, objective, assessment, and plan) approach to write a progress note.

INTRODUCTION

The term *case management* is used by helping professionals to denote activities that bring the client through a service delivery system to a desired outcome. Beyond that very general definition, case management may refer to an aspect, task, or special emphasis in human and social services.

Many agencies view case management as an overarching model for the processing of clients with SUD through the continuum of care from initial contact to closure, based on the specific treatment and recovery needs of each individual. Whatever the setting (e.g., inpatient, outpatient, halfway house) and whatever the intensity of services (e.g., 40 hours per week, 10 hours per week, 1 hour per week), the counselor assists the client through a series of stages from initial contact to final discharge. According to Ballew and Mink (1986), the counselor helps the client to navigate through a set of stages that he or she identifies as engaging, assessing, planning, accessing resources, coordinating (some would include monitoring), and disengaging. Individual, family, and group counseling processes and relationships drives the client through these stages.

The functions of case management include assessment, treatment/service planning, service coordination and system linkages, linking clients to services and resource monitoring, addressing problems other than SUD, and advocacy. All clients have case management needs, but these vary by severity, internal and external resources including coping skills, existence of co-occurring problems, and other disabilities or disorders. In working with clients, case managers must possess the same skills for empathy and engagement as in any counseling setting. When working with external systems, the case manager must learn considerable skills in mobilizing resources; bartering informally among service providers; pursuing informal networks; being knowledgeable about community systems; and being anticipatory, pragmatic, and flexible (CSAT, 1998, 13–14), all of which overlap with entrepreneurial, political, and/or fund-raising skills. Effective case management meets the goals of continuity of care, accessibility, accountability, and efficiency.

In some agencies, case management refers to a special emphasis on the coordinated and aggressive use of ancillary services to support all areas of individual life (e.g., housing, health care, mental health services, financial services), in contrast to counseling or treatment of SUD alone. Sometimes a specific person, a case manager, will be responsible for coordinating access to external resources and facilitating client's use of such resources. For example, Mejta et al. (1994) describe the interventions case management model. The underlying assumptions and philosophy of the model are that there are a "constellation of problems that encourage continued drug use and antisocial behavior" (303) and there is a limited period of time to initiate action before the motivation to change dissipates. These two variables necessitate a proactive, coordinated, and decisive system of client management. The expression, *intensive case management services (ICMS)*, is used throughout the social services, including welfare-to-work projects, workers' compensation, SUD treatment, and mental-health delivery systems. It refers to a consortium of programs working to provide comprehensive, integrated, or "wrap-around" services. ICMS are seen as necessary to avoid fragmentation of care and to mobilize services for fragile populations who refuse treatment, such as chronic welfare recipients, the mentally ill, and the homeless. Consortia can range from small to large regional system-wide efforts. In the SUD field, a prime example of the latter was the Target Cities Program, initiated by the federal Center for Substance Abuse Treatment in 1991 for several urban areas.[a] The funded cities used a Central Intake Unit to unify the various treatment providers of initial screening, assessment, and referral functions.

SUD counselor certification boards affiliated with the International Certification Reciprocity Consortium limit the definition of *case management*

[a]The Center for Substance Abuse Treatment (CSAT) operates as part of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services (HHS).

to coordination of service activities only, excluding such functions as screening, assessment, and treatment planning. According to this definition, case management responsibilities of SUD counselors include planning and coordinating with clients in recovery as they access, link with, and use supportive services; client advocacy to secure resources; and education of clients to increase their awareness of community services. This definition is also found in the SUD counselor competency consensus document (CSAT, 1997).

THE MARRIAGE OF CASE MANAGEMENT AND COUNSELING

Human services professions often have drawn a distinction between counseling, which focuses on process (client self-awareness, self-reflection, and decision making), and case management, which focuses on outcome (e.g., goals, objectives, action steps, plans). In social welfare and offender services, the titles of case manager and caseworker may, in fact, denote individuals who perform duties outside of or not primarily pertaining to the counseling or clinical realms. These two important aspects of treatment, however, depend on each other for successful treatment. Clients will not agree to a treatment contract or follow the plan effectively if they do not see the need for the components of the plan as developed collaboratively with the counselor. This commitment can develop only within an empathic, supportive counseling relationship. Active listening and communication skills, such as reflection of content and feeling are also necessary to identify problems that need to be addressed in the treatment plan. It is a revolutionary experience for a client to work with someone who actually seems interested in hearing about his or her feelings, problems, and thoughts, rather than dealing with the formal and impersonal bureaucratic routines to which he or she may have been accustomed. In short, all of the counseling skills identified in this text come into play when carrying out the various processing and management functions discussed in this chapter and are crucial to their success.

SCREENING

All human services involve screening, which determines whether the client is eligible and appropriate for admission to an agency or needs referral to another agency to which he or she is eligible or appropriate for admission. Screening serves two major purposes:

1. It attests to the presence of a condition that may go unrecognized if not detected.
2. It provides data to decide whether a client is appropriate for a specific treatment program or vice versa.

In the screening phase, social, health, and criminal justice, workers determine if there is evidence for referral of a client to alcohol and/or drug treatment for further assessment. It is important that such screening take place because there is strong evidence that early intervention increases the success rate of treatment. Screening can have an active or passive connotation. That is, service delivery systems can attempt to screen large segments of the population in order to identify individuals with a particular condition. In many healthcare settings, this is known as *case finding*. SUD units at a medical center can work with the emergency room or general medical staff to seek out patients with SUD, just as all patients can be screened for a disease, such as tuberculosis.

The second purpose of screening relates to the initial process whereby it is determined that clients are appropriate for treatment or that they should be referred to other services. The counselor's recommendation depends on the client's clinical needs (such as health, living conditions, and severity of symptoms) and the capacity of an agency to provide such treatment. In order to provide such screening and recommendations, a counselor not only needs to know the client's symptoms and social and health problems but must also clearly understand his or her agency's eligibility requirements and scope of services as well as the eligibility requirements

and capabilities of other treatment agencies in the region. It also means that the counselor has an ethical obligation to refer clients to the most appropriate treatment available. Awareness of and a willingness to refer to a broad range of health and social service agencies are necessary.

Engaging

In addition to gathering information and evaluating treatment options, the screening interview serves the following purposes:

- Establish as much rapport as possible during the first contact
- Establish the boundaries of clients and counselors
- Explore the client's expectations and desired outcomes of treatment
- Describe the program

It is important to note that the screening or intake worker is usually the first person a client sees and is, therefore, the representative of the agency and, indeed, of the entire concept and system of SUD treatment. The initial impression made on the highly ambivalent client may be crucial to accepting or delaying the first step on the road to recovery. When SUD screening of large populations in health or social services settings is the method of the clients' entry to treatment, attention must be paid to the attitudes, motivations, and active listening skills of screening personnel who are not primarily trained as SUD counselors.

Screening Tools

It is useful for SUD counselors to be familiar with some of the screening tools that general and social service practitioners use. Although many clients abuse both alcohol and drugs, most screening tools are focused on either one or the other. Several instruments have been developed to detect alcohol problems, such as the CAGE mnemonic, the brief Michigan alcohol screening test (MAST), and the alcohol use disorders identification test (AUDIT). The CAGE is the shortest and has been demonstrated to be valid (Ewing, 1984). A physician, nurse, or social worker may integrate the CAGE questions into a medical interview. In a general interview, if clients indicate that they drink alcohol or have drunk in the past, the clinician can ask the following questions:

C = Have you ever thought you ought to **c**ut down on your drinking?
A = Have people **a**nnoyed you by criticizing your drinking?
G = Have you ever felt **g**uilty about your drinking?
E = Have you ever had an **e**ye-opener—a first drink—in the morning after a hangover?

Any positive response should be followed up with concerned interest. Two positive responses would indicate need for referral. Use of drugs and medications also should be investigated.

Kinney (1996) uses the mnemonics HALT and BUMP to list questions that can be helpful in gathering data to indicate alcohol or drug problems.

H = Do you usually use drugs and/or drinks to get **h**igh?
A = Do you sometimes drink or use drugs **a**lone?
L = Have you found yourself **l**ooking forward to drinking or using?
T = Have you noticed an increase in **t**olerance of alcohol or drugs?
B = Do you have memory lapses, **b**lackouts that occur during drinking?
U = Do you find yourself using drugs or drinking in **u**nplanned ways?
M = Do you drink or use when you feel anxious, stressed, or depressed, or for **m**edicinal reasons?
P = Do you work at **p**rotecting your supply, having drugs or alcohol available at all times?

A few positive responses to screening instruments are often taken as proof of SUD; however, they only indicate the need for further assessment. It is important that anyone who is doing screening realize that the results of screening are a preliminary indicator of a problem and not a diagnosis.

FIGURES 8.1 and **8.2** are examples of tools to screen for abuse of drugs and alcohol by adolescents

Please read carefully and circle the appropriate response.

Have you ever done something crazy while high and had to make excuses for your behavior later?	Yes	No
Have you ever felt really burnt out for a day after using drugs?	Yes	No
Have you ever gotten out of bed in the morning and really felt wasted?	Yes	No
Did you ever get high in school?	Yes	No
Have you gotten into a fight while you were high (including drinking)?	Yes	No
Do you think about getting high a lot of the time?	Yes	No
Have you ever thought about committing suicide when you were high?	Yes	No
Have you run away from home, partly because of an argument over drug use?	Yes	No
Did you ever try to stick to one drug after a bad experience mixing drugs?	Yes	No
Have you gotten into a physical fight during a family argument over drugs?	Yes	No
Have you ever been suspended because of something you did while high?	Yes	No
Have you ever had a beer or some booze to get over a hangover?	Yes	No
Do you usually keep a supply (of drugs) for emergencies, no matter how small?	Yes	No
Have you ever smoked some pot to get over a hangover?	Yes	No
Have you ever felt nervous or cranky after you stopped using for a while?	Yes	No

Thank You for Your Cooperation.

ID#: _____ Age: _____ Gender _____ Race _____
Results: No. of yes answers: _____ No. of no answers: _____
Offense(s): _____
Comments: _____

Referred for further assessment? Yes _____ No _____

FIGURE 8.1 Substance abuse screening instrument

and adults. (Details about specific screening tools are in CSAT, 1991; 1997.)

Assessment

Assessment is a broad term that encompasses a variety of critical knowledge and skills in SUD counseling. It includes those activities, skills, and tools that facilitate the gathering of information throughout the case management and treatment process.

- It is designed to elicit clients' concerns, desires, fears, beliefs, values, and life experiences.
- It is a means to determine clients' needs, strengths, and resources and the impediments to successful treatment that might lie in misunderstanding, anxiety, perception, confusion, or denial.
- It uses tools and documents, each of which serves a specific purpose in the continuum of care—this may include a mental-health status exam, a suicidality assessment instrument, or a discharge summary. Client self-reporting is only one source of data. With the clients' informed consent, the counselor will seek information from family, employers, referring agencies, and past treatment agencies.

Screening Adults for Alcohol Abuse	Answer Yes or No
1. Do you feel that you are a normal drinker? (By "normal" we mean that you drink less than or as much as most other people.)	_____
2. Does your wife, husband, parent, or other near relative ever worry or complain about your drinking?	_____
3. Do you ever feel guilty about your drinking?	_____
4. Do friends or relatives think you are a normal drinker?	_____
5. Are you able to stop drinking when you want to?	_____
6. Have you ever attended a meeting of Alcoholics Anonymous?	_____
7. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?	_____
8. Have you ever gotten into trouble at work because of your drinking?	_____
9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	_____
10. Have you ever gone to anyone for help about your drinking?	_____
11. Have you ever been in a hospital because of drinking?	_____
12. Have you ever been arrested for driving under the influence of alcoholic beverages?	_____
13. Have you ever been arrested, even for a few hours, because of other drunken behavior?	_____

FIGURE 8.2 Short Michigan alcohol screening test (SMART).

Although assessment may appear to be a separate stage of case management, it is, in fact, an ongoing process that informs treatment planning and the clinical use of individual, group, and family treatment. Initial assumptions about clients may be supported or need to be revised as more data become available and the client demonstrates change and movement into recovery. According to Hester and Miller (1995), there are six purposes for evaluation in SUD counseling (see **TABLE 8.1**).

Intake

The *intake* procedure is the point of formal admission to a treatment program. This assumes that initial assessment (e.g., through the screening process) has justified the step of admitting a client to a particular program. Also, at this point, enough information should be available to prescribe the early critical components of treatment that are necessary and possible for this client. The intake procedures comprise a variety of documents and formalities, including those involving confidentiality. Some

ACTIVITY 8.1 What do these people need?

Form groups of three. Assign each group a scenario and each person a role: client, counselor, or observer. Using the following scenarios, enact a screening interview to determine if the client needs a more in-depth assessment. As the counselor, you are working as an identification and referral counselor in a substance-abuse screening program. Using your listening and feedback skills, try to motivate the client to agree to further assessment. When playing the client, try to stay in character. Role play each scenario for 10 minutes, allowing the observer 5 minutes to give observations. After all the role plays are complete, process and discuss them in the large group for 15 to 30 minutes.

SCENARIO 1: The client is seeing this counselor as a result of a driving-while-intoxicated (DWI) arrest, her second. Following the first offense, she attended DWI school. To be without her automobile would be a serious inconvenience, so she is anxious to do whatever it takes to get her license back. Therefore, she is determined to be cooperative, but she is not convinced she has a problem.

SCENARIO 2: The client has finally agreed to see a counselor, but only after an ultimatum from his wife that she would leave unless he seeks help. The precipitating problem is serious nightly quarrels that begin over dinner and end with the family in tears and his storming out of the house. He attributes the quarreling to the topic under discussion when the argument erupts (e.g., the children's grades, finances, the in-laws coming to visit) and his family's inability to listen to reason.

SCENARIO 3: A 65-year-old grandmother was referred by a visiting nurse. She was found in a stupor on her couch last week. Nearby were a bottle of pills (Darvon) and an empty bottle of sherry. She lives alone and sees her daughter about once a month. She has arthritis and is sometimes in pain. The nurse visits weekly and helps with some chores. The nurse insisted she come to the hospital for treatment and help.

TABLE 8.1 Purposes for Evaluation of Clients

Type	Purpose
Screening	To determine whether the client needs further evaluation
Diagnosis	To determine if criteria are met to make a clear diagnosis
Ongoing evaluation	To determine the nature and extent of the client's problems
Motivation	To determine the ways in which the client is ready and able to change
Treatment Planning	To determine appropriate interventions and needs for services
Follow-up	To determine what has changed and which aftercare services the client needs

Source: Modified from Hester, R. K., and R. M. Miller. eds. 1995. *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*, 2nd ed. New York: Simon and Schuster.

minimal orientation to treatment usually takes place at this point. If screening has been done externally (e.g., at a referring social-service agency), the intake process becomes the client's first exposure to the treating agency and to treatment. Again, the intake person must be sure to use empathy, active listening skills, and other "human" aspects in this supposedly routine bureaucratic procedure.

Diagnosis

Diagnosis is a medical term that is defined as follows.

> 1 a. the art of identifying a disease from its signs and symptoms b. the decision reached by diagnosis.
> 2. a. Concise description of a taxon (*Merriam-Webster* 1993, 177).

A diagnosis is also a categorization made after objective, standard diagnosing (diagnostic) activities. Diagnosis is done by matching clients' signs (observable objective data, such as is gathered in laboratory tests) and symptoms (information received from the patient) to established criteria that describe specific medical categories. For example, a diagnosis of strep throat is made following a demonstration that *Streptococcus bacilli* are found in a patient's throat, by obtaining a sample on a cotton swab and growing it in a culture. Procedures to diagnose SUDs, which are described variously as biologic, psychological, and spiritual disorders, cannot be so simple and straightforward. Diagnosis should not be confused with a biopsychosocial assessment. It is only a part of such an assessment and does not give enough information to make important clinical decisions about clients. Diagnosis is usually performed by physicians or clinical psychologists. However, it is important that counselors be familiar with diagnostic criteria. The first reason is that physicians often rely on input from counselors and social workers to make diagnoses. Second, understanding signs and symptoms assists counselors in determining relevant data to explore in a clinical (biopsychosocial) assessment interview with clients. Third, and most important, being certain that a client has a SUD predicts reasonable therapeutic interventions that are necessary for counseling to be effective.

There are a number of diagnostic systems in behavioral health fields, but, by far, the most accepted and used system is the *Diagnostic and Statistical Manual, Fifth Edition* (DSM-5) published by the American Psychiatric Association (APA, 2013). The new DSM-5 is replacing the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM4-TR; ASAM, 2000; APA, 2000). The DSM4-TR does not use the term *addiction* or *alcoholism* but rather refers to substance abuse and *substance dependence*. The DSM-5 avoids identifying either substance abuse or substance dependence but instead sees **substance use disorders** on a continuum of problems from mild to severe. The DSM-5 allows for the term *addiction* to be used at the discretion of the provider. It contains two broad categories—substance-induced disorders and substance-use disorders. Substance-induced disorders are conditions that develop from the immediate use of a substance, such as intoxication, withdrawal, or mental state caused by intoxication or withdrawal. Inclusion of a condition or syndrome in the DSM-5 does not automatically imply mental illness. In fact, the DSM-5 is designed to acommodate any kind of adjustment or emotional or learning problem conceivable. In the arena of chemicals, one can be diagnosed as drunk or high (known as *substance intoxication*) for any of nine chemicals, or as following a pattern of substance use disorders on any of ten chemicals (alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedative–hypnotics, stimulants, tobacco, and other unknown.). A client can have a diagnosis of cannabis substance use disorder, as well as any of a number of accompanying personality disorders, psychoses, and/or organic disorders that are related to chemical use, aging, and so on.

The DSM-5 describes *substance* use disorders as "a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues to use the substance despite significant substance-related problems" APA 2013,483). The symptoms for each substance (excluding caffeine) are as follows:

1. The substance is taken in larger amounts or over longer periods than intended
2. Persistent desire and/or failure to cut down on use
3. Excessive time spent in obtaining and using a substance or recovering from the effects of the substance
4. Craving, or a strong desire to use the substance
5. Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home

6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the substance use
7. Important social, occupational, or recreational activities are given up or reduced because of substance use
8. Recurrent substance use in situations in which it is physically hazardous
9. Substance use continuing despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to be caused by or exacerbated by continued substance use
10. Tolerance as marked by either increased amounts to achieve intoxication or diminished effect with continued use
11. Withdrawal either characterized by substance-specific withdrawal symptoms or use of substance or medications taken to avoid withdrawal

These criteria can be clustered into four major areas: (1) loss of control or impaired control: a progressive inability to predict the consequences of the use of a substance, desired or failed attempts to reduce or stop compulsive use, involving a strong craving or the need to drink or use drugs, (2) social impairment: substance use leading to problems at work, family, school, or loss of meaningful social and recreational activities (risky use as in driving while intoxicated or using machinery; and (4) pharmacologic conditions, such as tolerance and/or withdrawal (Hovrath et al, 2016).

Often, the client does not perceive that these symptoms mean he or she has SUD, is dependent, or has any problems whatsoever. This phenomenon is often referred to as *denial* or ambivalence, which is not a conscious effort to distort the truth. It is normal to expect that clients will minimize, rationalize, or, in some other way, deny that they have a substance abuse problem. Insistence that a client accept a stigmatizing label of "addict" or "alcoholic" will trigger resistance to counselor intervention and interpretation.

The new DSM-5, by identifying a range of symptoms from mild (presence of two to three symptoms), through moderate (presence of four to five symptoms), to severe (presence of six or more symptoms); avoids the need to arbitrarily force a diagnosis of either substance abuse or dependency and instead encourages the counselor and client to collaboratively "explore who he is and not defend who he is not" (Fetting, 2016, 48).

Additional clinical issues that arise from the attempt to upgrade from DSM4 to DSM-5 will be discussed later in the text when we consider specific co-occurring psychiatric disorders.

Although a thorough description of the etiology of SUD is beyond the scope of this book, it can be beneficial for the counselor to know the risk factors that might lead to SUDs. Examining these as part of an assessment can lead to a better understanding of how the client came to develop an SUD. Some of the SUD risk factors are as follows:

- Genetics: There is strong evidence that those with a SUD are more likely to have relatives with a SUD (particularly with alcohol use disorder—those with alcohol disorders are six times more likely to have blood relatives who have alcohol disorders)
- Gender: Males have a significantly higher risk of having SUDs than females
- Having a mental illness: People with depression, attention deficit hyperactivity disorder (ADHD), bipolar disorders, and anxiety disorders have higher incidence of SUDs. Because a predisposition for mental illness is inherited, so is the tendency to cope by self-medicating.
- Peers who use: People conforming to peer groups who accept and encourage drug and alcohol use are at greater risk
- Family conflict, poor parenting, and lack of emotional family attachment result in individuals being at higher risk
- Loneliness or feeling isolated, which can relate to mood disorders or poor social skills
- The age of onset of use: Usually, the younger a person starts drinking or using drugs, the more at risk he or she is.

- Stress: A person who has a high level of stress or who has no healthy coping skills will often use alcohol or drugs to manage stress, which can lead to SUD. (Nordquist, 2016; NIDA, 1997);

None of these alone would necessarily cause a SUD. However, the combination of conditions, along with opportunity, encouragement, and access to addicting substances, increase the probability of problematic use.

ASSESSMENT OF READINESS TO CHANGE

Three assessments of readiness to change can be incorporated into the formal assessment and/or treatment plan. These are the importance rules, confidence ruler, and readiness ruler. These rulers are shown and described in Chapter 3.

ASSESSMENT INSTRUMENTS

A thorough biopsychophysical assessment that creates vital data for collaborative treatment planning uses both formal and informal approaches. Informal data are collected through an interview in which information is requested or brought out as the counselor or clients discuss presenting problems. However, since some important data may be missed, treatment programs also use a variety of validated formal assessment instruments. The following are three well-known and often-used assessment tools (There are many other assessment tools that agencies may use. Counselors would need to be trained and supervised in using these tools. For more information on assessment instruments, see Samet, Waxman, Hatzenbuehler, & Hasin, , 2007).

1. **Addiction Severity Index (ASI):** ASI is a semi-structured interview design for adults, which captures problems in six areas—medical, employment, drug and alcohol use, legal status, family/social, and psychiatric (McLellan, Carise, Coyne, & Jackson, 1980).
2. **Adult Substance Abuse Subtle Screening Inventory-4 (SASSI-4):** This is a brief scale that is validated with the DSM-5 continuum and distinguishes SUD from psychological problems (MHS, 2017).
3. **The Alcohol Use Disorder and Associated Disabilities Interview Schedule-5 (AUDADIS-5ET):** The AUDADIS-5 is a fully structured, computer-assisted diagnostic interview designed for trained lay interviewes (Hasin et al., 2016)

Biopsychosocial Assessment

Biopsychosocial assessment provides a detailed overview of the social, biologic, family, employment, and medical history of the client. It explores the critical issues in each major area of the client's life. It examines the client's functioning and negotiation of developmental problems that may have arisen in each of the areas. A thorough biopsychosocial assessment identifies the critical issues to be addressed in a treatment plan.

Components of Biopsychosocial Assessment

There is tremendous variation among the activities used to provide a comprehensive biopsychosocial assessment. The types of instruments employed vary in length, format, focus, detail, degree of specificity, and areas of knowledge to be elicited. Most biopsychosocial assessments address the following areas:

- *Childhood and adolescence*, including parental drug and alcohol use, loss of parent(s); relationships with parents, stepparents, or other caregivers, social and cultural beliefs, and messages given in the family
- *History of substance use and abuse*, including first use of alcohol and drugs, the patterns and changes, and the experiences that occurred under the influence of substance, up until the present. This should include use of tobacco and over-the-counter medications.

- *Health problems and medical treatments*, past and present, including those related to drug use or abuse, withdrawal, hospitalizations and the reasons for them (e.g., physical or mental, alcohol- or drug-related), HIV status, other sexually transmitted diseases (STDs) and infections, and medications
- *Mental health history*, including previous evaluations and treatment summaries as well as the client's evaluation of whether previous treatments were helpful and why or why not.
- *Family and social functioning*, including marriage(s), divorces, relationships with children, friends, and the impact of alcohol and drug use on these relationships. There are two categories of family: present family (spouse, children, and significant others) and family of origin (parent, other relatives, and significant others, including peers or mentors who influenced the client's life). Is there a family history of alcohol or drug abuse or mental problems?
- *Employment, education, and recreation*, including past and present work and school problems and achievements, past and present ways the client relaxes and has fun, and the role of drugs and alcohol in these areas
- *Sexual history*, including problems, sexual orientation, and the role of drugs and alcohol in this area
- *Finances*, including income, sources of income, debts, changes in financial status, and the role of alcohol and drugs
- *Legal issues*, including criminal history (probation, parole, having served time), incidence of DWIs, whether previous or present treatment is court-mandated, and the role of drugs and alcohol in a client's involvement in the criminaljustice system.

Assessment of Severity

The American Society for Addiction Medicine (ASAM) has six dimensions to determine the severity of the SUD (Mee-Lee, 2013) formerly known as The ASAM Criteria, formerly known as the ASAM Patient Placement Criteria, can be accessed at https://www.asam.org/resources/the-asam-criteria/about. The dimensions are

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional, Behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery and Living Environment

Depending on this multidimensional assessment, the individual is placed in the appropriate level of care, which was outlined in Chapter One and which may be viewed at http:asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care

ACTIVITY 8.2 What's the best way to ask?

Break into groups of three to five. Choose one of the nine areas of biopsychosocial assessment outlined earlier. Develop assessment questions for that knowledge area. In doing so, consider the impact of each question on the client, the appropriate timing, and the effect on the development of empathy and a treatment alliance. For example, in the area of family and friends, you might ask, "Who was important to you as you grew up?" "Who could you turn to in your life?" "Who were you close to?" "Who did you have a problem or conflict with?" "Have you lost someone important to you?" "What are some good memories you have of your childhood/adolescent years?"

TREATMENT PLANS

Like assessment, treatment planning is an ongoing process that begins with and builds on a core of information as treatment progresses. On the basis of information gleaned from a sound assessment, a client and a counselor can collaborate to identify problems, goals, and objectives of treatment. Once this is done, they can determine priorities, the

methods of treatment, and a schedule, which are all part of the initial treatment plan. A treatment plan provides a framework for logical decision making by the joint effort of the counselor and the client, as well as reinforcement that clients are responsible for their recovery. In addition to input from the client and the counselor, the clinical supervisor and the agency's treatment philosophy influence treatment planning.

Some time and a considerable amount of paperwork are involved in writing and maintaining an effective treatment plan (**FIGURE 8.3**). Although counselors often avoid or resist doing paperwork, there are good reasons to document the treatment plan and treatment:

- *To give direction and focus to the counseling process*. Treatment plans provide the clients feedback on their progress and refocus them, if necessary. The documentation helps the counselor review the issues and progress with the client and supervisor.
- *To give tangible evidence of progress toward recovery*. Clients have an opportunity to see each step, no matter how small, of success and check it off the list. This increases the client's sense of self-efficacy and reinforces commitment to treatment.
- *To facilitate discussion of difficult issues that, if not addressed, would impair treatment.* Often, in writing out and implementing the plan, such issues are identified and clarified and can be addressed effectively. Clients often leave treatment against professional advice because of failed expectations or concerns that were not identified or discussed.

This is "boilerplate," which is similar to standards that have been established by such entities as the Joint Commission (formerly the Joint Commissions for Accreditation of Health Care Organizations (JCAHO):

1. Based on a comprehensive assessment process and modified over time as warranted with receipt of new assessment information
2. Reflects participation from appropriate disciplines as warranted
3. Identifies the client's presenting needs and specifies the persons' strengths, resources, and limitations
4. Reflects a collaborative effort between clinicians and clients served
5. Consists of specific goals that pertain to the attainment, maintenance, and/or re-establishment of physical and emotional health, prioritized by importance
6. Identifies specific objectives that relate directly to the treatment goals, action steps, and timelines for each activity
7. Includes criteria for ascertaining whether objectives have been met
8. Identifies each person responsible for implementing, coordinating, and monitoring the treatment plan or its components
9. Identifies readiness to change in the Prochaska/DiClemente model, i.e., precontemplative, contemplative, etc.
10. Identifies the services and/or settings necessary for meeting the client's needs and goals (counseling methods used, coordination of services needed, identification of resources), including current or anticipated gaps in services
11. Specifies the frequency of treatment contacts
12. Includes provisions for periodic re-evaluations and revisions, as warranted
13. Anticipates the date when treatment will be terminated, and plans for appropriate posttreatment supports and services and re-entry tasks

FIGURE 8.3 Features of an individualized treatment/service plan.

- *To give a clear picture of the client's issues, history, progress, and current situation to all in-house members (present and future) of a treatment team.* In-house members might include a group leader, a family counselor, a supervisor, or anyone who needs to take over the case

Treatment Planning Process

Many students have an aversion to treatment planning

- They think it involves too much paperwork and means less time for seeing clients
- They think it is done according to a set formula or routine—cookie-cutter approach
- They think that the plan is left unused in the files once they are written
- They worry about the additional tasks of writing progress notes that document the progress, or lack of it, in meeting the goals of the plan
- They think it cuts into the spontaneity of the counseling session

But treatment planning *should* be the following:

- A dynamic means of engaging and motivating clients in setting realistic and clear goals and objectives to move in healthy and productive directions
- A way to provide hope for change
- A way of enabling clients to observe changes within themselves as they meet realistic objectives
- A way to provide protection in court-ordered cases as the written plan is a legal document

The treatment planning process can be seen as a series of 13 steps or components.

1. *Identify issues*. The counselor uses the assessment results as a database. In addition, the counselor receives information from the client that helps to identify the primary concerns, problems, and issues.
2. *Identify needs*. After reviewing the client's case history, the counselor creates a list of the client's needs. Problems or obstacles identified by the client often can be reframed as needs (or "change areas"), which is less judgmental and more hopeful and motivating. Modern clinical practice disapproves of pathologizing people and reducing them to a collection of symptoms or problems.
   - Use nonstigmatizing language: Instead of "alcohol dependence" or "Charles is an addict," one could state, "Charles is experiencing increased tolerance for alcohol as evidenced by the need for more alcohol to relax," or (more severe) "Charles needs to drink to avoid acute abstinence syndrome symptoms as evidenced by having 'the shakes' in the morning." Instead of "Client is promiscuous" use, "Client participates in unprotected sex four times a week." Instead of "Client is resistant to treatment" use, "In the past 12 months, client has dropped out of three treatment programs prior to completion." Instead of, "Client is in denial" state the discrepancy as, "Client reports two DWIs in the past year but states that alcohol use is not problem" (Stilen, Carise, Roget, & Wendler, 2005, 212).
3. *List strengths and resources*. From the history and from what the counselor knows of the agencies and community resources, he or she develops a list of the client's strengths and a list of resources. It is important that the client review and internalize (own) these needs and resources (see DeJong & Miller, 1995).
4. *Identify stage of readiness*. Use the importance, confidence, and readiness rulers to assess the client's readiness to change.
5. *Set long-term goals*. With an understanding of the client's problems and needs, the counselor and client set long-term goals. Goals are broad, general outcomes that, when achieved, indicate that the treatment is complete. These could include being free of drugs and alcohol, having stable family relationships, returning to employment, having solid support systems, such as 12-step groups, and

so on. Goals provide inspiration, purpose, and direction to the treatment process.

6. *Write objectives*. Each need of the client should translate into an outcome objective. Outcome objectives must be specific, concrete, measurable, and relevant to the goals. *Specific* means that what the client will do, say, or demonstrate in the treatment process. *Concrete* means there is no confusion about what constitutes the desired behavior of the client. *Relevant* means that it should lead toward attaining the identified goals. "Marcia will learn to cope with strong feelings and conflicts without the use of alcohol" can have subgoals or short-term goals.
   - Marcia will get on the waiting list of the Friendly Farms inpatient rehabilitation center. Target date: March 1.
   - Marcia will find a home group and sponsor in Narcotics Anonymous. Target Date: April 15.
   - Upon admission to Friendly Farms, Marcia will participate in individual, group, family, and didactic therapy sessions and review the treatment plan with her counselor every week.

   An objective is a short-term step that the client will take toward reaching the long-term treatment goal. Objectives should be the following:
   - *Specific:* Use specific behavioral terms to indicate how functioning will be improved
   - *Measurable*: Objectives, interventions, and achievement are measurable via assessment scale or scores, client report, and/or mental status change
   - *Attainable*: During the active treatment phase, focus on improvements, not "cures"
   - *Realistic*: Achievable goals given the clients' environment, support, diagnosis, and level of functioning
   - *Time limited*. They have target dates

   These can be referred to as the acronym SMART (Stilen et al., 2005). They should be stated in the client's own language. They should focus on improvements rather than expect a "cure." They also can be developed collaboratively with clients by asking open-ended questions, such as "what small things do you think you could do to work toward the goal?"

   The counselor should be able to judge whether the client needs some suggestions, however. If the goal is "Hector will follow a plan to help him attain employability," there is a series of suggested knowledge and skills that would help to structure the treatment activity as well as reduce anxiety by breaking down the plan to steps that, in and of themselves, are not overwhelming.
   - Assessment of skills and interests
   - Learning how to read and understand the employment section of the newspaper
   - Learning to use online sites, such as Craigslist.org and Monster.com to identify jobs
   - Learning résumé writing skills
   - Learning how to produce an effective cover letter
   - Learning interviewing skills, such as how to be appropriately verbal and nonverbal and how to use your appearance to promote yourself effectively
7. *Prioritize*. Because there may be many, perhaps too many, objectives, it is important to prioritize them. Criteria can be weighted to establish priorities, for example: (a) How important is it to the client? The more essential it is, the more likely the client will attempt to do what is necessary. (b) How realistic is it given the strengths and resources of the client? (c) What must be accomplished before the next thing can be done? Is there a logical order to the objectives? (d) How critical is it to the client's sobriety?
8. *List the steps*. The counselor, together with the client, develops a set of steps that lead up to the objective. These are the activities that the client, the counselor, and significant others engage in to accomplish the objective. It is important to write concrete, specific, and achievable activities to accomplish the

objective. For example, simply to state that Jim, a chronically unemployed male, "will become employed during February" misses the point. An effective list of steps might include, but are not limited to, writing a résumé, having the résumé prepared attractively and duplicated, completing a course of vocational rehabilitation, identifying a number of possible employers, acquiring clothing appropriate for a job interview, and so on.[b]

9. *Interventions*. An intervention is what the program staff will do to assist a client in meeting an objective. We need to identify the following:
   - The theoretical approach that is the basis for our actions (e.g., rational–emotive behavior therapy, 12-step facilitation)
   - The treatment services and modalities utilized (e.g., group counseling, personal, and social skills development at facility A or B)
   - The treatment frequency/number of hours per week or month that the client will be seen for the identified treatment service
10. *Name the actors*. In each step toward the objective, it is critical to name the person who is responsible for carrying it out. It is important to give the client as much responsibility as possible. However, it is not always possible for the client to do everything. The counselor may have to make certain contacts or collect certain information. For example, if the client lost his driver's license, his wife may agree to take him to the clinic.
11. *Set deadlines*. It is not realistic to assume all deadlines will be met, but setting a deadline for each step and each objective allows an understanding between counselor and client of a reasonable timeline.
12. *Write a discharge summary*. When all objectives are met and they demonstrate that the client is ready for discharge, it is time to write a discharge plan. It summarizes what has been accomplished in treatment and, most important, provides a plan for the client to continue in recovery, indicating the steps he or she must take if there is a need for more help.
13. *Medication management*. This includes prescriptions, amounts, and compliance with medical regimen.

This process requires refinement, depending on the specific treatment setting (residential, outpatient, detox) and mission of the program or agency in which the counselor works. Realistic goals and objectives vary. It is important to remember that a treatment plan is not set in stone. It is a guiding document that needs to be renegotiated with the client when unexpected problems arise or objectives prove too difficult to meet.

The formulation of treatment goals takes into consideration the stage of treatment and recovery. SUD counseling professionals are familiar with typical, common (almost invariable) issues of clients at each stage. For example, in very early treatment of a client who is barely postdetoxification, thought processes may still be confused, and the motivation to stay sober and in treatment is threatened by uncomfortable and unfamiliar physical and psychological states. Overall, treatment goals include alleviating anxiety and keeping the client focused on simple sobriety-maintenance steps and cognitions. Alcoholics Anonymous (not a treatment program) captures this in exhortations to novice members: "Don't drink and go to meetings." "Stay away from people, places, and things connected to drinking/taking drugs." Objectives for the newly sober should be simple and concrete. Maintaining a substance-free state 1 day at a time is about all that one can reasonably put on the client's plate. When this treatment plan is successful, it reinforces the hopes for success in working with the counselor on future changes, personal growth, and challenges.

[b] For an individual living with SUD for a long time, such an organized series of relatively simple, concrete steps might be necessary to form "straight" relationships. Such a list might be to make two phone calls to (potential) friends you met at a meeting; write down how you felt before, during, and after each call; tell people in the group meeting about a feeling you have about them (like them, annoyed or hurt by something they said).

Because of the common pattern among clients in a given stage, some agencies follow a standard format for goals and objectives in early and middle treatment. Such a list can be helpful to prompt or remind counselors of items that may come into play, but treatment planning requires individualization of goals and objectives to correspond to the gender, culture, age, and characteristics of each client.

AFFIRMATIVE FOCUS

In implementing the treatment plan, we must keep in mind the fact that clients may have experienced significant rejections and failures and that underneath their veneer of daring, there is a sense of hopelessness, helplessness, and inadequacy. Therefore, it is important to build into the treatment plan all kinds of positive reinforcements, even when the improvements are small and incremental. Verbal recognition, award certificates for "member of the week," and graduation ceremonies are appreciated and sustain motivation. Even the manner in which a relapse is dealt with can be framed in an affirmative way: "It's great that you were honest with us and returned to treatment; that was difficult and showed your determination." This should be meant honestly and not as "laying it on thick" with sentimental platitudes and false emotions.

MONITORING OUTCOMES

It is important to monitor the attainment of outcomes. This can be overdone or underdone. A counselor can micromanage and overtrack the attainment of outcomes, which disempowers the client; prevents the client from internalizing treatment/service goals, takes away from empathetic engagement, and mentally and emotionally exhausts the counselor. On the other end of the continuum, there is laziness, neglect, and failing to track progress in reaching treatment/service goals. In the center is the zone of optimal engagement and effectiveness.

A client may quickly gain better self-management skills and a level of functioning once out from under the mind-numbing effects of psychoactive drugs. If behavioral objectives/outcomes were set up when the client was at a lower global assessment of functioning (GAF) scale, ASAM level of severity, or other rating of functioning, it may have to be revised to avoid an overly complex treatment plan.

Recurrence prevention continues to be a vital component of treatment planning throughout treatment, if not a lifelong concern. Planning should take into account not only the learning of coping mechanisms for high-risk situations and self-efficacy for a sober lifestyle but also planning what to do if a relapse has begun (Chiazuzzi, 1991; Gorski & Miller, 1982; Marlatt & Gordon, 1985).

ACTIVITY 8.3 What do we want to do here?

To practice writing treatment goals, write two treatment objectives you might have for a client. Then, in groups of three or four members, pick three treatment objectives that best represent your ideas. Have each group report its objectives.

Process:

- ☐ Whose objective is it? Would the client take ownership of it?
- ☐ When in the treatment process would it be appropriate to address the goal?
- ☐ How would you or the client know when the objective is accomplished?
- ☐ What would the client need to do to accomplish the objective, and what resources would he or she need?

ACTIVITY 8.4 Okay, how are we going to do this?

In small groups, read the case of Lee C., and then complete the following steps 1 through 8.

Case: Lee C.

Lee C. is a 25-year-old married male who is participating in an outpatient chemical

dependency program. He is an electrician who had worked steadily until he was recently suspended from his job after a period of absenteeism and tardiness due to his drinking. Lee has been in treatment in the past and has maintained several periods of sobriety ranging from 3 to 6 months, with Alcoholics Anonymous participation. He often states that he drinks after arguments with his wife. They often fight about money and his staying with his mother after they fight. He often drinks with his best friend and co-worker, Kim. Lee's wife does not permit him to live in the house when he is drinking, but his mother always allows him to stay with her. Lee recognizes he has "some kind of drinking problem" and wishes to stay sober because he is afraid of losing his wife and his job. Following the steps, write a treatment plan for Lee C.

1. List Lee's strengths and resources.
2. List his needs.
3. Write a goal for Lee.
4. Write a problem statement for Lee.
5. Write an objective for him.
6. Write a set of steps to accomplish the objective.
7. Determine who will be responsible for each step.
8. Set a date for each step.

ACTIVITY 8.5 Are these good objectives?

Review and evaluate the following treatment objectives. Which objectives do you believe are satisfactory and complete? Rewrite objectives that are unsatisfactory or incomplete.

1. Mr. A will improve his self-esteem.
2. Mrs. B will work on her sobriety.
3. Mr. C will attend five AA meetings per week for the next 6 weeks.
4. Ms. D will start attending community college.
5. Mr. E will improve his social skills by the end of group therapy.
6. Mrs. F will participate by the third week of group by describing how her dependence on pills affected her.
7. Mr. G will participate in treatment.
8. The H family will learn to communicate more effectively through therapy by the end of the next month.

PROGRESS NOTES

The frequency of meetings between client and counselor depends on the context and the level of care (inpatient rehabilitation, intensive outpatient treatment, outpatient treatment); the intensity of help the client needs; and, of course, the limitations imposed by third-party payers and managed-care organizations. There are important functions fulfilled by these meetings. First, the counselor checks with the client on the progress toward the objectives and goals of the plan. Second, regular individual, group, and family sessions are scheduled in order to work through problems and issues that the treatment plan has identified. And third, unforeseen crises that occur must be addressed in order for the plan to proceed. The plan must be renegotiated as circumstances and priorities change.

Each contact with a client requires documentation, whether the contact was a phone call, an individual meeting, or a group session. Continued accreditation of the agency as well as a positive evaluation of the employee often depends on careful documentation. Healthcare and social services settings use the term *chart notes* or *progress notes*, which are kept in official files of the agency. Most SUD counselors do not keep private notes on clients, unless they are in private practice. Counselors record the particulars of a meeting, either immediately after the meeting or on the same day, while it is fresh in the counselor's mind (so time and intervening circumstances do not distort memories). The counselor can use these notes to refresh his or her memory just prior to the next meeting, which is especially helpful if the counselor has a huge caseload or there is a long time between meetings.

One well-known way of organizing progress notes is through SOAP, an acronym for subjective, objective, assessment, and plan. It is, in a sense, a "miniplan" around each significant client contact. The subjective (S) focuses on the client's

perception of the problem. The objective (O) is the factual data the counselor obtains about the situation, for instance, laboratory or other tests, counselors' observations, records, and reports from reliable sources. The assessment (A) is an analysis of the factual data and the client's perceptions of the immediate issues. The plan (P) is a description of steps needed to be taken to solve the problems or work through the issues. For more details and material on case recording, see Wilson (1976).

For example, using the case of Lee C., Lee agrees to avoid people who influence him to drink. Lee comes into a session to discuss this issue. The record of the meeting could look like this:

- **S**—Lee is concerned that his friend Kim will stop by on Friday and ask him to go out drinking. He is concerned that he will have difficulty saying no because he has not been able to do this in the past.
- **O**—According to the assessment and report from family members, Lee has demonstrated difficulty in asserting himself when pressured.
- **A**—Clearly, Lee's sobriety is at risk if he goes out with his friend Kim. Lee needs a strategy to assert himself and explain that he cannot go out with Kim.
- **P**—In the counseling session, Lee practiced responses he could make to his friend Kim. In Thursday night's group, Lee will discuss these issues and practice his responses with the group and ask for group support.[c]

An alternative and newer form of organizing progress notes is the SOAIGP format (Kagle, 1991). In this format,

S = *Supplemental*, new or revised information obtained from clients, family, or peers
O = *Observations* from the counselor and those of other staff
A = *Activities* or tasks of treatment
I = *Impressions*, assessments, hypotheses, and so on
G = Current *goals*
P = Additional *plan* or action steps to be taken

Client information contained in agency documents, such as treatment plans and progress notes are under confidentiality guidelines. The counseling field is beginning to contend with the difficulties of ensuring confidentiality when information is filed and stored in a computerized management information system. Each agency should have guidelines for handling electronic files securely.

RESOURCES AND SERVICES

Throughout the treatment process, the counselor must use his or her expertise to connect the client to the resources necessary to carry out the treatment plan. The counselor has this primary responsibility because he or she is the expert on the array of local health, educational, social, and economic resources that the client may use to address specific needs, in order to reach identified goals. This means that the counselor must have a thorough understanding of the social services in the communities served by the agency. It is useful for counselors to visit, get to know local programs, and develop personal contacts within each program. This facilitates referrals and ensures that a client will not be sent to an agency that cannot or will not be helpful.

It might be beneficial for the counselor to develop a personal directory of social and health services. This directory should contain all agencies in the continuum of care for treatment of SUDs. Directories are available through the United Way; local councils on alcoholism and addiction; and various state, county, and municipal agencies. They are good references to begin to develop a personal directory. The advantage of a personal directory is that it can be expanded with information the counselor learns about specific nuances of a program

[c]Refusal skills that help Lee, which he can practice in a group setting, are "I statements," empathetic refusal, and limit setting ("I like you and I'd like to have some fun with you, but I really can't go out drinking"), which recognize the feelings and needs of both parties.

(e.g., which programs are most responsive to the cultural, ethnic, and personal needs of clients). Moreover, printed directories can become out of date in 1 year. To build a useful, personal directory of resources, a counselor should include answers to the following questions:

- What are the eligibility requirements for the program?
- What services can a client expect from this agency? What is expected from the client?
- What is the cost of the service? Is it free? Is there a sliding fee scale? Does the program take insurance, including Medicare and Medicaid?
- What is the protocol for referral?
- What is the culture, economic status and ethnic makeup of the client population?
- Does the program provide services for needs such as disabilities (e.g., wheelchair access, deafness, blindness), foreign languages, babysitting, transportation, education, or job development skills?
- Who is the contact (name, telephone and fax numbers, email, and street addresses)?
- What are the hours of operation? Does the agency provide services during business hours only, or on weekends, evenings, and holidays as well?
- How long has the agency been operating? What is its track record? Who funds it?

The case of Mrs. Harris is an example of case management from intake to discharge. It illustrates the need to know the offerings of other resources and their contact people in order to coordinate all aspects and stages of a client's care.

> Mrs. Harris was referred by the human resources (HR) department of an urban college to the in-house Employee Assistance Program (EAP). The HR administrator had gathered information that documented decrements in Mrs. Harris's job performance, which warranted referral to the EAP. Mrs. Harris is a long-time, well-liked employee, and a recent widow who also was approaching retirement. Screening by the EAP administrator indicated the strong possibility of late-onset alcohol abuse or dependency syndrome. Mrs. Harris's depression and grief were obvious, but she clearly did not feel comfortable to divulge information about drinking to someone who represented her employer. The EAP administrator thought that it would be useless and possibly insulting or threatening to confront Mrs. Harris strongly. Therefore, he decided to refer her to an outpatient alcoholism program in the community. The initial EAP screening impressions were established when Mrs. Harris acknowledged to the agency's intake counselor the degree to which she had been drinking. That intake counselor recommended to the referring EAP administrator that Mrs. Harris undergo medical detoxification prior to further treatment. Because she was consuming more than a pint of whiskey per day, and considering her age, outpatient detoxification was not indicated because of the possibility of medical complications. Because there was no local detoxification facility, the EAP administrator contacted a medical center in a neighboring city and arranged Mrs. Harris's admission. At the same time, because of the waiting period for admission to inpatient rehabilitation, the EAP staff contacted the admissions department of an inpatient alcoholism rehabilitation program specializing in EAP referrals so that upon completion of a 5-day detox stay, Mrs. Harris could be transported without a hiatus to the rehabilitation setting. The EAP also notified the HR department that Mrs. Harris would require a 5-week medical leave.
>
> After determining that Mrs. Harris's sister was a relative whom he trusted with information about her planned treatment, the EAP administrator worked with her to ensure that a bag of clothes would be packed and that Mrs. Harris would be present the next day, at the time scheduled for the medical center van to pick her up from her sister's home and transport her to the detoxification unit. She detoxified from alcohol in four days, and was transported to the inpatient rehab setting. Following discharge, Mrs. Harris was cleared to return to work; she was obligated to attend the outpatient program for continuing care (*aftercare*). The EAP administrator monitored

her aftercare via telephone and sent a monthly report to the HR department that Mrs. Harris was meeting the requirements of the EAP. None of the details of diagnosis and treatment went into Mrs. Harris's HR file, nor were they communicated to her supervisors. Mrs. Harris had become isolated from her church, an affiliation that she greatly valued. She was ashamed of her drinking and sought to avoid humiliation by a self-imposed ostracism. In discussions with the EAP staff and in treatment, her desire to find a way out of this situation emerged as a motivation for recovery, in addition to the formal requirements of the HR department for continued employment. Following treatment, she felt encouraged to re-establish her contacts with church and community. In this way, she also renewed the social support she needed to negotiate the stages of grief and loss of her husband. These steps successfully cemented her sobriety, which she maintained until retirement two years later, at which time contact with the EAP staff ended.

IMPEDIMENTS TO TREATMENT

Some impediments to entering treatment are posed by caretaker roles, such as parent, breadwinner, household manager, and caretaker of ill or elderly parents. It is difficult to find time to attend an outpatient program, and it is seemingly impossible to find a way to enter intensive outpatient or inpatient rehabilitation. There are specialized programs for women and their children and for pregnant women. Components of such programs often include childcare, compensatory special-education programs for children, screening for fetal alcohol syndrome, neonatal withdrawal units, parenting skills, vocational–educational rehabilitation, personal and social skills development, nutritional counseling and augmentation, and transportation. Some of these services are provided by social services agencies working with the SUD agency to provide integrated case management. Staff should be aware of them to make appropriate referrals.

Physical and Mental Abuse

Especially with women, it is necessary to assess whether the client has been or is being physically or sexually abused, usually by a relative or mate. Unfortunately, it is unlikely for women who are being abused to enter treatment. One of the elements of battered woman syndrome is that the dominating abusers isolate the woman from family and social relationships that might propel them in the direction of help. Moreover, the woman's sense of self is so low that she seldom thinks of getting help without outside encouragement. The tendency is to drink and take drugs more to desensitize herself to be able to get through the day. Of course, the abuser is highly threatened by the prospect of the woman entering treatment and usually prevents it. Often, an abused woman seeks or accepts help only when her children's lives and safety are at risk and when children's protective services enter the picture. While rates vary by population and among studies, many agency directors state that at least half of the girls and women in treatment with their agencies have histories of physical, sexual, or emotional abuse. At the least, an abused client brings associated guilt, anger, and/or shame. Worse, an abused client may qualify for a diagnosis of post-traumatic stress disorder (PTSD). In one study of women with SUD at Amity House, a long-term therapeutic community in Tucson, Arizona, 35 of 55 residents had been raped or molested before the age of 21, and an additional 15 after the age of 21 (Stevens & Gilder, 1994). A valuable manual for screening, assessment, and case management of battered and abused women is available from the Center for Substance Abuse Treatment (1997).

Ethnicity and Social Class

The ethnic background and social class of clients also affect use and abuse of substances. Middle-class Caucasian women fit a bell curve of normal distribution in which moderate drinking is the modal or most typical pattern. In lower income African-American women, the distribution is flatter, with more nondrinkers and more heavy drinkers than moderate drinkers. Nondrinking is

associated with women in middle age and has a high correlation to church affiliation (Cahalan, Cisin, & Crossley, 1969).

Self-Assessment

Counselors usually make assessments of self-image, self-esteem, and self-efficacy from their general observations of a client's presentation, affect, body language, and oral reports. Psychosocial assessment of females with SUD should rate self-efficacy and self-esteem because powerlessness, shame, and stigma are more often a major concern for female than for male substance abusers. Personal history may reveal depression, common in females with SUD, as antecedent to SUD, secondary to it, or antecedent to but worsened by it.

Treatment planning for women with SUD needs to address trauma, abuse, shame, and self-efficacy as issues in their own right and in recurrence prevention. Many women recovering from alcohol abuse and other SUDs report women's groups as a setting in which such issues can be addressed and links shown, and where they can build a positive image and identity of recovering womanhood. In later stages of treatment, they need to construct models of a positive occupational and social role, interacting with recovering and nonrecovering individuals.

Criminal Offenses

As is well documented, the vast proportion of crime is alcohol and drug related, and treatment reduces recidivism (Lipton, 1995). Treatment of criminal offenders must not be cursory and should include a meaningful, long-term relapse-prevention component. Even where treatment has occurred in prison, continuing care upon release is a priority. Offenders are especially at risk for relapse. They are the archetypal "hot-house" plant, coming from a "total institution" setting and flung into a chaotic, overstimulating environment with multiple requirements, stressors, decisions, and lack of support, as well as the task of being responsible for themselves (CSAT, 1993, vii). They must look for jobs but jail time on their résumés and the stigma of "felon" becomes a major obstacle. They may have been involved in criminal activity and the criminal justice system since adolescence, and never learned appropriate adult financial, occupational, and interpersonal skills. They have a greater need for habilitation than rehabilitation as. Contrary to the common image of the offender as evil, the average offender who receives help from organizations, such as The Fortune Society or Offender Aid and Restoration has a defeated, lost, and fragile quality. Such organizations generally provide or give a referral to vocational training, achievement of high school equivalency diplomas, SUD counseling, job-seeking skills, parenting skills, and childcare for those attending program services. Many employ ex-offenders, which provides positive role-models for those who may feel destined to stay in the role of chronic recidivist.

Treatment and case management of an offender with SUD require an integrated system. This involves the court, prison officials, probation and parole authorities, and the treatment network. Collaborative planning between criminal justice and treatment systems can make an effective joint effort to treat offenders with SUD (CSAT, 1995). Drug courts, which are often the link between the systems, have been spreading from Florida to Texas and north.

There are many points of contact between the criminal justice and SUD treatment systems. Offenders with SUD are processed in a variety of ways, at the judge's discretion. Factors in the disposal of a criminal case by the judge include the offense and its severity; criminal history of the offender; evaluation and the recommendations made by prosecutors, special court staff, or external social services agency; plea bargaining efforts by attorneys for the defendant; and the options available in the area, such as the following:

1. Pretrial hearing, with charges dropped or delayed contingent on entry into treatment for substance abuse
2. Presentencing plea bargaining, with placement in a diversion or treatment program

3. Probation to a treatment program
4. Treatment in prison
5. Serving a sentence in a halfway house, day-reporting center, or therapeutic community
6. Parole contingent on entry into treatment

Although a large proportion of clients have entered treatment through mandated referrals from the criminal justice system, the proportion grew much larger in the United States during the late 1990s because state and federal funding for SUD treatment declined, as did the ability to seek reimbursement from managed-care entities and third-party payers. At the same time, criminal justice funds increased. Agencies began to pursue government contracts to process offenders and many either started new components for that purpose or shifted the overall focus of the agency. These system changes have implications for the development of SUD counselors. Many counselors who entered the profession as an extension of their own recovery have been dismayed that the offender population is less motivated to enter recovery than they had expected, and that their role in offender treatment amounts to noncharismatic case management or "babysitting" clients. Although there are many excellent programs for offenders with SUD, often adaptations of the therapeutic community model, some privatized correctional behavioral health services have not met clinical standards to which SUD professionals are accustomed.

COMMUNITY LINKAGES

A referral network among community institutions is invaluable. Because many individuals turn to clergy in crises, informed clergy can recognize early SUD in individuals and signs of SUD in families, even if it is not the individual with SUD who comes for help. Treatment can complement reintegration into the community via religious affiliation. Clergy can be an important bridge to treatment not only by referral but also by preliminary pastoral counseling and education and by supportive formal intervention by family members. As trusted and respected authorities in a community, clergy also can be very influential in an ongoing system that supports recovery. Optimally, treatment agencies should form a seamless network with clergy and pastoral care, with pastoral counseling training for clergy in SUD, family, and treatment issues. African-American clergy, in particular, are already a bulwark of help in both urban and rural communities (Sexton, Carlson, Siegal, Leukefeld, & Booth, 2006). Although *clergy* may be defined habitually to include only mainstream denominations, it should include alternative religions and healers, such as the *espiritistas, santeros,* and *curanderos* among the Latino community. SUD agencies can conduct training and educational efforts among clergy, or they can import trainers from their local councils on SUD to enable clergy and other influential community leaders to acquire skills in identifying and referring problem users.

An elementary task of any treatment agency is to establish a formal, ongoing, collaborative relationship with school administrators and counseling staff for timely intervention and referral of students. If the school has no SUD counselor (Student Assistance Counselor or Coordinator), the agency could help the school establish this office, bring in other resources, or establish a satellite office at the school, depending on the needs and desires of the school.

The treatment agency also should establish formal and informal collaborative relationships with local employee assistance programs, child welfare agencies, Temporary Assistance for Needy Families (TANF) and food stamp offices, and other human and social services agencies, for the purpose of referral linkages and collaborative prevention efforts. It is outside of the scope of this text to describe all of the new, science-based prevention strategies that can be implemented in communities where agencies exist.

It is critical to enlist the aid of community institutions in sending prevention and intervention messages. At the very least, agency literature can be made available on site. Again, a formal relationship with the school system is a *must* for treatment agencies. Regardless of how hard the individual with SUD and/or his or her family has

worked, maintaining sobriety is an uphill battle in a community that has no supporting role. Established institutions should consciously and actively give out messages that support, esteem, and, perhaps, reward prevention, encourage appropriate intervention and treatment. Counselors and agencies can—at the very least—provide literature to churches, stores, movie theaters, libraries, grocery stores, and other places where the public gathers. The literature, such as pamphlets or posters, will succinctly inform readers about signs of SUD and give a telephone number to call for further information.

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CHAPTER 9

CO-OCCURRING DISORDERS

OBJECTIVES

At the end of this chapter, students will be able to:

1. Describe the extent of mental illness within the substance abuse population.
2. Explain the problems related to how clients' co-occurring disorders (COD) are often underserved.
3. List eight principles of comprehensive continuous integrated system of care (CCISC) of COD.
4. Describe the four-quadrant model of categorizing severity of care for COD clients.
5. List at least eight of Mueser's 12 principles of care for COD clients.
6. Describe the unique aspects of the wellness recovery action plan (WRAP) approach.
7. List at least three psychiatric medications for treatment of mental illness in each category: antipsychotics, antidepressants, and antimanics.
8. List at least three DSM-5 criteria for the diagnosis of schizophrenia.
9. List at least three DSM-5 criteria for the diagnosis of major depression.
10. List at least three DSM-5 criteria for the diagnosis of bipolar illness.
11. Describe at least five ways that substance abuse and psychiatric symptoms can interact to cause diagnostic confusion and mislabeling.
12. List at least two DSM-5 criteria for the diagnosis of antisocial personality disorder.
13. List at least two DSM-5 criteria for the diagnosis of borderline personality disorder.

INTRODUCTION

One of the curiosities in the history of medicine is the separation of substance use disorders (SUDs) and psychiatric disorders as fields of study and treatment. Contributing to this separation was that physicians found substance abusers difficult to treat, uncooperative, and not profitable. Furthermore, SUD treatment began as an outgrowth of grassroots self-help ideologies. People with co-occurring psychiatric and substance abuse problems suffered from this disconnect. In the last few decades, integrated systems of treatment have come into being.

The authors note emphatically that one chapter of a text cannot do justice to the development of all of the knowledge and skills needed to provide services to individuals with severe mental illness and SUD. Moreover, knowledge can swiftly go out of date as, for example, when new medications are developed. Even the basic psychiatric compendium of disorders is subject to new editions and updates within editions (APA, 2013; 2016)

It is the rule, not the exception, that individuals with a SUD have an additional mental health problem. According to surveys done by the National Mental Health Association (2006), 52% of people diagnosed with alcohol abuse or dependence also had a mental disorder and 59% of those with other drug abuse problems also had a mental illness diagnosis. The National Alliance on Mental Illness (NAMI, 2011) indicates similar prevalence data, stating that 50% of individuals with severe mental illness are affected by substance abuse and 37% of alcohol abusers and 53% of drug users have a serious mental illness. Although co-occurring disorder statistics and even treatment programs are usually limited to those with so-called "severe mental illnesses," problems, such as obsessive–compulsive disorder, posttraumatic stress disorders, and panic disorders can surely be severe, chronic, and debilitating; many of these individuals also have a SUD. To confound our efforts at coming up with an accurate picture, even individuals in substance abuse treatment may have an undiagnosed, overlooked, or untreated psychiatric problem, and those in mental health treatment are often unnoticed abusers of psychoactive substances (Kivlahan, Heiman, Wright, Mundt, & Shupe, 1991).

The term *co-occurring disorder (COD)*, to a large extent, has replaced a variety of acronyms to describe people with both psychiatric and chemical-use problems, which brought stigma to the labeled individual. In this chapter, CODs refer to such individuals. The old acronyms included MICA = mentally ill chemical abuser; MISA = mentally ill substance abuser; and MISU = mentally ill substance using and several others.

Among people with SUD and additional severe psychiatric disorders, there are higher rates of suicide and suicidality, homelessness, legal and medical problems, and longer and more frequent hospitalizations (Baker, 1991). Because it is uncommon for simultaneous and effective attention to be paid to all of their many, varied, and complex needs (Cohen & Levy, 1992), people with CODs receive fewer services than other client populations in proportion to their needs. Those who are diagnosed with CODs belong to two stigmatized social categories. Until recently, they were underdiagnosed, undertreated, and often dumped from one system to another or discharged early from treatment as soon as they had been stabilized. Their experience of treatment was less successful than that of single-diagnosis clients. Until recently, when patients with CODs did receive treatment for both psychiatric and addictive disorders, it was often sequential (first for one disorder, then the other) or parallel treatment (alternating between units and services), rather than a single, integrated model or facility.

In the 1990s, the behavioral health field increasingly recognized and began to plan for integrated case management and treatment of COD clients (Baker, 1991; Mueser, Drake, & Noordsy, 1998). The degree to which treatment models are integrated, however, still varies greatly among states, counties, and municipalities. On the downside, cost-containment and managed-care trends tend to cause those with CODs to be released from the treatment system before sufficient time has elapsed to address or even properly assess

their problems. Funding for inpatient treatment has been cut continuously since the 1960s without the provision of adequate community support systems. One and a quarter million mentally ill people decline in prisons, and approximately one-half of prisoners have mental health problems. More disturbingly, these numbers quadrupled from 1998 to 2006 (Human Rights Watch, 2006).

Integrated, Comprehensive Care Models

The comprehensive continuous integrated system of care (CCISC) model has been identified by SAMHSA as an exemplary practice (CSAT, 2005). It has been implemented in an increasing number of states (Bachman & Duckworth, 2003). As outlined by Kenneth Minkoff, a leader in integrative COD care (Minkoff & Cline, 2004), the eight research- and consensus-derived principles that guide the implementation of the CCISC are the following:

1. Dual diagnosis is an expectation, not an exception.
2. The *four-quadrant model* for categorizing people with CODs according to high and low severity for CD (chemical dependency) and MH (mental health) are high–high (Quadrant IV), low MH–high CD (Quadrant III), high MH–low CD (Quadrant II), and low–low (Quadrant I). With high MH needs, integrated treatment takes place in the mental health system, however, with relatively high chemical abuse problems, treatment takes place within the SUD treatment system. (The assigned quadrant can change in any direction as people improve or deteriorate in their psychiatric or substance using status—thus, the quadrants are best viewed as states, not traits!)
3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting.
4. Case management and care must be balanced with empathic detachment, expectation, contracting, and contingent learning for each client, and in each service setting.
5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.
6. There is no single, correct intervention for COD; interventions must be individualized according to the quadrant, diagnosis, level of functioning, external constraints or supports, and phase of recovery/stage of change.
7. Clinical outcomes for COD must also be individualized. Abstinence and full mental illness recovery are usually long-term goals, but short-term clinical outcomes must be individualized and may include reduction in symptoms or use of substances, increases in level of functioning, reduction in internal and external harm, and step-down in levels of care.[a]

Mueser, Noordsy, and Drake (2003, 16–33) identify more principles of integrated treatment:

1. Shared decision making among all stakeholders, including clients
2. The same clinicians providing both the mental health and the substance abuse treatment services
3. Residential support: safe, "dry" housing
4. Assertive community treatment, services delivered where clients are located
5. Vocational rehabilitation and supported employment
6. Family education
7. Social skills training
8. Stress management and coping skills training
9. Assertive case management, not waiting for clients to develop motivation and initiative; actively engaging reluctant individuals
10. Peer and self-help group involvement
11. Medication management and psychoeducational services concerning medications and medication side effects
12. Alternative recreational activities

[a] Adapted from Minkoff and Cline (2004).

Contingency management (CM) techniques are a useful component of COD treatment plans. CM is a system of positive and negative consequences that address specific target behaviors. It is based on simple behavioral conditioning familiar to students in Psych 101 as positive and negative reinforcement. Clinic attendance, medication adherence, and following simple behavioral prescriptions (such as personal hygiene) can be reinforced with cash, vouchers, prizes, retail items, and privileges, such as flexibility in methadone dosing or passes. The system must be well defined and based on a behavioral contract with time limitations. The contract should be subject to review to keep it realistic and up to date (CSAT, 2005, 122–123).

As with all clients, treatment goals need to be broken down into clear and measurable outcomes, such as (Mueser et al., 2003, 79) the following:

- Goal: Improved skills for making friends and meeting people. Objective: Client initiates at least three conversations per week, including one in a new place.
- Goal: Developing alternative recreational activity. Objective: Client tries one new recreational activity per week and two old activities.

Wellness Recovery Action Plan

Mary Ellen Copeland (2002) developed a practical, concrete, and easy-to-follow set of tools and actions to facilitate recovery from CODs. This includes the following:

- Good medical care for physical problems
- Self-advocacy skills
- Medication management habits for clients
- Relaxation exercises
- A clear, posted crisis plan that involves:
  - Monitoring for crisis triggers
  - Monitoring the level of stimulation in the environment and making sure it is not too high or too low
  - Links to support individuals
  - Instructions to caregivers
  - A suicide prevention plan
- Postcrisis planning
- Ongoing peer support

More details along with guidelines for copyrighted use of handouts are available at http://www.mentalhealthrecovery.com/wrap/wellness-recovery.php. Concise descriptions of specific programs that use the wellness recovery action plan (WRAP) perspective are at http://www.mentalhealthrecovery.com/wrap/program-descriptions.php.

Myriads of Dual Diagnoses

Given the range and severity both of SUDs and psychiatric syndromes, there is a near-infinite variety of combined syndromes. In terms of the primacy of SUD or psychiatric illness, they range from those who suffer primarily from psychiatric disorders and who "self-medicate" with alcohol or illegal drugs, through complex cases in which psychiatric and SUD symptoms are hard to tell apart, to people with an SUD whose chemical use causes organic brain syndromes, such as stimulant psychoses, alcohol-induced hallucinosis, or psychotic conditions associated with the use of hallucinogens.

It is almost always the case that unless the chemical-dependency counselor is also credentialed in psychiatric social work, psychiatric nursing, or psychology, he or she is expressly denied the role of diagnosing a client. Nevertheless, because the counselor must treat the chemical abuse and dependency of people suffering from other psychiatric conditions, he or she must be aware of behavior that suggests a serious psychiatric disorder in order to alert the agency to the necessity of psychiatric consultation.

Issues of Medication

Because the counselor may be counseling clients who are taking medications prescribed for psychiatric conditions, he or she must be familiar with the categories and names of commonly prescribed medications. It is important to distinguish antipsychotic, antimanic, or antidepressant medications from drugs of abuse. Although some "garbage head" abusers (those who use a mixture of various drugs) or experimenting teenagers

might take a Prozac (antidepressant) or a Haldol (antipsychotic), drugs in these categories are rarely abused. Some recovering people distrust psychiatric medications for a variety of reasons: they have been misdiagnosed as psychotic and misprescribed these medications; they have been given major tranquilizers as a behavioral control strategy (e.g., in prison); they have a drug-free philosophy; or the medications have undesirable side effects. Yet, these drugs are frequently lifesavers, and they permit the social integration of the severely affected.

A complete and up-to-date guide to psychotherapeutic medications may be downloaded for free from the Mid America Addiction Technology Transfer Center (ATTC, 2014).

Diagnostic Issues

Clients arrive for treatment with any of a number of prior diagnoses, usually according to the categorization system in the Diagnositc and Statistical Manual of Mental Disorders-5th Edition. (APA, 2013). The DSM is a multicommittee attempt at comprehensive categorization or taxonomy of mental disorders. It is a guide to systematic diagnosis and classification of clients. It does not pretend to substitute for, nor does it espouse a theory of, mental disorders. It does not explain why someone is schizophrenic, a kleptomaniac, or has attention-deficit disorder. The categories are not "basic" underlying conditions but terms found useful over the years that have some discrete validity to them in that they describe recurring clusters of symptoms. Some diagnoses may be symptoms of others, or they may be ideal types rarely found in nature. Some are more discrete than others: schizophrenia and bipolar mood disorder are fairly clear biologically-based brain disorders, almost as obvious as strep throat or a broken leg. Why someone has "avoidant personality" is less clear and perhaps reflective of some as yet unexplained syndrome or imbalance, if it is a real "disease" at all. The DSM-5 working groups attempted to move from the concept of psychiatric syndromes as "categories" toward a model that viewed them as points on a continuum or spectrum. They did this in some cases, such as in the autistic and schizophrenic spectrum, but not for others, such as in the antisocial personality disorder.

Misdiagnosis can occur in psychiatry even without the complicating factors of SUD. In a survey of bipolar members of a national support organization for depressive and manic–depressive (bipolar)patients (Lish, Dime-Meenan, & Whybrow, 1994), three-quarters of respondents stated it had taken an average of 8 years to get a correct diagnosis. The similarities of psychiatric and SUD phenomena outlined in **TABLE 9.1**, the fragmentation of the behavioral health fields and the irregular interaction of COD clients with the healthcare system make it all but inevitable that COD clients will be underdiagnosed and misdiagnosed. To establish a valid psychiatric diagnosis, the symptoms must manifest long after intoxication has abated.

TABLE 9.1 Similarities of Addictive and Psychiatric Phenomena

Drug Syndromes	can be confused with	Psychiatric Syndromes
Alcohol Withdrawal		Paranoid schizophrenia
High-dosage amphetamines		Paranoid schizophrenia
Chronic cocaine use		Paranoid schizophrenia
Cocaine withdrawal		Major depression
PCP overdose		Schizophrenia
Cocaine intoxication		Manic state

Alcohol and other drug abuse (AODA) and psychiatric symptoms (PS) can interact in the following ways:

1. AODA may prompt the emergence or re-emergence of PS
2. AODA may worsen pre-existing PS
3. AODA may ameliorate, dampen, hide, mask, or disguise PS
4. AODA may mimic PS
5. Cessation of AODA following development of tolerance or dependence results in a withdrawal syndrome that may mimic psychiatric symptoms
6. PS must be distinguished from ambivalence, noncooperation, and lack of motivation associated with AODA
7. PS increases the risk of AODA
8. Side effects of antipsychotic medications (i.e., sedation, involuntary physical movements) may be mistaken for symptoms of either PS or AODA
9. Relative domination and severity of PS and AODA symptoms may wax and wane, diminish, or re-emerge. Case management functions, such as screening, assessment, and treatment planning are ongoing with COD clients.

For example, one cannot take as evidence of psychosis, the paranoia of an active crack cocaine user, the hallucinations of an active lysergic acid diethylamide (LSD) or phencyclidine (PCP) user, or the hallucinations of a client with delirium tremens. In 1987, such misdiagnoses resulted in an inpatient psychiatric unit in Brooklyn, New York, being filled with more "paranoid schizophrenics" than might be found in the state of Texas. This was due to the newness of crack cocaine, which was epidemic at the time, and the unfamiliarity with the symptoms of acute cocaine intoxication and abuse by psychiatric staff who had been trained abroad.

A factor that confounds assessment is that in those with CODs, substance use may mask pathology, numb its sharpest points, exacerbate it, or simultaneously improve and worsen different symptoms. Depressants blunt the mania of the bipolar client but make the depressed even more depressed. Alcohol or marijuana is the drug of choice of some people with schizophrenia. Marijuana soothes anxieties and holds demons at bay, without the agitation of alcoholic hangovers and withdrawal; yet, alcohol and marijuana make cognition and memory all the more vague. Crack cocaine and "angel dust" (PCP) are dangerous for people with symptoms of paranoia or who are prone to violence as they may aggravate those symptoms. Within the COD treatment community, there is considerable controversy about how long to wait with a clean-and-sober client in order to determine whether his or her symptoms constitute a "real" psychiatric problem (Evans & Sullivan, 1990, 58–59). With the present day's short-term treatment limits, it may be next to impossible to make such a determination.

The COD client population presents several specific treatment problems:

- Instead of feeling better after detoxification, as the nonpsychiatric individual with SUD does, the self-medicating COD client may feel the full force of his or her schizophrenia, PTSD, or other symptoms
- A COD client may focus on psychiatric problems while in SUD treatment but may explain his or her problems in terms of drugs while with the mental health professional. With such interchangeable or free-floating ambivalence, both conditions may be denied (Doweiko, 1997, 275).
- To the COD client, chemical use can be the means of coping with a devastating mental affliction. Chemicals seem to provide some sense of control, even though the underlying syndrome is not addressed or is worsened. Counselors must recognize and empathetically reflect these motives if a treatment alliance is to be made.
- Most categories of COD are quite fragile; traditional confrontational methods would not be appropriate (Evans & Sullivan, 1990, 30).
- With high mental health needs, the COD client can be assumed to have major life

problems, such as committing criminal act(s), homelessness, and poor physical health. These must be addressed early in treatment or the client will be overwhelmed and devastated by life problems that will preclude engagement in treatment. The COD client is also more likely than the client without a co-occurring disorder to be involved in many systems yet be overlooked by all. Therefore, comprehensive services that provide continuity of care are needed (CSAT, 2005, 39, 47).

- The COD client suffers from multiple stigmata, which he or she has likely internalized into a helpless, hopeless, and self-loathing persona. The client is also likely to be isolated and socially disengaged. The therapeutic relationship with the counselor, perhaps the only stable and/or healthy relationship that the client has ever known, will be central to any measure of recovery.
- Treatment staff are often pessimistic about the chances of a deteriorated and decompensated COD client to ever get better.

In the writing of the DSM-5, there was a movement toward considering psychiatric disorders as points on a continuum or spectrum. For example, autism was seen as a continuum from mild to severe. (APA, 2013, 50–51) The autism spectrum absorbed Asperger's syndrome as a mild point on the spectrum, which recognizes three levels of severity (op. cit. 52). Asperger's syndrome encompassed "quirky," "socially inept" people who nevertheless often exhibited talents in music, mathematics, or other fields.

SCHIZOPHRENIA

Schizophrenia is a biologically based brain disorder. Like cancer, it is not just one well-defined disease. Schizophrenia results from some combination of inherited neurologic vulnerability, and any of a number of external risk factors, including some in utero (usually second-trimester) environmental stressors (Andreasen, 1999).

Identical (monozygotic) twins have a concordance rate of close to 50% for schizophrenia. This shows that schizophrenia is, in part, based on an inherited predisposition or vulnerability. Starting in the late 1980s, structural differences in the brains of schizophrenics were demonstrated. These observations also applied to twin studies. That is, where one identical twin is schizophrenic, there are significant differences in the brain structures of the two (Andreasen, Swayze, Flaum, Yates, & McChesney, 1990; Barta, Pearlson, Powers, Richards, & Tune, 1990; Shenton et al., 1992; Suddath, Christison, Torrey, Casanova, & Weinberger, 1990), and there are even subtle differences in fingerprints and other minor physical anomalies (Mellor, 1992; Schiffman et al., 2002). Recently, the Salk Institute for Biological Studies (Brennand et al., 2011; Calloway, 2011; Salk Institute, 2011) grew stem cells of schizophrenics into neurons and found that they did not connect normally, although the antipsychotic drug loxapine seemed to help reverse that effect. However, if schizophrenia was based totally on genetics, identical twins would always both be schizophrenic, or not. Family history is probably a necessary factor in a majority of cases, but it is not a sufficient explanation. A variety of pregnancy, delivery, and perinatal problems also has been implicated, which may include nutritional problems and viruses. A greater incidence of schizophrenia has been found in influenza epidemics, even among those without a family history of schizophrenia (O'Callaghan, et al., 1991; O'Callaghan, Sham, Takei, Glover, & Murray, 1991). Schizophrenia, then, is a neurodevelopmental disorder with variations in etiology to the extent that genetics or environmental trauma are involved.

Schizophrenia has an age of onset usually between 16 and 23 years. The major symptoms of schizophrenia include the following:

- *Delusions* (distortions of inferential thinking). One common set of delusions is that in which unrealistic associations are made between events in the world and the client. An example might be that a person seen

on television is perceived to be talking to or about the schizophrenic client. Such delusions are called *ideas of reference*. They include but are not limited to paranoid persecutory delusions, often that a governmental agency is monitoring their thoughts, or even that thoughts are being inserted in their mind.

- *Hallucinations* (major perceptual distortions), which are more likely to be auditory than visual in schizophrenic patients.
- *Disorganized speech often called a "word salad", or mumbling to them selves*
- *Disorganized behavior, such as wearing clothes totally inappropriate to the season*
- *Flat affect* (restricted range and intensity of emotional expression), affect that is incongruous to the situation, and apathy or avolition.
- *Other neurocognitive deficits,* such as difficulty in concentrating; sensory overload; and difficulty in sorting, integrating, organizing, and responding to sensations and information.

Schizophrenia is *not* caused by bad parenting, disordered family communication, or mothers who send contradictory or inconsistent signals. Family members of persons with schizophrenia have no more of a role in creating this disease than they do in cases of multiple sclerosis or Alzheimer's disease among their relatives. Neither is it caused by the surfacing of unconscious and unbearable thoughts or feelings, the alienation of modern society, or traumatic losses. Finally, abuse of alcohol or other drugs can cause any number of emotional or mental problems, or brain damage, but not schizophrenia proper.

The DSM-5 recognizes a schizophrenia spectrum, which includes schizotypal personality disorder as a mild touch of schizophrenia and several other related subtypes.

The treatment of schizophrenia involves antipsychotic medications (also known as neuroleptics or major tranquilizers), which can greatly reduce the severity of psychotic symptoms, such as hallucinations and bizarre behavior. However, they are much less likely to affect the so-called "negative" symptoms, such as lack of motivation or flat affect. Medications do not cure this brain disease, and some have side effects such as tremors, twitching, and tics. Psychiatrists call such behaviors *extrapyramidal symptoms* or *tardive dyskinesia (TD)*.

In addition to medication, schizophrenic COD clients and their families require education on the nature of their conditions as well as supportive case management, which may include monitoring medications, supportive group apartment programs, day treatment programs, occupational training, and programs to train clients in activities of daily living. Formulating or carrying out a treatment plan with a person with severe schizophrenia is obviously more difficult than with people with SUDs only.

Confrontive treatment and "tough-love" forms of intervention are not recommended for people with serious mental illness (Loneck & Way, 1997). The simple and concrete nature of 12-step slogans and suggestions, and the nonconfrontive and nonjudgmental quality of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), make these groups a congenial environment for many COD clients, as does motivational enhancement therapy. Supportive group therapy and topical groups that focus on medication or daily living skills are also useful components of a COD program. However, not all AA/NA members and groups are knowledgeable about the necessity for antipsychotic medications. In some areas, specialized "double-trouble" groups exist, such as Dual Diagnosis Anonymous and Dual Recovery groups. Meetings can be easily located via utilization of a search engine.

Asher and Gask (2010) published an interesting set of interviews with homeless, substance-abusing schizophrenics to gain insight into their varied motives for using. A link to the complete document is provided in the bibliography.

Mood Disorders

The two overall categories of mood disorders are depression and bipolar disorder (manic depression), which manifest in unusual swings or fluctuations

between mood extremes. Depression must be differentiated from simple exhaustion, normal grief, thyroid disease, dementias, and the "crash" or mood slump at the end of a stimulant "binge" or overindulgence. Although depression itself is broken down into dysthymia (formerly, neurotic depression), which is the relatively mild variety, and major depression, there is a continuum of pathology, the true nature of which may be masked or exaggerated when presented to a counseling professional. Depression is a complex phenomenon, and each depressed client probably suffers from a unique mix of etiologic variables, which may include the following:

- Biochemical predisposition, which often has a genetic basis (Torrey et al., 1994)
- Biologic stressors, such as fatigue and pain
- Cognitive and behavioral factors, such as lack of self-efficacy, learned helplessness, and problematic thinking patterns and beliefs (**TABLE 9.2**)
- Unresolved, impacted grief and anger
- Interpersonal factors, such as lack of support systems and poor interpersonal skills, which lead to isolation
- Depressants, such as alcohol, barbiturates, or benzodiazepines

Antidepressant medications are often successful in the alleviation of severe depression. These medications are not stimulants and may require several weeks to take effect. The client also may require trials of various antidepressants before the most efficacious drug is identified. The vast majority of individuals treated for severe depression is now prescribed medications belonging to the SSRI category (selective serotonin reuptake inhibitors such as

- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluoxetine (Prozac)
- Paroxetine (Paxil)
- Sertraline (Zoloft)

Varieties of talk therapy are also helpful in the resolution of emotional, cognitive, and behavioral aspects of depression.

Bipolar (manic–depressive) affective disorder is based on one or more biochemical vulnerabilities and can be triggered by trauma, substance abuse, fatigue, or stress. In the manic phase of the disorder, thoughts race and gravitate toward grandiosity, behavior is reckless, and energy is boundless. Sooner or later, the patient "crashes" or falls into a phase of depression. There are several subtypes of bipolar disorder with which the counselor should become acquainted. At least one-half of people with this disorder go on to substance abuse syndromes and are at great risk for suicidal attempts. The simple chemical lithium carbonate enables many to stabilize their mood swings, as do a number of medications first used as anticonvulsants.

TABLE 9.2 Depressive Thinking Patterns

Dichotomous thinking such as "all-or-none" self-statements
Awfulizing or catastrophizing
Jumping to conclusions, especially negative extrapolations and expectations
"Should" or "must" statements, demandingness
Self-referential, guilty, codependent thinking
Feeling helpless, powerless
Believing that one cannot tolerate frustrations, anxieties, or pain
Overgeneralizing about failures

Source: Summarized from the work of Aaron Beck, Albert Ellis, and others.

People with co-occurring bipolar disorder and SUDs are at great risk for overdose and death. Singers Janis Joplin and Amy Winehouse are but two examples of people who succumbed at an early age to this combination. Bipolar disorders, together with stimulant abuse, are tricky to diagnose accurately. While bipolar disorder is typically underdiagnosed or misdiagnosed in the general population, it can be overdiagnosed among stimulant misusers (Goldberg et al., 2008).

CASE IN POINT

Ups and Downs

Mr. K., an adjunct professor and counselor at a community college, burst into an office, perched on a desk, and began to demonstrate his karate techniques. He described his plans to enroll in medical as well as law school, and he explained his activities as a director of motion pictures. Two weeks later, his demeanor was totally different: His speech was slowed, his affect dejected, and his gaze averted. Mr. K. was put on medical leave and successfully referred into psychiatric treatment. He was correctly diagnosed as having bipolar mood disorder. His mood was stabilized through a course of lithium carbonate, and he returned to work in 3 months. His medication (lithium carbonate) is monitored carefully because it has a very narrow therapeutic index; that is, it has a small window between being ineffective and being toxic. He also attends a support group for people who have bipolar disorder.

PERSONALITY DISORDERS

Chemical abusers often have diagnoses that fall within the broad category of personality disorders. Criticisms of the classification scheme in the DSM-5 include that people are seldom diagnosed with only one personality disorder (PD), but rather two or more (Biskin & Paris, 2013). Furthermore, there is a large proportion of people who have a "personality disorder—not otherwise specified." This calls into question the validity of the categories. It was proposed to cut down the number of PDs; however, in the end, they were all retained.

In view of spatial limitations, this discussion addresses only the most common personality disorders diagnosed among people with SUDs: antisocial personality disorder (ASPD) and borderline personality disorder (BPD).

Antisocial Personality Disorder

Antisocial personality disorder (ASPD; DSM-55 301.7) may be diagnosed only in individuals who are at least 18 years old and who manifest a "pervasive pattern of disregard for and violations of the rights of others, as indicated by three or more of the following: unlawful behaviors, deceitfulness, impulsivity, irritability and aggressiveness, reckless disregard for safety, consistent irresponsibility, lack of remorse" (APA, 2013, 659). A diagnosis of ASPD means that there is a high degree of sociopathy or psychopathy (all three terms tend to be used interchangeably). "Psychopathy" is easily confused with "insanity" but is another variant on the theme of a remorseless, antisocial personality.

It is important to avoid describing social problems in psychiatric terms. Clients who grew up in family environments affected by SUD probably lacked proper role models and had inadequate or abusive parenting, and thus, are insufficiently socialized or habilitated. Others turn to crime because of lack of job skills or economic opportunity. Substance abusers in particular, may be incapable of sustaining regular employment and may turn to criminal behavior to raise funds for survival needs and drugs. Others participate in fighting, vandalism, stealing, and unwanted sexual behavior while intoxicated, which can also be perceived as antisocial behavior. A quarter of a century ago, SUD researcher Marc Schuckit differentiated sociopathy proper, which precedes alcohol abuse, from "secondary sociopathy" of the alcohol abuser (Schuckit, 1973). The DSM-5 offers guidelines on this issue of differential diagnosis, stating that the diagnosis of ASPD is not made unless signs were

also present in childhood. Moreover, it states that the diagnosis may be misapplied to settings where antisocial behavior is part of a survival strategy (662,3). However, if both substance abuse and antisocial behavior began in childhood, the client may be diagnosed as suffering from both a substance-related disorder and an antisocial personality disorder, "even though some antisocial acts may be a consequence of the substance-related disorder." To complicate the picture, both sociopathy and substance abuse are linked to other disorders. It is mentioned, almost as an aside, that the likelihood of developing ASPD is increased when there is early onset of attention-deficit hyperactivity disorder (ADHD). Many individuals who have ADHD and/or periodic depression find it difficult to attain or sustain employment and drift into extralegal or manipulative means of survival. Such individuals are also at risk for SUDs.

Counselors should pay attention to one of the trademark features of the true, early onset sociopath: "lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another" (APA, 2013, 661). People who have ADHD and/or are substance abusers who act in ways verging on the sociopathic are less likely than a true sociopath to be conscienceless about predation against members of their families. Crack users are portrayed in the media as engaging in horrific abuse and neglect of their own families, yet numerous recovering users of crack cocaine are truly remorseful about the effects of their SUDs on their families. Also, some professionals falsely assume that a client who has multiple convictions or who has been incarcerated for long periods of time is a hardened sociopath not amenable to treatment for personality disorder. Yet many clients, once freed from the matrix of extralegal economic systems, subcultures of drug abuse, and the prison environment, are rehabilitated in offender programs within a frame of time that suggests that their core personality traits are not those of a basic sociopath.

One with a true antisocial personality is difficult to engage in chemical dependency treatment. He or she is likely to feign insight and personal change to escape sanctions and mandates of the criminal justice system. Group treatment and therapeutic milieu (e.g., application of the therapeutic community model to offenders with SUD) are more likely to address underlying sociopathy than is individual counseling.

Recent studies have shown differences in brain structure and brain wave activity in core ASP/sociopaths, indicating that, for some, there is a biologic basis for this disorder (Gregory et al., 2012).

Finally, it is important to remember that psychopathy can range from mild to severe. Psychologist Robert Hare (1999) developed the *Psychopathy Checklist*, which determined how severely affected a person with psychopathy/sociopathy is. Unfortunately, this model of a psychopathy spectrum is not included in the DSM-5.

Borderline Personality Disorder

In popular speech, "borderline" often refers to being on the edge of insanity. But the client's borderline personality disorder (BPD) is not defined by a point on a continuum from normalcy to insanity or from neurosis to psychosis; her or his disorder is a separate entity entirely. Most BPD clients represent a "stable instability," a severe disturbance in personality development and integration with a distinct cluster of symptoms. The BPD client shows instability; rapid changes; and extremes in relationships, moods, attitudes, and behavior and decision making, including impulsive self-destructive, and destructive behaviors. Many authors and schools of thought have contended with the borderline personality; in the universe of possibilities, each major author has delimited a slightly, or more than slightly, different subset of the psychiatrically disordered (Stone, 1986, 492).

According to the DSM-5, borderline personality disorder is marked by a "pervasive pattern of interpersonal relationships, self-image, and affects, and marked impulsivity" (APA, 2013, 663). Clients with borderline personality disorders are intense and unstable. They also have sudden, dramatic, or impulsive shifts in occupational or

educational goals. Clients with BPD often engage in impulsive, dangerous behaviors in the areas of sexuality, substance abuse, and suicidality. Persons with BPD and chemical abuse vary tremendously along the global assessment of functioning (GAF) scale (O'Connell, 1988), ranging from those with stable jobs and relationships to those who are severely self-destructive and who have psychotic episodes, often triggered by substance abuse, that require hospitalization. Although severe BPD is often associated with self-harm, it is an error to assume that most teenagers who exhibit "cutting" behavior are diagnosable as being true BPDs.

According to the neopsychoanalytic object-relations theorist Otto Kernberg (1975), the client with BPD "splits" contradictory ego states:

> He or she may seem to like and idealize someone one day, but hate and devalue the same person the next day. To make this work, the client also uses the mechanism of denial, manifesting an "emotional amnesia" about the preceding attitude or feeling. The client may switch from the "all-good" evaluation to the "all-bad" one when an individual cannot meet all of his or her considerable needs.

Many modern psychiatric authorities agree that BPD has no single origin (Gabbard, 1995). Some researchers (Akiskal et al., 1985) have concluded that the preponderance of biologically based problems among borderline diagnoses (affective disorders, attention deficit, substance abuse) warrant removing it from the realm of "personality disorder." Still, whatever its origins, it describes a type or level of personality functioning familiar to many clinicians.

There are a variety of possibilities to consider when confronted with a diagnosis of borderline personality disorder. The borderline personality can be an adaptation to any combination of mood disorder, ADHD, or SUD. Severe SUDs can appear as a borderline personality disorder. Mood swings and amnesia, induced by alcohol, "blackouts," impulsive behavior while intoxicated, and massive use of denial and discussion to construct an account of this chaotic, out-of-control situation can present a clinical picture not unlike that described as BPD. At the very least, BPD can contribute to chemical abuse and dependency as a result of the need to self-medicate, relax, and numb pain.

Many problems of clients with BPD may be symptoms of mood disorders. People who are depressed may manifest extreme irritability and flashes of hostility, modifying thought, rationalizing, or storytelling.

Chemical abuse can be a "keystone" in the archway of borderline personality disorder. Sobriety can afford the opportunity to grow and heal. Indeed, to avoid recurrence, clients and counselors must address previously masked, powerful emotions, painful anxieties, and conflicts.

Post-Traumatic Stress Disorder (PTSD)

Full-blown PTSD, a serious psychiatric condition, is discussed in our section on Trauma Informed Care within the chapter Sustaining Recovery.

Attention-Deficit Hyperactivity Disorder

Attention-deficit hyperactivity disorder (ADHD) is a genetically based neurologic disability. Although it is thought of as a childhood learning disability, it affects many aspects of functioning and often persists in some form into adulthood. ADHD is marked by inattention, disorganization; distractibility; impulsivity; and inability to concentrate, sustain, and follow through on efforts. There also may be motor hyperactivity and "fidgetiness," which are really less of a disability than the other features. Although ADHD varies in its severity, it often results in impaired educational and career efforts (Kelly & Raimundo, 1995; Wender, 1986). This, together with the relationship problems and social rejection experienced by many ADHD sufferers, may result in depression and self-esteem and self-efficacy problems—typical risk factors for chemical abuse (Biederman et al., 1995; Horner & Scheibe, 1997). Added to this is the need to diminish (i.e., self-medicate) "high-strung," frustration-intolerant, irritable, anxious, and sometimes insomniac temperamental qualities.

A majority of clients with ADHD report some, even significant, help from medications, including (paradoxically) stimulants such as Ritalin, Adderall, and Strattera and antidepressants such as Norpramin (desipramine).

Support groups are often beneficial. Clients with ADHD need to learn about their condition in order to reduce guilt and shame; learn drug-free coping strategies; and educate their families, teachers, and peers.

The client with ADHD often has a history of chaotic and unstable relationships, which were based on impulsivity and mood swings. In addition, having experienced pervasive relationship failures; even including childhood scapegoating, rejection, and abuse; the ADHD client may be tremendously ambivalent about relationships. This is reminiscent of the borderline personality disorder discussed earlier, which makes diagnosis challenging. When the individual is also a chemical abuser, it may be difficult indeed to untangle the skein of behaviors.

There is tremendous variation in approaches to diagnosis of ADHD. In some areas, it appears that ADHD is underdiagnosed, yet parent groups in some parts of the United States claim that ADHD is overdiagnosed and that stimulant medications are overprescribed. SUD educators occasionally encounter bright, recovering students with undiagnosed ADHD or other learning disabilities.

COD clients can and do recover. Psychotropics can stabilize the client's mental health issues, and the tools of SUD counseling can aid the recovery from chemical dependency. In our teaching venues, we have had the pleasure of having graduates of COD programs who were assuming counseling roles. To be sure, these were individuals whose mental health issues were those of mood disorders, not pervasive sociopathy or severe disorganized schizophrenia.

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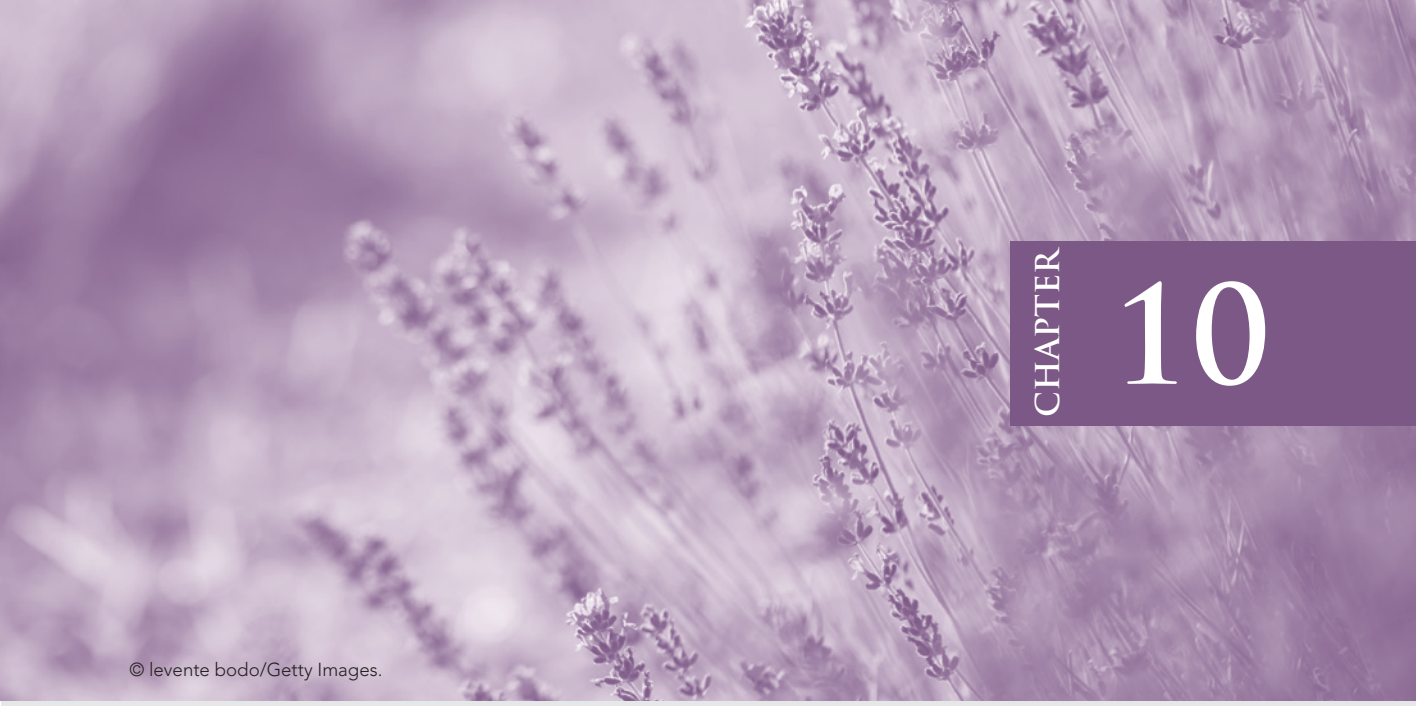

CHAPTER 10

SPECIAL POPULATIONS

OBJECTIVES

At the end of this chapter, students will be able to:

1. Explain why being culturally competent is an ethical responsibility.
2. Describe the importance of assessing the client's cultural identity and his or her mental maps.
3. Provide at least two examples of how cultures evaluate and create myths about drugs.
4. Provide at least two examples of how cultures differ in their rules about drug use.
5. Explain how families label deviant behavior and its significance in counseling.
6. Describe how bicultural identity can create significant issues for both clients and counselors.
7. Describe at least two effects of acculturation stress on substance abusing clients.
8. Describe issues specific to the development and treatment of substance use disorders (SUDs) of women.
9. Describe issues specific to the development and treatment of SUDs of adolescents.
10. Explain issues specific to the development and treatment of SUDs of elderly clients.
11. Name issues specific to the development and treatment of SUDs of lesbian, gay, bisexual, and transgender, and queer clients (LGBTQ).
12. Identify three barriers to treatment for individuals with disabilities.

INTRODUCTION

This chapter surveys the variation in beliefs and behavior regarding substance use and abuse among cultural groups, and discusses special considerations in providing counseling services. Counseling for different age-groups, genders, sexual preference, and people with disabilities are also discussed

CULTURAL GROUPS AND CULTURAL COMPETENCE

In 1973, the American Psychological Association (APA) declared it unethical for clinical services to overlook the cultural backgrounds of their clients and for services to be denied or unavailable because staff lack "cultural competency." In setting standards for professional training in clinical psychology, the APA declared,

> "The provision of professional services to persons of culturally diverse backgrounds, by people not competent in understanding, and providing professional services to such groups shall be considered unethical. It shall be equally unethical to deny such persons professional services because the present staff is inadequately prepared. It shall therefore be the obligation of all service agencies to employ competent persons or to provide continuing education for the present staff to meet the service needs of the culturally diverse population it serves
>
> (Korman, 1973, 105).

To engage clients in treatment and understand their thoughts about substance use and expectations of treatment, counselors need information about the lifestyles of the groups to which clients belong. *Culture* is a learned, shared, changing map of reality and system of rules concerning behavior, ideas, communication, and values. Lifestyles of segments of society, such as ethnic groups, age groups, social classes, and regions form subcultures.

ACTIVITY 10.1 Doing a Family Cultural History

Ask each student to select another student who looks different from them (skin tone, age, dress, gender, hair style, etc.). Have the students interview each other to determine the following information:

What is his or her name? Does he or she know where he or she got his or her name and does it have any specific meaning in his or her family or culture?

What is the person's understanding of his or her culture and/or ethnicity?

Is he or she first, second, or third generation immigrants?

Does he or she speak another language not learned in school? Does he or she think in that language?

What was his or her neighborhood like growing up?

What was his or her socioeconomic conditions? His or her religion? Any family traditions he or she remember?

Who was he or she allowed to date and bring home to meet the family?

Process by having each student introduce their partner. Ask if they encountered surprises in their interviews. Ask if they began to realize they had more in common than they thought. Depending on the size of the class, this exercise should take anywhere from 30 minutes to an hour.

Culture shapes beliefs and behavior regarding chemical use, abuse, intoxication, problems, user roles, and curing. Increasingly, cultural competence is built into treatment programs.

Treatment providers need to be aware of barriers to treatment presented by family attitudes toward participation in substance abuse programs. Treatment for Russian teenagers was aided by involving grandparents, to whom the youth are more likely to listen than their parents (Sachs, 1999). Latina participants in a therapeutic community (Kail & Elbereth, 2002; 2003) described how gender in cultural context presented several barriers

to treatment—family members had no idea about what treatment entailed, and having a daughter in a drug program would be a big embarrassment. The female network of friends and relatives is expected to be "sympatico," with supportive and harmonious—not confrontational—social relationships. Being in a sex industry, a way of earning a living was also a factor in keeping women "on the street" rather than in a recovery milieu.

Treatment and prevention programs may espouse values, definitions, and norms concerning alcohol and other drugs that are not congruent with those of the occupational or residential community. It is difficult to intervene in "cultures of drinking" in which the environment defines heavy use as normal and even expected. The late Lakota anthropologist Beatrice Medicine (2007) stated that, "withdrawing from the world of drink on all Lakota reservations and social groups is a very painful process . . . with social isolation being the price one must pay for sobriety" (120). Statements, such as, "You're too good to drink with us?" and "You think you're white now" are used to pressure people whose grasp on sobriety is already tenuous.

Until recent decades, cultural competency skills had trouble becoming part of standard practice in human services; culture tending to remain a peripheral or exotic concern.

Research

Many studies of the cultural contexts of chemical abuse have investigated how and why beliefs and behaviors vary and how they shape individuals with SUD. However, due to the wide variety of subgroups and the constant cultural change that occurs, a comprehensive, clear map of chemical use among United States subgroups does not exist. Another problem is that ethnographers tend to study the most "pure" cultures in order to obtain neat, clear descriptions of rules and customs, while SUD counselors work among the least pure cultures—those that are constantly changing and are blended, disorganized, and often alienated from cultural roots. The client population varies from those who, for example, drink heavily within their standard cultural context to crack users whose ethnic affiliations are unimportant.

Some assumptions about ethnic behaviors are based on observations made decades earlier, and cultural competency trainings can be fatally anachronistic. Rather than relying on old assumptions or informal observations of others, counselors must develop their own cultural competency.

Cultural Competence

Counselors are ethically mandated to build their awareness and knowledge of their clients' cultures. But the prospect seems daunting as it involves having to learn all about Albanians, Bulgarians, Czechs, Danes, Ethiopians, Finns, and so on. This task is made even more impossible by a matrix of intra-group variation within many ethnicities, according to social class, geography, gender, age, and generation of arrival. Training can highlight crucial issues but cannot begin to address these vicissitudes of variation. Because a counselor cannot be a human encyclopedia, to be culturally competent, he or she must learn the skills of a detective and have the eye of a cultural anthropologist to investigate and learn about cultural patterns in client communities. A counseling skill that must be developed is the ability to elicit information regarding mental maps and categories; value systems regarding alcohol and other drugs; concepts of normality and deviance; models of SUD, abuse, and curing in the client culture or subculture; and the symbolic and ceremonial importance of drug use (Myers & Stolberg, 2003).

Culture Defines Drug Use

Cultural and subcultural obstacles include mental maps, charts, and categorizations of reality: colors, kinship categories, roles, and even chemicals. Consider the following actual interview:

Professor: Do you consider yourself a heavy drinker?
Student: No, I only drink beer.
Professor: You were drunk when you came in here last week.
Student: No, we only had a few beers.

This interview illustrates a mental map shared by many Americans; one that places beer almost outside of the domain of alcoholic beverages, a step above soda. A prevention message aimed at modification of that mental map is, "When you drink a lot of beer, you drink a lot!" A beer has the same amount of alcohol as a shot of bourbon.

"I would never use drugs; I only drink" is the kind of statement made by a large proportion of Americans who put alcohol and drugs in different categories. Alcohol and other drug-abuse education counters this mapping by pointing out that alcohol is a drug. Similar to the way people do not consider beer alcohol, many people do not consider marijuana a drug. For example, Rita, a 22-year-old woman who was a crack addict and prostitute, said that while discussing her first "date" as a prostitute (Ratner, 1992):

> **INTERVIEWER:** Did you buy drugs with the money?
> **RITA:** No, I wasn't using drugs yet—I bought reefer.

While placing a drug "off the map" may be simply naïve, it contributes to denying or defining away SUDs. Treatment personnel need to be aware of the words clients use. Just as *drug* meant anything stronger than marijuana, "reefer," to Rita, the word *alcoholic* is sometimes used by people with an alcoholic use disorder in reference to those whose disorder is more severe. Their definition agrees with an aphorism, "An alcoholic is anyone who drinks more than I do."

Culture Includes Evaluations of and Values Associated with Drugs

People put drugs into "good" and "bad" categories. Cultures weave *myths*, which are sometimes totally fallacious, or merely exaggerate or misinterpret some real effect. In the 1930s, American college students acquired a "reverence for strong drink" (Room, 1984) and considered heavy use romantic and adult. American culture in general evaluates beverages containing ethanol as sexy, mature, sophisticated, facilitating socialization, and enhancing status if the brand is prestigious. In the 1930s and 1940s, many people thought that marijuana was literally a "killer weed." In the exaggerated portrayal in the film *Reefer Madness*, marijuana resulted in homicidal psychoses and suicides, as if it were a large, combined dose of crack and angel dust.

Another example of cultural evaluations of drugs appeared in Gilbert's (1993) review of literature on Mexican American drinking patterns, which revealed consistent findings that men view alcohol as having many positive effects. Men had more positive expectations and fewer restrictions of use than women. This gender gap closed significantly in studies of Mexican Americans born in the United States.

Cultural Rules Tell Us When, Where, and How Many Drugs Can Be Taken

Many cultures, such as the traditional Italian, French, and Jewish cultures, permit moderate drinking within the family, especially at meals, but disapprove of "drunken" behaviors. Along with such commonalities, there are many differences among groups. Italians consider wine a food, while Orthodox Jews use wine for rituals. In one study of Scandinavian nations, drinking was considered absolutely separated from work. Where drinking was permitted, however, it was allowed to go on to the point of intoxication (Mäkelä, 1986). In the United States, there are a vast variety of subgroups: some heavy-drinking clients may live in a community where it is not considered excessive to drink with their friends out of paper bags or on the street in the morning. Other clients may belong to a "workplace culture of drinking," at a post office or construction site, for example. If a client's drinking is not much greater than that of his or her peers, to be "treated" for this behavior might seem as strange as going into rehab for eating birthday cake!

Culture Often Gives Ceremonial Meaning to the Use of Alcohol

In a variety of cultures, rituals involve the use of alcohol, hallucinogens, or stimulants to alter states of consciousness, for healing or spiritual

purposes, or during a "time out" when normal rules are suspended. It is important to note that this behavior involves no social disruption and is culturally sanctioned. Hallucinogen use by practitioners of Native American religions and cannabis use by Rastafarians fall under legal sanctions.

Culture Defines "Problem Behavior" Associated with Chemical Use

A person's use of drugs is identified as a problem when it has negative effects on a cultural group or subgroup. Californians in one study emphasized driving while intoxicated as a major problem, whereas Poles in Poland and Mexicans in Mexico focused on family disturbances and productivity (Österberg, 1986, 13). Some U.S. campus cultural maps do not define fighting on Spring Break when intoxicated as "problematical."

Culture Defines the Origin of Drug-Related Problems

When it is generally recognized that some problems are drug related, a cultural group looks for the cause. United States citizens define alcohol use disorder as a disease far more than do the French Canadians or French (Babor et al., 1986). Some South Bronx Hispanics ascribe alcoholism to "spells," spirits, mal ojo (the evil eye), and *brujeria* (witchcraft) (Myers, 1983). On the other hand, a group may ignore or bypass the entire SUD and attribute it directly to supernatural influence, ulcers, divorce, and car accidents that the counselor recognizes as based on alcohol use disorder. If a problem is traced back to a supernatural cause, a supernatural solution can be called upon. Thus, many seek the help of a folk healer (e.g., *espiritista, santero*).

Also, the client may be influenced by older members in the extended family who interpret the symptoms, make folk diagnoses, and suggest or plan action. These significant others are frequently less acculturated than the client, and they adhere to traditional belief systems.

Cultures Have Elements that Can Be Used to Encourage Healthier Choices

For example, although it is commonplace to cite Latino machismo as an incentive to drink, it is also manly to take care of your family. Many religious bodies that a client may wish to join or rejoin, support healthy behaviors in individuals and families.

Culture Shapes SUD Careers

For example, African Americans are diagnosed as having alcohol use disorder at an earlier mean age than Caucasians (James & Johnson, 1996) and may progress into extremely heavy use at an earlier age. Based on a Caucasian model, it would be unlikely to see a 35-year-old with alcoholic organic brain syndrome (AOBS). Clinicians working with such expectations could misdiagnose clients with AOBS as suffering from, say, schizophrenia.

Trends in drug use among various subgroups change continually, and SUD counselors should participate in inservice or other training to ensure that their knowledge of such patterns is not out of date. The recent rise in opioid use, SUD, and overdoses is much greater among white individuals, unmarried individuals, and males Heroin use between Whites and non-Caucasian was fairly similar f 2001–2002, at 0.34% and 0.32% respectively, by 2012–2013, the percentage of Caucasian who had used heroin jumped to 1.90%. Just 1.05% of non-Caucasian in 2012–2013 used heroin (Madras, 2017; Martins et al., 2017)

Smokable methamphetamine or "ice" was the subject of a moral panic, with public service announcements featuring wizened, toothless users. Researchers were surprised that African Americans, by and large, did not join in the epidemic of use. Sexton et al. (2005) reported that African Americans in the rural South and elsewhere considered ice to be a "White man's drug;" that the distribution networks were run by White gangsters; that users and dealers were dangerous and unstable; children, in particular, were endangered; and that impurities, such as battery acid, were used in the manufacturing process. Eventually, some African

Americans did become users of ice, but far fewer than expected.

Culture Shapes Personality and Psychiatric Symptoms, Responses of the Kin Network, and Diagnostic Decisions Based on Those Symptoms

There is a universal structure and chemistry in the human nervous system that is vulnerable to characteristic disorders. Major mood disorders (clinical or major depression and bipolar, or manic-depressive, illnesses) are related to abnormal neurotransmitter functioning at the synapse. Culture shapes the symptoms and manifestations of these diseases.

Psychiatric Labeling of a Client Begins with the Ways Deviance Is Assessed by His or Her Family and Peers

In one study, significantly more Irish families than Jewish families tolerated deviant thinking in a psychotic relative, while significantly more Jewish families than Irish families tolerated out-of-line verbal emotionality (Wylan & Mintz, 1976).

Psychiatric Mislabeling of a Client Can Continue with Mental Health Professionals and Medical Institutions

African Americans with alcoholic organic brain syndromes ("wet brain") are often misdiagnosed as schizophrenic (Bell et al., 1985). Minorities with bipolar disorder are also misdiagnosed as schizophrenic (Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983). Hispanic women with dramatic emotional expression are commonly misdiagnosed as suffering from psychiatric or neurologic syndromes (Myers, 1983). As mentioned earlier, in the 1980s, New York City psychiatric wards were filled with what should have struck clinical administrators as a disproportionate number of people diagnosed as "paranoid schizophrenics"; those patients were, in fact, suffering from crack paranoia. Currently, stimulant psychosis is recognized much more frequently by mental health professionals.

Ethnic Subgroups and Acculturation

Counselors must watch for statements that claim to describe the behavior of a cultural group as a whole. Any description of typical cultural behavior is only a description of the most common or most frequent behavior—the mode or center of the bell curve in a frequency distribution. For example, many Norwegians cry less than Italians, but there are still some Italians who cry less than some Norwegians! With groups in the process of changing, there is an even greater range of variation. Counselors must take into account subgroups: rich and poor, urban and rural, male and female, and the degree to which groups have been absorbed. It would be a tremendous disservice, for example, to make statements about "African American" drinking patterns, which runs the gamut from middle-class cocktail lounges, to blue-collar wakes, to birthday parties, to the "bottle-gang" of the homeless and poor. African-American middle-class women drinkers are not so different from Caucasian middle-class women drinkers, who are typically "moderate," with few nondrinkers and few heavy drinkers. Poorer African-American women in groups have a larger proportion of nondrinkers; but among those who do drink, there are more heavy than moderate drinkers. African-American men are more tolerant than women of heavy drinking. Breaking it down further, those who are married, older, and church affiliated were associated with nonacceptance of heavy drinking (Gary & Gary, 1985).

Gordon (1981) studied three Hispanic groups, all new to the United States and all blue-collar workers. Dominicans drank less after migration than before migration. They emphasized suave or sophisticated drinking and saw drunkenness as *indecente* (not respectable). People with alcohol use disorder were believed to be sick, perhaps from some tragic experience. Guatemalans drank more after migration than before migration; one-third of the males were often intoxicated and overindulged most weekends. Being inebriated was glamorous and sentimentalized. They boasted of hangovers,

even when they did not have one. The Puerto Ricans broke down into three categories: middle-class American-style moderate drinkers; depressed, wife-abusing, alcohol-abusing welfare recipients; and various sorts of polydrug abusers, including diffusion from mainland "druggie" youth culture (Gordon, 1981). This represents only a fragment of the subcultural and acculturative spectrum.

Twenty-one years later, Michelle Shedlin and Sherry Deren (2002) conducted ethnographic research in the Dominican community of Washington Heights, New York. City They found that "getting ahead" for economic stability and family support were still important values. Moreover, "control and self-control ... emerged as the most important attribute to be maintained in life ... control of the family ... future ... behavior ... resources ... mind and body, are all seen as necessary for success and the respect of the family, of friends, and the community here and in the Dominican Republic" (78). What was intriguing in terms of treatment was that these values persisted even among drug users. A common expression among drug users was, "I am trying to dominate/control the drug(s)." Crack use, in particular, was seen as loss of control, but even crack users evaluated themselves as relatively in or out of control in their use of that substance. Treatment providers working with clients totally immersed in the SUD lifestyles can appeal to cultural values in their facilitation of clients' motivational and decisional balance.

BICULTURALISM AND TRICULTURALISM

For years, or even generations, after immigration, people may straddle two worlds. This is known as biculturalism. With indulgence in drugs, there is another added dimension. Individuals may be involved and enmeshed, to some extent, in all three cultures or, as noted here, isolated. Decades ago, anthropologist and psychiatrist Joseph Westermeyer (1981;1984) noted that among drug users, many "suspended" their ethnicity. One Chicano subject stated that he had "put being a Chicano on the shelf." A Navaho informant abandoned contact with her Native American social networks and ceremonies. Tellingly, though quite poor, she had not sold valuable turquoise jewelry left to her by her grandmother. More recently, William L. White (1996, 12–14) described the substance user as enmeshed in the drug culture, or bicultural, in terms of the drug culture and the culture of origin, or simply "acultural," isolated solitary users of psychoactive drugs or alcohol. The term *code-switching* usually applies to communicative behaviors, such as speech or body language. For example, people change from English to their native language and back again during a conversation, a paragraph, even a sentence. The concept of code-switching deserves applicability beyond communication, and it can shed light on help-seeking and help-rejecting behaviors of clients in mental health and SUD treatment settings. This can be a function of an individual fluctuating between health resources of folk and "official" medical culture. The late Julio Martinez, who served as Director of the New York State Division of Addiction Services, recounted how he was brought to an *espiritista*, for both his heroin abuse and a bone infection that gave him a permanent limp, before he was recruited to a therapeutic community (personal communication to Peter Myers, 1980).

Bell and Evans (1981, 20–22) point out that the SUD counselor, like the teacher or any other staff member in a helping or human services system, may not be aware of a bicultural identity because he or she only sees one "face" of the client. The seemingly successfully bicultural individual may, in fact, be adrift between the two cultures and escape from one to another when uncomfortable. In addition, if the "home" culture is the substance-abusing milieu and the counselor and/or treatment system is predominantly identified with the majority culture, this adds a motivational or cognitive disadvantage to the clean-and-sober road. Bell and Evans (1981, 28–29) further note that cultural identity has different "faces": how individuals see themselves; how they think others see them; and how they see themselves in relation to others.

Acculturative Stress

Families undergoing *acculturative stress* are at risk for development of chemical abuse and dependency. It is stressful and frustrating when individuals and families are no longer in their traditional culture but cannot successfully assimilate into the new culture. Some stress-inducing factors are ambivalence of meaningful participation in the social structure, especially in a way that communicates a "loss of face"; reversal of power roles; lack of deference to elders; ambivalence of culturally important roles, such as breadwinner; isolation; lack of support systems; and communication or role patterns that result in not using support systems. Acculturation is uneven within the ethnic subculture: the poor, women, older persons, and city-dwelling families may be more immersed in traditional behavior patterns than economically stable men, youth, and rural families. This can lead to strain within the peer or family network (Avanzo, Frye, and Froman, 1994).

Behavioral problems, including drug use, are linked in many studies not only to intergenerational differences due to different stages of acculturation, which accentuates family conflict, distance, and alienation, but also to the inflexibility of parents to the traits of the new culture (Adrados, 1993; Page, 1990, 176; Rio, Santisteban, & Szapocznik, 1990, 211–212; Szapocznik & Kurtines, 1989).

In the past decade, treatment and prevention programs have emphasized ethnic identity development as an essential component of a recovery program or sobriety culture. Ethnic revitalization movements with a temperance twist have a long history among Native Americans, beginning with the Seneca/Iriquois chief Handsome Lake whose mystical revelations in 1799 transformed not only his own alcohol use disorder but also his depressed tribal culture (Wallace, 1969). Among Native American populations of the present, such programs as the Red Road to Wellbriety (White Bison, 2011), the Healing Forest model, the Talking Circle, and the Medicine Wheel (Coyhis, 2000) have shown great promise in melding cultural/ethnic pride with a temperance and recovery message.

OTHER DIMENSIONS OF CULTURAL COMPETENCY

We have stressed cultural competency about beliefs and behavior pertaining to drug use. But client culture covers far more, and much of it is pertinent to a counselor's work:

- Kinship groups (nuclear vs extended family): kinship and peer networks; family structure, rules, and roles
- Community support systems, formal and informal: the bodega and barbershop, church, guys in the playground and on the stoop, gangs and cliques, other community institutions
- Social networks of substance users and their interface with the community
- Religious beliefs and behavior
- Beliefs and behavior on illness and curing; folk alternatives to U.S. medical systems; supernatural and natural theories of dysfunction, for example, Santería and espiritismo among Caribbean Latinos
- Attitudes toward deviance: stigma associated with SUD and co-occurring disorders, acceptance of active users and recovered users in the kin or peer group
- Language, dialects, and special terminology in use
- Body language (gesture, posture, facial expression) and use of space
- Economics; survival strategies, underground economy, structural unemployment
- Important ceremonial activities
- Music and folk art (including tattoos)
- Bicultural identity, degree of assimilation and acculturation, acculturative stress factors operating on the client and his or her family

Cultural competency in these areas informs many aspects of treatment. For example, case

management practices are affected by a knowledgeable approach to the patterns of authority in the family that can facilitate referral into and successful completion of treatment. Cultural competency also demonstrates interest and engagement and in the building of a treatment alliance, especially with a population that feels socially marginal, even segregated from the dominant culture.

Knowledge of music that is popular with a population is a quick and easy way to demonstrate some interest and bonding with the client culture. One of the authors really impressed staff when he identified music playing in an Arabic-run candy store (Farid Al-Atrache) that he was for years called "Farid" by the staff, who were surprised that an American would relate to their popular culture. Rural Mexicans now residing in the southwestern United States compose narrative ballads called *corridos* that concern celebrities and heroes, rebellion, and the adventures of bandits and smugglers. The Grammy and Latin Grammy winning group Los Tigres del Norte is comparable to the Beatles in popularity with Mexican youth. The *narcocorrido* is a version chronicling the adventures of drug smugglers (Wald, 2001). Clients may be encouraged to compose a corrido with a recovery message. With young Puerto Rican and Dominican clients, the musical genre is *reggaeton*. If you take the time to learn the arts associated with a culture, your clients may be pleasantly surprised and feel more respected.

A comprehensive list of cultural competencies and objectives from the American Counseling Association is available at this link in the bibliography (ACA, 1992). It is important for counselors and counselor-trainees to be familiar with the document.

Activity 10.2 Developing Cultural Competence

Each member of the class will identify examples of three of the competencies identified in the document from their client population or members of their family or community (ACA, 1992) and report to the class for discussion.

AGE GROUPS

Childhood

SUD is culturally defined as an adult enterprise. The vast majority of SUD agencies do not admit individuals aged 12 years or younger. Nevertheless, children do smoke cigarettes and marijuana, drink, and engage in inhalant abuse. Experimentation or casual use progresses and solidifies into a pattern of abuse, especially among neglected, abused, or isolated children and children suffering from undiagnosed and untreated learning or behavioral disabilities. The abuse of *inhalants*—vapors emitted by volatile substances, such as solvents, glues, and correction fluids—is a special issue among counselors working with the child and preadolescent population. Inhalant abuse is common among hungry and homeless children in a variety of nations from Central America to southern Asia as well as among children in inner-city districts of North America. Inhalant abuse among children is often associated with a total lack of nurturing family structure. The use of many other substances, such as tobacco and alcohol, is motivated by a desire to augment status by appearing sophisticated and mature. Thus, their use can serve as a rite of passage. Admission to and participation in gangs are also often linked to drinking and drugging. When gang membership is seen as a logical self-protective strategy as well as a normative peer activity, prevention messages alone do not have much influence.

A general awareness of the typical developmental issues, conflicts, and stressors found in various age groups can facilitate assessment of critical issues facing clients.

Adolescence

Individuals from ages 13 to 20 years are in a special risk period for use of alcohol and other drugs. Individual risk factors are compounded by the confluence of developmental conflicts and stressors that occur during adolescence and by the desire to try out symbols of adult freedom. It is imperative that developmental issues be

assessed, especially conflicts in maturational tasks, independence, sex, romance, and intimacy (Filstead & Anderson, 1983).

The clinical observations of Levine (1984) found adolescent substance abuse to be associated with a "developmental logjam" of unchallenged dilemmas, which result in some combination of boredom, drift, malaise, inability to conceive of a future for themselves, social isolation, separation problems, meaninglessness, difficulty in achieving intimacy, and dissatisfaction with their own impulsive behaviors (28–38, 41). Attention-deficit hyperactivity disorder (ADHD) or other learning disabilities, depression, and family problems can aggravate this logjam. Taking risks, rebelling, and abusing substances are often linked to adolescents' attempts to resolve these conflicts. Initial assessment of these issues is difficult when clients find these topics painful and threatening, cannot articulate them, and are slow to trust a counselor who is associated with disliked authority structures.

In addition, SUD counselors need to learn the skill of diagnostically differentiating the youth who is experimenting or using as a rite of passage and the youth who is seriously abusing substances. On college campuses, the situation is complicated by an entrenched and ancient tradition of binge drinking. This practice remains fairly constant, even as prevention programs make gains against use of cocaine and marijuana in college populations. Among high school and college-aged youth, heavy drinking is associated with a majority of driving fatalities, sexually transmitted diseases, academic failure, accidents, unwanted sexual encounters, violence, property damage, and insurance claims.

Adolescent Treatment

Treatment models simply duplicated from settings for adults are not appropriate to the developmental stage and needs of youth. This became glaringly obvious from studies in the 1990s that showed a woeful lack of abstinence among youth treated in many models (Liddle & Rowe, 2006). For example, features of high-risk situations for teenagers are different than for adults. Unsupervised social situations where teens are "having fun" are risky, whereas for adults, it is negative emotional states involving anger and interpersonal conflict. Second, youth have little motivation to abstain, because they do not have or cannot visualize the negative consequences, unlike the adult who may face liver problems, loss of employment, and so forth (Brown & Ramo, 2006).

Case-finding and appropriate referrals are difficult due to institutional denial., participation of adult role models in heavy drinking, campus tradition, and encapsulated subcultures of abuse in fraternity settings. Counselors must consider an appropriate level of care in referring an adolescent: Experimentation or casual use does not warrant referral into an intensive rehabilitation program. It is understandably difficult to convince students or their parents to accept an inpatient referral during the academic year. There is no shortage of role models of recovery for adults in SUD treatment, nor of subcultures of recovery (e.g., AA, NA, therapeutic communities, Smart Recovery). In the treatment of adolescents; however, one dilemma is the dearth of a recovery subculture.

The development of the Young People in Recovery program is the beginning of such a subculture, providing role models and reducing stigma. Some treatment programs have a group of graduates or alumni who have "made it,"who are in long term recovery, whom clients can trust and identify with, and who can give them hope and pointers on how to get into long term recvoery

However, many substance-abusing adolescents are often in environments in which users set the tone and in which successful clean-and-sober adult role models are lacking. It is especially difficult for these young people to think through the consequences for their entire lives, leave the "using society" (which may comprise the majority of their family and friends), and stay clean and sober.

Experimentation with or abuse of substances is seldom the only problematic area for adolescents. It is often a part of a constellation of so-called acting-out behaviors. Other parts of the picture include depression, learning disabilities, suicidal ideation or gestures, truancy, driving while intoxicated

(DWI) charges or convictions, history of family SUDs, child abuse or molestation, vandalism, and petty (or not-so-petty) crimes. Counselors must beware of assumptions underlying assessment that lead to imagining a greater role for substance abuse in adolescents' problems than is actually the case. For example, the depressed, learning-disabled adolescent will not magically prosper when she stops using marijuana. Although depression and learning disabilities are worsened significantly and masked by chronic use of marijuana, eliminating the marijuana will not eliminate them as well. Failure to address such other issues jeopardizes recovery.

Adolescent treatment walks a fine line between treatment per se and prevention. Strategies need to capture their imaginations, excite them, and offer alternatives to using drugs. Programs that treat adolescents as a major component of their services need activities that:

- Are age-appropriate
- Are attractive
- Offer the opportunity to attain developmental milestones
- Help them identify and reach some maturational goals, such as obtaining a high school equivalency degree and acquiring occupational skills
- Build a positive self-image
- Assess and build upon natural resiliency factors

These activities may be recreational, educational, vocational, artistic, journalistic, or athletic, depending on the needs of the client.

Some troubled and substance-abusing adolescents find an Outward Bound–type program helpful. Such programs are physically, socially, mentally, and emotionally challenging outdoor group adventures in remote areas (Gillis & Simpson, 1992; 1994). However, because of costs, space availability, and the status of the client, Outward Bound is not appropriate to all adolescent addicts. Project Adventure incorporates many of the same features but with minimal travel requirement. Local variations came into existence in many states during the 1990s, but their growth has been stymied by limited funding. Special sports programs that incorporate therapeutic elements and antidrug messages have also been successful in creating an alternative to subcultures of abuse. These programs are sponsored by local government, social service agencies, the Police Athletic League, and community coalitions. An example is the Midnight Basketball Coalition program, which originated in 1986 in Atlanta, Georgia, and now exists in a dozen cities.

Motivational enhancement therapy (MET) and cognitive behavioral therapy (CBT) have been adapted to adolescent treatment, one example being the combined MET/CBT approach in one iteration of the Cannabis Youth Treatment (CYT) project of CSAT. This approach delivers five individual MET sessions and three CBT group sessions within a 6-week period and is known as MET/CBT5. The MET component seeks to motivate adolescents and help them decide that the costs of use outweigh the benefits. The CBT component teaches coping skills so that they can initiate and sustain change effectively, specifically: refusal skills, establishing a supportive social network, coping with unanticipated high-risk situations, and making a plan for coping with, minor lapses Another version of this treatment adds seven more CBT group sessions for a total time in treatment of 12 weeks. In the extra CBT sessions, adolescents learn to cope with interpersonal problems, bad feelings, depression, and craving without using. The group setting affords a laboratory to practice skills (Titus & Dennis, 2006, 105–107). One can view this as facilitating developmental tasks, given that many adolescent abusers have feelings of being "stuck" in a developmental malaise. Taking CYT to a different system level, there is a version that includes parent education meetings, therapeutic home visits that examine family roles and routines, referral to self-help groups, and case management designed to facilitate treatment attendance (Titus & Dennis, 2006, 107).

CYT research reports impediments to treatment and recovery that include the following:

- A large percentage of clients with co-occurring problems, such as multisubstance abuse, depression, and suicidality, ADHD,

illegal activities, and alcohol/drugs in the home; adolescent treatment needs to be integrated with co-occurring disorders treatment
- Low recognition of substance abuse as a problem (only 20 out of 96% are formally diagnosed with abuse or dependence; Titus & Dennis, 2006, 111–113)

CYT manuals (CSAT, 2001) are available online at the link provided in the bibliography

When treatment is provided in a therapeutic community setting, important modification must be made. Education needs to be a major focus of the stay, so the facility needs to be set up more as a school than as a "rehab" clinic (Jainchill, 2006). Adolescents will be much less likely to tolerate harsh confrontational methods unless absolutely compelled to remain. As discussed later in this chapter, adolescents with ADHD tend to have a disastrous experience in residential therapeutic community settings that demand attention to detail, such as turning out lights and making beds. ADHD adolescents can and should be expected to be responsible; it is just more difficult if the community setting requires attention to detail, and errors are going to be made.

Links to resources for adolescent treatment are available at http://www.chestnut.org/LI/APSS/SASATE/resources/.

The Middle-Aged and the Elderly

With much of public and government attention focused on the opioid epidemic among young people, it is easy to overlook other spikes in SUD. Alcohol abuse, prescription opioid use, and use of sedatives and tranquilizers have increased significantly in the previous and current decade.

Middle-aged and the elderly are categories that cannot be delineated precisely. However, late middle age is often defined as age 55+, and senior citizens (the elderly) are defined as 65+. Another difficult milestone in life is late middle age and retirement. The empty nest, where children grow up and leave the familial house; loss of body image as persons lose the ability to be as physically active and perceive themselves to be less attractive; loss of friends, family, work friendships, and occupational role bring grief, regret, disappointment, loneliness, and isolation. Loss of friends to aging and death in their social networks is also painful. Counselors must teach and facilitate processing of losses and encourage new involvements and initiatives. Mrs. Harris was a widow approaching retirement whose drinking went from social to abusive after her husband's death. Her church peers were by-and-large teetotalers who disapproved of her drinking alcohol; her shame isolated her from the church, which she longed to rejoin. In assessment, it is important to differentiate between a late-onset alcoholic as in the case of Mrs. Harris and an individual with SUD who has simply aged along with his or her long-time SUD. The late-onset addict is less deteriorated and less antisocial and has fewer coexisting problems than the long-term addict.

Assessment of an elderly client must be informed about diagnostic issues typical of this age group. These issues include the differentiation among symptoms of alcohol or illicit drug use, use of prescription and over-the-counter drugs, and any combination thereof (**FIGURE 10.1**). This is compounded by the fact that the elderly are frequently overmedicated and often self-medicate. The bodies of the elderly do not detoxify substances quickly, which results in high levels of psychoactive substances lingering in the blood and brain. Medical care for the elderly is often compartmentalized. More than one physician may be involved in prescribing medications, and some seniors have difficulty keeping track of them. Possibilities of overmedication or medication interactions are not always monitored adequately. Depression in the elderly can be generated or compounded by prescribed depressants and by alcohol use. Especially in this age group, it is important to determine whether problems with memory and cognition are results of alcohol and illegal drugs, incorrect use of prescriptions, or senile dementia.

What are the risk factors for seniors?

Problems, pain, and anxieties

Retirees sometimes feel the loss of a meaningful part to play in society, feelings of worthlessness and obsolescence, loss of an occupational identity, the loss of friends on the job, loss of earned income, stress of living on a fixed income, and boredom.

Children "leave the nest," parents have passed away, and people may feel lonely. The illness and deaths of family and friends create loss and grief, which may be difficult to bear.

People may feel disappointed when life expectations don't pan out.

Physical pain and fatigue often accompany the aging process, as well as stress and loss of body functions and skills.

Chronic illnesses are accompanied by restricted activity, pain, stress, and fear.

Possible reactions

Depression

Denial

Repression or restriction of feelings

Withdrawal from others

Use of alcohol or other drugs to "numb" or deny feelings

Medication problems

Losing track of prescriptions

Forgetting how much was taken

Seeing several physicians who prescribe

Overprescription of sedatives

Other aspects of alcohol and other drug use

It is often hidden and private, not often in a bar or at a party.

It is often rapid in onset.

The effects are often worsened by use of prescribed medications and over-the-counter medications, which may contain sedating substances.

The effects of substance abuse may be hard to differentiate from memory and thinking problems of some elderly.

The effects are often compounded by decrease in liver function so that it becomes harder to eliminate substances from the body.

Older drinkers tend to attribute negative physical symptoms of drinking to aging.

FIGURE 10.1 Screening senior citizens for substance abuse.

Source: Courtesy of Essex County College Senior Alcohol and Drug Abuse Prevention Project, with support from the Newark Municipal Alliance.

Clinical concerns when treating the elderly that have been identified by SAMHSA (CSAT, 2001) include the following:

- Being sensitive to self-esteem needs, which are accentuated in clients who may feel depleted physically, socially, and emotionally. Counselors must avoid communicating a patronizing, dismissive, or impatient attitude. The term "substance abuse" should be avoided; refer directly to alcohol use and sedative use.

- Being sensitive to the possibility that perceptual acuity and speed may diminish with age. Avoid unnecessary background noise. Pause and give other cues when topics change.
- Be sensitive to cognitive needs and have access to assessment data on cognitive impairments. Avoid ridicule if a client manifests a lack of understanding; keep explanations simple, and encourage clients to ask about words or concepts they do not understand.

SEXUALITY

GENDER

Women are underrepresented in treatment in proportion to their numbers in the population with SUD, and programs addressing their special needs are also relatively few. According to the Centers for Disease Control (2007), 60% of women of child-bearing age drink, and, of those, one-third reported binge drinking (five drinks in a row in the last 2 weeks) compared with 43% of men; 23% of women reported any illicit drug use during the past year compared with 31% of males. When assessing a female client, it is important to explore relationships with significant others; support systems; impediments to treatment; and issues of abuse, shame, and stigma.

The degree to which a woman with SUD associates with a chemically abusing spouse or boyfriend is an important factor in her patterns of use. Covington 2000 andHser and colleagues 1987 that women tend to stay with chemically abusing partners perhaps participating in the drug use, whereas nonusing mates are more likely to abandon women with SUD. Covington 2000 Hser et al 1987

The degree of social support for entering treatment is significant. Women have much less support to enter treatment than men. The variety of reasons include social stigma, the history of alcohol use disorder as a men's disease, and ambivalence of one's SUDs. Counselors must remember the distinction between social support and support to enter treatment. Alcohol abuse among women tends to be hidden in the house by both the drinker and her family. When questions are asked about a woman's functioning, answers are given in terms of fatigue, minor illness, or even depression. Men are more likely, when intoxicated, to get into public displays that eventually become noted in a police or hospital report. Statistics, therefore, tend to hide the proportion of women drinkers.

Lederer (1994, 264–266) has examined gender roles in ambivalence from a feminist perspective. These issues may be summed up as follows:

- Women's thoughts and feelings are discounted by their spouses and others, which lowers their self-esteem and leads to denial of their perceptions of the family situation
- Women are held responsible for the emotional well-being of the family, which leads women into self-blaming, enabling roles, and denying situations that "must be," ipso facto, their fault
- Women may go along with their husbands' ambivalence because they have taken on executive authority in the family due to the SUD and dysfunctionality of their spouse. In sobriety, the husband might want his dominant role restored.

In some studies, women were found to progress in their drinking more rapidly than men, known as "telescoping" and also to progress into treatment faster than men (Lewis & Nixon, 2013).

LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER CLIENTS (LGBTQ)

Chemical abuse among LGBTQ persons can be linked to their social status as outcast, stigmatized, and deviant, which contributes to pain and isolation

and can lead to substance abuse. For many decades, the "gay bar" was a secret gathering place, the only setting where gays and lesbians could interact, be open about their sexuality, safely explore possible relationships, and be themselves. Gay Pride marches beginning in the 1970s in New York City featured many contingents that marched behind the banners of their bars. However, the gay bar scene has dwindled considerably over the past several decades. In San Francisco, the number of exclusively gay bars dropped from 178 to 33 (Thomas, 2011).

While the old, stigmatized, outcast status has changed a great deal in recent decades, it is still true that a majority of gay and particularly transgender people have suffered some form of ostracism, discrimination, or family rejection. Clinicians with competency in the area of LGBTQ alcohol and drug use agree that treatment must provide a framework for the client not only to acknowledge sexual orientation but also to explore unresolved sexual issues.

Shame interferes with sobriety, and counselors should create an environment that provides an opportunity to release shame and reclaim pride. It is not surprising that recovery and "coming out" often go hand in hand; a counselor's assessment should recognize that this difficult period can be a time of increased risk of alcohol and other drug abuse. Gays with SUD are an underserved population because of a spectrum of antigay attitudes in treatment agencies, ignorance of gay issues, or anxiety about gay issues. Considerable cultural change has occurred around the stigma associated with sexual preference, as reflected in changes in same-sex marriage laws in several states.

Clients in the treatment facility are a microcosm of their culture, which, unfortunately, includes homophobia. One can imagine the stress and conflict of either concealing or acknowledging a homosexual orientation in group treatment. Yet, it is far too glib simply to recommend referral to a facility that specializes in treating gays and lesbians. Given the fact that facilities specializing in treating GLBTQ people are few and far between and that reimbursement may be difficult, counselors would generally limit such special referrals to those whose recovery seriously requires it. Gay and lesbian AA, NA, and Al-Anon groups are more accessible, especially in medium-size and large cities.

Sexual preference plays a role in epidemiology. There has been an over-representation of crystal methamphetamine users in the gay community, which is also associated with sexual compulsivity, failure to use safe sex, and consequent raised risks of sexually transmitted diseases, including HIV/AIDS (Braine et al., 2011; Marshall et al., 2011). A providers guide to working with gay and lesbian clients may be downloaded at https://store.samhsa.gov/shin/content/SMA12-4104/SMA12-4104.pdf

DISABILITIES AND SUD

Imagine:

- Having hearing loss but assigned to a treatment program where no one uses or interprets American sign language
- Being rejected from a residential treatment program because they cannot accommodate your wheelchair or provide you with assistance getting into bed
- Being visually impaired and in a treatment program where there are no Braille or audio materials for you to learn about SUD or participate in treatment planning

Estimates of how many Americans have a disability depend on the varying definitions of disability. One estimate by the U.S. Census (1997) is that one in five have some form of disability, and one in ten have a severe disability. This includes a wide range of citizens whose physical, sensory, or cognitive impairments limit one or more major life activities. Physical disabilities include, but are not limited to, spinal cord injury, cerebral palsy, multiple sclerosis, amputation, spina bifida, and arthritis. Sensory disabilities include being deaf, hard of hearing, blind, or visually impaired. Cognitive disabilities are associated with mental retardation and fetal alcohol syndrome as well as traumatic brain injury or stroke.

The disabled have a much higher prevalence of SUD than the general population (CSAT, 1998). Many studies indicate that 20% or more of people qualifying for state vocational rehabilitation service systems have symptoms of a SUD (Buss & Cramer, 1989). The estimate of SUDs varies according to the type of disability, ranging from 25% for visually impaired or mobility impaired people to 62% for people with spinal cord injuries (Greer, Roberts, & Jenkins, 1990). In a review of the literature, Amos Sales (2005) indicated that individuals with a disability are more likely to have a SUD yet are less likely to get treatment. There are several reasons for the higher prevalence: disabilities as a result of an accident involving drug and alcohol use, such as spinal cord injury or traumatic brain injuries. These accidents may well have been a consequence of substance abuse that goes undetected. People with disabilities often have more access to drugs on which they may become dependent. They may suffer isolation and discrimination, feel stigmatized, and be under- or unemployed. People with disabilities often experience periods of depression, anger, guilt, grief, social isolation, and physical pain that they may self-medicate with alcohol or other drugs (CPNJ, 1998).

People with CODs and substance abuse problems often do not receive adequate access to and accommodation for SUD treatment. There are at least three major reasons for this:

1. *Barriers that the SUD treatment system creates for people with disabilities*. Barriers can be physical, communication, and/or attitudinal. Physical barriers may be stairs, small doorways, or lack of handicapped bathrooms. Communication barriers include failure to provide interpreter service or other communication assistance devices necessary for people with hearing loss, those who are hard of hearing, or visually impaired. Attitudinal barriers are the result of stereotyping and misguided beliefs about people with disabilities: Some staff assume that people with disabilities do not use or abuse alcohol and/or drugs. Others chalk up a client's inability to meet treatment protocols to lack of motivation or unwillingness to invest in treatment. Some also fear that a person with a disability will make others in treatment uncomfortable, or they think that serving a person with a disability is too expensive or will cause extreme programmatic changes. It is true that some accommodations and some investment in time and funds are necessary, but they are generally more reasonable and less extreme than is often believed (CPNJ, 1998).
2. *Family, friends, and disability service providers often fail to intervene with a person who is abusing drugs and/or alcohol*. They may believe the person is already stigmatized with their disability; service providers may not understand the progressive nature of SUD and the potential harm it can do to family, friends, or clients; or some may assume that the use is acceptable and reasonable given the life circumstances of the client. Disability service providers may feel uncomfortable in intervening with their clients and lack awareness of the services available for prevention, intervention, and treatment.
3. *Failure to complete treatment*. There are many people with "hidden" disabilities who become treatment fail ures because the disability goes unrecognized and appropriate accommodations in treatment methods are not made. A client may be cognitively impaired and fail to comprehend the materials used in treatment, or a person may have a visual or hearing problem that requires that he or she be close to the front of the room or utilize devices designed to enhance his or her visual or auditory acuity. There are many such examples in which increased awareness and willingness to address these impairments would improve treatment outcomes.

What can be done to improve the access and completion of appropriate treatment for addicted clients with disabilities?

- There must be greater advocacy for clients with disabilities

- SUD treatment programs must work toward becoming compliant with the Americans with Disabilities Act (for a description of the American Disabilities Act and the agencies and programs that need to be in compliance, see http://www.ada.gov/pubs/ada.htm)
- SUD treatment administrators need to develop policies and procedures that contain statements of nondiscrimination, describe methods of accommodation, and promote significant training for their staff
- SUD treatment professionals need to increase their sensitivity and awareness to the specific needs of and resources for clients with disabilities
- Disability service providers need to increase their awareness of signs and symptoms of substance abuse, effective intervention methods, and SUD treatment resources

ACTIVITY 10.3 Identifying disability issues and barriers

Case Study: John

Background information: John is a 35-year-old married male. At age 17, John had a job delivering propane tanks. One day, he did not carefully attach a tank to the truck, and the resultant explosion tossed John up into the air, causing him to land on his back, which resulted in a spinal cord injury that paralyzed him from the waist down. John received a large monetary settlement for his accident and bought himself a house. He married at 26. John knows he should be acquiring new skills to make a living and get a new job but has been discouraged and demoralized. He has been spending the settlement money on drugs and partying.

Substance Abuse History: There is no history of substance abuse in John's family. John began drinking at age 12 years and was drinking regularly by the age of 15 year. He was a star athlete in high school and was drinking and doing drugs when there were no games scheduled. Because John did not abuse drugs during sports, the school did not recognize his problem. After the accident, John became bitter and angry. In spite of friends bringing drugs during his stint in physical rehabilitation, no one in the rehabilitation facility addressed his drug and alcohol use with him. He chose not to go for rehabilitation and "with nothing to do," increased his drug and alcohol use.

Present situation: John's parents were originally supportive of his lifestyle but now realize that he needs help. At the insistence of his parents and his wife, he has come to an outpatient mental health and drug abuse clinic for help. You are the clinician he will be seeing.

Questions:

- What are treatment issues that need to be explored with John?
- What might be the barriers to John getting the help he needs?
- What can be done to ensure access and accommodation for treatment services for John?
- What are John's long-term needs, and what resources and/or agencies can be mobilized to meet them?

Case Study: Sharon

Background information: Sharon is a 29-year-old single female born with a hearing deficit, a result of her mother's bout with rubella during her pregnancy with Sharon. When Sharon was 7 years old, her parents separated. Her father continued to maintain contact with her and her brother. Sharon recalls her mother being verbally, physically, and emotionally abusive.

However, Sharon also claims her mother taught her to speak at 18 months. She learned limited sign language at age 7, developed lip reading skills, and learned American sign language in college. Sharon describes herself as being very isolated and lonely in childhood. She is angry at her parents for not providing her with specialized services for the hard of hearing during her youth.

At age 20, Sharon went to a vocational rehabilitation agency and was trained in medical recordkeeping. Although she completed her training, Sharon could not function on the job due to drug abuse.

She was frequently late or absent and eventually stopped working.

Substance Abuse History: Sharon began to drink during her senior year in high school. She continued drinking and began smoking marijuana every day, recalling that she only felt comfortable when she was high and did not have to deal with her feelings.

Present Situation: Sharon recently got drunk and attempted suicide. Upon discharge from a psychiatric unit where she was treated for this attempt, she was sent to a substance abuse treatment center for her SUD. You are the counselor who will initially see her.

QUESTIONS:

- What treatment needs does Sharon have?
- What might be major barriers to Sharon receiving treatment?
- What can be done to ensure access and accommodation of treatment for Sharon?
- To what long-term services and programs should Sharon be referred?

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INDEX

D

E

F

G

H

I

J

L

M

N

O

P

Q

R

S

T

U

W