The Licensed Chemical Dependency Counselor Written Exam: A Preparation Curriculum

Developed for the

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Aknowledgements

I. Introduction

A. How to Use This Curriculum

Taking the Licensed Chemical Dependency Counselor (LCDC) written exam is an important milestone in a counselor's career. This curriculum is designed to summarize the large body of knowledge to which LCDC candidates have already been exposed through formal education and training or self study. The curriculum may be used for independent self-study, to facilitate discussion in study groups, or as the basis of exam preparation workshops.

The purpose of this curriculum is to reinforce previous learning, reminding candidates of what they already know. It is a tool for systematically reviewing the material and determining what content areas have been mastered sufficiently and which ones require more study. Candidates are encouraged to carefully read the curriculum a few paragraphs or pages at a time, highlighting important terms and making notes in the margins. Discussing the material with others and using the resources in the suggested reading list can provide clarification when needed.

A secondary purpose of the curriculum is to level the field for candidates who may have gaps in their knowledge for not having been exposed to a thorough, systematic program of study, or whose coursework was completed some time ago. While we hope that this curriculum will be a valuable tool for preparing for the written exam, it is not intended to take the place of conscientiously completing a high-quality counselor preparation program.

B. The Purpose of the LCDC Written Exam

The State of Texas licenses chemical dependency counselors, as it does other professionals, in order to meet its responsibility to protect consumers from harm inflicted by unqualified practitioners. It does this by assuring that new counselors have met minimal competency requirements. That is, the exam samples the information that new counselors are expected to know, not everything that a seasoned counselor should know.

Counseling is both rewarding and difficult work. By requiring that new counselors demonstrate a solid foundation of the appropriate knowledge, the licensing exam actually helps to set up counselors for success. Therefore, rather than view the exam as a barrier to be overcome, view it as a bridge. There are steps to cross it, and the reward on the other side is worth the effort.

C. Description of the Written Exam

The LCDC written exam administered in Texas is the same exam given in most of the United States, as well as internationally. The International Certification and Reciprocity Consortium (IC&RC) contracted with a professional testing company to develop the exam based on a recent study of what alcohol and other drug counselors actually do. The

Texas Certification Board of Addiction Professionals (TCBAP) is responsible for administering the exam in Texas. Candidates may download application forms for testing and access exam results from TCBAP's Web site (www.tcbap.org). Candidates will automatically receive their results through the mail. This report includes the total score, and scores for each content domain: Assessment, Counseling, Case Management, Client, Family and Community Education, and Professional Responsibility.

The written exam consists of 150 multiple-choice items, each with five answer options. Candidates have 3 ½ hours to complete the exam by marking the best answer for each item on a separate answer sheet. The raw score, the number of correctly answered items, is statistically converted to a scaled score, which ranges from 200 to 800 points. A passing score is 500 or more scaled points.

The written exam is constructed by selecting items from a large pool of items called an item bank. Candidates do not know beforehand specifically how items will be worded. Each administration uses a version of the exam with the same blueprint. Each version of the written exam is statistically adjusted to be of the same difficulty level. Therefore, each candidate takes an exam with the same number of items per domain and of equal difficulty.

D. Descriptions of the Domains

The *Assessment* domain (37 items; 24 percent of the exam) includes items regarding interview techniques, diagnosing substance related disorders and recognizing co-existing disorders, treatment planning, and knowledge of specific alcohol and other drug instruments.

The *Counseling* domain (40 items; 27 percent of the exam) includes items regarding basic counseling skills, counseling modalities and strategies, counseling theories, relapse prevention, and documenting counseling activities.

The *Case Management* domain (23 items; 15 percent of the exam) includes items regarding matching clients to community resources and services, referral procedures, consultation procedures, client advocacy, evaluating case management effectiveness, and documenting case management activities.

The *Client/Family/Community Education* domain (16 items; 11 percent of the exam) includes items regarding communicating information to individuals, families and communities about the biological, emotional and behavioral effects of alcohol and other drug use, and educating others about prevention and treatment.

The *Professional Responsibility* domain (34 items; 23 percent of the exam) includes items regarding codes of ethics, promoting client rights, professional development, relating effectively with other professionals, cultural competence, professional organizations, and counselor self awareness.

E. Suggestions for Effective Studying

There are two main reasons that an examinee may not perform as well as desired on this type of exam. One is insufficient mastery of the material, and the other is difficulty with the examination process itself. Both sources of difficulty are preventable.

Study strategies that work best for one person may not work best for another. Study strategies make sense when they suit an individual's particular learning style, allow enough time for deep learning, and are something with which the person can follow through. Some study strategies that are sound for all examinees for the LCDC written exam follow:

- *Aim for quality of study time, not just quantity.* Information makes it into longterm memory when it is processed deeply; that is, its meaning is understood. This is more effective than rote memorization, particularly for large quantities of material, some of which is complex. It is more efficient to spend 1 thoughtful hour on learning material than 5 hours repeatedly skimming it. Studying to learn, not just memorize, is wise.

- *Study the right material.* While the exam items themselves are kept secure, the general topics that are covered by the exam questions are not a secret. Candidates may use this curriculum to help focus their study efforts. It is wise to balance the attention given each area of the exam. For example, it would be a poor strategy to spend time becoming an expert on 10 different counseling theories if that resulted in neglecting other important topics.

- *Avoid complacency.* Knowledge of the 12 core functions and experience as a person in recovery are insufficient to prepare a candidate to pass the examination. Working in the field is probably insufficient, because the written exam taps knowledge more than skills, and performing a skill is not the same as demonstrating knowledge of that skill. For example, examinees do not demonstrate their interviewing skills on the licensing exam. However, they might be asked to recognize the advantages of using motivational interviewing or identify an appropriate counselor reflection statement.

- *Make a reasonable study plan.* An organized approach will make preparing for the exam a manageable task. Divide the material into topics. Study only one topic per study session, and, if possible, only one topic per day. Study for small blocks of time (1 or 2 hours) over several weeks. Studying small chunks of material over a longer period of time, called *distributed practice*, results in better learning than massed practice, also called *cramming*. People who say that they perform well on exams when they cram probably already knew the material before their cram session. If one has already learned the material, looking over it again at the last minute will not hurt. But waiting until the last minute to learn new material is a risky strategy.

- *Make emotions work for you.* Some nervousness in anticipation of taking a licensing exam is normal and can provide energy that can be directed toward preparing for it. Note that normal nervousness does not have to become uncomfortable anxiety. Appropriate self-messages, such as, "I have every reason to expect to perform well on this task," and "My conscientious study and good attitude are preparing me adequately for this task" can help turn anxiety into positive anticipation.

- *Keep a positive attitude.* Focus on positive messages from yourself and others. Some appropriate self-messages are "I am not going to be asked about everything in the drug and alcohol counseling field," "I do not have to answer 100 percent of the items correctly," and "This is only one of many challenges that I have met and will meet in my career." Keep in mind that any negative messages that you may hear from other people arise from questionable motivation and are certainly unhelpful.

- *Join a study group—maybe.* Depending on one's learning style, a study group can be enjoyable and helpful, or a tiresome distraction. The composition of a study group also matters. Study group members who are somewhat evenly matched as far as overall level of knowledge and motivation tend to work best. Otherwise, there is a risk of some members engaging in "social loafing" and letting others do most of the work.

- *Practice answering multiple-choice items.* Multiple-choice items have their own special structure and a particular rhythm to their wording. While the actual exam items are kept secure, practice items addressing similar content are available commercially in print format and on compact disk. Familiarity with answering this type of question can make the exam go more smoothly.

F. Suggestions for Taking the Exam

To perform well on the exam, it is necessary not only to have mastered the material but also to know how to test well. Some suggestions follow:

- *Take care of physical needs the day of the examination.* Sleep well the night before, eat well, and arrive for testing early enough so that there is time to relax a few minutes before being called to test.

- *Expect items to be interspersed according to difficulty level and domain represented.* On the exam, items do not become progressively easier or more difficult. All of the assessment items are not clustered together, followed by the professional responsibility items, etc.

- *Read each item carefully and completely before answering.* Words like "best," "first," and "except" in the stem of the item can make all the difference in

determining the correct answer. Read through all of the answer choices. Only one is the best answer. The other four choices, called distractors, are there to pull examinees' attention away from the best answer.

- ***Do not spend several minutes on one item.*** Move along, and come back to items that require more thought, if needed.

- ***Choose the best answer of those provided.*** Another correct answer may exist but is not one of the choices. This does not mean that this is a trick question.

- ***Make educated guesses if needed.*** Even if an examinee is unsure of the best answer, there are usually some answer choices that can be eliminated. The advice, "when in doubt, choose C," does not apply to professionally developed exams, and therefore does not apply in this situation. Each item should be answered, since there is no penalty for guessing.

- ***Remember that exam items reflect current knowledge as described in the alcohol and other drug counseling literature.*** The correct answer to some items may or may not resemble an examinee's opinion or how things are done where they work. For example, an examinee may believe that treatment for a substance related disorder should take place before treatment for a co-occurring disorder. However, the generally accepted treatment standard is concurrent treatment for all disorders.

G. Summary

Preparing for the LCDC Written Exam can be a challenging and enjoyable task, particularly if candidates appreciate the reasons behind taking the exam and adopt a positive attitude toward the process. To perform well on the exam, it is useful to know something about its structure and to be familiar with answering multiple-choice items. It is also important to carefully review the topics represented on the exam. This curriculum is designed to help candidates focus their study efforts, thereby helping them cross the bridge to licensure as a chemical dependency counselor.

II. Assessment

A. Overview of Assessment

Assessment is an ongoing process through which the counselor collaborates with the client and others to gather and interpret information necessary for planning treatment and evaluating client progress (CSAT, 2002, p. 35). Tools of assessment include counselors' observations, clinical interviews, laboratory tests, and instruments such as tests and self-report inventories.

Interviews with other people in the client's life can corroborate client self reports. Family members may provide information about a client's developmental history, early attachments, and how the client fit into the family. Other sources of information are friends, staff, school records, and physicians. Appropriate documentation of client consent is required before counselors can solicit information from outside sources.

B. Cultural Relevance

Assessment should be culturally relevant, taking into account the client's social context. A behavior may carry a meaning in the client's culture that is different from that of the counselor's culture. For example, communicating with a deceased loved one might indicate complicated mourning to a counselor with a certain view of death, while to a client with a different view, it is an accepted method of continuing a relationship with a loved one who will be seen again in time. In this case it would be inappropriate to interpret the client's behavior as pathological, particularly since it caused the client no subjective distress.

Counselors should also be aware that culture influences how clients report their difficulties. For example, some clients may report somatic symptoms such as stomach upset or headache, and these are actually indicative of depression (Watkins, Lewellen & Barrett, 2001, p. 69). Clients may have ways of expressing their distress that are particular to their culture. Counselors may want to become familiar with the idiomatic expressions used by the clients with whom they frequently work. Examples of such expressions used by some Spanish-speaking clients are ataque de nervios, mal de ojo, locura, and susto (American Psychiatric Association, 2000, p. 898-903).

C. Explaining Assessment to Clients

Clients need to know the procedures being used in their assessment, and they need to have an opportunity to ask questions about them. They need to know that the purpose of the assessment is to gather information that will help determine the counseling interventions that will be most helpful to them. Clients are likely to cooperate with the assessment process if rapport has been established and the reason for the assessment procedures is clear.

When explaining assessment results to clients, counselors should use nontechnical language that the client understands. The counselor should offer results not as a proclamation but tentatively for the client's consideration. For example, "What this score suggests is that you may have alcohol dependence" is preferable to "According to this test, you are an alcoholic." Clients should have an opportunity to ask questions and indicate their level of agreement with the assessment results.

D. Biopsychosocial Perspective

The biopsychosocial perspective recognizes that there are biological, psychological, and social causes of substance abuse and dependence. Biological factors include brain chemistry problems, which may be genetic. Genetics influence biochemistry, and biochemistry makes some people particularly vulnerable to addiction to certain drugs once they try them. Psychological factors include cognitive styles, personality traits, and early developmental experiences. Social factors include poverty, oppression, poorly developed social skills, and family dysfunction (Watkins, et al., 2001, p. 3). Counselors' assessments emphasize psychological and social factors.

A psychosocial assessment will produce information on clients' presenting problems, alcohol and other drug use, psychiatric and chemical dependency treatment, medical history and current health status, relationships with family, social and leisure activities, education and vocational training, employment history, legal problems, mental/ emotional functioning, and strengths and weaknesses. If a counselor asks a client only about alcohol or drug use, it is not possible to formulate a comprehensive diagnostic impression or treatment plan.

E. Additional Assessment Services

When the counselor's assessment identifies a potential mental health problem, an appropriate referral for additional assessment should be made. For example, a psychological assessment may be necessary to establish the presence of schizophrenia or major depressive disorder. When a client has physical complaints or the counselor has concerns about the client's physical health, a physical examination by a licensed medical health professional is necessary.

Although these symptoms may not be life threatening, immediate medical evaluation should be sought for clients who present with hallucinations, severe tremors, tachycardia, confusion or delirium, or uncontrollable agitation, or who have ingested unknown substances or quantities of substances. When assessing clients' potential for serious withdrawal, risk factors include a history of difficult withdrawal, a history of seizures, and dependence on multiple substances (Kinney, 2003, p. 236).

F. Interviewing Clients

Interviews must be conducted skillfully in order to put the client at ease and to collect valid information. Establishing rapport, a comfortable working relationship, with the

client helps assure the client's trust and cooperation. Culturally sensitive language, including using "people first" language, communicates respect to clients. Examples are referring to the client as a person with alcohol dependence rather than an alcoholic; a homosexual person rather than a homosexual, or a person with schizophrenia rather than a schizophrenic.

Motivational interviewing, which is used not only for assessment, but for all phases of treatment, is a style of interacting with clients that is particularly helpful for reducing defensiveness and encouraging therapeutic collaboration between the counselor and client. With motivational interviewing, counselors use the interpersonal process to enhance clients' motivation to change (Miller & Rollnick, 2002). It encourages clients to move on to the next stage of readiness for change (DiClemente & Velasquez, 2002).

Motivational interviewing respects the client's perception of the problem. For example, a client who does not acknowledge having a problem with alcohol is not labeled as being in denial. Instead, the client is recognized as being at the precontemplation stage of readiness for change. The counselor's responsibility is not to persuade the client to adopt the counselor's view of the client's problem but rather to engage the client in a dialogue that promotes the client nondefensively reexamining the situation and coming to determine that a problem exists.

G. Assessment Instruments

Dozens of instruments are available to counselors to aid their identification of, and treatment planning for, substance related disorders. Many of these are described in detail or reproduced in their entirety along with psychometric data, suggestions for use, and training requirements in the free publication *Assessing Alcohol Problems: A Guide for Clinicians and Researchers* (NIAAA, 2003).

There are several issues to consider when selecting an instrument, including the reliability and validity of the instrument. *Reliability* has to do with the consistency with which an instrument measures. *Validity* has to do with what the instrument measures and how it is used. An instrument that identifies every person who takes it as being alcohol dependent lacks adequate validity to be useful, because it is mismeasuring the construct of alcohol dependence. A sound instrument, one that has documented evidence for its reliability and validity, is being used in an invalid way if it is used to make improper decisions; for example, if a screening instrument is used to make a diagnosis.

H. Screening Instruments

A screening instrument is one that distinguishes individuals who do not have a disorder from those who might have one. In other words, the counselor screens out cases. The cases that remain require further assessment in order to make a diagnosis. Several screening instruments are described below:

- *Alcohol Use Disorders Identification Test (AUDIT).* The 10 items on this instrument developed by the World Health Organization ask about frequency of drinking, alcohol dependence, and problems caused by alcohol. Scores range from 0 to 40, with a score of 8 or higher indicating the likelihood of harmful alcohol consumption.

- *CAGE Questionnaire.* An answer of yes to one or more questions indicates the possibility of alcohol dependence. The four questions are "Have you ever felt you should cut down on your drinking?" "Have people ever annoyed you by criticizing your drinking?" "Have you ever felt bad or guilty about your drinking?" or "Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)

- *Drug Abuse Screening Test (DAST).* Adapted from the MAST (described below), this self-report instrument is used to detect abuse of or dependence on drugs other than alcohol. It provides a measure of lifetime problem severity.

- *Michigan Alcoholism Screening Test (MAST).* This instrument requires yes/no answers to 25 questions. Scores indicate the absence of alcohol dependence (0 to 3), possible substance dependence (4), or likely alcohol dependence (5 or higher). A Brief MAST (10 items) and a 13-item Short MAST (SMAST) are available, as is a Geriatric MAST (MAST-G).

- *Rapid Alcohol Problems Screen (RAPS4).* An answer of yes to one or more questions indicates the possibility of alcohol dependence during the past year. The questions have to do with remorse, amnesia, performance of life duties, and starting the day with alcohol.

- *Substance Abuse Subtle Screening Inventory (SASSI) 3.* This brief self report is designed to identify individuals with a high probability of having a substance related disorder. A version designed for adolescents, the SASSI-A2 is for clients ages 12 to 18.

- *TWEAK.* This five-item instrument was designed to screen for harmful drinking in pregnant women. The items have to do with tolerance, worry of close friends and relatives, using alcohol as an eye opener, amnesia (blackouts), and felt need to cut down on drinking.

I. Comprehensive Measures of Drinking

Time Line Follow Back (TLFB) Procedure. This instrument makes connections between significant events in the client's life and alcohol/drug use patterns and intensity, for the past year. It includes a calendar and a standard drink conversion chart to aid memory. It may be particularly useful in working with elderly clients (Kinney, 2003, p. 416).

Other measures of drinking that go beyond screening for abuse or dependence include the Cognitive Lifetime Drinking History (CLDH), Drinking Self Monitoring Log (DSML), and Form 90.

J. Diagnostic Instruments

- ***Alcohol Dependence Scale (ADS).*** This 25-item instrument provides a quantitative measure of the severity of alcohol dependence.

- ***Diagnostic Interview Schedule (DIS-IV) Alcohol Module.*** The 28 questions permit diagnosis of alcohol abuse or dependence.

- ***Impaired Control Scale (ICS).*** This pencil and paper self-administered instrument measures clients' attempts to control their drinking during the last 6 months and their perception of their ability to control it now.

Other diagnostic instruments are the Obsessive Compulsive Drinking Scale (OCDS), the Short Alcohol Dependence Data (SADD), and the Substance Dependence Severity Scale (SDSS).

K. Instruments to Aid Treatment Planning

- ***Addiction Severity Index (ASI).*** This is a semi-structured interview with seven subscales addressing problems in the areas of family/social status, medical status, employment and support, drug use, alcohol use, legal status, and psychiatric status. It is useful for treatment planning and outcome evaluation with adult clients.

- ***Alcohol Use Inventory (AUI).*** This self-report inventory is in multiple-choice format, for ages 16 and above. It is based on the multiple condition theory, which takes into account individuals' different styles of drinking, perceptions of alcohol's benefits and consequences, and how they want to deal with drinking problems.

- ***Coping Behaviours Inventory (CBI).*** This instrument measures factors that are related to relapse risk: positive thinking, negative thinking, avoidance/distraction, and seeking social supports.

Other instruments to aid treatment planning include the Comprehensive Adolescent Severity Inventory (CASI), Drinking Expectancy Questionnaire (DEQ), Drinking Related Internal-External Locus of Control Scale (DRIE), Negative Alcohol Expectancy Questionnaire (NAEQ), Personal Experience Inventory (PEI), and Teen Addiction Severity Index (T-ASI).

L. Instruments That Measure Other Constructs

LCDCs should recognize some of the more popular instruments used to measure psychological constructs other than substance abuse and dependence, even if they do not administer them.

- *The Wechsler Adult Intelligence Scale (WAIS III)* is a popular intelligence test.

- *The Strong Interest Inventory* is a vocational interest scale that compares clients' interests to those of people who are happy in different occupations.

- *The Minnesota Multiphasic Personality Inventory (MMPI-2)* is a personality inventory that contains several clinical scales that detect pathology. The MMPI-2 contains the MacAndrew Alcoholism Scale, which indirectly screens for alcohol problems by identifying attitudes that often accompany alcohol abuse and dependence.

- *The Mental Status Exam* is a series of observations about a client's appearance, behavior, attention, mood, affect, perceptual and thought processes, judgment, and memory at a given point in time. It includes observations of a client's orientation to time, place, and person.

- *The Myers-Briggs Type Indicator (MBTI)* is a personality inventory that looks at clients' preferred ways of being in the world, and assigns them to 1 of 16 personality types. It does not detect pathology. It is frequently used in vocational and relationship counseling.

- *The Beck Depression Inventory II* is for clients age 13 and older. Individuals rate themselves on 21 groups of statements that tap the affective, behavioral, cognitive, and physiological symptoms of depression for the 2 weeks prior to testing. It is sensitive to changes over short periods of time, so it can be used repeatedly to track changing levels of depression over the course of treatment. Scores are interpreted as indicating minimal (0 to 13), mild (14 to 19), moderate (20 to 28), or severe (29 to 63) depression.

M. Physiological Measures

Physiological measures of alcohol or drug use can be a useful part of the assessment process. They may be used to corroborate clients' self reports of what they are using or that they are abstinent. Empathically communicating the lab results may enhance clients' motivation. Using biomarker measures at intervals throughout treatment may provide early identification of relapse (Allen, Sillanaukee, Strid & Litten, 2003, p. 47). Any laboratory test can produce false negatives or false positives, so they should be used with caution.

Most commercially available urine testing kits used for drug screening are based on the enzyme multiplied immunoassay test (EMIT), which uses antibodies that react to the presence of a drug or its metabolites. EMIT kits can detect PCP, heroin, the cocaine metabolite benzoylecgonine, and marijuana metabolites. A more expensive and sensitive test is gas chromatography/mass spectrometry (Ray & Ksir, 2004, p. 108).

One biomarker detected in blood samples is elevated gamma-glutamyltransferase (GGT) levels, which indicates prolonged, rather than episodic, heavy drinking. Two other screens for heavy drinking are aspartate aminotransferase (ASAT) and alanine aminotransferase (ALAT). Most laboratory tests, including GGT, ASAT, and ALAT, are better for identifying medical complications connected with drinking than assessing alcohol use itself. An exception is the test for carbohydrate deficient transferrin (CDT) levels, which is sensitive enough to pick up moderate drinking over a period of a few weeks (Allen, et. al. 2003, p. 39; Kinney, 2003, p. 225).

N. Assessing for Suicide Risk

Use of an assessment tool to supplement the clinical interview aids with thoroughness and helps guide the counselor's clinical judgment when assessing for suicide risk. Several instruments, such as the Suicide Assessment Checklist, the Suicide Intent Scale, and the SAD PERSONS Scale, are available. Some risk factors are being male, being over 65, having depression, having attempted suicide previously, having alcohol or drug abuse or dependence, being psychotic, having little social support, and having a chronic illness.

O. Assessing Readiness for Change

In order to be effective, counselor interventions must match the client's stage of readiness for change. Counselors can listen for client statements during interviews for clues regarding a client's stage of readiness for change. For a more formal assessment of readiness for change, counselors may use the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES), which provides scores on three scales that indicate motivation to change drinking behavior. The University of Rhode Island Change Assessment Scale (URICA) is a self-report instrument that measures clients' motivation to change.

P. Assessing Families

The Family Tree Questionnaire (FTQ) helps clients report information about the incidence of alcohol problems in their blood relatives. Clients assign relatives to categories of drinker groups such as never drank, social drinker, possible problem drinker, and definite problem drinker.

A genogram is a pictorial representation of family structure, usually at least three generations, using a standard set of symbols (e.g., squares for males and circles for females). The client and counselor construct the genogram together and use it to aid exploration of behaviors and issues.

Q. The DSM-IV-TR

There are several reasons for counselors to be familiar with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (American Psychiatric Association, 2000). First, it contains the diagnostic criteria for the substance related disorders. Second, LCDCs are sometimes required to uses the DSM-IV-TR to complete a comprehensive diagnostic impression. Third, counselors must be familiar enough with co-occurring disorders that may influence the course of substance abuse treatment. For example, a very depressed client may lack the cognitive focus and motivation to benefit from treatment, or a counselor might misinterpret the depressed client's lethargy and lack of motivation as resistance (CSAT, 1995, p. 3).

There are five axes in the DSM-IV-TR. Axis I contains 16 categories of clinical disorders, one of which is Substance Related Disorders. They include both Substance Use Disorders and Substance Induced Disorders. The Substance Use Disorders are substance abuse and substance dependence. The Substance Induced Disorders are substance intoxication and substance withdrawal, as well as substance induced delirium, persisting dementia, persisting amnestic disorder, psychotic disorder, mood disorder, anxiety disorder, sexual dysfunction disorder, and sleep disorder.

The other categories on axis I are Mood Disorders, Anxiety Disorders, Schizophrenia and other Psychotic Disorders, Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence, Delirium, Dementia, Amnestic and other Cognitive Disorders, Mental Disorders Due to a General Medical Condition, Somatoform Disorders, Factitious Disorders, Dissociative Disorders, Sexual and Gender Identity Disorders, Eating Disorders, Sleep Disorders, Impulse-control Disorders not elsewhere specified, and Adjustment Disorders and Other Conditions that may be a Focus of Clinical Attention.

Mood disorders that frequently appear with substance abuse and dependence are major depressive disorder, bipolar I disorder, and bipolar II disorder. If the mood disturbance is a direct physiological consequence of a drug of abuse or medication, the proper diagnosis is substance-induced mood disorder. Anxiety disorders that counselors are likely to encounter include obsessive-compulsive disorder, acute stress disorder, generalized anxiety disorder, specific phobia and social phobia. If anxiety is a direct physiological consequence of a drug of abuse or medication, the proper diagnosis is substance-induced anxiety disorder.

Axis II contains the personality disorders as well as mental retardation. The personality disorders are organized into three clusters. Cluster A represents personality disorders that feature odd, eccentric, isolative, or suspicious behavior. They are the Paranoid, Schizoid, and Schizotypal personality disorders.

Cluster B personality disorders often co-occur with substance abuse and dependence, and are characterized by dramatic, emotional, erratic, or impulsive behavior, or a reduced capacity for empathy. Antisocial personality disorder features a pervasive pattern of

disregard for and violation of the rights of others. Borderline personality disorder features a pervasive pattern of instability in interpersonal relationships, self-images, affects, and control over impulses; some criteria include: frantic efforts to avoid real or imagined abandonment, impulsivity in at least two areas that are potentially self-damaging, chronic feelings of emptiness. Histrionic personality disorder features a pervasive pattern of excessive emotionality and attention seeking. Narcissistic personality disorder features a pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy.

Cluster C personality disorders feature anxious, fearful, and perfectionistic behavior. They are the Avoidant, Dependent, and Obsessive-Compulsive personality disorders. Axis III contains 16 general medical conditions that are potentially relevant to the understanding or management of the client's diagnosed disorder.

Axis IV contains nine psychosocial and environmental problems that may affect the client's diagnosis, treatment, and prognosis. They are problems with primary support group, problems related to the social environment, educational problems, occupational problems, housing problems, economic problems, problems with access to healthcare services, problems related to interaction with the legal system/crime, and other psychosocial and environmental problems (American Psychiatric Association, 2000, p. 31–32).

Axis V is the Global Assessment of Functioning (GAF) scale, which assigns a number (0 to 100) to the counselor's judgment of the client's overall level of psychological, social, and occupational functioning. It is useful for planning treatment and measuring its outcome.

R. Diagnosing Substance Abuse and Substance Dependence

The LCDC scope of practice includes diagnosing Substance Related Disorders and completing axes I, IV, and V. If the counselor is almost certain that the full criteria for a disorder will be met, but not enough information is available yet to be sure, the term "provisional" is added to the diagnosis. When a diagnosis is not being made yet pending gathering of additional information, the term "deferred" is used. LCDCs will usually enter deferred on axis II and on axis III, unless the client reports a medical problem.

- *Substance abuse* is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by at least one of the four following criteria occurring within a 12-month period: There is recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home; there is recurrent substance use in situations in which it is physically hazardous; there are recurrent substance-related legal problems; and/or there is continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. Additionally, if symptoms have ever met the criteria for substance dependence,

substance abuse cannot be diagnosed for that class of substance (American Psychiatric Association, 2000, p. 199).

- *Substance dependence,* according to the DSM-IV-TR, is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following seven criteria, occurring at any time in the same 12-month period: Tolerance is present, as defined by either a need for markedly increased amounts of the substance to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount of the substance; withdrawal is present, as manifested by either the characteristic withdrawal syndrome for the substance or the same or a closely related substance being taken to relieve or avoid withdrawal symptoms; the substance is often taken in larger amounts or over a longer period than was intended; there is a persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time is spent in activities necessary to obtain the substance, use the substance (e.g., chain-smoking), or recover from its effects; important social, occupational, or recreational activities are given up or reduced because of substance use; and/or the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (American Psychiatric Association, 2000, p. 197–198).

  The counselor specifies whether or not physiological dependence, defined as evidence of tolerance or withdrawal is present. There are six additional specifiers used for a diagnosis of substance dependence. They are early full remission, early partial remission, sustained full remission, sustained partial remission, on agonist therapy, and in a controlled environment (American Psychiatric Association, 2000, p. 195–197).

- *Polysubstance dependence* is the proper diagnosis for a client who has repeatedly taken at least three groups of substances, and who meets criteria for dependence for the substances as a group, but not for the substances individually. This is different than a client separately meeting diagnostic criteria for dependence for more than one drug (e.g., both alcohol and cocaine), in which case, multiple diagnoses should be made (American Psychiatric Association, 2000, p. 293–294).

- *Dually diagnosed clients* have one or more other psychiatric disorders along with substance abuse or substance dependence, all of the disorders should be treated concurrently and aggressively (Kinney, 2003, p. 456). This may require the counselor to work cooperatively with other professionals treating the client for the co-occurring disorder. It may be necessary for the counselor to educate the others involved in the client's care of how the substance related disorder can affect treatment for the co-occurring disorder.

  Substance use problems and psychiatric symptoms can be related in several ways. They can independently coexist. Substance use can initiate or exacerbate a

psychiatric disorder in vulnerable individuals. Substance use can mask psychiatric symptoms and syndromes. Substance use withdrawal can cause and mimic psychiatric syndromes. Lastly, substance use and mental disorders can mimic one another. For example alcohol and sedatives can mimic depression and anxiety. A person with paranoid delusions related to schizophrenia may appear to be using cocaine (adapted from CSAT, 1995, p. 4).

There exists a large specialized vocabulary used to describe symptoms of various disorders. Some of the more common terms with which counselors should be familiar are affect, mood, delusion, hallucination, and illusion.

- *Affect* is the external expression of an internal emotional state. With blunted affect there is less than normal intensity of emotion. Inappropriate affect means that the expression does not match what is being said or thought; for example, a client smiles broadly when speaking of a serious loss. Labile affect refers to expression that shifts very quickly and has abnormal variability; for example, a client laughs one second and cries the next. Disturbances of affect occur with several disorders, including mood disorders and schizophrenic disorders.

- *Mood* is a sustained emotion, and changes less frequently than affect. Mood that is in the normal range, neither depressed nor elevated, is called euthymic. Dysphoric moods are unpleasant ones such as anxiety, sadness, or irritability. Elevated mood is a feeling of euphoria or elation (American Psychiatric Association, 2000, p. 825).

- *Delusions* are false beliefs that are maintained despite proof against their truth. Some types of delusions are grandiose, bizarre, and persecutory, thought broadcasting and thought insertion.

- *Hallucinations* occur when a person perceives something in the absence of a sensory input. They may involve any of the senses: auditory, visual, olfactory, gustatory, or tactile. The presence of command hallucinations, such as voices telling a person to hurt himself or herself or someone else, is a risk factor for violent behavior.

- *Illusions* are misperceptions of actual sensory input; for example, perceiving movement when staring at the moon.

S. The Written Assessment Summary

The written assessment summary is a report that brings together client information from all sources in a succinct format that makes it helpful in formulating the treatment plan. The first section of the assessment summary is usually a statement about the client's presenting problems and circumstances leading to treatment. Other sections include paragraphs about past and present alcohol and other drug use, past psychiatric and substance related treatment, significant medical history and current health status, family

structure, current living situation, past and current relationships with others, education and vocational history, and legal history and current status.

Client strengths and weaknesses are listed. Examples of strengths are a desire to work and the ability to distinguish right from wrong in everyday situations. Examples of weaknesses, or factors that are predictive of poor outcome unless they are overcome, are having no social support network and having few marketable skills.

A diagnostic impression may follow, with an entry for each of the five DSM-IV-TR axes. For example:

Axis I   304.80 Polysubstance Dependence in partial remission
Axis II   Deferred
Axis III   Deferred; reports frequent headaches
Axis IV   Homeless
Axis V   35

T. Treatment Plans

Treatment planning is the process by which the counselor and client identify and rank problems needing resolution, establish agreed-upon immediate and long-term goals and decide on treatment methods and the resources to be used (Herdman, 2001, p. 37). Treatment planning is based on a comprehensive assessment of the client's strengths, problems/needs, and preferences. It may include an initial plan for discharge, including discharge criteria. The written treatment plan should be individualized, reviewed regularly, and amended as needed to meet changing client needs.

Components of a treatment plan

There are four main components to a treatment plan: problems, goals, objectives, and strategies.

- *Problem statements* should be in the client's own words if possible and may take the form of an answer to the question, "Why are you here?" The problem should be described as specifically as possible and include the evidence for the problem. An example of a problem is "engaging in dangerous behavior while under the influence of alcohol, as evidenced by arrest for driving while intoxicated, engaging in sex without a condom, and engaging in physical altercations with family members."

- *Goal statements* answer the question, "What is necessary to remedy the problem?" The goal should be acceptable to the client, so abstinence as a treatment goal is only appropriate when the client chooses it. Evidence suggests that abstinence should be the ultimate goal for clients diagnosed with substance dependence. However, some clients diagnosed with substance abuse have other options for their ultimate treatment goal. Goals should be stated in terms of the

presence of something (e.g., the client will maintain sobriety) rather than the absence of something (the client will not drink).

- *Objectives* are the specific things the client will do to meet the goal. Objectives are stated in behavioral terms, and they are observable; that is, the counselor can see the client do them. A good objective is realistic, time specific, appropriate to the level of treatment, and measurable. An objective is measurable when the frequency, amount, duration, and intensity of the behavior are indicated.

- *Strategies* are what the counselor will do to help meet the client's objectives. The theoretical model to be used (e.g., reality therapy) should be indicated as well as the specific techniques to be employed (e.g., assertiveness training or refusal skills training). The strategies, also called interventions, the counselor uses should have demonstrated effectiveness and also take into account the client's stage of readiness for change.

The following example illustrates the connection between the four parts of a treatment plan. An adolescent is brought for counseling by his parents because he has been expelled from school.

Counselor: Why do you think your parents have brought you to talk to me?
Client: I am having trouble in school. I got expelled for fighting and drinking on school grounds. (This is the **PROBLEM**)
Counselor: What do you want to happen at this point?
Client: I want back into school and my parents off my back. (This is the **GOAL**)
Counselor: What are you willing to do to get back into and stay in school?
Client: I am willing to stop drinking, or at least not drink until after school on weekdays. (This becomes the **OBJECTIVE**: Abstain from drinking until after 4:00 on weekdays)
Counselor: This is how I think I can best help you abstain from drinking on weekdays, for now. First, I'd like you to attend weekly group meetings with other teens to discuss the pros and cons of using alcohol, so you can make an informed decision about what you want to do. Second, I will meet with your parents and your school counselor to discuss conditions under which everybody can feel comfortable with you going back to campus. (This is the **STRATEGY:** Group counseling and advocating with the parents and school).

U. Summary

Assessment involves gathering information about the client in order to make an informed diagnostic impression and an appropriate treatment plan. Counselors rely upon observations of client behavior, clinical interviews, laboratory tests, and formal assessment instruments to gather data about the client's past and current functioning in all areas of life and the client's stage of readiness for change. Formal assessment instruments can aid with screening and diagnosis of substance related disorders and with treatment planning and treatment outcome measurement. Familiarity with disorders that co-occur

with substance related disorders is necessary to develop complete written assessment summaries and treatment plans and to work cooperatively with other professionals involved in the client's care.

III. Counseling

This chapter will provide information about basic counseling approaches, types of available treatment, group counseling, crisis intervention, counseling theories, the intervention process, and therapeutic communities.

A. Clinical Skills Used With Many Counseling Approaches

- *Active listening* involves attending skills and reflective listening. Through utilizing active listening skills the counselor will be able to connect with the client and be able to reflect the client's emotions, thoughts, and attitudes. By providing reflection to the addict, the counselor can interject an observing perspective that may be lacking (Myers & Salt, 2000).

- *Empathy* is the ability to perceive another person's experience and communicate that perception back to the person (Welch & Gonzalez, 1999).

- *Concreteness* is a process by which the counselor relates the vague aspects of the client in direct expression of feelings and experiences in specific concrete terms to assist the client to develop more functional coping skills. (Welch & Gonzalez, 1999).

- *Paraphrasing* includes the therapeutic qualities of empathy and warmth. 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 can increase trust and can reduce resistance. (Myers & Salt, 2000)

- *Reflecting* occurs when the counselor restates content that had generated emotion from the client—it is a reflection of feeling. Reflection of feeling captures and expresses to the client the core of what he or she is feeling. It allows the client to be aware of his or her own expressed emotions and how the counselor understood his or her emotional message. The counselor should be careful not to interpret the client's feelings. When reflecting feelings, the counselor remains neutral and nonjudgmental by not offering opinions, judgments, or advice (Myers & Salt, 2000).

- *Simplifying* involves the reflection and restatement of what the client said. It removes confusion, avoids intellectualizations and convoluted explanations, and can help the client stay focused on concerns, feelings, and problems in the here and now (Myers & Salt, 2000).

- *Summarizing* is the tying together of the main points, themes, and issues presented by clients during part or all of a session (Myers & Salt, 2000).

- *Attending* refers to ways in which the clinician demonstrates that she/he is listening to the client through the use of cues (Myers & Salt, 2000).

- *Probing* involves asking open-ended questions to clarify information and to help the client toward a new understanding (Doyle, 1998).

- *Re-framing* consists of offering a different perspective on a situation the client is facing (Evans, Hearn, Uhlemann, & Ivey, 2004).

- *Exploring alternatives* is working with the client to examine various options (Evans, et al., 2004).

- *Self-disclosure* is when the clinician shares something about him/herself for the benefit of the client (Evans, et al., 2004).

- *Confrontation* involves the use of a statement or question to raise some discrepancy within the client (Evans, et al., 2004).

- *Immediacy* consists of dealing openly with issues that are present in the clinical relationship (Evans, et al., 2004).

Corey and Corey (2002) indicated that effective helpers have a healthy self-concept, hold positive beliefs about people, are aware and respectful of cultural differences, have the ability to listen and understand, and posses empathy, congruence, warmth, compassion, genuineness, and positive regard.

B. Types of Available Treatment

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

  – A setting in which the entire course of treatment takes place without removal from the community or disruption of the client's occupational status

  – Can be an initial point of contact for many individuals who may enter treatment as a walk-in or because the agency is known to an employer or family member

  – Aftercare can be provided to clients referred upon discharge from an inpatient program

- *Intensive outpatient programs (IOPs) or intensive outpatient treatment programs (IOTPs).* A more structured setting in which the client is present at the facility from about 10 to 30 hours per week. IOPs/IOTPs fill a gap between outpatient and inpatient care while costing about half of residential treatment. These programs also allow clients to continue in work and family life, they promote bonding among clients, and they allow clients to practice relapse-prevention techniques in real-life situations (Johnson, 2004).

- *Inpatient treatment programs.* Involves a live-in setting with a stay of 4 weeks and includes therapeutic communities with a stay from 4 to 24 months. Inpatient programs may be medical or non-medical, and may or may not include a detoxification unit. Individual, group, and family treatment may occur as well as education and relapse prevention training (Johnson, 2004).

- *Chemical substitution program, such as methadone-maintenance.* The systematic dispensation of a legal drug that enables the addicted client to attain social stability, stop criminal activity, and enter the educational and occupational world. Methadone maintenance is effective because it is administered orally; in controlled doses; can be administered once a day; and the rushes, highs, and lows are absent, and the client can function appropriately in society (Johnson, 2004).

C. Group Counseling

Yalom's eleven therapeutic factors of group treatment

1. *Instillation of hope.* By watching other group members get better, clients begin to believe that they can get better also.

2. *Universality.* Clients often enter therapy feeling that they are all alone. In the group, clients hear others share similar problems, concerns, experiences, and other aspects of their lives, and they begin to feel that they are not alone.

3. *Imparting of information.* Clients can learn more about their illness, symptoms, and behavior from education provided by the group therapist. They might also receive advice and direct guidance from peers about how to deal with their problems.

4. *Altruism.* Clients often enter treatment with the belief that they have nothing of value to offer others. In groups, clients learn that they are capable of helping others. Their self-esteem is enhanced as a result of helping others, and they become less absorbed in their problems.

5. *The corrective recapitulation of the primary family group.* The group therapy situation resembles the early family in a number of ways; thus clients have the tendency to re-experience old family conflicts within the group. The group

therapist challenges any maladaptive behavior patterns and roles, because the behavior or role that the client took on in his/her family of origin is often exhibited in the group. If the behavior or role is dysfunctional, it can be corrected rather than allowed to continue in the group.

6. ***Development of socializing techniques.*** Group therapy helps clients develop social skills. Some groups do so by using such procedures as role-playing in which members rehearse certain difficult situations (a job interview, asking for a date, etc.), while other groups offer constructive criticism. Members of groups learn to listen, respond to others, avoid interrupting while others are talking, be less judgmental, and be more capable of expressing empathy. These skills will be of great value in future social interactions.

7. ***Imitative behavior.*** Group members often model their behavior after behavioral aspects of other group members as well as that of the therapist.

8. ***Cohesiveness.*** This is the sense of "groupness" or closeness, of being accepted, and of being a valued member of a valued group. This satisfies the need to belong.

9. ***Interpersonal learning.*** Given enough time, persons will behave in the group in ways similar to how they behave outside the group. Maladaptive behavior that disrupts the client's adjustment to society is reactivated as he/she interacts with others in the therapy group. The group helps individuals develop adaptive and more gratifying interpersonal relationships. Interpersonal learning involves the identification and modification of maladaptive interpersonal relationships.

10. ***Catharsis.*** The open expression and release of feelings is an important part of group therapy. Group members learn how to express feelings. They also learn that the expression of feelings is not socially wrong.

11. ***Existential feelings.*** The existential frame of reference states that to a certain degree, anxiety and sickness exist because of a person's confrontation with certain "ultimate concerns" of existence, such as death, freedom, isolation, and meaninglessness. Group therapy deals with these concerns realistically as group members openly discuss their concerns (Yalom, 1995).

All 11 therapeutic factors are present in substance abuse groups. Clients gain hope as they watch other group members recover; they learn that they are not alone in their drug addiction; they model their behavior after positive behavior from other group members; and they learn that the expression of feelings in group is an important tool in recovery.

Goals of group therapy

While the members of a specific group decide the specific focus or goals of a group, Corey and Corey (2002) indicate the following as some of the broad goals common to most groups:

- Interpersonal learning
- Learning to trust one's self and others
- Develop conflict resolution skills
- Learn how one's culture affects personal decisions
- Increased social skills
- A greater empathetic understanding of the needs of others
- Learn to confront appropriately
- Identify plans for changing behavior
- Assistance and support as the client works to recover

Stages of group development (Tuckman & Jensen, 1977)

1. *Forming.* The first phase of group development. Members may be somewhat uncomfortable with each other. The leader may need to be quite active in this stage until members learn to trust each other.

2. *Storming*. The power and control stage. Members vie for the pecking order and to take some of the power from the leader, so that it can become their group. The leader needs to be quite active in managing conflict so that the group continues to feel safe. Flexibility is of the utmost importance in this stage.

3. *Norming.* Intimacy stage. The group is beginning to build cohesion.

4. *Performing.* A cohesive group. Members are more comfortable and able to help each other grow and change.

5. *Mourning (adjourning).* Separation stage. Occurs when members terminate, especially long-term members. The facilitator gets a new job and the entire group ends. In substance abuse groups this phase needs to be handled well, as many clients relapse around issues of loss. The leader may need to be quite active in this phase, facilitating feelings around separation.

Yalom's four stages of group development (Corey & Corey, 2002)

1. Initial (Orientation)
2. Transition (Conflict)
3. Working (Cohesion)
4. Termination

Tasks of the group leader

- Help build cohesion
- Manage conflict
- Dismantle subgroups
- Deal with challenging group members
- Deal with relapse
- Support members in their recovery efforts
- Develop group cohesion

D. Crisis Intervention and Suicide

- *Crisis.* An acute physical and/or emotional event. An event, occurring during treatment that threatens to impact progress. For addicted clients, crisis often increases the risk of relapse.

- *Crisis intervention.* "Those services which respond to an alcohol and/or other drug abuser's needs during acute emotional and/or physical distress." (Herdman, 2001)

Steps in crisis intervention

1. *Establish a helping relationship.* Help the client achieve symptom relief.

2. *Assure safety.* To self or others as well as the client's safety from others. Help the client return to his/her level of functioning prior to the crisis

3. *Conduct an assessment.* Discover what caused the crisis (death in the family, loss of job, end of a relationship, etc.).

4. *Give support.* Provide resources and support to remedy the situation. If the client is dealing with a loss, a referral to a grief support group may be appropriate.

5. *Assist with action plans.* Because the client may be in such a state of distress, it may be necessary to identify some action step that will bring the client toward a pre-crisis state at the first session. Counselors may be more directive than usual. Help the client gain insight (connect current stress to past experiences in order to grow).

6. *Arrange for follow-up*. Help the client develop coping skills (Welfel & Patterson, 2005

What to do

- Intervene right away. A crisis often gets worse without immediate intervention.

- Instill hope
- Provide support
- Problem solve right away rather than striving for insight
- Provide positive feedback

Stages of crisis intervention

1. *Assessment stage.*

   - Discover what led to the crisis.
   - Look at precipitating events.
   - Assess the client's present psychosocial state.
   - Collaboratively define the problem with the client.

2. *Implementation*

   - Gather more data from the client.
   - Discuss how the client dealt with similar crises in the past.
   - Identify client's strengths, resources, and supports that can possibly help with the crisis.

3. *Termination.* This should be a mutual decision.

Suicide—What to assess

- *Plan.* How clear is the client's plan? The more detailed the plan, the greater the concern.

- *Is it a suicidal attempt or an ideation (idea)?*

- *Method and means.* Discover how the client plans to commit suicide. Does he/she have a gun, pills, etc.?

- *Family history of suicide.* Suicide runs in families.

- *Previous attempts.* Previous suicide attempts increase the risk of suicide.

- *Recent use of chemicals.* Recent substance use increases the risk of suicide.

- *Determine sources of support.*

- Help the client *develop a suicide prevention plan.*

- Make sure you *consult with your supervisor* and a consulting psychiatrist when working with a suicidal client.

E. Theories of Counseling

1. Analytic-oriented therapies

(a.) Psychoanalytic theory

(i.) *Originator.* Sigmund Freud

(ii.) *Focus of psychoanalytic theory.* Resolving unconscious conflicts from the past.

(iii.) *View of human nature.* One's behavior is determined by irrational forces, unconscious motivation, and biological and instinctive drives, as they evolve through key psychosexual stages of development. Freud believed that the mind is made up of three forces, which interact with each other in order for us to make decisions. He also believed that these three forces are in conflict with each other. The three forces, described below, are the Id, Ego, and Superego:

- The *Id* is the primitive part of the personality. Freud believed that at birth the child is all id. The id is the unconscious part of our personality and operates on the pleasure principle, whose goal is to gain pleasure and avoid pain.

- The *Ego* is the conscious part of our personality that operates on the reality principle, the realistic and logical part of the personality. The goal of the ego is to take care of id impulses without harming the superego.

- The *Superego* is the conscience, a person's moral code; the part of the personality that is aware of right and wrong; the judicial part of the personality; the internalization of the moral standards of parents and society.

Freud believed that when something is threatening to our ego, anxiety occurs and we instinctively develop defense mechanisms to cope with the anxiety and relieve or block emotional pain. Some of the defense mechanisms include the following:

- *Denial* is pretending that something that is true is not true.

- *Repression* is involuntary removal of threatening thoughts, experiences, and feelings from our consciousness. Freud believed that many of our painful experiences of the first 5 years of our lives are repressed, buried in our unconscious minds.

- *Projection* is attributing to another what you are actually experiencing. This unconsciously allows one to avoid dealing with his/her own experiences.

- *Rationalizing* is making excuses for unacceptable behavior. This allows one to avoid the pain of the behavior.

- *Minimizing* is the unconscious process of making problems seem less severe than they actually are.

- *Compensation* is developing positive traits to unconsciously mask weaknesses and mistakes.

(iv.) Goal of psychoanalytic therapy. To bring material from the unconscious mind to the conscious awareness so that one can change (insight); to work through unresolved issues from various psychosexual stages of development.

(v.) Techniques utilized in psychoanalytic therapy include:

- *Interpretations.* The therapist acts as an expert in interpreting the meaning of the patient's concerns and the meaning of unconscious material.

- *Free association.* Historically, the therapist sat behind the patient so that expressions of shock and judgment wouldn't affect the client's disclosure. The client would then be asked to "free associate," that is, to state aloud the first words that came to his/her mind. Psychoanalysts believe this material comes directly from the unconscious mind and is useful material for interpretation.

- *Dream interpretation.* The analyst listens to dreams and believes that a great deal of unconscious material can be uncovered in dreams.

- *Transference.* The patient unconsciously responds to the analyst, as if he/she were a significant other from his/her past, often a parental figure. Psychoanalysts encourage transference, believing they can help the client have a corrective parental experience. Analysts should also be aware of *countertransference* reactions—negative feelings that are stirred up in the analyst as he/she interacts with the patient— as the patient may remind the analyst of someone from his/her past (Corey, 2005).

(vi.) A psychoanalytic view of alcoholism. A psychoanalytic view of alcoholism involved the oral stage of development. The oral stage covers

the period from birth to about 18 months. During this phase, the infant's main source of libidinal gratification is derived from sucking, which of course, involves the mouth, lips, and tongue. As the infant's needs for oral gratification are fulfilled, he/she is free from a state of tension and frustration. This satisfied state induces calm in the infant and allows him/her to sleep. The theory of psychoanalysis asserts that these dynamics form one's basic orientation to frustration. Persons who never had their oral needs met during infancy tend to anticipate disappointment at every turn and adopt a pessimistic outlook on life.

Alcoholism is thought to be an ineffective and destructive attempt at resolving conflict from the oral period. Thus, it has been described as an "oral fixation." Alcoholics are persons with unmet oral needs who are easily frustrated and thus turn to the bottle for relief. The act of drinking, especially from a bottle, is thought to be symbolic of a desire to return to the security and comfort of suckling from the mother's breast.

The psychoanalytic view of substance abuse includes the seeking oral gratification and that chemical dependence stems from an unconscious death wish and self-destructive tendencies of the id.

(vii.) Addiction counseling and psychoanalysis. The focus on addressing issues of denial and other defense mechanisms in addictions treatment is influenced by psychoanalysis. Modern analysts believe that clients may not be ready for deep insight until a period of abstinence has been achieved and that rapport building with addicted clients may be more important than free association.

(b.) Adlerian therapy

(i.) *Originator.* Alfred Adler

(ii.) *Focus of Adlerian therapy.* Helping clients see how issues from their past continue to influence them and to help them resolve issues from their past (insight oriented therapy)

(iii.) *View of human nature.* What an individual becomes in life is greatly influenced by the first 6 years of life. Sibling order, as established in the early years of life, plays a dramatic role in shaping a person's life. Individuals possess feelings of inferiority, which are a result of inborn and social conditions (sibling order, not reaching goals, etc.).

(iv.) *Goal of Adlerian therapy.* The goal of Adlerian therapy is to correct faulty assumptions and mistaken goals. Help a client move beyond feelings of inferiority as he/she works to achieve the following five life tasks:

- Relating to others (friendship)
- Making a contribution (work)
- Achieving intimacy (love and family relationships)
- Getting along with ourselves (self acceptance)
- Developing our spiritual dimension (meaning connectedness, relationship with the universe)

*(v.) Techniques of Adlerian therap**y***

- Build relationships to establish an egalitarian relationship and to work on agreed-upon goals.
- Explore mistaken goals and faulty assumptions.
- Help clients develop their social interests and goals
- Do a comprehensive assessment of the client's functioning.
- Explore sibling order and impact of sibling order on current behavior.
- Help clients achieve the five life tasks (Corey, 2005).

2. Experiential and relationship-oriented therapies

(a.) Existential therapy

(i.) Originators. Viktor Frankl and Rollo May

(ii.) Focus of existential therapy. The focus is on the human condition and includes the capacity for self-awareness, freedom to choose one's fate, anxiety, responsibility, the search for meaning, relationship with self and others, and facing death as a reality.

(iii.) Goal of existential therapy. The goal of existential therapy is to assist clients to see that they are unrestricted and to become aware of their possibilities, to help them recognize that they are responsible for the events that happen in their lives, and to assist them in being able to identify those things that restrict their ability to choose.

(iv.) Techniques of existential therapy. Existential therapy focuses on understanding first and technique second so the counselor can borrow techniques from other therapeutic approaches.

(v.) Application for existential approach. The existential therapeutic approach is suited for clients dealing with a developmental crisis or a transition in life and for those with concerns about making choices, dealing with the freedom of making choices and responsibility, dealing with guilt and anxiety, realizing values, or trying to make sense of life (Corey, 2005).

(vi.) *Addictions counseling and existential therapy.* Because of the nature of addiction and the ill-defined concepts of Existential therapy, it may not be ideally suited for clients in the first stages of recovery when mental functioning may be impaired or are in crisis and need direction. It might be better suited for those in middle and late-stage recovery to assist them in dealing with life issues related to how they relate to being alone, their relationships with others, and their freedom to make life choices.

(b.) Gestalt therapy

(i.) *Originator.* Fritz Perls

(ii.) *Focus of gestalt therapy.* An experiential therapy geared toward helping clients gain awareness of what they are experiencing and doing in the here and now.

(iii.) *Goal of gestalt therapy.* Helping clients deal with unfinished business from the past in the here and now.

(iv.) *Gestalt therapy is influenced by:*

- Psychoanalysis—Perls was originally a psychoanalyst.

- Gestalt Psychology

- Psychodrama—Therapeutic acting (reenactments), helping clients rewrite scripts or deal with unfinished business

- Existential therapy—It is up to the individual to find his/her purpose in life.

   Perls believed that nothing exists except the here and now, that the past has gone, the future has not arrived, and only the present is significant. Gestalt therapy differs from psychoanalysis in that instead of focusing on the past, it deals with unfinished business in the here and now.

(v.) *What about unfinished business?*
- Resentments
- Rage
- Hatred
- Unresolved grief

(vi.) *Techniques of gestalt therapy.* Unfinished business persists until it is dealt with. Gestalt therapists deal with unfinished business in the here and now, using experiential methods such as the following:

- The empty chair—A client has strong resentments against his/her father who has died. While the client sits across from an empty chair, the therapist helps him/her deal with unfinished business by pretending that his/her father is sitting in the empty chair and shares feelings geared toward working through the resentments.

- Letter writing—Writing a letter that addresses unfinished business and reading the letter aloud

- Role playing

- Psychodrama

- Re-enactments (Corey, 2005)

(vii.)   Addiction counseling and gestalt therapy. Many addiction counselors believe that unfinished business (resentments, unresolved grief, etc.) is a leading cause of relapse. Some counselors actually use Gestalt techniques in individual and group work; particularly role-plays, empty chair work, and letter writing. Counselors often help clients develop tools that help them deal with powerful emotions, such as rage, connected to their pasts.

(c.) Person-centered therapy

(i.)   Originator. Carl Rogers

(ii.)   Focus of person-centered therapy. The here and now.

(iii.)   View of human nature. People are trustworthy, resourceful, and capable of resolving their own problems. Three characteristics of the therapist help create the kind of climate in which clients can examine their own problems and change. The three characteristics are:

- Unconditional positive regard (acceptance of and caring for the client)
- Genuineness (congruence)
- Accurate empathy

(iv.)   Goals of person-centered therapy. This is a client-directed therapy. The concept of "staying where the client is" comes from person-centered therapy, a non-directive form of therapy. The goal of person-centered therapy is to provide a climate that will enable clients to reach many of their own conclusions, develop congruence, change, and grow.

(v.) *Techniques of person-centered therapy.*

- The use of personal characteristics (genuiness, empathy, unconditional positive regard, and a relationship of equals).

- Ask open-ended questions and use attending skills to help keep the conversation going and to build rapport (Corey, 2005).

(vi.) *Addiction counseling and person-centered therapy.* Many ideas about building rapport with addicted clients come from the person-centered approach, namely: empathy, genuineness, caring, acceptance (unconditional positive regard), asking open-ended questions to facilitate the building of rapport, etc. Many counselors believe that building a strong therapeutic relationship is the beginning foundation of helping clients recover.

3.   Action-oriented therapies

(a.)   Reality therapy

(i.)   Originator. William Glasser

Trained as a classic psychoanalyst and working as a consulting psychiatrist in the Vienna School for Girls, he was frustrated, because psychoanalysis was not working with this population. He developed a form of therapy known as reality therapy.

(ii.)   Focus of reality therapy. Helping clients to change in the here and now.

(iii.) View of human nature. Human beings have two basic needs:

- To love and be loved by others

- To feel worthwhile to self and others

Glasser believes that when these two basic needs are not met, people will exhibit symptoms (delinquency, crime, violence, drug abuse, etc.).

(iv.)   Goal of reality therapy. A major goal of reality therapy is to hold people accountable for their behavior and to teach them better and more effective ways of getting their needs met.

(v.) Techniques of reality therapy.

- Challenge inappropriate behavior. ("Just because you use drugs does not give you the right to steal from your mother and violate others.")

- The therapist does not accept excuses for irresponsible behavior.

- As a here-and-now therapy, the therapist focuses on what the client is doing rather than why.

- The therapist believes in natural consequences for behavior rather than punishment.

- Emphasize responsibility. ("Regardless of your problem, it is not right to make other people suffer.")

- Focus on the client's strengths.

- Actively discuss the client's current behavior.

- Discourage excuses for irresponsible and ineffective behavior.

- Help clients achieve goals.

- Help clients find constructive ways to meet their basic needs.

(vi.) *Unique characteristics of reality therapy.*

- Rejection of the medical model and de-emphasis on diagnosis.

- Helping clients develop successful identities and positive addictions (distance running, meditation, etc.).

- Emphasis on responsibility. "Even with your problems, you are still responsible for your behavior."

- De-emphasis on transference, encouraging the counselor to be him/herself, not "hiding behind" being like the parent (Corey, 2005).

(vii.) Addiction Counseling and Reality Therapy. Many addiction counselors believe in holding clients accountable for their behavior and that there are natural social consequences for behavior. Many feel that to avoid holding clients accountable for their behavior is a form of enabling.

(b.) *Rational emotive behavior therapy*

(i.) *Originator.* Albert Ellis

(ii.) *Focus of rational emotive behavioral therapy.* The here and now.

(iii.) *View of human nature.* Rational emotive therapy is based on the belief that people are born with the potential for rational or irrational thoughts. People learn irrational beliefs from significant others as children. Since these thoughts are learned, people have the power to change their thoughts and their behavior, as irrational thoughts can lead to self-destructive behavior.

(iv.) *Goal of rational emotive behavior therapy.* To assist clients to confront faulty or irrational beliefs with evidence they gather that contradicts those beliefs, and to assist clients to become aware of their automatic thought processes and to learn to change them.

(v.) *Core beliefs that cause disturbances.*

- It is necessary to be loved by all.
- One should be thoroughly competent.
- Things are awful if they are not exactly the way I want them to be.
- I must have approval from all significant people in my life.
- It's easier to avoid dealing with life's difficulties than to strive for more rewarding endeavors.

(vi.) *Some of the results of irrational beliefs are:*

- Self criticism

- Isolation

- Self abuse

- Avoiding relationships

- Never striving to reach potential

- Drug use, etc.

(vii.) *Techniques of rational emotive behavioral therapy.* Using a variety of cognitive, emotive, and behavioral methods, particularly the A-B-C approach, to help clients challenge and minimize their irrational beliefs, so that they are able to change.

(viii.) *The A-B-C approach.*

- Activating event (something occurs)

- The individual's belief about the event (if the person is thinking irrationally, his/her view is often distorted)

- Emotional and behavioral consequence of the belief, often a painful consequence

(ix.) *Example.*

- Client calls his mom on the phone. His mom says, "I have to go; I'll talk to you later." She quickly hangs up the phone. (Activating event)

- (Client's irrational belief) "I am unlovable; my own mom hates me."

- (Emotional consequence of the belief) The client goes to a tavern and gets drunk.

(x.) *The therapist helps clients change irrational beliefs, using the following:*

- Disputing and challenging irrational beliefs. The following are methods of challenging irrational beliefs:

  - Detecting irrational beliefs (Clients are helped to see that words such as "ought," "should," "must," "always," or "never" lead to irrational beliefs.)

  - Clients are helped to dispute irrational beliefs by paying attention to the exception to the rule. (Client statement: "I am stupid." Therapist: "When is that not true?")

  - To argue themselves out of the belief.

  - To search for evidence that the belief is not true.

  - Homework. Give clients assignment to check on assumptions. ("Instead of assuming that your mother hates you, ask why she did not stay on the phone long.")

- The client arrives at an effective philosophy, which is rational. The new philosophy replaces irrational thoughts with rational thoughts.

(xi.)   *Other therapist techniques.*

- Help client stop thinking irrationally.

- Help client eliminate self-defeating habits and behavior.

- Help client accept self and others (Corey, 2005).

(xii.)   *Addiction counseling and rational emotive behavioral therapy.* Addicted clients have many irrational beliefs, which contribute to their continued drug use, such as the following:

- "I am a terrible person."

- "I am unlovable."

- "I mess up everything."

- "I am a loser."

The self-help community calls these thoughts "stinkin' thinkin'." Counselors often help clients recover by helping them challenge these beliefs.

(c.) Cognitive behavioral therapy

(i.)   *Originator.* Aaron Beck (This model is similar to Rational Emotive Behavioral Therapy developed by Albert Ellis. A primary difference is that Rational Emotive Behavioral Therapy is more directive and the therapist is more in a teaching mode. Beck uses more Socratic questions to help clients reach their own conclusions.)

(ii.)   *Focus of cognitive behavioral therapy.* The here and now.

(iii.)   *View of human nature.* Individuals with emotional problems often have faulty thinking as a result of having inadequate or incorrect information.

(iv.)   *Goal of cognitive behavioral therapy.* The goal of cognitive behavioral therapy is to help clients change faulty thinking and thus modify behavior by teaching clients how to identify and challenge these faulty beliefs cognitively (thinking). Beck calls these faulty beliefs cognitive

distortions, and they include the following:

- Over-generalization

- Minimization—making a situation smaller than it actually is

- Magnification—making a situation seem greater than it actually is

- Personalizing events

- Arbitrary inferences—reaching conclusions without evidence

- Labeling yourself ("I'm stupid")

- Polarized thinking (black or white thinking)—thinking things are either all good or all bad ("I am either all good or all bad.")

(v.) *Therapeutic procedure.*

- Explain cognitive behavioral therapy

- Ask client to monitor his/her thoughts and the feelings and behaviors that accompanies those thoughts

- Challenge the client's thought process

- Help client challenge his/her beliefs and assumptions

- Help client develop coping skills

(vi.) *Techniques of cognitive behavioral therapy.*

- Challenge assumptions and faulty beliefs through Socratic questions, such as:

  – Where is your evidence that that is true?

  – Where did the evidence come from?

  – What is the worst thing that could happen if you continued to think this way?

  – What is the worst thing that could happen if you changed your thinking?

– Giving homework to test their beliefs in the real world.

– Instilling hope—letting clients know that others have had similar problems and turned their lives around (Corey, 2005).

(vii.) *Addiction counseling and cognitive behavioral therapy.* The field of addictions continues to move in the direction of evidence-based practice. There have been a number of studies with positive outcomes using cognitive behavioral therapy with cocaine addicts and chronic relapsers.

4. Brief therapies

Brief interventions and therapy approaches are time limited, structured, and directed toward a specific goal. They follow a specific plan and have timelines for the adoption of specific behaviors and include the transtheoretical model (stages of change model) and constructivism.

(a.) The transtheoretical model (Stages of Change model)

(i.) *Originators.* J. O. Prochaska and C.C. DiClemente

(ii.) *Focus of transtheoretical model.* The clinician can use brief interventions to motivate particular behavioral changes at each stage of this process. Understanding these stages can help the clinician to accept a client's current position and avoid getting ahead of the client and provoking resistance.

(iii.) *Goal of transtheoretical model.* The basic goal is to reduce the client's risk of harm from continued use of substances. Specific goals for individual clients is determined by the consumption pattern, consequences of use, and the setting in which the brief intervention is delivered. The key is to extract a single, measurable behavioral change from the broad process of recovery that will allow the client to experience a small, incremental success and help clinicians develop brief interventions tailored to clients' needs. This model describes the following five stages of client readiness for change:

- Precontemplation—user is not considering change, not recognizing that a problem exists.

- Contemplation—acknowledging the problem, the user is ambivalent about change.

- Determination (Preparation)—begins once the user has decided to change and begins to plan steps toward recovery.

- Action—putting the plan for change into action, user tries new behaviors, but these are not yet stable.

- Maintenance—user establishes new behaviors on a long term basis, keeping up the changes.

(iv.) *Applications.* An abstainer can be educated about substance use with the aim of preventing a substance abuse disorder; a light or moderate user can be educated about guidelines for low-risk and potential problems of increased use; can address an at-risk-user on the level of use, encourage moderation or abstinence, and educate about consequences of risky behavior and risks associated with increased use; with an abuser, can prevent any increase in the use of substances, facilitate introspection about the consequences of risky behavior, encourage client to consider assessment or treatment, and encourage moderation or abstinence; with a substance-dependent user, encourage user to consider treatment, contemplate abstinence, return to treatment after a relapse, or recommend the optimal behavioral change and level of care (Connors, Donovan, & DiClemente, 2001; CSAT, 1999).

(b.) Constructivism

(i.) *Originator.* George Kelly, expanded by Neimeryer and Mahoney. (Suggests that people have a system of constructs and symbols that reflect their view of themselves and their world. Clinicians view problems as an expression of a discrepancy between people's adaptive capacities and the current demands of their environment (Mahoney, 1988).

(ii.) *Focus of constructivism.* Treatment begins with a focus on current problems and distress, then shifts to an exploration of patterns or recurrent difficulties, and finally moves on to understanding the processes that contribute to the continuation of the problem. Clinicians pay considerable attention to background and believe that early attachment plays an important part in shaping who we are.

(iii.) *View of human nature.* Constructionists view people generally in positive and optimistic terms, seeing them as "pro-active, goal-directed, and purposive organisms" (Neimeryer 1993). People operate according to the knowledge they possess which reflects their perspective on their experience and reflects their actions.

(iv.) *Goal of constructivism.* Help people develop possibilities to recognize that experiences have a variety of alternative meanings and interpretations. People's knowledge can then be assessed and either changed or validated, leading to knowledge that allows more satisfying ways of being.

(v.) *Applications.* Constructivism is being applied to a wide range of concerns and settings. Used in schools to promote active, social, and creative learning; used with couples and families; and used to treat a broad range of problems and mental disorders, including attention deficit disorder, post-traumatic stress disorder, and grief (Seligman, 2001).

(vi.) *Addiction counseling and constructivism.* Counseling is a very intimate and personalized exchange between human beings. In treatment, both embark on exploration. Clinicians do not direct the process or seek to persuade, analyze, or instruct. They use reflection, elaboration, and metaphors to advance the process. They serve as co-investigators helping clients construct a more rewarding way of being and coping.

5. Systems perspective-oriented therapies

(a.) Feminist therapy

(i.) *Originators.* Helene Deutsch and Karen Horney. (Originally developed by psychodynamic and developmental theorists as a reaction to Freud's lack of understanding of women. Seeks to acknowledge and counteract women's limited and often inferior roles and to broaden and legitimize women's perspectives. This approach has evolved out of recognition that both genders are harmed when constrained by narrow and hierarchical roles and relationships. Has the potential to help both men and women change themselves and their societies and act together to make a difference (Forcey and Nash, 1998).)

(ii.) *Focus of feminist therapy.* Helps women value their traditional roles while examining the discriminatory aspects of their societies and recognizing that they need not be limited to the roles of mother, wife, and caregiver or have an identity that is restricted to the spiritual, nurturing, and emotional. Particular attention is paid to the unique roles of women such as motherhood and the mother-daughter bond in a way that recognizes their great value and gives the message that biology need not be destiny, that they have control over their own lives.

(iii.) *View of human nature.* Challenges many of the traditional views of human nature in which social arrangements are assumed to be rooted in a person's gender. Gender-biased theories have clear limitations where gender-free theories explain differences in the behavior of men and

women in terms of the socialization processes.

(iv.) *Goal of feminist therapy.* Seeks to give women a shared view of their social position and a sense of community with other women while affording them greater power as well as new possibilities and ways of seeking knowledge. Stresses the importance of relationships that respect diversity, inclusiveness, and plurality rather than discrimination. The overriding goals are client empowerment and social transformation.

(v.) *Application.* Feminist therapy has considerable potential for both good and harm. It can contribute to anger and distance between genders, or it can provide great service because of its emphasis on the human potential and people's ability and right to make choices that will enable them to live their lives in rewarding ways. Can be used in family, sexual misconduct, domestic violence, and psychological abuse counseling. (Corey, 2005; Seligman, 2001).

(vi.) *Addiction counseling and feminist therapy.* Many of the principles of feminist therapy can be incorporated in addiction counseling. Choosing for oneself instead of living life determined by social dictates, the importance of a collaborative relationship, learning coping skills, and by encouraging positive social activism.

(b.) Family systems therapy (multigenerational family therapy)

(i.) *Primary developer.* Murray Bowen

(ii.) *Focus of family systems therapy.* Past and present, three generations in the family of origin. In the 1950s Bowen was working with schizophrenic patients in a hospital. He noted that schizophrenics often made progress in the hospital, but when they returned home, they often became ill again. Bowen postulated that perhaps the family plays a role in the patient's illness. He then began working with the entire family and began to believe that the family is a system similar to other systems (the Solar System, the human body, etc.), with everyone in the system affecting everyone else in the system, with no one being the blame or the cause of the problem.

(iii.) *Some observations about the family system.*

- What happens with one person in a family affects everyone else in the family.

- When anxiety pervades the family, the tendency toward togetherness is most observable (family enmeshment).

- Families strive for homeostasis. Families have their sense of comfort. They often resist change by returning to where they started. Example: Family members say they want their alcoholic relative to stop drinking. However, he/she has been drinking for 30 years. They are accustomed to the drinking. They may unconsciously engage in behavior (e.g., putting liquor in the refrigerator) to increase the chance that the drinking will continue, upsetting the alcoholic, so that he/she is likely to drink.

- Family members are often ambivalent about the chemically dependent family member getting sober. Sobriety can upset the homeostasis (balance); they may therefore resist change.

- Systems theorists do not believe the "identified" patient (e.g., the alcoholic) is the cause of all the family problems.

- Families resist change.

- Change in one family member automatically leads to change in other family members.

- Problems in families can occur generation after generation after generation. (Bowen introduced the field to genograms, in which he would trace problems in families over three generations.)

(iv.) *The cornerstones of family systems theory.*

- Differentiation of self—The ability of family members to preserve a degree of autonomy in the face of pressure for togetherness.

- The triangle—A two-person relationship is unstable when tense or anxious. When anxiety exceeds a tolerable level, they will automatically involve a significant third person.

- Nuclear family emotional process—Marital partners have similar levels of differentiation and undifferentiation.

- The multigenerational transmission process—The process in the family operates generation after generation.

- Emotional cutoffs—The way family members try to distance themselves from over-attachments in the family of origin. Examples include running away, disappearing, drug use, etc. Bowen believed that the only healthy way to leave a family is through differentiation. He believed that running away or disappearing from an unhealthy or

enmeshed family system set one up to enter an equally enmeshed relationship. An example is a 16-year-old child who runs away from an enmeshed addicted family and winds up in a cult.

(v.) *Goal of family systems therapy.* The main goal is the differentiation of self for all family members. This helps to decrease anxiety and enmeshment. The therapist tries to remain neutral and stay out of triangles and to avoid getting enmeshed in the family system. If the teenager or child is the "identified patient," Bowen does most of the family work with his/her parent(s), believing that problems in children and adolescents are connected to parental problems (Lawson, & Lawson, 1998).

(vi.) *Addiction counseling and family systems therapy (multigenerational family therapy).* Many addiction counselors who work with families view addiction from a systems perspective. Addictions counselors also work to decrease "anxiety" and enmeshment by getting family members to focus on their own recovery (seek counseling for co-dependence, attend Alanon meetings, etc.)

(c.) *Human validation process model (communications therapy)*

(i.) *Originator.* Virginia Satir

(ii.) *Focus of the human validation process model (communications therapy).* The here and now.

(iii.) *View of human nature.* Satir believed that it is unnecessary to delve deeply into a family's past in order to help facilitate change. She believed that how family members communicate in the present is based on their past.

(iv.) *Goal of the human validation process model (communications therapy).* The primary goal is to teach family members how to communicate effectively in the here and now.

(v.) *Role of the therapist.*

- To model healthy and congruent communication

- Be a facilitator

- Be a resource person

- Be an investigator

(vi.) *Techniques of the human validation process model (communications therapy).*

- The therapist will exemplify clear communication—asking for clarification, repeating statements made by family members to make sure they understand, repeating statements more than once for clarification.

- The therapist will help family members be aware of incongruent messages that block communication. "You say you're happy, but you look sad."

- The therapist will help family members learn how to check on assumptions. Instead of pretending that every family member has a crystal ball and can read your mind. "Ask him/her what he/she is thinking instead of assuming you know."

- The therapist will help family members say what they mean.

- The therapist will communicate that all family members are important. Satir often spent a great deal of time interviewing the children with the parents watching. This sends the message to parents that their kids are important.

- The therapist will not accept the notion that the identified patient is the cause of all family problems, a belief held by Systems theorists as well.

- The therapist works toward strengthening the parental relationship, believing that problems in children often have to do with poor communication in the parental relationship.

- The therapist makes sure that no one speaks for anyone else. Satir noticed that one sign of poor communication in families is enmeshment. Examples are family members finishing sentences for each other, interrupting each other, etc.

- The therapist interprets anger as hurt. When family members are angry with each other, it is more difficult to communicate, getting in touch with the gentler emotions, the hurt that lies underneath the anger helps.

(vii.) *When is therapy complete?*

- When family members can speak for themselves.

- When they can send clear messages.

- When they know how to check on assumptions.

- When they can communicate their hurts, dreams, wishes, and aspirations.

- When they can see how other family members view them.

- When they are aware of how they view themselves (Lawson, & Lawson, 1998).

(vii.) *Addiction counseling and the human validation process model (communications therapy).* Many addictions counselors are aware of enmeshed and unhealthy communication among family members in addicted families. Some counselors work to help family members listen to each other more, interrupt each other less, and speak for themselves.

(d.) Structural family therapy

(i.) *Originator.* Salvador Minuchin

(ii.) *Focus of structural family therapy.* The present and past.

(iii.) *Goal of structural family therapy.* The goal is to modify the present. Since the past was important in determining the family's present functioning, it is manifested in the present and will be available to change by interventions that change the present.

(iv.) *Tasks of the therapist.*

- Assess the structure of the family. The following are three subsystems that can be observed in a nuclear family:

  – Parent subsystem

  – Sibling subsystem

  – Sibling/parent subsystem

- Assess the nature of the boundaries within the family. The following are three types of boundaries commonly seen in families:

  – Clear boundaries

Firm yet flexible

Family members are supported and nurtured

A balance between autonomy and connectedness

Freedom to individuate

- Rigid boundaries (loose boundaries)

  There is too much distance between family members

  Family members are isolated from one another and from systems in the community

  Children fight for their own boundaries and negotiate for themselves without parental protection

- Diffuse boundaries

  Enmeshment

  The opposite of rigid boundaries

  Everyone is in everyone else's business.

  The parents are too accessible

  The necessary distinctions among the subsystems are not present

- To help restructure the family, create healthier/clear boundaries.

- Facilitate change in the actual sessions.

- The therapist assigns homework to consolidate changes made during sessions. For example, when working with an addicted family, the therapist observes that the mother and daughter have a poor relationship (rigid boundaries) and no communication. The mother and daughter are given an assignment to come up with an activity that they can do together to strengthen their relationship.

- The therapist works to strengthen various subsets within the family.

- The therapist works to loosen certain tightly enmeshed bonds. For example, Tom, the spouse of an alcoholic, has developed an enmeshed

relationship with his oldest daughter in response to his wife's alcoholism. In many ways, Tom treats his oldest daughter as though she were his wife. The structural family therapist holds several sessions with only the wife and husband present and also helps the couple identify activities that the mother and daughter can do together to strengthen their relationship, simultaneously decreasing the intensity of the daughter's enmeshment with her father (Lawson, & Lawson, 1998).

(v.) *Addiction counseling and structural family therapy.* Many addictions counselors are aware of boundary problems existing in addicted families and often recommend strategies to strengthen family relationships in recovery.

F. The Intervention Process

In the past it was commonly believed that an alcoholic could only recover if he/she hit rock bottom. In the 1970s Vernon Johnson of the Johnson Institute wrote a book entitled, *I'll Quit Tomorrow*, in which he outlined the intervention process, which, at that time, was a new approach to working with alcoholics.

The intervention process involves a meeting of family members and significant others of the addicted individual with the assistance of a trained counselor. An intervention can be successful when confrontation is used appropriately, in a detached and caring manner. Following are definitions of key terms and a discussion of intervention process:

Definition of key terms

- *Enabling.* Is unwittingly protecting a person from the full negative consequences of his or her behavior out of a sense of love, compassion, fear, or survival instinct. This behavior, while unintentional, helps to allow the problem to worsen. One goal of the intervention process is to eliminate enabling.

- *Intervention.* Is a process by which the harmful, progressive, and destructive effects of chemical dependency are interrupted and the chemically dependent person is helped to stop using mood-altering chemicals and to develop new, healthier ways of coping with his or her needs and problems. If applied, that person may not need to "hit rock bottom" before such help can be given. This approach involves presenting reality to a person who is out of touch with reality, in an objective, nonjudgmental, and caring way (Johnson, 2004).

Steps to doing an intervention

- The organizer usually begins by gathering an intervention team of meaningful persons who have either witnessed the drug-using behavior firsthand or who are

aware of the consequences of the use.

- After the intervention team participants are chosen, they begin to gather the data. Through homework, the participants make written lists of specific incidents or conditions related to the person's drinking or drug use that legitimize their concern. Each team member should explicitly describe a particular incident, preferably one that the writer observed firsthand. The written statement should contain no angry accusations or anything that is likely to make the chemically dependent person defensive.

- Rehearse and designate a chairperson. Go over each item on the written list that team members have prepared. Make sure items are written in a non-accusatory, nonjudgmental manner. Determine the order in which team members will read their lists. It's often helpful to have a very influential person go first. Rehearsals also allow you to find out if some members of the team may get too emotional.

- Determine realistic, caring, and firm steps you will take if the person does not get help at the end of the intervention. Make the decision to no longer enable.

- Find out about available treatment options prior to the actual intervention, including if there is an opening and what the financial costs will be.

- At the designated time and location, the participants come together and confront the individual about his or her chemical use.

The entire intervention process usually progresses well when guided by a trained counselor (Johnson, 2004).

Interventions can be successful, even if the addict does not get help because:

- By coming together for the first time, family members can be a source of support for each other.

- They can learn to discontinue enabling.

- They can receive help for themselves.

- It will be harder for the addict to deny that his/her drug use is a problem, because he/she has heard from family members and friends that the drug use affects them (Johnson, 2004).

G. The Therapeutic Community

Therapeutic communities are based on the idea that substance abuse is a disorder of the whole person and that recovery is a self-help process of incremental learning toward stable change in behavior, attitudes, and values of right living that are associated with maintaining abstinence (DeLeon, 1995). In other words, substance abusers need to learn a whole new way of being, to be resocialized so that they can function as a substance free person in the larger society. Not all residential drug abuse treatment programs are therapeutic communities.

Therapeutic communities are based on a social learning model. The goal is for clients to learn to be different by participating in a community that operates by different rules than the community from which they came. Clients learn these new rules together as they participate in the therapeutic community. It is estimated that at least 80 percent of parolees, probationers and criminal offenders have a substance abuse or dependence problem (O'Brien & Devlin, 1997).

According to DeLeon (1995) the components of the therapeutic community are:

- *Participant roles.* Members contribute directly to all activities of daily life in the therapeutic community.

- *Membership feedback.* Peers observe each other and offer authentic reactions to one another.

- *Membership as role models*. Each person models how change can occur.

- *Collective formats for guiding individual change.* Individuals attend groups, meetings, seminars, and recreation with others.

- *Shared norms and values.* The members agree on what is correct behavior and right living.

- *Structure and systems.* The community is organized so that members see how they depend on one another; members learn the value of living responsibly and respecting authority.

- *Open communication.* Personal information is shared to aid the individual's recovery and the recovery of other members.

- *Relationships.* The support of others provides encouragement.

According to DeLeon (1995), the basic components of a therapeutic community program also include:

- Being housed separately from the drug-related environment and other institutional programs.

- A community environment with shared (communal) space; messages of right living and recovery displayed on the walls, daily schedules, and the organizational structure of the community, and individual members' names are displayed.

- Community activities include preparing and serving meals, daily groups, meetings and ceremonies and rituals.

- All members are expected to act as role models.

- Staff is considered community members, who are rational authorities, role models, facilitators, and guides in the self-help community method.

- Days are formally structured with various activities that have fixed times and formats in order to teach self-structure, time management, and the planning, setting, and meeting of goals to members who may have lived very unstructured, disordered lives.

- The treatment is organized into phases that reflect a developmental view of the change process.

- Work is considered both therapeutic and educational.

- There is an organized therapeutic community curriculum, whose concepts are taught in groups, meetings, seminars, etc.

- Peer encounter groups are used.

- Members participate in awareness training, which raises consciousness about the reciprocal impact of one's own conduct and the conduct of others.

- Members participate in emotional growth training, which includes identifying and expressing feelings appropriately.

There is evidence that therapeutic communities are effective in helping some clients change. Be aware that methods used by early therapeutic communities, such as aggressive confrontation and awareness assignments designed to break clients down, are not supported by the evidence as being effective (Johnson, 2004). The professional practice of alcohol and other drug counseling requires that counselors be respectful of clients at all times. Interventions that humiliate the client, even if it is supposedly for the client's "own good," are not acceptable practice.

IV. Case Management

A. Introduction

Case management is a coordinated approach to the delivery of health, substance abuse, mental health, and social services so that clients are linked with appropriate services to address specific needs and achieve stated goals (CSAT, 2000, p. 1). The International Certification & Reciprocity Consortium (IC&RC) includes case management as one of the 12 core functions, describing it as activities that bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals.

A counselor may act as his or her clients' case manager, or a dedicated staff member may be assigned case management duties for several counselors' clients. In either situation, case management is important because, in most cases, several different people are involved in a client's comprehensive care, and they need to work together in a coordinated way. Clients' co-occurring disorders, physical illnesses, and disabilities must be considered in planning case management. Case management is necessary because clients often have multiple needs, and it is rare that all of the necessary services are found in one place. Counselors need to explain this rationale for case management to their clients.

B. The Functions of Case Management

The following are the five main functions of case management:
- *Assessment.* Identify clients' strengths, weaknesses, and needs.

- *Planning.* Negotiate what the client wants and develop a plan for achieving it.

- *Linking.* Help clients obtain required services by referring or transferring clients to services in the formal and informal care-giving systems.

- *Advocacy.* Intercede on behalf of the client to obtain needed resources.

- *Monitoring.* Evaluate progress continuously and take action if needed.

C. Models of Case Management

The brokerage/generalist, assertive community treatment, strengths-based, and clinical/rehabilitation case management models are adapted from the mental health treatment field for use with substance abusing and dependent clients (CSAT, 2000). Each model, as outlined below, emphasizes different functions of case management:

- ***Brokerage/generalist model.*** In this model, the case manager identifies clients' needs and helps them access the necessary resources. Ongoing monitoring is not

emphasized, nor is advocacy. The brokerage/generalist model is most useful when there is a problem with access, not availability, of resources.

- *Assertive community treatment model.* In this model the case manager has frequent, long-term contact with clients in their natural settings (e.g., home), focusing on the practical problems of daily living. Advocacy is emphasized.

- *Strengths-based model.* In this model, the case manager supports clients in their search for resources. It encourages the use of informal helping networks as opposed to institutional ones. It involves aggressive outreach to clients, helps clients develop their own goals, and emphasizes the role of advocacy. Some of the principles of the strengths perspective are encouraging client control over the search for those resources they perceive as needed and viewing the community as a resource and not a barrier (Siegal, Rapp, Kelliher, Fisher, Wagner & Cole, 1995).

  Part of the value of traditional substance abuse treatment based on the disease concept is that it gives straightforward structure to a life that may have lacked adequate rules and structure. The strengths-based approach is an alternative to the disease concept approach, which some assert may actually intensify problems for some clients (Siegal, et al., 1995).

- *Clinical/rehabilitation model.* In this model, the case manager is also the client's counselor. So the counselor provides both the clinical help (therapy) and the resource acquisition help (case management).

D. Principles of Case Management

The following principles apply to all of the models of case management. Case management consolidates client care to a single point of responsibility, and is always community-based, culturally sensitive, pragmatic, and client-driven. It is anticipatory in that it prepares clients for the next stage of treatment. Case management strives for interventions that intrude on the client's life as little as possible while being effective (Bois & Graham, 1997, p. 63). Note that case management activities should focus on fitting services to the client rather than the client to services. It is possible that some clients do not need every aspect of a particular program.

E. The Treatment Continuum

Case management supports the client through all phases of his/her substance abuse/dependence treatment. The phases are case finding and pretreatment, primary treatment, aftercare, and disengagement (CSAT, 2000).

- *Case finding and pretreatment.* Case finding refers to how treatment programs get clients. For example, the program may have a relationship with law enforcement authorities, public welfare agencies, or managed care companies. At

this phase, the case manager tries to remove barriers that would keep the potential client from entering treatment. Examples of barriers to treatment include lack of transportation, childcare, or money. The presence of a co-occurring disorder, or being unable to attend treatment during certain hours might be a barrier to participating in some treatment programs. It is sometimes important that barriers to entering treatment be removed quickly, since clients may lose their motivation to enter treatment if there is a delay in getting started. In this phase, the case manager assesses the client in order to identify problems that would be amenable to treatment.

- *Primary treatment.* At this phase, the case manager orients the client to the program and may help the client resolve immediate problems that would keep him/her from focusing on treatment. The case manager makes a plan for resource acquisition to meet the client's short-term needs. The case manager also organizes the timing and application of services, provides support during transitions, promotes client independence, intervenes to avoid or respond to crises, and develops external support structures to facilitate community integration, advocates for the client in all areas of life, coordinates the timing of various interventions to ensure that the client can achieve goals, and plans for discharge and re-entry into the community.

  Clients benefit from case management services while participating in any category or level of primary treatment. The American Society of Addiction Medicine's (2001) levels are early intervention (level .05), outpatient services (level I), intensive outpatient or partial hospitalization (level II), residential or inpatient services (level III), and medically managed intensive inpatient services (level IV).

- *Aftercare.* Aftercare, sometimes called continuing care, follows discharge. At this phase, case managers help clients transition out of treatment and take responsibility for their lives. The client may need housing, a source of income, or a social support system.

- *Disengagement.* Ideally, disengagement can take place over time. The case manager and client can discuss what the client learned from interacting with different service providers and be encouraged to continue accessing the resources the client needs in life.

F. Case Management Improves Outcomes

Clients are more likely to get appropriate services when attention is paid to case management, and this increases the likelihood of positive outcomes. For example, McLellan, Hagan, Levine, Meyers, Gould, Bencivengo & Jaffe (1999) found that clients who had received clinical case management had better outcomes in terms of alcohol use, medical status, employment, family relations, and legal status at 6 months following treatment than those who did not. They noted that case management worked best when

staff was trained to collaborate with each other rather than engage in rivalry and when pre-contracting for services to ensure availability was arranged.

G. Community Resources

Case management may involve coordination with a variety of resources in the community including child protection systems, criminal justice institutions, primary health care providers, psychological testing services, social service systems, family therapy services, housing programs, vocational rehabilitation programs, health insurance companies, and self help groups. Counselors need to be personally familiar with the resources in the local community. This includes knowing something about the resources' treatment philosophies, personnel, and logistics, such as costs and hours of operation.

H. Advocacy and Coordination in Case Management

Advocacy is part of case management, and may involve coordinating with families, community agencies, legal systems, and legislative bodies (CSAT, 2000, p. 3) in order to obtain a service, practical help, support from others, or information for clients. Examples of coordination include giving or receiving information regarding specific clients, keeping another agency informed about the client's treatment process, obtaining or receiving information from another agency, and communicating with other agencies in planning aftercare (Graham, Timney, Bois, & Wedgerfield, 1995, p. 441).

I. Culturally Sensitive Case Management

Counselors should be as culturally sensitive in their case management responsibilities as they are in their other duties. Clients should be linked to service providers whose values are consistent with their own and who will provide culturally sensitive care. For example, members of oppressed groups may not be comfortable with the 12-Step idea of accepting one's powerlessness, given their societal powerlessness (CSAT, 2001, p. 52). If this is the case, the client should not be linked with resources that stress the concept of powerlessness.

J. Case Management with Women

Culturally sensitive case management is particularly important when working with women for several reasons. One is that some case finding methods, such as drunk driver programs, drug courts, and employee assistance programs, may not find women as often as men. Outreach efforts may find more women in medical, mental health, and family counseling service settings (Blume, 1998, p. 422). Outreach to women is crucial because women may be reluctant to present for treatment without encouragement. Women tend to respond favorably to attempts to encourage and support steps toward change, using internal strengths and natural network of support. Counselors who have not been encouraged to take an active role in case management may see doing so as enabling, rather than as appropriate assistance that increase the likelihood of a positive outcome (Brindis & Theidon, 1997).

K. Case Management with Adolescents

Counselors provide case management services for adolescent clients by encouraging family involvement; providing support; tracking substance abuse relapse episodes following treatment; connecting the youth with school, work, and community resources; and helping youth fulfill legal obligations (Godley, Godley, Pratt, & Wallace, 1994).

L. Documentation of Case Management Activities

All case management activities should be documented as part of the client's record. Notes regarding case management activities will appear throughout the client's record, since they occur at all phases of treatment. A guiding question for deciding what to include in the client's record is "What do others need to know to respond therapeutically?" (Kinney, 2003, p. 288). Examples of entries related to case management activities are properly completed release forms to share information with other treatment providers and notes of counselors' efforts to advocate for clients, such as "met with school guidance counselor to ensure support for client's treatment" (Graham et al., 1995, p. 441). Entries should indicate what the counselor coordinated, with whom, when, and why. Note also that counselor records, including electronic files, are legal documents.

M. Evaluating Case Management Effectiveness

Counselors are expected to monitor the effectiveness of case management activities for individual clients. Treatment programs should track effectiveness for groups of clients. Information about effectiveness can be gathered through interviews with clients, collateral interviews, and interviews with professionals who worked with the client. Examples of information that can be collected include frequency of client relapses based on self reports and collateral reports, urine screen results, and case manager observations of the client's behavior. Some programs (e.g., Godley, et al., 1994) report quarterly the percent of clients who relapsed, were arrested, who linked with the recommended support systems, or who made progress toward their educational or vocational goals.

N. Summary

Counselors' case management efforts are important throughout all phases of treatment, because client outcomes are improved when their needs, even those not directly related to their substance abuse or dependence problem, are met. Quality case management ensures that all the people involved in serving a client are working cooperatively toward meeting the client's needs. Familiarity with resources in the community, including self help groups, criminal justice institutions, social service providers, and vocational rehabilitation programs, is necessary to coordinate a comprehensive package of services for clients.

V. Client, Family, and Community Education

This chapter will include information about the etiology of substance related disorders; how substance abuse/dependence are prevented; the treatment and recovery continuum; effects of alcohol/drugs on the family; physical health risks associated with alcohol/drug use; a description of several self-help groups; and pharmacology-specific effects of drugs on the body.

A. Etiology of Substance Related Disorders

The etiology or cause of substance related disorders has been identified as involving several factors that may appear independently or in combination with other such factors. There is evidence that genetic factors play a role in both dependence and abuse. Other causal theories cite the use of drugs as a means to cover up or get relief from other problems related to mental illness, stress, issues involving relationships, self-esteem and work, and others. Thus the using behavior is also looked at as a possible symptom of other issues or problems (Kinney, 2003).

Views of the etiology of substance related disorders encompass sociocultural, behavioral, and biological factors as discussed below:

- The *sociocultural view* includes stressful socioeconomic conditions and cultural differences in drinking patterns that suggest that sociocultural context can enhance or reduce risk of substance use, abuse, and dependence. Cultural norms affect exposure to drugs which in turn influences drug behavior. Social pressures may also affect attitudes toward drugs, especially in cultures where drug taking is linked to social/cultural traditions (Kinney, 2003; Carroll, 2000).

- The *behavioral view* suggests the influence of both positive and negative reinforcement as causal factors for continued drug use.

  Positive reinforcement is when the processes experienced become associated with drug use and its pleasant effects. When the feelings produced by drugs are pleasurable, it increases the likelihood of future use. Drugs of abuse stimulate the "pleasure pathway" in the brain (mesolimbic dopamine system). This can be direct stimulation by drugs such as cocaine and amphetamines, or indirect stimulation by drugs such as heroin and alcohol—reinforcing pleasure is a result of its effects on GABA neurotransmitters (Kinney 2003; Carroll, 2000).

  The behavioral view also suggests that drug use is negatively reinforcing. Drug use is negatively reinforcing when it provides escape from negative feelings. The process of use may be called tension reduction or self-medication. Some drugs produce this effect by enhancing activity of the GABA neurotransmitters, which reduce the anxiety/fear responses. Increased use or levels of use have been noted among people who have experienced traumas such as physical or sexual abuse.

Another example of negative reinforcement is using to avoid unpleasant withdrawal symptoms (Kinney 2003; Carroll, 2000).

- The ***biological view*** states there is a difference between children of alcohol-dependent parents and those of non-dependent parents with respect to genetic predisposition and/or biochemical factors.

  Research has shown that male children of alcohol-dependent biological parents are four times more likely than children of non-dependent parents to develop substance dependence, regardless of whether they are raised by their biological or adoptive parents. Female children of alcohol-dependent, biological parents are more likely to develop other disorders, such as depression, but more research is needed (Kinney 2003; Carroll, 2000).

  Research has also shown that there is a genetic factor that, when present, indicates an increased predisposition for some individuals to become substance dependent should they begin to use. Some individuals are more likely to have the gene present that regulates the sensitivity of dopamine receptor sites in the reward center of the brain (mesolimbic dopamine system). This indicates that some may have a biological vulnerability to substance dependence relating to an enhanced sensitivity to rewarding effects of drugs. The presence of the gene does not mean an individual will definitely become chemically dependent just like the absence of the gene does not mean that an individual would not become dependent with sufficient use over time (Kinney 2003; Carroll, 2000).

  Biochemical factors noted state that the brain adjusts after use, so it has less of some key neurotransmitter in the system and the need for more influences continued substance use. The differences in ones' ability to metabolize alcohol may affect the individual's continued alcohol use. Some individuals are lacking the enzyme, aldehyde dehydrogenase, which breaks down a by-product of alcohol (acetaldehyde). Increased acetaldehyde may cause an individual to feel sick and experience alcohol-flush syndrome, common among Asians, thus this would not reinforce continued use (Kinney 2003; Carroll, 2000).

B. How Substance Abuse/Dependence Are Prevented

Prevention programs are usually designed to address several areas such as: prevent drug use from ever starting; if it has started, stop it as soon as possible; where use has advanced, work to stop and reverse the progression while assisting to restore people to health; equip people with the powers of resistance, decision-making, problem-solving, and conflict resolution skills aimed at instilling resiliency and alternatives to drug use (Ray & Ksir, 2004).

Prevention methods include the following approaches:

- Reduce the supply of illegal drugs available in society, usually through interdiction, legislation, and legal penalties.

- Reduce the demand for drugs through treatment of drug abuse, education, emotional development, moral growth, and individual and community activities.

Primary prevention is intended mainly for the young who have little or no experience with drugs, and this approach tries to anticipate and prevent initial drug use by:

- Promoting abstinence
- Developing refusal skills
- Educating the young about the dangers of drugs
- Increasing the age of legal use (of alcohol and tobacco)
- Promoting viable alternatives, activities that do not include drug use (Ray & Ksir, 2004)

Secondary prevention seeks to stop the experimental, social/recreational, and habitual use and abuse from turning into addiction by acting when the symptoms are first recognized. Secondary prevention incorporates intervention, education, and skill building to provide skills to avoid future use and promote abstinence. Instead of jail, drug diversion programs direct first-time offenders into education and rehabilitation programs (Kinney, 2003).

Tertiary prevention focuses on stopping the progressive damage of drug use and assisting drug abusers back to a healthier state. Tertiary prevention incorporates the following strategies: group intervention as a means to get people into treatment that includes detoxification, abstinence, and recovery; desensitize the drug user to the people, places, or things that trigger use; use of family therapy, group therapy, and residential therapeutic communities; use of pharmacological strategies such as methadone maintenance; promotion of healthier life styles, and use of aftercare support systems, usually utilizing 12-step programs (Kinney, 2003).

 Additionally, prevention efforts have been defined by the group that is being targeted for the prevention effort; universal, for the general population, selective, for identified at-risk groups, and indicated, for identified high-risk individuals (Kinney, 2003).

C. The Treatment and Recovery Continuum

Treatment and recovery must be viewed on a continuum much like the substance abuse diagnosis continuum that contains the following categories of substance use:

- Nonuse
- Moderate and non-problematic use
- Heavy and non-problematic use

- Heavy use with moderate life problems
- Heavy use with serious life problems
- Dependency/addiction with life and health problems (Lewis, Dana, &Blevins, 2002)

As outlined below, the treatment and recovery continuum of care incorporates identification, assessment, stabilization, rehabilitation, relapse prevention, and substance substitution if necessary:

- *Identification* of an individual can be made through many different channels, self-identification, court order, a condition of one's probation or parole, and/or through appropriate intervention techniques. This could involve the screening process used to help determine the likelihood that an individual has a problem with drugs or alcohol (Kinney, 2003).

- *Assessment* is the collection of data from the individual and corroborative sources to determine the extent of the individual's problem and their strengths, weaknesses, and needs. This information is used to formulate the plan of treatment to include goals and methods and resources to be used (Herdman, 2001).

- *Stabilization* includes the need for detoxification at an appropriate medical facility if needed.

- *Rehabilitation/treatment programs* will vary from setting to setting with the primary focus on the care of the client. The continuum of treatment depends on the assessment and diagnosis of the client and can range from providing education, an intensive outpatient program, to an inpatient residential program. Substance abuse and associated treatment services should be individualized and be of the type and intensity appropriate to meet the needs of the client. The continuum of substance abuse and associated services may be provided within a facility by coordination of programming among other facilities, such as a medical facility and through sharing arrangements with community resources. Clients should move among the components of the continuum as is clinically appropriate, with minimal disruption in treatment and in a manner that facilitates positive treatment outcomes. Case management should be used to ensure that clients receive all necessary services in a timely and coordinated manner. The utilization of individual, group, and family/significant other counseling should be utilized as needed to assist in meeting the needs of the client. All substance abuse programs should be sensitive to the needs of special populations involving the homeless, those with a dual diagnosis, HIV infected persons, the elderly, ethnic and racial minorities, and both males and females (Kinney, 2003).

- *Relapse prevention* is an important part of treatment from the time services are first provided. Counseling/treatment is basically working on problems and

concerns that have played a role in the client's using behavior and to learn to make decisions and choices that do not facilitate relapse. Recovery and relapse are both ongoing processes not an event. Thus relapse prevention should be approached as a process with the identification of individualized triggers and a plan to confront those triggers should they occur. Relapse prevention should be made a valuable part of the client's aftercare program and discharge goals (Kinney, 2003).

When discussing relapse prevention it is always suggested that a discussion of the abstinence violation effect (AVE) be included. The abstinence violation effect refers to the tendency for some people to use substances problematically when they believe abstinence is too difficult a goal to achieve or maintain. AVE relates to what happens when a person attempting to abstain from a negative habitual behavior, such as drug use, engages in the behavior and then faces conflict and guilt by making internal attributions to explain why he or she did it, thus making the individual more likely to continue using the drug, for instance, in order to cope with self-blame and guilt (Ray & Ksir, 2004).

- *Drug substitution* is the substitution of a legal drug for an illegal one to assist the client in making positive life changes. An example of this would be a methadone program.

D. Effects of Alcohol/Drugs on the Family

The effects of substance abuse/dependence on the family make it a family illness/disease, as every member can be affected by the behaviors of the user. There is no way that the family members of the substance abuse/dependent person can completely ignore the problems. Problems may manifest themselves through embarrassing social behaviors, financial difficulties, relationship issues, lack of effective communications, loss of or difficulty on the job, poor or lack of parenting skills, and physical or other abuse issues which all may be related directly or indirectly to the using behaviors. The family's response to the situation can include six stages, denial, attempts to eliminate the problem, disorganization and chaos, reorganization in spite of the problem, efforts to escape, and family reorganization (Kinney, 2003).

The following is a brief explanation of the six stages that occur as a family deals with addiction.

1. *Denial* usually takes place early on when the occasional excessive drinking episodes are explained away by both partners as isolated instances with no reason for concern.

2. *Attempts to eliminate* the problem may occur when the user's partner realizes that the using behaviors are not normal and tries to pressure the user to control/cut down or quit substance use.

3. ***Disorganization and chaos*** occurs when the normal family operations have broken down and the user's partner has to deal with the critical situations that occur on a more frequent basis.

4. ***Reorganization in spite of the problem*** occurs when the user's partner takes charge and redirects her/his main focus away from the user and on to maintaining a family life in spite of the chemical use.

5. ***Efforts to escape*** may take the form of a separation or attempted divorce; however, if the family remains together, family life continues despite the user.

6. ***Family reorganization*** is when a separation occurs and the family reorganizes without the user. Reconciliation may take place but only with both partners making adjustments (Kinney, 2003).

Research has identified three approaches family members use in living with a substance dependent person: keeping out of the way of the substance-dependent person and managing one's own life; being the care-giver, getting into counseling, and trying to control the situation, including the substance abuse; and resigning to the idea that the user will always use and will never change, and continuing to maintain a facade that all is well in the family (Kinney, 2003).

Family members may develop coping styles as a survival technique to deal with the reality of what the substance abuse/dependence has done to the family unit. Three coping styles that may manifest are: the responsible one, adjuster, and the placater. Different, but similar, coping styles that may be seen in the family are: the family hero, the mascot, the scapegoat, and the lost child. Each of these coping styles has its own way of diverting the attention away from the real problem to make things seem better or not so bad (Kinney, 2003).

E. Physical Health Risks Associated With Alcohol/Drug Use

Physical health risks from the use of alcohol can be associated with the amount used, duration of use, and the condition of the individual using. Because of the potential for fetal alcohol syndrome and fetal alcohol effect, it is suggested that women who think they might be pregnant should not drink alcohol. Those with other medical conditions such as diabetes, seizure disorders, gastric ulcers, various skin conditions, and osteoporosis should not drink alcohol.

The chronic use of alcohol can affect all systems of the body and can have definite visible signs as well as have physical effects. Physical signs and symptoms of chronic alcohol use can include a weakened overall appearance, hyper-pigmented, jaundiced skin or a yellowish pigment to the whites of the eyes. There may be hoarseness in the voice; ataxia, a wide spaced unsteady gate; the appearance of spider veins; and dilated capillaries and acne-like lesions on the face and body. The nose may be enlarged and

bulbous, and there may be swelling of the parotid glands in the face which may give the appearance of having the mumps (Kinney, 2003).

The chronic use of alcohol affects the internal systems of the body as well as the outward appearance. The irritation caused by the alcohol may cause inflammation, abdominal pain, and bleeding of the esophagus and stomach (Kinney, 2003).

Chronic alcohol use is many times associated with acute pancreatitis, the acute inflammation of the pancreas. This may be caused by the swelling of the pancreatic duct causing a backup of the pancreatic digestive juices causing the irritation and swelling of the pancreas. It may also be related to the accumulation of fat in the pancreas caused by excessive drinking and when the pancreatic enzymes digest this fat it can cause injury to the pancreatic cells (Kinney, 2003).

While moderate alcohol use may decrease the risk of developing gallstones and gallbladder disease it has negative affects on the liver. Acute fatty liver is when fat deposits build up in the normal liver cells and can develop in anyone who has been drinking heavily even for a short period of time. Acute fatty liver may occur in non-alcohol dependent persons and is reversible if alcohol consumption is stopped (Kinney, 2003).

Alcoholic hepatitis often follows a heavy or extended bout of alcohol use and can occur in non-alcohol dependent persons. There is inflammation of the liver, metabolism is disrupted, jaundice, the yellowing of the skin and whites of the eyes, as well as other symptoms present with alcoholic hepatitis. Alcoholic hepatitis may be completely reversible in some people if they stop alcohol consumption and receive proper medical care (Kinney, 2003).

Cirrhosis is caused when there is permanent, widespread destruction of liver cells, which are replaced with nonfunctioning scar tissue. The liver cells are unable to perform their necessary functions and while progression may possibly be slowed down by stopping the consumption of alcohol, it is irreversible and fatal if alcohol is continued to be consumed (Kinney, 2003).

Anemia, the insufficient function or number of red blood cells, is the most common red blood cell related problem in chronic alcohol users. Alcohol may affect the nutrient levels in the body affecting the production of red blood cells as well; the buildup of toxins may also reduce red blood cell production. Those produced may very well be defective and not able to function appropriately. Alcohol use may contribute to bleeding from ulcers, and the red blood cells may be lost (Kinney, 2003).

The chronic use of alcohol affects the white blood cells, which are the body's main defense against infection. Alcohol has a toxic effect that directly reduces white blood cell reserves; it also interferes with the proper function of the white blood cells. The negative affects on the immune system increases the person's chances of infection (Kinney, 2003).

Chronic alcohol use can decrease the number of platelets, a major component for clotting blood. Thus, many long-term, heavy drinkers may be subject to some form of bleeding disorder or episodes of bleeding from ulcers, the nose, the gums, or other places (Kinney, 2003).

Alcoholic heart muscle disease (AHMD) is a serious condition in which the heart does not pump the amount of blood needed to meet the demands of the body and is thought to be a result of long-term, heavy drinking (Kinney, 2003).

Long-term, chronic drinking may also contribute to a reduction of vitamin B-1 and result in beriberi heart disease, when a normal heart fails to keep up with an abnormally high metabolic need of the body. This condition may be corrected with the stopping of alcohol consumption and the increase of B-1 (thiamine) in the body (Kinney, 2003).

Cardiac rhythm abnormalities have been associated with long-term, chronic alcohol use, such as sinus tachycardia and the speeding up of normal heartbeats, and may be associated with palpitations (Kinney, 2003).

Seasonal alcohol-induced arrhythmias may be related to heavy alcohol consumption associated with the holidays or may also occur after a heavy weekend of drinking. The symptoms of palpitations and arrhythmias usually clear up completely in a few days of stopping alcohol consumption (Kinney, 2003).

Using, as little as 2 ounces of pure alcohol can inhibit the production and output of the antidiuretic hormone (ADH) by the hypothalamic-pituitary region of the brain, which causes the kidneys to reabsorb less water and produce more urine output. This occurs when the blood alcohol level is increasing. When the alcohol level is steady or decreasing, suppressed reabsorbtion does not occur, but the opposite might happen with the retention of excess body water.

Long-term heavy alcohol use can adversely affect the reproductive system in men and women. A malfunctioning liver caused by alcohol-related damage can cause a change in the ratio between the testosterone (the male hormone) and estrogen (the female hormone) levels that are present in men and women. The decrease of the female hormone in women can lead to decreased fertility and missed menstrual periods; the development of traditionally male secondary sex characteristics, such as hair on the chest and face; a loss of female sexual characteristics; and interference with normal sexual functioning. In men, the decrease in testosterone can result in diminished libido, impotence, sterility, and a loss or reduction of chest and pubic hair reducing the appearance of secondary male sex characteristics. The increased female hormone levels in men can lead to a feminization of male features such as enlarged breasts and shrinking of the testicles (Kinney, 2003).

Because of alcohol's relaxation of inhibitions, sexual interests and pursuits may be increased; however, the ability to perform sexually can be reduced. Men may experience partial or total impotency even with an increased desire fueled by the alcohol. Stopping

the consumption of alcohol, reduction in liver disease, and a good nutritional diet could significantly improve but not necessarily reverse the sexual and reproductive functions (Kinney, 2003).

Alcohol affects the respiratory system by increasing respirations when low to moderate doses are used, and when larger and/or toxic amounts are used, the respiration rate decreases and may cause death in cases of acute alcohol poisoning. This is believed to occur due to alcohol's direct affect on the respiration center of the brain (Kinney, 2003).

Alcohol can also affect important mechanical and metabolic pulmonary defenses. It may contribute to chronic obstruction in airflow, cause bronchospasm, and may have significant affects on people with chronic obstructive pulmonary disease, asthma, and other pulmonary problems. Lung cancer is high among long-term, heavy drinkers with the direct association of smoking and alcohol use. Aspiration of vomit as a result of excessive alcohol use can lead to pulmonary infections such as aspiration pneumonia. Also, diminished defenses in the lungs and the immune system can increase the heavy, long-term alcohol user's chances of contracting other infections such as tuberculosis (Kinney, 2003).

The endocrine system, made up of the glands of the body and the hormones they secrete, can be affected by alcohol in three ways: the affect on the pituitary gland, direct affect on the glands themselves, and liver damage. The production of, the reception of, and the metabolizing of hormones may be affected by the use of alcohol (Kinney, 2003).

Skin can be affected directly and indirectly from long-term alcohol use. Alcohol dilates the vessels of the skin. Alcohol's affect on other systems of the body can be reflected in the condition of the skin, such as jaundice, itching, and changes in hair distribution, and skin infections may be indicative of liver dysfunction or abnormalities in the immune system (Kinney, 2003).

The musculoskeletal system is affected by long-term, heavy drinking in several ways. There are at least four types of arthritis associated with long-term, heavy drinking: gouty arthritis, degenerative arthritis, septic arthritis, and osteoarthritis. Additionally, alcohol use affects osteoporosis and aseptic necrosis (Kinney, 2003).

Alcohol consumption affects the central nervous system more profoundly than any other system of the body. With sufficient quantities of alcohol over time, the central nervous system adapts to the presence of alcohol. This adaptation to alcohol is the nature of tolerance, dependence, craving, and withdrawal. The central nervous system is affected more as the alcohol level is increasing compared to when it is decreasing, which is the Mellanby effect (Kinney, 2003).

Brain tissue damage can also occur as a result of long-term, heavy drinking, which may lead to the development of different organic brain syndromes. These syndromes are alcoholic dementia, an overall decline of intellect; Wernicke's disease associated with a vitamin B1 (thiamine) deficiency and may be corrected nutritionally; and Korsakoff's

psychosis which is characterized by the individual's inability to learn new information or remember recent events and appears to be irreversible. Wernicke's disease and Korsakoff's psychosis are often seen together and may be called Wernicke-Korsakoff syndrome (Kinney, 2003; Ray & Ksir, 2004).

Alcohol use can negatively affect one's ability to achieve good, restful sleep (Kinney, 2003).

Heavy alcohol consumption can lead to a blackout which is an amnesia-like state in which the individual may appear to be functioning normally yet later has no memory of what transpired. Blackouts are usually associated with alcohol dependence and are related to the dose taken. However, blackouts can occur in nondependent individuals as a result of a heavier than normal drinking episode in those who drank to the point of intoxication. The amnesia that occurs can be sudden in onset, complete, and permanent, or it can lack a definite onset and be something that the person is unaware of until reminded of it or recalls it spontaneously (Kinney, 2003).

F. A Description of Several Self-Help Groups

Self-help programs mentioned in this section consist of those utilizing the 12-steps of recovery, rational recovery, and moderate management.

12-Step programs

The 12-step programs are a fellowship of individuals working to overcome their addiction to chemicals or behaviors that have made their lives unmanageable.

- *Alcoholics Anonymous (AA)* "is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; we are self-supporting through our own contributions. AA is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety." (Alcoholics-anonymous, http://www.alcoholics-anonymous.org)

- *Narcotics Anonymous (NA)* "is a nonprofit fellowship or society of men and women for whom drugs had become a major problem. We…meet regularly to help each other stay clean. …We are not interested in what or how much you used …but only in what you want to do about your problem and how we can help." (Narcotics anonymous, http://www.na.org)

- *Cocaine Anonymous (CA)* "is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from their addiction … Our primary purpose

is to stay free from cocaine and all other mind-altering substances, and to help others achieve the same freedom." (Cocaine anonymous, http://www.ca.org)

- *Al-Anon* "groups are a fellowship of relatives and friends of alcoholics who share their experiences, strength, and hope in order to solve their common problems. We believe alcoholism is a family illness and that changed attitudes can aid recovery … Al-Anon has but one purpose: to help families of alcoholics. We do this by practicing the twelve Steps. By welcoming and giving comfort to families of alcoholics, and by giving understanding and encouragement to the alcoholic." (http://www.al-anon-alteen.org)

- *Alateen* "is a fellowship of young Al-Anon members, usually teenagers, whose lives have been affected by someone else's drinking." "Alateen is part of Al-Anon, which helps families and friends of alcoholics recover from the effects of living with the problem drinking of a relative or friend. Alateen is our recovery program for young people. Alateen groups are sponsored by Al-Anon members. Our program of recovery is adapted from Alcoholics Anonymous and is based upon the Twelve Steps, Twelve Traditions, and Twelve Concepts of Service. The only requirement for membership is that there be a problem of alcoholism in a relative or friend. Al-Anon/Alateen is not affiliated with any other organization or outside entity." (http://www.al-anon-alteen.org) Through Alateen younger people come together to share their experiences, strengths, and hopes with each other; discuss their difficulties; learn effective ways to cope with their problems; encourage one another; help each other understand the principles of the Al-Anon program; and learn how to use the Twelve Steps and Alateen's Twelve Traditions. (http://www.al-anon-alteen.org)

All 12-step support groups utilize the following 12 steps first adopted by AA:

- *Step 1.* "We admitted we were powerless over alcohol [cocaine, cigarettes, food, gambling, etc.] and that our lives had become unmanageable." (Inaba, Cohen, & Holstein, 1997) In this step, the individual acknowledges that alcohol is the problem for which she/he is powerless and the problem affects the whole life.

- *Step 2.* "Came to believe that a Power greater than ourselves could restore us to sanity." (Inaba, et al., 1997) In this step, the individual recognizes the insanity of the drinking behaviors and moves toward the gradual reliance on a higher/greater power to aid in restoring sanity.

- *Step 3.* "Made a decision to turn our will and our lives over to the care of God as we understood Him." (Inaba, et al., 1997) This step enables the individual to let go of the sinking life preserver, the bottle, and accept that there is an outside influence to provide direction. This is the beginning of the search outside of one's self for direction in life.

- *Step 4.* "Made a searching and fearless moral inventory of ourselves." (Inaba, et al., 1997) This step provokes individuals to look closer at the basic errors in the perception of the world and at the behaviors that were part of their drinking experience. This begins the process of teaching individuals about their responsibility during their drinking periods. Being an inventory, a space for positive attributes to enhance the non-drinking behaviors is available.

- *Step 5.* "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs." (Inaba, et al., 1997) This step provides the individual with a method of letting all the negative behaviors and wrong doings out into the open and not keeping them stuffed inside, helping to get rid of the guilt.

- *Step 6.* "Were entirely ready to have God remove all these defects of character." (Inaba, et al., 1997) In this step, the individual begins to "let go, let God," making the individual aware of the hanging on of old unhealthy behaviors.

- *Step 7.* "Humbly asked Him to remove our shortcomings." (Inaba, et al., 1997) In this step the individual admits to the fear of repeated unhealthy behaviors, while instilling hope that positive change is possible. At this stage, the recently sober individual is likely to have little self-esteem.

- *Step 8.* "Made a list of all persons we had harmed and became willing to make amends to them all." (Inaba, et al., 1997) This step helps the individual to review past behaviors and identify those who may have been harmed along the way to whom amends for those harms are to be made.

- *Step 9.* "Made direct amends to such people wherever possible, except when to do so would injure them or others." (Inaba, et al., 1997) This step along with Step 8 are used as a guide to sort out the actual injury the individual had done to others and to decide how to best deal with making amends for the injuries. Making amends is not seeking positive feedback but is simply making a concerted effort to clean up one's side of the situation. These steps help the individual to see the importance of recognizing and owning the behaviors and events that have occurred.

- *Step 10.* "Continued to take personal inventory and when we were wrong promptly admitted it." (Inaba, et al., 1997) This step helps to promote the support of sobriety as well as to continue the process of change. This step supports the individual in recognizing that he/she does not have to slip back into old behaviors by focusing on one's own behaviors and not making excuses.

- *Step 11.* "Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out." (Inaba, et al., 1997) This step, along with step

10, helps to promote the support of sobriety as well as to continue the process of change. It also encourages continued spiritual development.

- ***Step 12.*** "Having had a spiritual awakening as a result of these Steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs." (Inaba, et al., 1997) This step, along with step 10 and step 11, helps to promote the support of sobriety as well as to continue the process of change. This step is vital to assist the individual to maintain sobriety; the sharing of the 12-step process with others (Kinney, 2003).

Two-steppers is a phrase used to describe a few people who enter a 12-step program like AA, acknowledge they are addicts/alcoholics, get clean/dry out, and then begin their quest to help rescue others. This refers to the individual not working through the steps and applying them to one's life (Kinney, 2003).

1)   **Other self-help support groups**

- ***Rational Recovery*** emphasizes that individuals can take charge of their lives and they are capable of making the choice not to drink. It uses the addictive voice recognition technique (AVRT) to assist the individual to become aware of thoughts that support drinking behaviors. "Rational Recovery (RR) is a non-profit organization of self-help groups that use the principles of Rational Emotive Therapy (RET) as developed by Albert Ellis, Ph.D. RR is a national organization and an outgrowth of the Humanist movement. The basic philosophy of RR is based on the self-reliance of the individual and his or her ability to use rational thinking as the mainstay in a program of sustained abstinence from alcohol and chemical addiction." (Ward, 2004, http://www.humanistsofutah.org)

- ***Moderate Management (MM)*** is not intended for the alcoholic/alcohol-dependent person. It is intended for individuals considered problem drinkers who have experienced minor alcohol-related problems. Abstinence is not seen as the primary goal, but MM suggests guidelines and limits for moderate drinking. It "is a behavioral change program and national support group network for people concerned about their drinking and who desire to make positive lifestyle changes. MM empowers individual to accept personal responsibility for choosing and maintaining their own path, whether moderation or abstinence. MM promotes early self-recognition of risky drinking behavior when moderate drinking is a more easily achievable goal."   (http://www.moderation.org)

- ***The Secular Organization for Sobriety (SOS)***, also known as ***Save Our Selves***, group accepts individuals regardless of the chemical to which they are addicted and promote a one-day-at-a-time philosophy toward sobriety (Inaba, et al., 1997). It is a non-religious, non-spiritual means of obtaining sobriety, sobriety being the priority of the addicts' life (www.secularhumanism.org).

- ***Women for Sobriety (WFS)*** is another group with a spiritual base. Believing that the 12-steps of AA work better for men, they emphasize the power of positive emotions. This concept has spread to the formulation of ***Men for Sobriety*** (MFS) (Inaba, et al., 1997).

G. Pharmacology—Specific Effects of Drugs on the Body

Terms to remember:

- ***Drug*** is any substance that, after entering the body, can change either the structure or function of the body (Carroll, 2000).

- ***Medicine*** includes drugs that are used to prevent, treat, or diagnose illness and/or relieve pain (Carroll, 2000).

- ***Misuse (of drugs)*** is the unintentional or inappropriate use of a drug for other than what or how it was intended (Carroll, 2000).

- ***Abuse (of drugs)*** is the intentional use of a drug for other than what or how it was intended, or for the sole purpose of achieving an altered state of consciousness, or leads to any degree of mental, physical, emotional, or social impairment of the person using, the user's family, or society (Carroll, 2000).

- ***Intoxication*** is a temporary change caused by a significant amount of drug entering the body affecting one's emotional, cognitive and/or psychomotor functioning (Carroll, 2000).

- ***Dependence (to drugs)*** is a condition that, after using drugs, an individual finds it difficult or impossible to control use. Dependence or addiction usually involves a physical and/or psychological need for the drug in order to function normally, and it usually involves tolerance and withdrawal (Carroll, 2000).

- ***Physical dependence*** is a state of functional adaptation to a drug in which the presence of a foreign chemical becomes normal and necessary, and the absence of the drug would present an abnormal state (Carroll, 2000).

- ***Psychological dependence*** is when the individual has a strong desire to continue to use the drug for emotional reasons and is related to the rewarding effects of the drug. There are no physical withdrawal symptoms with the discontinuation of use (Carroll, 2000).

- ***Cross-dependence*** is evident when a person who is physically dependent to one drug can lessen or prevent withdrawal symptoms by using other drugs from the same or similar classification (Carroll, 2000).

- *Tolerance* is an altered physiological state that develops after repeated drug use when the body becomes accustomed and adapts to the presence of the drug and functions normally. Evidence of tolerance is when the drug has less of an effect when using the same dose, or when a larger dose must be used to get the desired effect (Carroll, 2000).

- *Pharmacodynamic tolerance* is when the nerve cells become less sensitive to the effects of the drug over time and repeated use (Inaba, et al., 1997).

- *Metabolic tolerance* is when the liver adapts to the presence of a drug over time and may produce more of the enzyme needed to break down the drug (Inaba, et al., 1997).

- *Behavioral tolerance* is when, after a period of time and repeated drug use, the users are able to modify their behavior in hopes that others will not notice they are intoxicated (Inaba, et al., 1997).

- *Cross-tolerance* is when the tolerance to a drug develops—the individual may also show an increased tolerance to the effects of another drug in the same class (Carroll, 2000).

- *Reverse tolerance (kindling effect)* is when the individual can become more sensitive to the drugs effects rather than less sensitive (Carroll, 2000).

- *Withdrawal* consists of negative symptoms that result from the abrupt discontinuation of the drug. The presence of withdrawal symptoms reveals physical dependence. The withdrawal symptoms of a particular drug usually involve the opposite reaction on the body than the drug's effects. For instance, the withdrawal symptoms of a depressant drug would result from the hyperactivity or hyper-arousal state of the central nervous system (Carroll, 2000).

- *Dose* is the amount of drug that is taken at any particular time (Carroll, 2000).

- *Half-life* is the length of time a drug remains in the body and continues to affect the user (Inaba, et al., 1997).

- *Threshold dose (minimal dose)* is the smallest amount of a drug that can produce a detectable response (Carroll, 2000).

- *Maximum effect* is the greatest response from a drug no matter the dose given or taken (Carroll, 2000).

- *Effective dose* is the amount of a drug necessary to get the desired effect in about 50 percent of those who use the drug (Ray & Ksir, 2004).

- *Lethal dose* is the dose of a drug that results in death (Carroll, 2000).

- *Therapeutic index* is the dose determined to be safe for use and get the desired effect of the drug; determined by dividing the lethal dose by the effective dose (Ray & Ksir, 2004).

- *Potency* is the amount of a drug necessary to produce the desired effect. The more potent a drug is, the less needed to get the desired effect (Lewis, Dana, & Blevins, 2002).

- *Drug interactions* are classified as additive, synergistic, or antagonistic. *Additive effects* occur when two or more drugs are used at the same time and the results are equal to the sum of the actions of the drugs used. *Synergistic interactions* occur when two or more drugs are used at the same time, and the results are greater than the sum of the actions of the drugs used. *Antagonistic interactions* occur when two or more drugs are used at the same time, and the results are less than the sum of the actions of the drugs or the drugs cancel out the effects of each other (Lewis, et al., 2002).

H. Route of Administration

Route of administration is the terminology used for how a person takes substances into the body that includes but may not be limited to:

- *Oral.* Substances can be taken by mouth and swallowed into the stomach.

- *Injected.* Using a needle and syringe, the substance can be injected *subcutaneously* (i.e., "skin popping") in the fatty layer just under the external skin layer; *intramuscularly* into the large muscles; or *intravenously* directly into a vein.

- *Inhalation.* Substances can be inhaled into the lungs by smoking or huffing.

- *Snorted.* Drugs can be inhaled into the nose and absorbed through the mucous membranes.

- *Transdermal.* The drug is absorbed through the skin from a patch.

- *Buccal administration.* The drug is absorbed through the mucous membranes in the mouth.

- *Rectal administration.* Drugs are administered by inserting them into the body through the rectum and are absorbed through the intestinal lining (Carroll, 2000).

The route of administration affects the onset of the drug's effects and the duration of the effects. The faster the absorption of the drug, the more intense the high; also, the faster

the absorption, the shorter the duration of action. Typically for drugs administered orally, it will take at least 15 minutes to feel the effect but will usually have a longer duration of effect as compared to inhaled or injected drugs. The effects of drugs administered through intravenous injection are usually felt quickly—a few seconds to a few minutes—but the effects are short in duration. The effects of drugs administered through inhalation are felt almost immediately—a few seconds—and, like injection, have a short duration period (Lewis, et al., 2002).

I. Motivation for Drug Use

The motivation for taking substances is to achieve a desired effect in a reasonably short period of time. This effect or altered mood state is brought about by the effects drugs have on the brain and neurotransmitter systems. Affects on the neurotransmitter systems include action on the levels of the neurotransmitters (i.e., the chemical messengers) and the receptor sites (i.e., the sites where the specific chemical messengers have their effects). The use of drugs may prevent a neurotransmitter from breaking down, leading to a build-up of the neurotransmitter; it can block the reuptake of the neurotransmitter by the sending cell thus making more of the neurotransmitter available to the receiving cell. Drugs can prevent a neurotransmitter from being produced at the normal level, or may block the receptor sites preventing the neurotransmitter from having its normal effects. Also, drugs can have an effect on the nerve cells in general as a toxin or just making them function slower than normal (Ray & Ksir, 2004; Carroll, 2000).

Neurotransmitters, the chemical messengers, are: GABA relates to inhibitory factors and slows communication. Norepinephrine usually associated with arousal reactions and moods. Dopamine usually associated with feeling of pleasure, Serotonin, usually associated with feelings of anxiety, depression, and aggressiveness, and Acetylcholine, which may be associated with arousal reactions or inhibitory factors (Ray & Ksir, 2004; Carroll, 2000).

Drugs also activate the pleasure/reward center of the brain, which is made up of the ventral tegmental area (VTA), and the nucleus accumbens and other structures of the brain. These are two structures of the brain that are involved in the reward system for all drugs, although other mechanisms might be involved for specific drugs (Inaba, et al., 1997; Carroll, 2000).

How a drug is distributed throughout the body, where it is stored, and how long it is stored are determined by whether the drug is fat or water-soluble. Fat-soluble drugs store in the fatty areas of the body can have longer lasting traces in the body that water-soluble drugs do not (Ray & Ksir, 2004; Carroll, 2000).

Abuse potential is generally related to the drug's speed of action and how long the effects last. Drugs such as cocaine and nicotine with effects that are felt quickly and also wear off quickly have a high abuse potential. Abuse potential is a pharmacological term based on the effects of a drug; however, there are social factors that may influence it such as social acceptance of use, and opportunity for use (Ray & Ksir, 2004; Carroll, 2000).

J. Classification of Drugs

Drugs of abuse can be classified in several ways (e.g., legal or illegal). Although such classifications do not necessarily reflect the drugs' effects or potential for abuse, classifications might provide an indication of the drugs' availability, how they are categorized on the controlled substances list, and/or their primary pharmacological effects.

Controlled Substances Act

Controlled substances, based on the Controlled Substance Act, are placed in 1 of 5 schedule categories, outlined below, depending on their abuse potential, potential for dependence/ addiction, and currently accepted medical use (Ray & Ksir, 2004; Carroll, 2000):

- *Schedule I.* "Any drug included here has a high level of abuse/dependence. Also, there is no accepted medical use. Included are heroin, LSD, and marijuana." (Ray & Ksir, 2004; Carroll, 2000)

- *Schedule II.* "These drugs are essentially similar to those in Schedule I. There is evidence of the potential for abuse/dependence. The distinguishing feature in Schedule II is that there is accepted medical use. There are restrictions on manufacture and distribution via production quotas and import and export controls. Prescriptions are non-refillable, Schedule II drugs include methadone, morphine, methamphetamine, and cocaine." (Ray & Ksir, 2004; Carroll, 2000)

- *Schedule III.* "Drugs in this category are considered to be at moderate risk or low risk for physical dependence but at high risk for psychological dependence. There are currently reasons for medical use." Schedule III drugs include anabolic steroids, most barbiturates, and ketamine (Ray & Ksir, 2004; Carroll, 2000)

- *Schedule IV.* "Drugs in this category are considered to be at low risk for physical dependence but moderate risk for psychological dependence. There are currently accepted indications for medical use." Schedule IV drugs include Xanax, Barbital, and Chloral hydrate (Ray & Ksir, 2004; Carroll, 2000).

- *Schedule V.* "Drugs in this category are considered to be at low risk for either physical dependence or psychological dependence. Again, there are currently accepted indications for medical use." Schedule V drugs include medical mixtures using small amounts of opium or codeine (Ray & Ksir, 2004; Carroll, 2000).

Classification by primary effects

Drugs may also be classified by grouping them according to their primary pharmacological effects such as are they uppers or stimulants, or are they downers or depressants.

- ***Depressants/sedative-hypnotics (central nervous system depressants).*** Drugs in this class slow/depress the activity of the central nervous system. Examples of drugs in this classification include, but are not limited to, alcohol, benzodiazepines, and barbiturates. They are usually taken orally. The desired effects are a reduction of anxiety with possible elation secondary to decreased alertness and judgment. Other acute effects include sedation, impaired judgment, impaired ability to operate vehicles or machinery, or respiratory and cardiac depression with overdose. The action of sedative-hypnotics is a depression of the activity at all excitable tissues; in general, it binds to GABA (inhibitory) receptors resulting in sedation (Ray & Ksir, 2004; Carroll, 2000).

  Intoxication associated with depressants include decreased inhibition, slowed reaction times, memory impairment, possible decrease in respirations, slurred speech, and unable to walk in a straight line (ataxia). Can lead to stupor, coma, and respiratory depression. Common problems include development of tolerance, physical dependence, and respiratory and cardiac depression with overdose (Ray & Ksir, 2004; Carroll, 2000).

  The severity and time of onset of withdrawal symptoms vary with the specific drug. Symptoms may include anxiety, state of hyper-arousal, elevated vital signs, sweating, tremulousness (shakes), altered perceptions, visual and tactile hallucinations and illusions, withdrawal seizures, and possibly death if involving alcohol or barbiturate withdrawal (Ray & Ksir, 2004; Carroll, 2000).

- **Stimulants.** Drugs in this class increase central nervous system activity. This classification includes cocaine, amphetamines, methamphetamines, and methylphenidate (Ritalin). Routes of administration vary, powered cocaine is snorted intranasally, can be liquified and injected intravenously, or it can be smoked as freebase or, more often, as crack. Amphetamines can be taken orally, injected intravenously, or smoked. Methylphenidate (Ritalin) is taken orally (Ray & Ksir, 2004; Carroll, 2000).

  The effects of snorting cocaine may be slow in onset and produce a high that lasts 20 to 30 minutes, while the onset of the intense rush from smoking cocaine is quicker and the high lasts about 5 to 10 minutes. Cocaine usually remains in the brain 2 to 3 days. The onset and duration of effects of Methamphetamine use are also connected to the route of administration. Through smoking or intravenous administration, the user immediately experiences an intense rush that lasts only a

few minutes; snorting produces effects in 3 to 5 minutes; and oral ingestion produces effects in 15 to 20 minutes and can last 8 to 24 hours. (Ray & Ksir, 2004; Carroll, 2000).

The desired effects from using stimulants are increased alertness and feelings of well-being, euphoria, increased energy, and heighten sexuality. Other acute effects include anxiety, confusion, irritability, possible medical problems that are cardiac, central nervous system, respiratory, or other system-related with the potential for death (Ray & Ksir, 2004; Carroll, 2000).

Cocaine affects neurotransmitters dopamine, norepinephrine, and serotonin. It blocks the reuptake of dopamine increasing the amount and prolonging the dopamine effects. It will decrease the normal amount of dopamine in the brain with prolonged use. Amphetamines direct the release of dopamine and norepinephrine, and the blocking of the reuptake creates a euphoric effect (Ray & Ksir, 2004; Carroll, 2000).

Intoxication associated with stimulants includes increased heart rate, elevated blood pressure and temperature, and decreased respiration. Physical exams may show dilated pupils, dry mouth, cardiac arrhythmias, twitching, and tremors. Convulsions may be witnessed, with the potential for stroke and coma to occur. Mentally there is impaired judgment, confusion, disinhibited behavior, paranoid thoughts, hypervigilance, hallucinations, elation, and/or depression with possible suicidal behavior (Ray & Ksir, 2004; Carroll, 2000).

Common problems of using stimulants are the development of tolerance and dependence, anxiety, confusion, social withdrawal, weight loss, psychosis, formication, and multiple medical problems with potential of death. With long-term chronic use of methamphetamines, there is the possibility of irreversible damage to the central nervous system (Ray & Ksir, 2004; Carroll, 2000).

Withdrawal symptoms include depression with the possibility of suicidal thoughts or attempts, excessive need for sleep, fatigue, lack of pleasure (anhedonia), increased appetite, and possible cravings for the drug. Withdrawal is usually not life threatening except for the potential for suicide (Ray & Ksir, 2004; Carroll, 2000).

- *Hallucinogens/dissociatives.* These drugs change sensory perception and have the ability to alter reality and produce hallucination-like effects. This classification includes naturally occurring and synthetically prepared drugs that include LSD, mescaline, psilocybin, psilocin, MDMA (ecstasy), PCP, and ketamine (Ray & Ksir, 2004; Carroll, 2000).

Routes of administration vary such as: LSD can be taken orally or smoked; MDMA can be taken orally or smoked; PCP can be taken orally, smoked, or snorted; and ketamine in powder can be snorted, or liquid may be injected. The length of action varies on the drug taken and route of administration and can last from several hours to several days (Ray & Ksir, 2004; Carroll, 2000).

The desired effects for this classification of drugs are the increased awareness of sensory input; the novel perceptions of unusual environment; altered body image; blurring of boundaries between self and environment; synthesia; the temporary modification of thought processes; obtaining special insights; increased empathy; hallucinations; feelings of strength, power, and invulnerability, especially with PCP; an overall feeling of pleasantness; floating; dream-like state; and possible sexual stimulation with ketamine (Ray & Ksir, 2004; Carroll, 2000).

Other effects of hallucinogens:

- LSD can include panic attacks, increased blood pressure, heart palpitations, tremors, nausea, muscle weakness, increased body temperature, ataxia, and in some cases accidental death (Ray & Ksir, 2004; Carroll, 2000).

- MDMA can include nausea, clenching of the jaw and teeth, muscle tension, blurred vision, panic attacks, confusion, depression, anxiety, paranoid psychosis, increased body temperature, and cardiac arrest (Ray & Ksir, 2004; Carroll, 2000).

- PCP can include psychotic reactions, bizarre behavior, outbursts of hostility and violence, and feelings of severe anxiety, doom, or impending death (Ray & Ksir, 2004; Carroll, 2000).

- Ketamine can include a frightening experience of complete sensory detachment, explained as a near-death experience, paranoia, boredom, and possible coma. (Ray & Ksir, 2004; Carroll, 2000).

- LSD is structurally related to serotonin and many of the behavioral effects are probably related to their binding to the serotonin receptors. MDMA acts on several different neurotransmitter sites to produce effects like LSD hallucinations and amphetamine-like arousal (Ray & Ksir, 2004; Carroll, 2000).

- LSD has no withdrawal or tolerance, but risk from one use is high. The user may experience flashbacks at a latter date (experience sensations similar to when using the drug when no drug has been used) (Ray & Ksir, 2004; Carroll, 2000).

- **Cannabinoids/cannabinols.** This category includes marijuana, hashish, and THC. The usual route of administration is smoking or oral. Its usual length of action

from smoking is 2 to 4 hours and through oral means is 5 to 12 hours. The desired effects are a sense of relaxation and well-being, euphoria, detachment, altered level of consciousness, altered perceptions, altered sense of time, and possible sexual arousal (Ray & Ksir, 2004; Carroll, 2000).

Other effects of cannabinoid use are slowed reaction time, altered perceptions, panic, anxiety, nausea, dizziness, depersonalization, paranoid thoughts, and trouble expressing thoughts. The effects are believed to be caused by the binding of the drug at specific THC receptor sites in the brain. Intoxication may cause increases in respiration and heart rate and a slight increase in body temperature. Upon examination, the users may exhibit red eyes, mild dilation of pupils, mild tremors, decreased coordination, decreased strength, less ability to perform complex motor tasks, and dry mouth. Mentally, the user may express feelings of depersonalization, an alteration in mood, disorganization, anxiety, panic, problems with memory, paranoid thoughts, and possible hallucinations (Ray & Ksir, 2004; Carroll, 2000).

Long-term, chronic canabinoid use can lead to problems such as dependence, panic, anxiety, paranoid thoughts, etc. They may also include respiratory problems, the possibility of an impaired immune system, possible reproductive problems, including low birth weight infants, and amotivational syndrome. Withdrawal usually consists of cravings, anxiety, irritability, nausea, anorexia, agitation, restlessness, tremors, and depression (Ray & Ksir, 2004; Carroll, 2000).

- ***Inhalants.*** These drugs consist mainly of chemicals that can be legally purchased and that are normally used for nonrecreational purposes. These include industrial solvents and aerosol sprays that include, but are not limited to, gasoline, kerosene, airplane glue, lacquer thinner, acetone, nail polish remover, lighter fluid, metallic paints, and typewriter correction fluids. Also included are amyl, butyl and isobutyl nitrite, and nitrous oxide gas (Ray & Ksir, 2004; Carroll, 2000).

  These drugs as implied are inhaled. Referred to has huffing or sniffing, the industrial solvents and aerosol sprays are often poured or sprayed on a cloth or into a plastic bag from which the individual inhales the fumes (Ray, & Ksir, 2004; Carroll, 2000).

  Inhalants reduce inhibition and produce euphoria, dizziness, slurred speech, an unsteady gait, and drowsiness. Nystagmus, the constant involuntary movement of the eyes, may be noted. The nitrites alter consciousness and enhance sexual pleasure. The individual may experience giddiness, headaches, and a sense that the user is about to pass out (Ray & Ksir, 2004; Carroll, 2000).

  An overdose of these substances may produce hallucinations, muscle spasms, headaches, dizziness, loss of balance, irregular heartbeat, and coma from lack of oxygen (Ray & Ksir, 2004; Carroll, 2000). Tolerance does not seem to develop

with inhalants with the exception of nitrous oxide for which tolerance can develop (Ray & Ksir, 2004; Carroll, 2000). There does not seem to be withdrawal symptoms from these substances, which indicate there is not physical dependence (Ray & Ksir, 2004; Carroll, 2000).

The critical acute effect of inhalants results from the method of administration, which can result in loss of consciousness, coma, or death from lack of oxygen. Respiratory arrest, cardiac arrhythmia, or asphyxiation may occur. Many of these substances are highly toxic, and chronic use may cause damage to the liver, kidneys, brain, and lungs (Ray & Ksir, 2004; Carroll, 2000).

- *Anabolic steroids.* Anabolic steroids are synthetic illicit drugs that are used to increase muscle mass and improve athletic performance. These drugs resemble the male sex hormone, testosterone. Some anabolic steroids are approved for medical use and are classified as schedule III drugs (Ray & Ksir, 2004; Carroll, 2000).

  Drugs in this classification include Depo-Testosterone, Durabolin, Danocrine, and Halotestin. Some anabolic steroids used for veterinary medicine are illicitly sold for human use and may be sold legally outside of the United States (Ray & Ksir, 2004; Carroll, 2000).

  Anabolic steroids are either injected or taken orally. Combining oral and injectable steroids is known as "stacking" (Ray & Ksir, 2004; Carroll, 2000).

  Anabolic steroids are used medically for testosterone replacement and treatment of muscle loss, blood anemia, and endometriosis. The effects of these drugs on muscle strength, body mass, and personality prompt the abuse of these drugs by athletes and by those who wish to improve their physical appearance. These drugs increase muscle strength, reduce body mass, and increase aggressiveness, competitiveness, and combativeness (Ray & Ksir, 2004; Carroll, 2000).

  When used illicitly to improve athletic performance or physical appearance, the dosage used is well beyond the therapeutic dose. There is no immediate danger of death or serious medical problems from high dosage levels of anabolic steroids; there are serious complications from long-term use (Ray & Ksir, 2004; Carroll, 2000).

  There is no evidence that one can develop tolerance to anabolic steroids. Physical and psychological dependence on anabolic steroids does occur, and there are withdrawal symptoms. Withdrawal symptoms include depression, fatigue, restlessness, insomnia, loss of appetite, and decreased interest in sex (Ray & Ksir, 2004; Carroll, 2000).

  Some of the acute and chronic effects of anabolic steroids on males include atrophy of testicles, impaired production of sperm, infertility, early baldness,

acne, and enlargement of the breasts. For females, there are masculizing effects including increased facial and body hair, lowered voice, and irregular or the stopping of the menstrual cycle. There is an increased risk of coronary artery disease. Anabolic steroids may cause jaundice and liver tumors. Mood swings with periods of unreasonable and uncontrolled anger and violence may be noted (Ray & Ksir, 2004; Carroll, 2000).

VI. Professional Responsibility

A. Introduction

Counselors are charged with several important responsibilities, all of which ultimately have to do with promoting client welfare and protecting client rights. These responsibilities include adhering to codes of ethics and standards of practice, respecting client diversity by working in a culturally sensitive manner, and engaging in supervision, consultation, and advocacy. Counselors must also continuously attend to their own wellbeing and evaluate their own effectiveness.

B. Ethics

Ethics are the rules of conduct recognized in a particular profession, the shared standards of what is good practice. Note that the ethicalness and the legality of an action are two different things, and occasionally they are in conflict. Ethical codes delineate mandatory ethics, the minimal standard of conduct that is acceptable. Ideally, counselors practice aspirational ethics, which focus on the spirit behind the code. For example, mandatory ethics permit a counselor to have a romantic relationship with a former client 2 years after the client's treatment ends. Aspirational ethics suggest that doing so even after 2 years is inadvisable.

C. Decision-making Models

Decision-making models provide a framework for systematically choosing a course of action when ethical codes do not specify how to act in a particular situation. The steps of one decision-making model are identify the problem, review the code of ethics and relevant laws, consult with another professional, consider possible courses of action and their consequences, choose a course of action, and evaluate the results (adapted from Corey, Corey & Callanan, 2003).

D. Fundamental Ethical Principles

When faced with an ethical dilemma, a situation to which there is not an ideal response, it can be useful to refer to the principles that underlie most professional codes of conduct. An ethical action will respect these principles (adapted from Remley & Herlihy, 2001) below as much as possible:

- *Autonomy.* Respect the client's independence and self-determination.
- *Nonmaleficence.* Do not harm the client.
- *Beneficence*. Provide benefit for the client.
- *Justice*. Be fair to the client.
- *Fidelity*. Be faithful to the client.
- *Veracity*. Be truthful with the client.

E. The NAADAC Principles

The National Association of Alcoholism and Drug Abuse Counselors (NAADAC) is a professional association that offers certification in substance abuse counseling. The principles (NAADAC, 1995) address nondiscrimination, responsibility, competence, legal and moral standards, public statements, publication credit, client welfare, confidentiality, client relationships, interprofessional relationships, remuneration, and societal obligations.

F. Ethical Standards

The ethical standards for LCDCs appear in the Texas Administrative Code and as LCDC Rule 150.121. The ethical standards address these important topics: applicants and licensed counselors' responsibility to comply with the standards, nondiscrimination, maintaining high quality service to clients, protecting the profession from unqualified or unethical persons, counselor sobriety, upholding the law and conducting oneself in a professional manner, documentation, publication credit, client welfare, privacy and confidentiality, dual relationships, relationships with other professionals, and fees.

Actions against a license for violating the ethical standards are described in LCDC Rule 150.122. They include refusal to issue or renew a license, suspension or revocation of a license, placing a counselor on probation if the counselor's license has been suspended, and reprimand of a license holder.

G. Promoting Client Rights

Counselors are required to adhere to Federal, State, and agency regulations that protect client rights. Two important sets of regulations pertaining to clients' rights to privacy are the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and 42 CFR, Part 2. HIPAA covers all personal health information that can be used to identify an individual. 42 CFR refers specifically to information that can be used to identify a person as an alcohol or drug abuser, or the recipient of a substance related diagnosis, referral, or treatment.

Federal law (42 Code of Federal Regulations, Part 2) prohibits counselors from divulging the fact that someone is in treatment or any details of their treatment without the client's written consent, when the client is in a clear state of mind. This applies to former clients, deceased clients, and those who merely applied to a treatment program but never attended. The Federal law applies to all federally assisted programs that diagnose, treat, or refer for substance abuse or dependence. If State law differs from the Federal law, the more stringent of the two should be followed. The consequences for violating the regulations about disclosing client-identifying information include fines, loss of the counseling license, and possible civil suits brought by the client.

- ***Exceptions to confidentiality.*** Confidentiality is not absolute; there are circumstances in which releases of information are not required to disclose client information. Clients should be told of these circumstances as part of the process of securing their informed consent for treatment. In every case, only the information required by law is to be disclosed. Some exceptions include instances in which information necessary to provide services may be shared among staff of a program, reporting child abuse or neglect (Public Law 99-401), threatening to harm another person, threatening suicide, committing or threatening a crime on program property or against program staff, medical emergencies, elder abuse, and court orders.

  A thorough discussion of the Federal law regarding confidentiality for substance abuse clients appears in the Center for Substance Abuse Treatment's (CSAT's) free Technical Assistance Publication Series publication #13 and #18. Both are available online in their entirety.

- ***Privilege.*** Privilege is a legal concept that refers to a client's right to keep confidential information out of legal proceedings. Technically, the client holds the privilege, so counselors may not disclose information in legal proceedings unless the client waives privilege or certain other conditions, which vary from State to State, are met. For all practical purposes, communication between a client and an LCDC is not considered privileged in Texas. Even so, a counselor who receives a subpoena should assert privilege. The court will review the situation and may then issue a court order that would permit disclosure, even if the client declines to waive privilege.

- ***Informed consent and releases of information.*** Client consents to release information about their treatment must contain certain specific information. This includes, but is not limited to, the purpose of the disclosure, the person to receive the disclosed information, and the date or condition under which the consent will expire. The consent may be revoked in writing or verbally, at the client's discretion.

  Counselors have to obtain consent from minor clients before releasing information. By law, releases of information must include a statement that the recipient of the disclosure cannot make subsequent disclosures unless federal regulations permit them to do so.

- ***Duty to warn.*** If a client threatens to harm another person who is reasonably identifiable, the counselor has a duty to warn the appropriate authorities of that threat. In Texas, counselors do not have a duty to warn the intended victim. In some States, counselors do have that duty, which originated in the California Supreme Court decision in Tarasoff v. Regents of the University of California.

- *Suicide threats*. Counselors may have to enlist the help of others when a client threatens self-harm. Counselors have the right to disclose the minimum amount of confidential information necessary to help prevent a client's suicide. This right exists because it is ethical, in terms of presumably serving the best interests of the client, not because there is a legal duty to do so.

H. Nonvoluntary Clients

Clients who have not sought treatment voluntarily should be given all of the information necessary to give informed consent for treatment, even if the consent is not, in the purest sense, voluntary. For example, they should be informed of the potential risks of treatment, duration and cost of treatment, the counseling approach to be used, their rights, and the limits to confidentiality. As always, decisions should be made in the best interests of the client, and the client should be informed of what may appear to be potentially conflicting loyalties that the counselor may have (e.g., to the client's employer, probation officer). Nonvoluntary clients should be allowed to exercise as much choice as possible regarding their treatment.

I.   Respecting Client Diversity

Counselors are required to be respectful of clients of all cultures. Cultural differences exist in clients' socioeconomic status, racial or ethnic identification, gender, sexual orientation, physical and cognitive ability, and religion. The first step in culturally sensitive counseling is to be aware of one's own lack of information about other cultures and one's prejudices. When a counselor encounters a client whose culture is unfamiliar, the counselor is responsible for obtaining the education and guidance necessary to understand that culture and to process any feelings that could interfere with counselor empathy. Otherwise, a counselor might unintentionally behave in a racist, ethnocentric, ageist, sexist, or heterosexist manner. If the counselor is unable to work effectively with a client, a conscientious referral should be made.

A key concept regarding diversity is that within-group differences are always greater than between-group differences. For example, there is more variation represented within the population of heterosexual clients and within the population of homosexual clients than there is between the two groups. Therefore, counselors should not make assumptions about individual clients based on the client's cultural identifications.

Counselors also need to be comfortable acknowledging and exploring the influence of culture with individual clients. For example, even though there are no biologically distinct races of people, the sociopolitical concept of race may have greatly influenced a client's self-image and life experiences; likewise for a female client and her experiences with sexism or an elderly client who has experienced ageism.

J. Professional Development

Professional development is an ongoing responsibility. It is accomplished through engaging in continuing education, self-evaluation, supervision, and consultation.

K. Continuing Education

Licensure as an LCDC is not the end of a counselor's education. Counselors are responsible for staying current in their field. This can be accomplished by formal education, attending workshops and conferences, and by reading professional journals and new books about substance abuse counseling. Texas law stipulates the minimum number of hours of continuing education required for licensure renewal. For LCDCs it is at least 60 hours every 2 years, unless the individual holds another license (as a physician, psychologist, LPC, or LMSW), in which case 24 hours are required every 2 years. Ethical practice requires that a counselor get the training necessary to stay sharp in one's job, even if that means exceeding the minimum number of hours of continuing education.

L. Self Evaluation

Professional practice requires that counselors continuously evaluate their own performance. Counselors must acknowledge the limits of their knowledge and skill and take care to practice within one's scope of competence as well as the scope of practice described in state law. In Texas, Rule 150.102 states that the scope of practice for a chemical dependency counselor includes services that address substance abuse/dependence and/or its impact on the service recipient as long as the counselor does not use techniques that exceed his or her professional competence. The service recipient may be the user, family member, or any other person involved in a significant relationship with an active user. LCDCs may diagnose substance disorders, but anything other than a mental health diagnostic impression must be determined by a qualified professional. Lastly, LCDCs are not qualified to treat individuals with a mental health disorder or provide family counseling to individuals whose presenting problems do not include chemical dependency.

Counselors must also evaluate how their personal beliefs and concerns affect the counseling process, so that they do not pursue personal agendas with clients, thereby reducing treatment quality. An unaware counselor may not present all potentially helpful options to clients, or fail to support clients' choices of which the counselor disapproves. For example, consider a counselor who believes that there is only one path to recovery for all clients, or that abstinence is the only proper goal for all clients, or that only counselors in recovery can work effectively with addicted clients.

Counselors are expected to monitor their own wellness, and to make healthy lifestyle choices, because this directly affects their professional effectiveness. If personal problems threaten counselor effectiveness, the counselor is responsible for securing

whatever assistance is needed. This applies to counselors who are in recovery from substance abuse or dependence and those who are not. Note that sometimes counselors violate ethical standards not because their motives are bad but because their judgment has become impaired from poorly-managed stress.

M. Supervision

The purposes of supervision are to promote the counselor's growth, protect the welfare of clients, monitor counselor performance, and empower the counselor to self-supervise and carry out their responsibilities as an independent professional (Haynes, Corey & Moulton, 2003). Powell (1998) describes four emphases of supervision: administrative, evaluative, clinical, and supportive. Administrative supervision focuses on matters such as case record maintenance and performance evaluation. Clinical supervision focuses on the clinical skills of the supervisee. Someone who has workplace authority over the counselor usually provides supervision. In peer supervision, experienced counselors provide supervision to one another.

There are several models of clinical supervision. One way of categorizing them is a developmental approach, a psychodynamic model, a skills model, a family therapy model, and a blended model (Powell, 1998). Whichever model of supervision is used, the exact responsibilities of the supervisor and supervisee should be spelled out, and supervisees should be informed at the outset how their performance is going to be evaluated. Providing competent supervision requires specialized knowledge and skills that differ from those required for counseling. Clinical supervisors are held legally responsible for the actions of counselor interns they supervise.

N. Consultation

A counselor seeks consultation in order to apply the expertise of another person toward better serving a client. Examples of people with whom LCDCs might consult are a client's physician, a marriage and family therapist, an AA sponsor, or a religious leader. Consultation between professionals within the same organization is called *internal consultation*. If the consultant and the consultee do not belong to the same organization it is called *external consultation*.

O. Referrals

In order to make proper referrals, LCDCs need to be able to recognize symptoms in clients that require assessment by other professionals such as physicians, psychologists, or licensed professional counselors. They also need to be familiar with services available in the community such as legal services, emergency services, and Alcoholics Anonymous and other self-help groups. It is good practice to be personally familiar with the philosophy, programs, and personnel of the services to which clients are referred and to be active in the referral; for example, to make the appointment for clients rather than just provide a phone number for them to call (Kinney, 2003, p. 243).

P. Advocacy

Advocacy is any activity designed to obtain a service, practical help, support, or information for a client (Graham, Timney, Bois & Wedgerfield, 1995, p. 441). Examples of advocacy are obtaining practical help such as money to pay for travel to treatment and securing an adolescent client's school counselor's support for treatment. Advocacy requires that counselors maintain effective relationships with other professionals, government organizations, and groups in the community that might be helpful to their clients' recovery.

Q. Summary

What makes counseling a profession is that its members share a common body of knowledge, a code of ethics, and a concern for their peers (Bissell & Royce, 1994, p. 1). Professional conduct results in quality service to clients, personal satisfaction, and protection from burning out, and in enhancement of the substance abuse counseling field's visibility and reputation in the community.

VII. Suggested Reading List

Each LCDC candidate has different written test preparation needs. Therefore, this section contains resources from which candidates may choose what they find most useful.

A. Adapted IC&RC Reading List

These books appear on the IC&RC's suggested reading list. They are the source of many, but not all, items on the test (IC&RC, 2003).

- American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders (4th edition, Text Revision). Washington, DC: American Psychiatric Association.

- Benshoff, J.J. & Janikowski, T. P. (2000). The Rehabilitation Model of Substance Abuse Counseling. Pacific Grove, CA: Brooks/Cole.

- Buelow, G. & Buelow, S. (1998). Psychotherapy in Chemical Dependence Treatment: A Practical and Integrative Approach. Pacific Grove, CA: Brooks/Cole.

- Corey, M.S. & Corey, G. (2002). Groups: Process and Practice (6th ed.). Pacific Grove, CA: Brooks/Cole.

- Corey, G. (2005). Theory and Practice of Counseling and Psychotherapy, (7th ed.). Pacific Grove, CA: Brooks/Cole.

- DeLeon, G. (2000). The Therapeutic Community: Theory, Model and Method. New York, NY: Springer Publishing.

- DiClemente, C. C. (2003). Addiction and Change: How Addictions Develop and Addicted People Recover. New York, NY: Guilford Press.

- Doweiko, H.E. (2002). Concepts of Chemical Dependency (6th ed), Pacific Grove, CA: Brooks/Cole.

- Fisher, G. & Harrison, T. (2005). Substance Abuse: Information for School Counselors, Social Workers, Therapists and Counselors (3rd ed.) Upper Saddle River, NJ: Allyn & Bacon.

- Herdman, J. (2001). Global Criteria: The 12 Core Functions of the Substance Abuse Counselor (3rd ed.). Holmes Beach, FL: Learning Publications, Inc.

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- Kinney, J. (2003). Loosening the Grip: A Handbook of Alcohol Information (7th ed.). New York, NY: McGraw Hill.

- McCollum, E. E. & Trepper, T. (2001). Family Solutions for Substance Abuse: Clinical and Counseling Approaches. Binghamton, NY: The Haworth Press.

- Miller, W.R. & Rollnick, S. (2002). Motivational Interviewing: Preparing People for Change (2nd ed.). New York, NY: Guilford Press.

- Powell, D. J. (1997). Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models, and Methods. San Francisco, CA: Jossey-Bass.

- Ray, O. & Ksir, C. (2004). Drugs, Society and Human Behavior (10th ed.). New York, NY: McGraw-Hill.

B. Suggested Reading

These readings contain testable material, although they may or may not have been used to produce test items. These are current, reputable sources of information for candidates who want to increase their confidence by studying a particular topic in some depth.

- Allen, J. P. & Wilson, V.B. (Eds.). (2003). Assessing Alcohol Problems: A Guide for Clinicians and Researchers (2nd ed.). Bethesda: MD: National Institute on Alcohol Abuse and Alcoholism.

- Bissell, L. & Royce, J.E. (1994). Ethics for Addiction Professionals (2nd ed.). Center City, MN: Hazelden Publishing and Educational Services.

- Blume, S.B. (1998). Addictive Disorders in Women. In R.J. Frances & S. Miller (Eds.), Clinical Textbook of Addictive Disorders (2nd ed.). (pp. 413-429). New York, NY: The Guildford Press.

- Brick, J. & Erickson, C.K. (1998). Drugs, the Brain, and Behavior: The Pharmacology of Abuse and Dependency. Binghamton, NY: The Haworth Press.

- Center for Substance Abuse Treatment (2001). Comprehensive Case Management for Substance Abuse Treatment. Treatment Improvement Protocol #27. Rockville, MD: Substance Abuse and Mental Health Services Administration.

- Center for Substance Abuse Treatment (1999). Confidentiality of Patient Records for Alcohol and Other Drug Treatment. Technical Assistance Publication Series #13. Rockville, MD: Substance Abuse and Mental Health Services

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- Center for Substance Abuse Treatment (1995). Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse. Treatment Improvement Protocol #9. Rockville, MD: Substance Abuse and Mental Health Services Administration.

- Corey, G., Corey, M.S., & Callanan, P. (2003). Issues and Ethics in the Helping Professions (6th. ed.). Pacific Grove, CA: Brooks/Cole- Thomson Learning.

- DiClemente, C.C. & Velasquez, M. M. (2002). Motivational Interviewing and the Stages of Change. In Motivational Interviewing: Preparing People for Change (2nd ed.). W. R. Miller & S. Rollnick (Eds.), (pp. 201-216). New York, NY: Guilford Press.

- Evans, K. & Sullivan, J. M. (1995). Treating Addicted Survivors of Trauma. New York, NY: Guilford Press.

- Fields, R. (2001). Drugs in Perspective: A Personalized Look at Substance Use and Abuse (4th ed.). Boston, MA: McGraw Hill.

- Hanson, G.R., Venturelli, P.J., Fleckenstein, A.E. (2004). Drugs and Society (8th ed.). Boston, MA: Jones and Bartlett.

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- Hood, A. B. & Johnson, R. W. (2002). Assessment in Counseling: A Guide to the Use of Psychological Assessment Procedures (3rd ed.). Alexandria, VA: American Counseling Association.

- Julien, R. M. (2001). A Primer of Drug Action (9th ed.). New York, NY: Worth Publishers.

- Lawson, G.W., Lawson, A.W., & Rivers, P.C. (2001). Essentials of Chemical Dependency Counseling (3rd ed.). Gaithersburg, MD: Aspen Publishers.

- National Association of Alcoholism and Drug Abuse Counselors (1995). Ethical Standards for Counselors. Alexandria: VA: http://www.naadac.org/documents/display.php?DocumentID=11

- National Institute on Drug Abuse (1999; reprinted 2000). Principles of Drug Addiction Treatment: A Research-based Guide. NIH Publication No. 99-4180. Available online: http://165.112.78.61/PODAT/PODATindex.html.

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- O'Connell, D. & Beyer, E. (2002). Managing the Dually Diagnosed Patient: Current Issues and Clinical Approaches. Binghamton, NY: Haworth Press.

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- Remley Jr., T.P., & Herlihy, B. (2001). Ethical, Legal and Professional Issues in Counseling. Upper Saddle River, NJ: Prentice-Hall.

- Velasquez, M.M., Maurer, G.G., Crouch, C., & DiClemente, C.C. (2001). Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual. New York, NY: Guilford Publishers.

- Watkins, T.R., Lewellen, A., Barrett, M.C. (2001). Dual Diagnosis: An Integrated Approach to Treatment. Thousand Oaks, CA: Sage Publications.

C. Video and Practice Testing Materials

- Lewis, J. & Carlson, J. (2001). Brief Therapy for Addictions Video Series. Allyn & Bacon. (The series demonstrates different theoretical approaches at work.)

- The Wellspring Review (2002). Written LCDC Exam Preparation CD. (The CD contains 500 practice multiple-choice items.)

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