



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Counseling

Introduction

Instructor Note: Welcome students to the world of counseling. In this introduction you will read about some history of drug & alcohol treatment, which is important as it provides a framework of understanding of where we started and perhaps, where we will be going. However, a significant portion of the introduction explains who a counselor is, what is expected of counselors, who are our clients, how do they come to us and more importantly, how do we keep them and move them forward. Read carefully this section has a wealth of information that you will need to have the appropriate, professional mindset.

Go forth and begin your journey!

History of Drug and Alcohol Treatment in America – Timeline of Notable Events

The phrase, **drug treatment**, is currently used to refer to treatment for problems with a wide array of substances including both illegal drugs and prescription medications. From the 1950's through the 1970's, however, drug treatment programs focused primarily on heroin and other opiates and were operated separately from programs focusing on alcohol. This division is reflected to this day in the fact that the federal government still maintains a National Institute on Drugs (NIDA) separate from the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Significant Events in the History of Addiction Treatment and Recovery in America

1750 to Early 1800s

Alcoholic mutual aid societies (sobriety "Circles") are formed within various Native American tribes. Some are part of, or evolve into, abstinence-based Native American cultural revitalization movements and temperance organizations.

1784



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Dr. Benjamin Rush's Inquiry into the Effects of Ardent Spirits on the Human Mind and Body catalogues the consequence of chronic drunkenness and argues that this condition is a disease that physicians should be treating. Rush's writing marks beginning of American temperance movement.

1810

Dr. Benjamin Rush calls for creation of a "Sober House" for the care of the confirmed drunkard.

1844 - 1845

Lodging Homes and later (1857) a Home for the Fallen are opened in Boston -- marking the roots of the 19th century inebriate home. As inebriate homes spread, they will spawn several alcoholic mutual aid societies such as the Godwin Association.

1845

Frederick Douglass (having earlier acknowledged a period of intemperance in his life) signs a pledge of abstinence and becomes involved in promoting temperance among African American people. His call for abstinence as a foundation of the drive to abolish slavery and prepare Black people for full citizenship anticipated modern Afrocentric models of addiction recovery.

1849

The Swedish physician Magnus Huss describes a disease resulting from chronic alcohol consumption and christens it Alcoholismus chronicus. This marks the introduction of the term alcoholism.

1864

The New York State Inebriate Asylum, the first in the country, is opened in Binghamton, NY. A growing network of inebriate asylums will treat alcoholism and addiction to a growing list of other drugs: opium, morphine, cocaine, chloral, ether, and chloroform.

1867

The opening of the Martha Washington Home in Chicago marks the first institution in America that specialized in the treatment of inebriate women.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

1870

The American Association for the Cure of Inebriety founded under the principle "Inebriety is a disease." The Association's Journal of Inebriety is published from 1876-1914.

1870's

New alcoholic mutual aid societies - the Ribbon Reform Clubs -- begin in the Northeast and spread throughout the U.S. over the next two decades. They are named for their members' practice of wearing a colored ribbon on their clothing so that they could recognize one another and convey a message of hope about recovery to the larger community.

1879

Dr. Leslie Keeley announces that "Drunkenness is a disease and I can cure it." He opens more than 120 Keeley Institutes across the U.S., marking the beginning of franchised, private, for-profit addiction treatment institutes/sanatoria in America.

1880's

Cocaine is recommended by Sigmund Freud and a number of American physicians in the treatment of alcoholism and morphine addiction. Bottled home cures for the alcohol and drug habits abound; most will be later exposed to contain alcohol, opium, morphine, cocaine and cannabis.

1891-1892

Keeley League (a Keeley Institute patient mutual aid society) founded. Keeley League members meet under the banner, "The Law Must Recognize a Leading Fact: Medical Not Penal Treatment Reforms the Drunkard." As inebriate homes and asylums close, alcoholics are relegated to city "drunk tanks," "cells" in "foul wards" of public hospitals, and the backwards of aging "insane asylums." Wealthy alcoholics/addicts will continue to seek discrete detoxification in private sanatoria know as "jitter joints," "jag farms" or "dip shops."

1901

The Charles B. Towns Hospital for Drug and Alcoholic Addictions in New York City marks the beginning of a new type of private "drying out" hospital for affluent alcoholics and addicts.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

1906

The Emmanuel Clinic in Boston begins the practice of lay therapy in the treatment of alcoholism. The Clinic will generate a number of noted lay therapists (Baylor, Chambers, Peabody) who will exert enormous influence on alcoholism treatment for several decades. The Jacoby Club serves as the Clinic's mutual aid society.

1919 – 1924

Forty-four communities establish morphine maintenance clinics (run by public health departments or police departments) to care for incurable and medically infirm addicts. All eventually close under threat of federal indictment. Treatment for narcotic addiction virtually disappears for all but the most affluent Americans.

1920's

Most inebriate homes, inebriate asylums and private addiction cure institutes collapse between 1910 and 1925. The Journal of Inebriety ceases publication in 1914 and its parent association collapses in the early 1920s.

1935

The opening of Shadel Sanatorium marks the introduction of aversive conditioning in an institutional alcoholism treatment setting.

The first federal "narcotics farm" (U.S. Public Health Prison Hospital) opens in Lexington, Kentucky. The second facility opens in Fort Worth, Texas in 1938. This marks the beginning of federal involvement in addiction research and addiction treatment.

The meeting of Bill W. and Dr. Bob S. (and Dr. Bob's last drink) mark the beginning of Alcoholics Anonymous (AA).

1939

The book, Alcoholics Anonymous, is published.

1940- 1945



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Recovered alcoholics in AA are recruited at Remington Arms, DuPont, Kaiser Shipyards, and North American Aviation to work in the first modern industrial alcoholism programs -- forerunners of today's employee assistance programs (EAPS).

1943

Yale Center of Alcohol studies initiates a significant research program, the Summer School of Alcohol Studies, the Yale Plan Outpatient Clinics, and the Yale Plan for Business and Industry. The Center will move to Rutgers in 1962.

1944

Marty Mann founds the National Committee for Education on Alcoholism (today the National Council on Alcoholism and Drug Dependence) around the following propositions:

1. Alcoholism is a disease.
2. The alcoholic, therefore, is a sick person.
3. The alcoholic can be helped.
4. The alcoholic is worth helping.
5. Alcoholism is our No. 4 public health problem, and our public responsibility.

Mann calls for a five-prong approach to be achieved by local NCEA affiliates:

1. Launching local public education campaigns on alcoholism.
2. Encouraging hospitals to admit alcoholics for acute detoxification.
3. Establishing local alcohol information centers.
4. Establishing local clinics for the diagnosis and treatment of alcoholism.
5. Establishing "rest centers" for the long-term care of alcoholics.

The first state alcoholism commissions are founded. They support fledgling efforts at local community education and treatment.

1947



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

An Addicts Anonymous group begins meeting at U.S. Public Health Hospital in Lexington, Kentucky. Meetings begin outside the institution in New York City under the name Narcotics Anonymous (NA) in 1949 but dissipate over time. The roots of today's NA can be traced to groups that began in California in 1953. International Doctors in AA founded.

1948

Alcoholics Victorious is founded within the Chicago Christian Industrial League and spreads as a Christian, recovery support group within many of the nation's urban missions.

1948 – 1950

The "Minnesota Model" of chemical dependency treatment emerges in the synergy between three institutions: Pioneer House, Hazelden, and Willmar State Hospital. (Antabuse) introduced as an adjunct in the treatment of alcoholism in the U.S. Other drugs used in the treatment of alcoholism during this period include barbiturates, amphetamines (Benzedrine), and LSD.

1950

The Twelve Traditions are formally adopted to govern the group life of AA. The National Institute of Mental Health establishes a special division on alcoholism Marty Mann's Primer on Alcoholism is published. American Medical Association (AMA) resolves to create a special committee to develop a program for "medicine's aggressive participation in the work of solving the problems of alcoholism."

Early 1950's

AA membership surpasses 90,000 as America (and Hollywood) becomes interested in the subject of alcoholism. Cinema portrayal of alcoholism includes such noted films as Lost Weekend, Days of Wine and Roses, and Come Back, Little Sheba.

1950's

The halfway house movement culminates in the founding (1958) of the Association of Halfway House Alcoholism Programs of North America.

1951



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Lois W. and Anne B. start a Clearing House for the growing number of Family Groups that have grown in tandem with AA through the 1940s. The opening of the Clearing House marks the formal organization of these groups into Al-Anon Family Groups.

1952

American Medical Association first defines alcoholism. R. Brinkley Smithers establishes the Christopher D. Smithers Foundation, a charitable organization that focuses its primary mission on the support of alcoholism education and treatment efforts. This focus followed Smithers' own recovery from alcoholism and his participation in the Yale Summer School of Alcohol Studies. By the mid-1990s, the Foundation and the Smithers family had donated more than \$37 million to support alcoholism-related projects.

1954

Ruth Fox, MD establishes the New York City Medical Society on Alcoholism, today known as the American Society of Addiction Medicine (ASAM). The Minnesota State Civil Service Commission becomes the first such body in the United States to approve a state job classification position for "Counselor on Alcoholism."

1956

The American Medical Association stops short of declaring alcoholism a disease but does recognize alcoholics as legitimate patients: "Hospitals should be urged to consider admission of such patients with a diagnosis of alcoholism based upon the condition of the individual patient, rather than a general objection to all such patients."

1957

The Veteran's Health Administration begins developing alcoholism treatment units within its national network of VA hospitals. American Hospital Association passes resolution to help prevent discrimination against alcoholics. Fordham University School of Social Services offers first full university course on alcoholism for credit.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

1958

The first ex-addict-directed therapeutic community - Synanon -- is founded by Charles Dederich. It will be widely replicated in the 1960s and 1970s.

1960

E.M. Jellinek publishes The Disease Concept of Alcoholism.

Early 1960's

Several states initiate civil commitment programs for narcotic addicts.

1963

American Public Health Association adopts an official statement on alcoholism, identifying it as a treatable illness. Dr. Vincent Dole, an endocrinologist, and Dr. Marie Nyswander, a psychiatrist specializing in addiction, introduce methadone blockade therapy in the treatment of narcotic addiction.

1964 - 1975

The insurance industry begins to reimburse the treatment of alcoholism on par with the treatment of other illnesses. This leads to a dramatic expansion in private and hospital-based inpatient treatment programs.

1966

Two federal Appeals Court decisions support the disease concept of alcoholism. President Johnson appoints first National Advisory Committee on Alcoholism and becomes the first President to address the country about alcoholism. He proclaims: "The alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment."

The National Center for the Prevention and Control of Alcoholism is created within the National Institute on Mental Health.

The Narcotic Addict Rehabilitation Act (NARA) marks a milestone of increased federal involvement in supporting development of local addiction treatment services.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

The New York Medical Society alters its mission to become the American Society on Addiction Medicine.

1967 - 1971

Special alcoholism counseling/treatment initiatives begin within all major branches of the U.S. Armed Forces.

1970

Congress passes the "Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act," known as the Hughes Act for its sponsor in the Senate, Harold E. Hughes. The legislation establishes the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Those testifying in support of the legislation include Marty Mann of NCA and Bill Wilson, Co-founder of AA.

1972

The Joint Commission on Accreditation of Hospitals develops accreditation standards for alcoholism treatment programs.

The Alcoholism Report, the first newsletter devoted exclusively to the field of alcoholism, begins publication.

The National Association of Alcoholism Counselors and Trainers is founded at a meeting of Organization for Economic Opportunity regional alcoholism programs. It will evolve into the National Association of Alcoholism and Drug Abuse Counselors (NAADAC).

The Food and Drug Administration approves use of methadone for treating heroin addiction.

The Drug Abuse Treatment Act of 1972 creates the Special Action Office for Drug Abuse Prevention that will lay the groundwork for the creation of the National Institute on Drug Abuse in 1974.

TASC (Treatment Alternatives to Street Crime) is created by the Drug Abuse and Treatment Act to screen addicts in the criminal justice system and then to link and manage their involvement in treatment services.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

1973

U.S. investigators first describe fetal alcohol syndrome (FAS), a pattern of birth defects observed in children born to alcoholic mothers.

Vernon Johnson's book, *I'll Quit Tomorrow*, introduces intervention technologies that will be widely used to reach alcoholics and addicts before they "hit bottom."

1974

The first of a series of studies on credentialing of counselors working in alcohol and drug treatment programs marks the beginning of a sustained process of certification and licensure of addiction counselors.

1978

First Lady Betty Ford speaks to the nation about entering recovery from addiction to alcohol and other drugs.

1980

President Carter appoints the National Commission on Alcoholism and Other Alcohol Related Problems chaired by Senator Harold Hughes. It only meets once.

Mothers Against Drunk Driving, a powerful grassroots advocacy group, is formed.

1981

The U.S. Postal Service issues a first-class stamp imprinted with "Alcoholism. You can beat it!"

Nancy Reagan's "Just Say No" anti-drug campaign is launched within a broader "zero tolerance" campaign that will reduce federal support for treatment and mark the beginning of the dramatic rise in the number of drug users incarcerated. The growth of addicted offenders in the 1980s will lead to the demand for drug courts and in-prison treatment in the 1990s.

1982



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

The federal Block Grant Program transfers responsibility for the delivery of treatment and prevention services to the states.

Former First Lady Betty Ford lends her name to a treatment center for alcoholism and other drug addictions.

Cocaine Anonymous is founded.

1982 – 1992

The number of women-only treatment units triple as NIAAA and NIDA focus attention on the special needs of addicted women.

1983

First certification exam for addiction medicine specialty is offered in California. National Association for Children of Alcoholics is founded.

1985

First appearance of crack cocaine focuses enormous public attention on the illegal drug problem. Concerns about cocaine-exposed infants lead to expansion of treatment resources for women and specialized programs to treat women involved in the child protection system.

American Academy of Psychiatrists in Alcoholism and Addictions is founded.

1985 – 1990

Addiction treatment becomes increasingly concerned about "special populations" and launches specialized treatment tracks for women, adolescents, the elderly, gays and lesbians, and the "dually diagnosed." As the challenges of treating new patterns of cocaine addiction grow, relapse tracks also become a common treatment innovation.

1987

President Reagan formally announces a renewed "War on Drugs"; the shift away from treatment toward punishment and incarceration intensifies.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

American Medical Association calls all drug dependencies diseases whose treatment is a legitimate part of medical practice.

1989

The publication of Stanton Peele's *Diseasing of America: Addiction Treatment Out of Control* marks the full emergence of a movement whose primary mission is opposition to Twelve Step programs and Twelve Step-oriented addiction treatment.

The first specialized "drug court" is started by Miami Judge Stanley Goldstein. It will spur a national movement to link addicted, non-violent offenders to treatment as an alternative to incarceration.

1989 – 1994

Following an erosion of alcoholism treatment reimbursement benefits by insurance carriers, an aggressive system of managed care all but eliminates the 28-day inpatient treatment program in hospitals and private, free-standing centers. The downsizing and closure of hospital-based treatment units sparks a trend toward the integration of many psychiatric and addiction treatment units and a renewed community trend of incorporating addiction treatment services under the umbrella of mental health or "behavioral health" services. Most inpatient treatment programs shift their emphasis toward outpatient and intensive outpatient services. The loss of residential services adds fuel to a growing recovery home movement.

1991

The American Society of Addiction Medicine publishes its ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders. The ASAM criteria shift treatment toward a "levels of care" system rather than a single modality indiscriminately applied to all those entering treatment.

1992

The Center for Substance Abuse Treatment created to expand the availability and quality of addiction treatment.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

The Americans With Disabilities Acts extends job protection (except in safety-sensitive positions) to alcoholics and recovering drug addicts in the private sector.

1995

U.S. Food and Drug Administration approves prescription use of naltrexone in treatment for alcoholism. Naltrexone marks the emergence of a new generation of pharmacological adjuncts in the treatment of alcoholism and other addictions.

2000

In a milestone article in the Journal of the American Medical Association, Drs. McLellan, Lewis, O'Brien, and Kleber call for the re-conceptualization and treatment of addiction as a chronic medical illness.

Instructor Note: In an effort to help you, the student, create easy to study “cheat sheets”, I will use the TAP 21 competencies for counseling at the beginning of each related section of this course.

Competency: Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy

Who Becomes a Counselor?

People do not gravitate to the counseling profession in the same way that people choose to become insurance agents, plumbers, or corporate executives. In working with new students in the CAP classes and in many discussions with my colleagues over the years, I find that behind a vague desire to “help people” there is usually a person searching for a life of more meaningful connection, both with self and with others. Often the student’s life had seemed filled with bad choices or ventures down blind alleys to dead ends, leaving the student looking for a better way to channel interpersonal energy. Sometimes individuals consider becoming counselors after overcoming some major life challenge such as addiction or a history of bad relationships. Perhaps an individual has encountered a particularly effective counselor or therapist and has a



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

desire to follow in those footsteps. Others may have had a bad experience with counseling and concluded that it can be done better.

People do not think of this work so much as a job, or even as a career. More typically, a constellation of life experiences that demand explanation and a sense that others seek one out for assistance and emotional sustenance become driving forces leading one toward the counseling profession. Many people who come to this profession feel that they have been called to it in some fashion (Foster, 1996).

You may think of yourself as having some unique talents or gifts for understanding others. Maybe you have led a successful, outwardly exemplary work life—making lots of money and building a reputation—but have been left feeling unfulfilled and dissatisfied. You may come to this work from a history of personal pain or trauma.

All kinds of life experiences and a wide variety of motivations for wanting to become a counselor are legitimate. Any and all of these provide fuel for the self-examination mill. You will want to examine your motivations because you will want to work cleanly with people, only minimally encumbered by your own unfinished business. This examination should involve both an intellectual review of your motivations and a review of the emotional issues related to your desire to do this work. Evidence (Goleman, 1995, 1998) suggests that your ***emotional connections to your desire for this work are at least as important as your intellectual ones.***

Some people are, of course, drawn to this profession for the wrong reasons—to take advantage of others' vulnerabilities or to work out their own personal problems (Witmer & Young, 1996). While you should not be primarily involved with this profession to promote your own self-awareness and understanding, you can nevertheless take comfort in the fact that the profession can lead you toward a greater understanding of yourself. ***The best counselors commit themselves to lifelong growth and learning (Spurling & Dryden, 1989), much of which comes via the clients they serve.***

The Nature of the Work

You are being called to a noble profession. It is a profession with many rewards and with attendant responsibilities. It is a privilege and an honor to be invited to share in some of the intimate details of another's life, and you are obliged to respect the gift that that sharing implies. But what is it, exactly, that you may anticipate being called upon to do? The reasons people seek out counselors are many and varied. Many people come for counseling to resolve some kind of personal or life problem. Usually, these people come with a genuine, positive desire to be helped, but you will also encounter the occasional client who will manipulate and con you (Kierulff, 1988). Sometimes personal problems precipitate crises, periods of deep emotional pain. People can become extremely distraught, and you may be called upon to help them through these difficult times.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

With desperate people who are trying to simply stay afloat in turbulent waters, your job is to provide an emotional life raft and maybe to help find the resources for them to move toward the safer shallows. In addition to their addiction issues the client may have marital or financial problems, or problems dealing with a child. Sometimes problems are poorly defined—just a vague dissatisfaction or feeling of emptiness or depression. The problems may be multiple, overlapping, and complex or relatively simple and easily remedied. Some people may have emotional, mental, or physical problems that severely impair their ability to function well in the world.

Whatever problems clients may feel they have, they are looking to a counselor to help make things better. If someone is in critical straits, some kind of crisis intervention may be necessary. Similarly, you may work to help people reconcile and correct serious behavioral problems. Those problems may have gotten them in trouble, and other people may have directed them toward counseling. They may have problems not only with drugs/alcohol, but, also with the law, their jobs and, of course, their families. Your job may be to help monitor, supervise, and support positive behavioral change. In these roles, you may be called upon to enforce rules and use leverage to keep people in treatment. The work here is most certainly not always “warm and fuzzy,” and it may run counter to what many people think of when they consider the nurturing, supportive role of the counselor. Appropriately tough enforcement of rules, needed response. You may function in a kind of cheerleading or coaching role, providing suggestions and support for new courses of action. Much of this work will be helping people to see their hidden talents and to recognize their own strengths that have gone unsupported.

Other clients of yours may function perfectly well but feel trapped within their functional lives, yearning for more but not knowing exactly what they want. A vast group of potential clients are those who are searching for personal growth and increased authenticity. They function well in their lives, may have solid jobs and intact families, and are successful by all traditional notions of the word “success.” Yet they feel incomplete, unfulfilled, and have deep longings for something more, something just out of the grasp of their awareness.

Your job as a counselor may thus be to call your client to greatness, to become an ally in the search for nobility and for the heroic that resides within us all. You may need to help some of your clients acknowledge the ways they keep themselves from becoming truly free and self-directed, the ways they have created their own little prisons, their “mind-forged manacles,” and some of the complex reasons for such retreat from real freedom. At its best, counseling is about assisting clients in responding to their particular calls to greatness. You will want your clients, to repeat the clichéd phrase, to be “the best that they can be.”

We all search for the heroic within us. When we shrink from our desires to embrace our unique talents and the gifts we might bring to the world, we are eaten from within by our own



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

dissatisfactions and stunted growth. It is this call to greatness that we assist many of our clients in answering and that we naturally seek to answer in our own lives. Here we are called on to play a philosopher-counselor role, and it stands to reason that the questions asked by our clients are similar to those with which we grapple ourselves.

The Rewards & Challenges of Counseling

Learning to be a counselor involves building a repertoire of assessment, responding, and helping skills. It involves, in other words, developing tools to help you help your client repair the mental and emotional “house” in which she lives. But it is much more than that. It is the development of wisdom; it is about learning how to connect effectively with people. It requires that you learn about yourself in the midst of assisting others (Guindon, 2011; Reinkraut, Motulsky, & Ritchie, 2009). It is both science and art. You should find particular joy in a profession where learning about yourself is prerequisite to learning how to do the work with others. What other professions can make such a claim? Moreover, learning to do this work has the tremendous potential for reaching into the other realms of our lives and enriching them. There is distinct potential for improving the general quality of your relationships with others, particularly your most intimate relationships, as a side benefit of becoming an effective counselor. Again, what other profession can offer such rewards?

This work is not without its difficulties and challenges, however. It can be emotionally draining and difficult, particularly when you deal every day with people who move from one crisis situation to another. It can at times be difficult to not take your clients’ problems home with you.

Instructor Note: I oftentimes suggest to my CAP students that they interview counselors working in the field, either as part of a formally assigned experience or more informally for their own education. They sit down and talk with counselors working in various substance abuse facilities, mental health agencies, and schools and ask them about their joys and frustrations with the work. They come back with interesting reports of these talks. It is not unusual for me to hear talk of the passion and dedication many of these counselors take in watching their clients, grow and experience their lives in health & recovery. They talk of how these counselors themselves report that they grow and learn from their interactions with their clients. My students are inspired by these stories. It is confirmation of their own initial desires to enter the field.

But there are also the stories of overwhelming caseloads, of a parade of difficult clients, of unresponsive agency administrators, and of unending paperwork. Some inpatient counselors talk of dramatically difficult clients with behavioral and emotional problems coupled with diminishing lengths of stay. Sometimes my students interview counselors who seem disconnected from their work, not particularly fond of their clients or their colleagues, and ready to work elsewhere but unwilling to



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

go out and look for another job. A general ambivalence, lack of energy, almost a depression surrounds these counselors—and students cannot help but wonder about the toll counseling takes on those who work in this field. They correctly wonder about the degree of help these counselors can afford their clients and speculate about the motivations that will continue to keep them at work in a field where adequate interpersonal payback has ceased. Words like “burnout” are mentioned in these discussions.

Ongoing counselor self-understanding and personal examination is more than a casual, self-indulgent preoccupation with self, or ego gratification. It is an ethical, professional obligation that you manage your relationship matrix variables, your own history, and your current emotional life so that full attention can be paid to your client’s relationship variables, history, and emotional life. You are also obliged to come to grips with counseling work itself should it ever become stale and unrewarding, for whatever reason, so that you can either quit and move on to something else or find ways to become revitalized and enthusiastic.

Instructor Note: For myself, I cannot thank this profession enough for giving me the tools and wherewithal to deal more effectively with my own family, friends, and other close relationships. I am not the perfect listener, and still have lapses in how closely I attend to friends and family, but I do at least know the difference between good and poor listening, the importance of solid emotional contact, and the need for give and take in a relationship. It is my fervent hope that this work benefits you in a similar fashion. I am convinced it has that potential. As much as this work is about helping others, it is also about helping yourself. You will become involved in reciprocal learning relationships with your clients, and they may teach you significant things about life.

There is even more about this work that is important. If we think of our own work as having the possible rippling effect of sending our clients, our students, and our colleagues out into the world with a greater appreciation of good communication and solid relationship skills, a greater sense of our shared humanity, we could consider ourselves pioneers for global connection.

The Purpose, Practice & Role of the Substance Abuse Counselor

Chapter 1

TAP 21 Definition of Counseling: A collaborative process that facilitates the client's progress toward mutually determined treatment goals and objectives.

Counseling includes methods that are sensitive to individual client characteristics and to the influence of significant others, as well as the client's cultural and social context. Competence in counseling is built on understanding of, appreciation of, and ability to appropriately use the contributions of various addiction counseling models as they apply to modalities of care for individuals, groups, families, couples, and significant others.

Competency: Facilitate the client's engagement in the treatment and recovery process.

Overview – Counseling practice

Before we continue on with the counseling coursework, let's talk about the role of the addiction counselor. What is the purpose of counseling in general, for any client but particularly the substance abusing client. The following is an overview of primary and significant roles an addiction counselor must play. An extended in-depth explanation will be included in the chapters that follow.

The role of the counselor in addiction treatment is to provide support, education, and nonjudgmental confrontation. The counselor must establish good rapport with the patient. The patient recovering from chemical addiction deserves to feel understood and that he or she has an ally. The counselor wants to convey to the patient that he or she appreciates the difficulty of this struggle and the need for support through the recovery process.

Overall, drug use is thought to be a multi-determined, maladaptive way of coping with life's problems. It sometimes becomes compulsive and leads to a progressive deterioration in one's life circumstances. Compulsive drug abuse is addiction, which is defined as a disease. It damages the addict physically, mentally, and spiritually.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

The metaphor of the hiker and the guide is useful for conceptualizing the counselor-patient relationship. The counselor guides the patient through at least the early stages of recovery, but the recovery process ultimately belongs to the patient. It is the patient alone who is responsible and accountable for his or her recovery. The counselor must emphasize this point to facilitate personal responsibility. Confronting the client may be useful to emphasize personal responsibility. However, when confrontation is necessary, the counselor should convey a supportive rather than a punitive attitude.

The client is the effective agent of change. It is the client who must take responsibility for working on and succeeding with a program of recovery. Although recovery is ultimately the client's responsibility, the client is encouraged to get a great deal of support from others, including counselors and other treatment staff, one's sponsor, and drug-free or recovering peers and family members.

The counselor must find a balance between being directive and allowing the client to be self-directed. This process is facilitated if the counselor uses a structure during the session that includes giving the client feedback about the most recent urine drug screens and about the client's progress in recovery and evaluatively processing any episodes of use or near use. The counselor identifies the relevant topic for discussion, based on what the client seems to need, and introduces that topic.

The client also is encouraged to be self-directed. For example, within the framework of a particular topic, perhaps coping with "social pressure to use," the client may explore how to manage this problem best and the counselor will respond to the client's direction. If the client seems unable to change some aspect of addictive behavior - for example, being around dangerous situations - the counselor should accept where the client is and assist the client to explore those perceptions or situations in a way that might allow himself or herself to do it differently, i.e., in a better way, the next time. However, the counselor should discourage regressive or other movements that lead back toward addiction. A balance needs to be struck so there is respect for the client and acceptance of where he or she is and continual, ongoing focus in the direction of abstinence and recovery.

Addiction counseling involves setting and encouraging the client to work toward predominantly *short-term* goals; although the goal of continued abstinence supported by a change in lifestyle is not short-term. an appropriate goal in addiction counseling might be for the client to terminate an abusive relationship that enabled the client's drug use, but it would not be an appropriate treatment goal for the client to work through issues stemming from his or her early abusive relationship with a parent. Another appropriate goal of addiction counseling would be to recognize the impact of one's dysphoric feelings on one's drug use and



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

to develop a strategy for responding in a new way that does not involve drug use. However, it would not be appropriate to do a cognitive analysis of the thoughts that underlie the dysphoria. The addiction counselor tries to provide the client with *concrete, behavioral options* to facilitate recovery.

Finally, addiction counseling *focuses primarily on the present* rather than the past. The counselor might become familiar with some of the significant historical data but would not direct interventions aimed at understanding the effects of past events, except perhaps those events that are related to the addiction. The client's past only becomes part of the present treatment if issues from the past are directly impacting their current everyday life.

Creating the Therapeutic Alliance

The counselor–client therapeutic alliance, this connection between people, is key to ensuring a successful counseling outcome (Brodsky, 2011; Gelso, 2011). In what was a revolutionary position of his time, Carl Rogers (1951) suggested that if counselors, or therapists, could supply their clients with a steady stream of certain basic human ingredients, the clients would solve their own dilemmas and feel better. In his writings and lectures, Rogers named three ingredients that counselors give to successful therapeutic relationships: ***congruence, unconditional positive regard, and empathic understanding***.

Other writers have maintained that while those ingredients might be necessary, they are probably of themselves insufficient to accomplish the broad goals and behavioral changes typically sought by our clients. Nevertheless, nearly all in the helping professions agree on the importance of those central factors to positive therapeutic outcomes. As a counselor, it is essential that you learn how to be personally genuine (congruence), to give your clients total acceptance without judgment (unconditional positive regard), and to develop a great capacity to see the world as they see it (empathic understanding). This is the nature of the empathic relationship. It is in this nurturing context that your other activities with clients will work best.

The counselor should create a sense of participating in a collaboration and partnership. This goal is best accomplished through three main avenues of approach.

1. The counselor should possess a thorough knowledge of addiction and the lifestyles of addicts.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

2. No matter how expert the counselor is, he or she must acknowledge that the client is the true expert in discussing his or her own life. The counselor must listen accurately, empathize effectively, and avoid passing judgment.
3. The counselor should convey to the client that he or she has an ally in the difficult progress toward recovery.

Each of these approaches should help strengthen the therapeutic alliance and make the relationship a collaborative one.

Generally, the interventions that are most helpful in fostering a strong therapeutic alliance are those that involve the counselor's active listening and those that emphasize collaboration (Luborsky et al. 1997). For example, after the client reports a relapse, the counselor might say, "Let's look at what happened and together develop a plan to help you avoid using next time." Such language highlights the combined effort in the relationship.

If the therapeutic relationship initially seems weak, the counselor might use the following simple strategy to address the problem: Ask the client what is not working in the relationship or what the client thinks is causing it not to work. Often the client knows full well what might improve the therapeutic relationship but, for whatever reason, does not feel comfortable enough to mention it until the counselor initiates the topic. For improvement to occur, the counselor should be willing to accept feedback from the client and possibly change the approach. However, in responding to a client's request to change, the counselor should not feel pressured to change, or in any way compromise, his or her philosophy of addiction treatment. Rather, the counselor may adjust his or her interpersonal style to improve the working alliance.

Behaviors That Should Not Be Done

The counselor should not be harshly judgmental of the client's addictive behaviors. After all, if the client did not suffer from addiction, he or she would not need drug counseling, so blaming the client for exhibiting these symptoms is useless. Also, clients often feel a great deal of shame associated with their addictive behaviors. In order to help resolve those feelings of shame and guilt, the counselor should encourage the client to speak honestly about drug use and other addictive behaviors and be accepting of what is said.

The counselor should be respectful of the client. The counselor should always be professional, including not being late for appointments and never treating or talking to the client in a derogatory or disrespectful manner. The counselor should avoid too much self-disclosure.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

While occasional appropriate self-disclosure can help the client to open up or motivate the client by providing a role model, too much self-disclosure removes the focus from the client's own recovery. ***A good rule for when to self-disclose, if the counselor is indeed so inclined, is for the counselor first to have a clear purpose or goal for the intervention and then to analyze why he or she is choosing to self-disclose at this particular time. If any doubt results from this analysis, it probably should lead to a more conservative, nondisclosure position.***

Lastly, counselors need to be aware of when their own issues are kicked up by a client's problem and refrain from responding from the context of their own personal issues. For example, consider the case where a counselor in recovery feels that it was extremely important for him or her to break ties with addicted peers. Now this counselor is working with a particular client who has an addicted spouse or partner and does not want to break these relationship ties. It is imperative that the counselor be flexible and responds creatively to the client's own perception of the problem. In this case, the counselor must not rigidly adhere to the notion of insisting that breaking ties with *all* addicts is the *only* acceptable path to recovery. In general, the reflexive, noncritical projection of the counselor's own needs or experiences onto that of the client's situation can be damaging or, at least, counterproductive.

Changes in the Addiction Field

As the addiction field has matured, it has tried to integrate conflicting theories and approaches to treatment, as well as to incorporate relevant research findings into a single, comprehensive model. Many positive changes have emerged, and the new view of motivation and the associated strategies to enhance client motivation fit into and reflect many of these changes. Some of the new features of treatment that have important implications for applying motivational methods are discussed below.

Focus on Client Competencies and Strengths

Whereas the treatment field has historically focused on the deficits and limitations of clients, there is a greater emphasis today on identifying, enhancing, and using clients' strengths and competencies. This trend parallels the principles of motivational counseling, which affirm the client, emphasize free choice, support and strengthen self-efficacy, and encourage optimism that change can be achieved. As with some aspects of the moral model of addiction, the responsibility for recovery again rests squarely on the client; however, the judgmental tone is eliminated.

Individualized and Client-Centered Treatment

In the past, clients frequently received standardized treatment, no matter what their problems or severity of substance dependence. Today, treatment is usually based on a client's individual needs, which are carefully and comprehensively assessed at intake. Research studies have



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

shown that positive treatment outcomes are associated with flexible program policies and a focus on individual client needs (Inciardi et al., 1993). Furthermore, clients are given choices about desirable and suitable treatment options, rather than having treatment prescribed. As noted, motivational approaches emphasize client choice and personal responsibility for change—even outside the treatment system. Motivational strategies elicit personal goals from clients and involve clients in selecting the type of treatment needed or desired from a menu of options.

A Shift Away From Labeling (*One of my favorite changes in working with clients*)

Historically, a diagnosis or disease defined the client and became a dehumanizing attribute of the individual. In modern medicine, individuals with asthma or a psychosis are seldom referred to—at least face to face—as “the asthmatic” or “the psychotic.” Similarly, in the substance use arena, there is a trend to avoid labeling persons with substance abuse disorders as “addicts” or “alcoholics.” Clinicians who use a motivational style avoid branding clients with names, especially those who may not agree with the diagnosis or do not see a particular behavior as problematic.

Therapeutic Partnerships for Change (*Pay close attention this is important stuff*)

In the past, especially in the medical model, clients passively received treatment. Today, treatment usually entails a partnership in which the client and the clinician agree on treatment goals and work together to develop strategies to meet those goals. The client is seen as an active partner in treatment planning. The clinician who uses motivational strategies establishes a therapeutic alliance with the client and elicits goals and change strategies from the client. The client has ultimate responsibility for making changes, with or without the clinician’s assistance. Although motivational strategies elicit statements from the client about intentions and plans for change, they also recognize biological reality: the heightened risk associated with a genetic predisposition to substance abuse or dependence and the powerful effect of substances on the brain, both of which can make change exceedingly difficult. In fact, motivational strategies ask the client to consider what they like about substances of choice—the motivations to use—before focusing on the less good or negative consequences, and weighing the value of each.

Use of Empathy, Not Authority and Power (*I LOVE this*)

Whereas the traditional treatment provider was seen as a disciplinarian and imbued with the power to recommend client termination for rule infractions, penalties for “dirty” urine, or promotion to a higher phase of treatment for successfully following direction, research now demonstrates that positive treatment outcomes are associated with high levels of clinician empathy reflected in warm and supportive listening (Landry, 1996). Clinician characteristics found to increase a client’s motivation include good interpersonal skills, confidence in the



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

therapeutic process, the capacity to meet the client where the client happens to be, and optimism that change is possible (Najavits and Weiss, 1994).

Impact of Managed Care on Treatment

Changes in health care financing (managed care) have markedly affected the amount of treatment provided, shifting the emphasis from inpatient to outpatient settings and capping the duration of some treatments. Still unknown is the overall impact of these changes on treatment access, quality, outcomes, and cost. In this context, it is important to remember that even within relatively brief treatment contacts, one can be helpful to clients in evoking change through motivational approaches. Brief motivational interventions can also be an effective way for intervening earlier in the development of substance abuse while severity and complexity of problems are lower (Obert et al., 1997).

Recognition of a Continuum of Substance Abuse Problems

Formerly, substance misuse, particularly alcoholism, was viewed as a progressive condition that, if left untreated, would inevitably lead to full-blown dependence and, likely, an early death. Currently, clinicians recognize that substance abuse disorders exist along a continuum from risky or problematic use through varying types of abuse that meets diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM V) (American Psychiatric Association [APA], 2013). Moreover, progression toward increasing severity is not automatic. Many individuals never progress beyond risky consumption, and others cycle back and forth through periods of abstinence, excessive use, and dependence. Recovery from substance dependence is seen as a multidimensional process that differs among people and changes over time within the same person (IOM, 1990a, 1990b). Motivational strategies can be effectively applied to persons in any stage of substance use through dependence. The crucial variable, as will be seen, is not the severity of the substance use pattern, but the client's readiness for change.

Acceptance of New Treatment Goals

In the past, addiction treatment, at least for clients having trouble with alcohol, was considered successful only if the client became abstinent and never returned to substance use following discharge—a goal that proved difficult to achieve (Brownell et al., 1986; Polich et al., 1981). The focus of treatment was almost entirely to have the client stop using and to start understanding the nature of her addiction. Today, treatment goals include a broad range of bio-psychosocial measures, such as reduction in substance use, improvement in health and psychosocial functioning, improvement in employment stability, and reduction in criminal justice activity. Recovery itself is multifaceted, and gains made toward recovery can appear in one aspect of a client's life, but not another; achieving the goal of abstinence does not necessarily translate



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

into improved life functioning for the client. Treatment outcomes include interim, incremental, and even temporary steps toward ultimate goals. Motivational strategies incorporate these ideas and help clients select and work toward the goals of most importance to them, including reducing substance use to less harmful levels, even though abstinence may become an ultimate goal if cutting back does not work. Harm reduction (e.g., reducing the intensity of use and high-risk behavior, substituting a less risky substance) can be an important goal in early treatment (APA, 1995). The client is encouraged to focus on personal values and goals, including spiritual aspirations and repair of marital and other important interpersonal relationships. Goals are set within a more holistic context, and significant others are often included in the motivational sessions.

Instructor Note: Okay, the foundation is set. The next chapter will help you start to understand how to build on that foundation. Becoming a counselor is the step before providing counseling. Think about your personality, your values and viewpoints as you read chapter 2. Be honest with yourself; figure out who you want to be as a professional, how you want to be perceived by clients, your co-workers and your supervisors. Let the self-exploration begin!

Being the Counselor & Counseling Basics

Chapter 2

Competency: Adapt counseling strategies to the individual characteristics of the client, including but not limited to disability, gender, sexual orientation, developmental level, culture, ethnicity, age, and health status.

Building Multicultural and Ethical Competence

As you embark on the process of learning more about yourself and your motivations to be a counselor, as well as about the skills necessary to do this work, you will want to simultaneously heighten your appreciation of the multicultural, diverse nature of the world in which you work. It is part of your obligation to make sure that you work in ways that ethically protect the safety of your clients, your agency and yourself. An awareness of issues related to dealing with people who might be different from you, and of the ethical principles that guide our profession, are as critical to doing solid counseling work as are self-understanding and a repertoire of skills. You want your clients to leave you feeling and doing better than when they started—or at the very least no worse. Your attention to the ethics of good practice, as well as to the worldview people bring to counseling, helps to ensure that no harm will be done.

Some of the basic assumptions held most sacred by European-American theories about effective counseling fly directly in the face of many non-Western cultural traditions. Some of these assumptions are firmly entrenched in the Western cultural ways of thinking about people, and entrenched as well within the thinking of counselors who have been raised in that tradition. Such assumptions, if unchallenged by the unaware counselor, may result in an inability to connect with clients who have different worldviews. The counselor grounded in Western cultural values may ignore—or even help to perpetuate—some of the real abuses of power and oppression that some clients endure due to the political forces and various biases at play in the world that those clients inhabit (Hanna, Talley, & Guindon, 2000).

Adopting a multicultural perspective and learning about ideas related to counseling from such a multicultural perspective are essential for those who want to be effective counselors. You live in a rapidly changing, incredibly diverse world, and you will encounter clients who have experiences and perspectives that are very different from yours. Rather than seeing these differences as a block to understanding, you can embrace such differences as a great opportunity to stretch your own thinking. This is yet another opportunity to learn more about yourself in relation to others, to learn from the clients you serve.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Cultural awareness includes an awareness of one's own philosophies of life and capabilities, recognition of different structures of reasoning, and an understanding of their effects on one's communication and helping style. Lack of such understanding may hinder effective intervention.

Adherence to a specific counseling theory or method may also limit the success of counseling. Many cultural groups do not share the values implied by the methods and thus do not share the counselor's expectations for the conduct or outcome of the counseling session. To counter these differences, effective counselors must investigate their clients' cultural background and be open to flexible definitions of "appropriate" or "correct" behavior (LaFromboise).

Another counseling barrier is language. Language differences may be perhaps the most important stumbling block to effective multicultural counseling and assessment.(Romero) Language barriers impede the counseling process when clients cannot express the complexity of their thoughts and feelings or resist discussing affectively charged issues. Counselors, too, may become frustrated by their lack of bilingual ability. At the worst, language barriers may lead to misdiagnosis and inappropriate placement.

Multicultural counseling seeks to rectify the imbalance of power, appreciating the value of the culture and using it to aid the client.

Although it is impossible to change backgrounds, addiction counselors can avoid the problems of stereotyping and false expectations by examining their own values and norms, researching their troubled individual's backgrounds, and finding counseling methods to suit those needs. Counselors cannot adopt the troubled human being's ethnicity or cultural heritage, but they can become more sensitive to these things and to their own and their clients' biases. Clinical sensitivity toward client expectation, attributions, values, roles, beliefs, and themes of coping and vulnerability is always necessary for effective outcomes. Three questions which counselors might use in assessing their approach are as follows (Jereb): (1) within what framework or context can I understand this client (assessment)? (2) Within what context do client and counselor determine what change in functioning is desirable (goal)? (3) What techniques can be used to effect the desired change (intervention)? Examination of their own assumptions, acceptance of the multiplicity of variables that constitute an individual's identity, and development of a client centered, balanced counseling method will aid the multicultural counselor in providing effective help.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Personal Characteristics of Effective Counselors

What is a healthy, or whole, counselor? What are those naturally occurring traits and features of personal awareness that contribute to wholeness and health and that result in effective counseling outcomes? There have been many attempts to isolate the specific characteristics of effective counselors, in no small part so that counselor education programs can become more adept at selecting candidates for training. The thinking here is that if we can select people who already have inherent personality characteristics that are suitable for this work, then training programs can focus on specific skills training to supplement those natural inclinations.

Many of these “laundry lists” of characteristics look like something out of the Girl or Boy Scouts Manual, using words like “trustworthy” and “loyal,” and are not especially helpful in making discriminating decisions about whom to select for counselor training. Researchers have uncovered evidence that certain factors do tend to contribute to better work in this field. For example, counselors who are more personally confident and socially adept (Williams, 1999) will have an easier time relating to their clients. The following ten favorable personality characteristics are also the least teachable to those who do not already possess them (Pope, 1996; Scheffler, 1984):

- ✚ Acceptance
- ✚ Empathy
- ✚ Emotional stability
- ✚ Flexibility
- ✚ Open-mindedness
- ✚ Interest in people
- ✚ Genuineness
- ✚ Confidence
- ✚ Sensitivity
- ✚ Fairness

Other lists of characteristics retain this range of personal characteristics and add specific qualities suggesting wisdom and maturity like inner directedness, feeling reactivity, spontaneity, self-regard, and capacity for intimate contact (Ritter, 1984), and spirituality and self-actualization.

The quality of the counseling relationship rather than any particular skill or technique may well be the hidden foundation for true counseling. The therapeutic alliance is a special bond created from compassion, trust, and courage to move forward together, which energizes the therapeutic process and facilitates healing. The professional must at all times maintain safe and



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

healthy boundaries that protect while empowering, while promoting the free expression of feelings and concerns by the client.

The role of the counselor in addiction treatment is to provide support, education and most importantly, non-judgmental questioning to those alcohol and or drug troubled human beings. It is essential that a counselor establish a good relationship with the alcohol and or drug troubled human being.

A human being recovering from a specific addiction deserves complete attention from the counselor and to feel understood. Consequently, the counselor should convey to this human being, their understanding of the struggles in all stages of recovery, and are willing to support the human being throughout the recovery process or counseling sessions, i.e. limited sessions sometimes due to HMO insurance regulations or insurance.

The trend in counseling for the twenty first century stresses the values and behaviors of the counselor. The quality of the relationship between the counselor and the troubled human being seems to be the most important factor to foster growth for the person troubled.

Counseling is an intimate style of learning. Due to this intimacy the counselor must share, without giving too much disclosure, with the troubled individual and become a real person. If a counselor is scared, or does not trust him/herself, the troubled human being can and will sense this fear thereby keeping themselves hidden from the counselor. However, if the counselor is genuine and alive, the counselor will be able to connect with the troubled person who is seeking their help. (LaCrosse)

The counselor then becomes a model for the troubled human being. If the counselor models incongruent behavior, lack of enthusiasm, and less than honest sharing by hiding behind a desk or vague in offering assistance, then expect the troubled human being to mimic the same behaviors as the counselor. It has been shown that when the counselor models realness by engaging in appropriate self-disclosure, the troubled individual tends to do the same. This allows the troubled human being to become more of what they are capable of becoming. The degree to which the counselor becomes alive and real, the level of psychological wellness the counselor is at, the greater the outcome for success with the troubled human becomes.

The Counselor as a “Whole Person”



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Counseling can be draining and difficult work, particularly when one's caseload is comprised largely of people who are consistently in serious difficulty. Wegscheider (1981) proposed looking at the counselor's state of wellness from the perspective of "wholeness." In this model different aspects, or "selves," comprise the whole counselor, each of which needs care and attention. These "selves" of ours are comprised of the following elements:

- ✚ Physical self
- ✚ Emotional self
- ✚ Social and familial self
- ✚ Intellectual self
- ✚ Working self
- ✚ Aesthetic self
- ✚ Spiritual self

It should be obvious that counselors who wish to do good work with people need to function at relatively high levels in each of these areas. Effective counselors acknowledge that a balanced personal life is central to doing good counseling work (Reyak-Schelar & Feldman, 1984). A life that overemphasizes one or two of these areas, to the exclusion of others, is a life that runs a bit off balance and compromises the capacity to respond to those needs in others.

A Counselor's Levels of Awareness

You function on multiple levels of awareness regarding your thoughts and feelings, and your facility at managing and moving among those fluid levels is key to your success in work as a counselor. The foundation of counselor awareness is the intrapersonal level of awareness. It is how you are feeling and what you are thinking, and it is determined by the cumulative sum of your emotional and cognitive experience as it is acted upon by the current situation in which you find yourself. Some would argue that what we think determines what we feel. In any case, no one would deny that emotions are a large part of our total being or that caring for our emotional selves is a critical aspect of counselor self-care (Wilson, 1994). To be an effective counselor, you will need to regularly check in with yourself at this level, to look at your internal experience and reflect on what you are feeling and thinking.

The interpersonal awareness; this relates to the dynamics of your interactions with other individuals. It is about intimacy, contact, and conflict—all the relationship variables at play between you and one other person. Interpersonal awareness means that as you interact with a client, part of your mind is simultaneously standing back, looking on, and reflecting on the quality of the interaction. Throughout your practice as a counselor you will need to regularly check your awareness at both the intrapersonal and interpersonal levels.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

The Effective Counselor

The man who would learn the human mind will gain almost nothing from experimental psychology. Far better for him to put away his academic gown, to say good-bye to the study, and to wander with human heart through the world. There, in the horrors of the prison, the asylum, and the hospital, in the drinking-shops, brothels, and gambling halls, in the salons of the elegant, in the exchanges, socialist meetings, churches, religious revivals, and sectarian ecstasies, through love and hate, through the experience of passion in every form of his own body, he would reap richer store of knowledge than textbooks a foot thick could give him. Then he would know how to doctor the sick with real knowledge of the human soul. (Jung, 1961, 71)

Nobody said learning to become a counselor is easy. It is a rare profession indeed that requires academic preparation and training and also demands that you expand and examine yourself personally. You don't need to take Jung's advice literally because academic and intellectual training are critically important in learning to do counseling work, but his words remind us that we must attend to other responsibilities as well.

Who you are as a person will largely determine how effective you will be in working with others as a counselor. You are, in your individual person, your own single best tool for helping others. Your values, beliefs, and personal background— simply how you live your daily life—will influence the lives of your clients. All of your history, your personal conduct, and your attitudes about people and the world around you are at play in the counseling relationship. The degree to which you understand yourself will have a lot to do with how effective you will be with your clients (Kottler, 1993).

Life experience helps to shape the person of the counselor; the wider and more divergent the life experience, the greater the capacity of the counselor to do this work. Counseling is both science, represented by your professional course work and preparation, and art, represented by your personal evolution. In addition to developing your counseling skills you need to have a working knowledge of basic diagnostic and assessment strategies, differential treatment approaches, and the ramifications of ethical and legal dilemmas you will confront in your work.

The Counselor as a Therapeutic Person



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

So what does it take and how can counselors become therapeutic, modeling awareness and growth for those troubled human beings served? It is important for counselors to have their own identity. That is, the counselor knows who he or she is, what the counselor needs or wants out of life, and what is truly important. The road the counselor travels is clear all the way to the horizon, yet the counselor is willing to stop every now and then to check the map, to ensure the road is still available. Unlike others, the counselor who knows what he or she want will not mirror others, due to the fact that he or she respect and appreciate themselves.

The addiction counselor is able to recognize and accept his or her own power. These counselors do not have to diminish, feel superior over, or bully others to feel powerful. The power the counselor uses is healthy, is modeled appropriately, while avoiding power's abusive nature. The counselor does not settle for less, rather the counselor extends him or herself to become more. These are the counselors that can think and live outside the box, can leave the security of the known for the unknown. It is the thirst for knowledge that drives and motivates these counselors with the realization that having limited awareness means limited freedom in helping those troubled. (Covey)

A truly therapeutic addiction counselor will develop his or her own counseling style. This style is based on philosophy of life and the counselors own life experiences. While the counselor may from time to time borrow ideas and techniques from other counselors, there is a strong idealism to avoid a robotic, programmed technique. Additionally, the counselor can experience and know the world in which the troubled human being, who is being served, lives in, yet the counselor does not own it. There is that "I don't know how you feel right now, all I know is how I felt when that happened to me" attitude.

Another characteristic of a therapeutic counselor is the authenticity, sincerity, and honesty in which the counselor models. The therapeutic counselor can laugh. Laugh at themselves; know how to have appropriate fun. Having a sense of humor allows the counselor to put problems and personal imperfections into perspective. When it comes to making mistakes, the counselor is willing to admit the mistake, learn from the mistake, and more importantly, not dismiss the error lightly, yet does not dwell on the issue.

The counselor can appreciate from where he or she came, i.e., their culture. There is awareness of how personal culture affects them. There is a deep respect for the diversity of other cultures, while being sensitive to the uniqueness and differences of others. There is the ability to reinvent, revitalize, and change, while working on becoming the human being the counselors always wanted to become. The counselor knows how to make the appropriate choices that shape his or her life. There is a sincere interest in the wellness of other human beings. This wellness is based on respect, care, trust, and a real value of other human beings. While these



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

characteristics are not all inclusive, finally, the counselor is able to maintain healthy boundaries. While each counselor strives to be fully involved with the troubled person being served, the counselor does not carry a suitcase of his or her troubled human beings problems around with him or her. The counselor has acquired the knowledge and the ability to say no. The counselor can recognize burn out and getting crispy around the edges. More importantly, the counselor knows how to take care of him or her, when this happens. Being an effective therapeutic counselor does not mean being a martyr to the cause.

Counselors in Recovery Themselves

Many counselors in this field are either in recovery themselves or have a family member who was addicted. Our view is that an in-depth knowledge of addiction and the tools for recovery and an ability to empathize with the client are essential attributes of an effective addiction counselor. One way, but not the only way, to acquire this knowledge and ability is to be in recovery oneself. If a counselor is in recovery, he or she should be relatively emotionally healthy and stable. In practice, many facilities require a minimum of 5 years in recovery and some facilities require only one year. In a setting that employs multiple counselors, the optimal situation is to have recovering and non-formerly addicted counselors, because this mix tends to foster the greatest amount of learning from one another.

Counselor Approach to Treatment

Best practices tend to merge the bio-psychosocial theoretical perspective of addictive disorders. This includes supportive counseling, motivating client readiness for change and coping skills-training techniques. The goals of treatment are to establish and maintain abstinence from the illicit use of all psychoactive drugs, foster development of (nonchemical) coping and problem-solving skills to stop and ultimately eliminate impulses to "self-medicate" with psychoactive drugs, and to enhance and sustain client motivation for change. The approach is based on 12- Step facilitation therapy, cognitive-behavioral, motivational, and insight-oriented techniques according to each client's individual needs. These best practices counseling standards can be applied in any level of care and throughout the continuum of addictions treatment.

The therapeutic approach is empathic, client centered, and flexible. Strong emphasis is placed on developing a good working alliance with the client to facilitate behavioral change.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

The counselor attempts to work with and through rather than against a client's resistance to change. Aggressive confrontation of denial, the hallmark of traditional addiction counseling, is seen as counterproductive and antithetical to this approach.

Group and individual counseling are delivered within the context of a flexible treatment program that also includes psych-education (PE), pharmacotherapy for coexisting psychiatric disorders and where indicated, urine testing and alcohol breathalyzer tests to encourage and verify abstinence. Client participation in self-help is encouraged but not mandated.

Effective Approaches in Counseling

Counseling includes methods that are sensitive to individual client characteristics and to the influence of significant others, as well as the client's cultural and social context. Competence in counseling is built upon an understanding of, appreciation of, and ability to appropriately use the contributions of various addiction counseling models as they apply to modalities of care for individuals, groups, families, couples, and significant others.

Counselors are Agents of Change

Best practice standards promotes the development of a strong therapeutic alliance between client and counselor along with positive bonding among clients within a group. Caseload size may vary according to the given needs of each program.

Client Vulnerability – Respecting the Power Differential

The requirement for counselor personal growth and self-examination may also provide a good firsthand introduction to how vulnerable it can feel to be a client. For anyone who has never experienced the joys, or the terrors, of being a client, it is an excellent empathy-enhancing experience. What better way to begin to understand how it feels to be a client than to sit in that other chair? It is a truism that seeking counseling is a courageous act. Seeking help or asking for assistance puts one in a position of vulnerability. The act can be doubly courageous for those who see asking for help as some kind of personal weakness (Shapiro, 1984). Many people who come to treatment may have tried other ways of solving their problems, including using family, friends, and their own internal resources. This may be particularly true for people from some cultural backgrounds where seeking help outside the family is not valued and may be frowned upon (Pedersen & Ivey, 1993).

Ethical principles for counseling practice dictate closely guarded boundaries for the counselor–client relationship, prohibiting interactions beyond those that occur within the actual time of professional contact. Protection of the vulnerable client from the more powerful counselor is a



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

cornerstone of professional codes of conduct, which acknowledge that the counselor–client relationship has tremendous potential for harm as well as for help.

Educational Requirements

In the field of drug counseling, experience is viewed as at least as valuable as formal education, so the range of formal education is broader than in clinical psychology, for example. Generally the range of education is high school graduate to doctorate, with the majority of counselors having a CAP, a bachelor's or master's degree in social work, counseling psychology, or other human services field.

Counselor, Heal Thyself

Counseling students often begin to doubt themselves, particularly their own relative mental health and emotional stability. They ask, “How can I help someone else, when I’m such a wreck myself?” ***This is a legitimate question (and unfortunately too rarely asked by those who need to ask it most).*** There is such a lot to think about and work through. Your own personal family history, your work life, your loves, your other relationships, your belief system—not to mention all of the course work you are trying to absorb—can all conspire to make you feel inadequate. At times it seems too complex, too cumbersome to sort through, yet there are glimpses of light and clarity that can give you hope and inspiration. You will find supervisors, mentors, and guides—or counselors of your own—to help you shoulder the burden.

It is important to remember that this profession does not require us to be perfect people. If it did, it would be a lonely, unpopulated field. Some of your greatest difficulties and struggles may, in fact, become your greatest assets in understanding the pains and difficulties of others. It is all about the awareness and understanding—and the sense of humility—that you bring to your work, the capacity that you have for seeing yourself with all your strengths and blemishes, that will make it possible for you to work well with others (Gladding, 2002; Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005).

You need to give yourself the time to learn about this profession and about yourself. The process of increasing your self-understanding and the parallel process of learning to work effectively as a counselor is a lifelong, magnificent journey. The two processes feed upon and nurture each other; in this mutual nurturance lies much of the great satisfaction of this work.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Basic Principles of Counseling

Respect for the client

The skill of a counselor lies in communicating a sense of self-respect to the client. The client needs to accept the belief that every person possesses the inherent strength and capacity to 'make it' in life, and that each person has the right to choose his their own alternatives and make their own decisions. It is also important that respect for the client should be reflected in the manner the counselor conducts themselves. Counselors should always be professional; for instance they should not be late for appointments and never talk to or treat the client in a derogatory or disrespectful manner.

Being a Role Model

The counselor should set an example to the client through their personal behavior and attitude.

Confidentiality

Maintaining confidentiality is very important in a counseling relationship as this leads to the development of trust. The counselor should not reveal the client's identity, personal details and such information to other people without the client's permission. In addition, they must assure the client that confidentiality will be maintained to gain client trust.

To be in Command

Once an assessment is made and counseling has begun, the counselor should be able to guide the client away from trivialities or irrelevancies. The counselor who allows themselves to be manipulated without knowing it will not be able to command the client's respect.

Emphasizing the Client's Personal Responsibility for Recovery

The counselor should be able to guide the client in the early stages of recovery and convey the understanding that the recovery process ultimately rests with the client.

Providing Direction and Encouraging Self-Direction

The counselor must strike a balance between providing direction and allowing the client to be self-directed. It is essential that the counselor create a structure in the session that includes



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

giving the client feedback on their progress in recovery. The counselor identifies the relevant topics for discussion, based on what the client seems to need, and introduces those topics. If the patient seems unable to change some aspect of addictive behavior, the counselor should accept the situation and assist them to explore those perceptions or situations in a way that might allow them to deal with them differently. A balance needs to be maintained so that there is respect for the patient, acceptance of where they are, and still provide motivation for abstinence and recovery.

Conscious of their Own Issues

The counselor needs to be aware of the possibility of their own issues being triggered by a client's problems; the counselor must consciously refrain from basing their response in the context of their own personal issues. For example, a counselor in recovery may feel that it is personally important for them to break ties with addicted peers to maintain sobriety. If this counselor happens to work with a client who has an addicted sister with whom the patient has a valuable relationship, it is important that the counselor be flexible and respond creatively to the client's own perception of the problem.

Therapeutic Communication Skills Needed in Counseling

The outcome of a meeting between the counselor and the client will depend a great deal on how comfortable the client feels with the counselor, so that they may entrust their genuine feelings to the counselor, including information which the client may feel is very private and personal and which they are reluctant to share. This can be achieved by the use of certain communication skills that create an atmosphere of support for the client and the process. The process of communication between the client and the counselor in the counseling situation is a continuous two-way sequence. This sequence of events ensures that the counselor listens (receives the message); processes (considers the message in combination with previous knowledge and experience); and responds (delivers a response to the original message).



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098



I will briefly explain the communication skills listed above.

LISTENING

Attending

This refers to a concern by the counselor with all aspects of the client's communication. It includes listening to the verbal content, observing nonverbal cues and then communicating back to the client that s/he is paying attention. The skill of attending is the foundation on which all other skills are built.

Guidelines for effective attending:

- ✚ communicate listening through eye contact and facial expression
- ✚ maintain a relaxed physical posture and lean forward occasionally, using natural hand and arm movements
- ✚ verbally 'follow' the client, using a variety of brief encouragements such as 'um-hm', 'yes', or repeating key words.

Attending helps the client to:

- ✚ relax and feel comfortable
- ✚ express his ideas and feelings freely in his own way



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

- ✚ trust the counselor
- ✚ feel more responsible for what happens in the session by enabling them to direct the session.

Attending enables the counselor to:

- ✚ obtain accurate inferences about the client through careful observation.

Paraphrasing

Paraphrasing is a response that restates the content of the client's previous statement. It concentrates primarily on the words spoken, the content which refers to events, people and things. In paraphrasing, the counselor reflects to the client the verbal essence of his/her last comment or last few comments. More often, paraphrasing uses words that are similar to the client's, but fewer in number.

For example:

Client – My mother constantly irritates me. She picks on me for no reason at all. She likes only my younger brother and pampers him all the time. She is the reason for my drug taking. Even if I give up drugs, she will not change.

Counselor – You are having problems in getting along with your mother. You are concerned about your relationship with her.

Paraphrasing helps the client to:

- ✚ realize that the counselor understands what he is saying
- ✚ get a sense of direction
- ✚ clarify his remarks

It enables the counselor to:

- ✚ verify her perceptions of the verbal content of the client's statements
- ✚ spotlight an issue

Reflection of Feelings

The counselor expresses the essence of the client's feelings, either stated or implied; this is 'reflection of feelings'. Unlike paraphrasing, the focus is primarily on the emotional element of the client's communication. The counselor tries to perceive the emotional state of the client and feed back a response that demonstrates his/her understanding of the client's state. It lets the client know that the counselor understands what s/he is experiencing and feeling. This

empathy reinforces the client's willingness to express his/her feelings more openly. It also gives the client an opportunity to recognize and accept his/her feelings.

Through reflection of feelings problem areas can be identified without the client feeling pushed. It also helps the client understand that feelings cause certain types of behavior.

Reflection of feelings helps the client to:

- ✚ realize that the counselor understands what the client feels and experiences
- ✚ bring to the surface any feelings that may have been expressed only vaguely
- ✚ learn that feelings and behavior are connected.

It enables the counselor to:

- ✚ check whether or not she is accurately reflecting what the client is experiencing
- ✚ bring out problem areas without the client being pushed

Summarizing

Summarizing is the tying together by the counselor of the main points discussed in a counseling session. Summarizing can focus on both feelings and content (information), and is appropriate after discussion of a particular topic within the session or as a review, at the end of the session, of the principle issues discussed. In either case, the summary should be brief, to the point, and without new or added meanings.

Counselor – We discussed your relationship with your wife. You said that there were conflicts right from the start. The conflicts related to the way money was handled and that she often felt you gave more importance to your friends. Yet on the whole, things did go on well and you were quite happy until 3 years ago. Then the conflicts became more frequent and more intense so much so that she even left you twice and talked of divorce too. This was also the time when your drinking was at its peak. Have I understood the situation properly?

Summarizing clarifies the client's meaning by pulling his/her scattered thoughts and feelings together. It can terminate a session in a logical way through a review of the major issues discussed in the entire session and also help link one session to the next.

Summarizing helps the client to:

- ✚ clarify meaning
- ✚ realize that the counselor understands what he is saying and feeling
- ✚ have a sense of movement and progress.

It enables the counselor to:

- ✚ ensure continuity in the direction of the session by providing focus



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

- ✚ verify her perceptions of the content and feelings discussed
- ✚ terminate a session in a logical way
- ✚ focus on one issue while acknowledging the existence of other concerns.

PROCESSING

This takes place within the counselor, between listening and responding to the client. This includes the counselor's ability in mentally cataloguing data - the client's beliefs, knowledge, attitudes and expectations and thereafter factors influencing the client's judgment and performance.

The information given by the client and his family in bits and pieces is put together using the counselor's own judgment and observations. S/he then understands the situation in its totality. Based on this processing, the counselor helps the client develop a meaningful plan for the future.

Responding

Probing

Probing is the counselor's use of a question or statement to direct the client's attention inward to explore their situation in greater depth. A probing question should be open-ended, requiring more than a one-word answer ('yes' or 'no') from the client. Probing helps to focus the client's attention on a feeling or content area. It may encourage the client to elaborate, clarify or illustrate what s/he has been saying. It sometimes enhances the client's awareness and understanding of their situation and feelings. Probing directs the client's attention to areas that, according to the counselor, need attention.

The counselor should use her/his judgment to identify the subject or feelings touched upon by the client that needs further exploration. It is important that the counselor uses the technique of 'probing' only after 'attending' to the client.

Probing helps the client to:

- ✚ focus his attention on a feeling or content area
- ✚ become aware of and understand his situation or feelings
- ✚ focus his attention on areas the counselor thinks need attention.

It enables the counselor to:

- ✚ better understand what the client is describing.

Interpreting

Effective interpreting has three components – determining and restating basic messages; adding counselor’s ideas for a new frame of reference; and checking out these ideas with the client.

It is very important that the counselor uses the skills of attending, paraphrasing, reflection of feelings and summarizing prior to and in conjunction with interpreting. The first step in interpreting is to determine the basic messages the client has expressed or displayed, and restate them. As the counselor is restating them, s/he will have some idea about alternative ways of viewing the client’s situation, or may begin to see connections, relationships or patterns in the events the client describes. When these ideas are included in the material being restated to the client, the counselor adds his/her ideas to offer the client a new frame of reference from which to view their situation.

Because the counselor is offering alternative viewpoints, it is very important to phrase them tentatively or to check the client his reaction to the new point of view. Tentative phrases like ‘The way I see it ...’ or ‘I wonder if ...’ are appropriate ways to begin an interpretation. Then there is a better chance that the client will see the offered interpretation as a possibility rather than as a judgment. He is thus more likely to react to an interpretation openly if it is offered tentatively.

Interpreting helps the client to:

- ✚ realize that there are more ways than one to look at most situations, problems and solutions
- ✚ become more flexible and to explore new points of view
- ✚ understand his problems more clearly.

Interpreting enables the counselor to:

- ✚ share a new perspective for the client to consider
- ✚ open out new coping strategies to deal with the issues.

Confronting

Confrontation is the deliberate use of a question or statement by the counselor to induce the client to face what the counselor thinks the client is avoiding. The counselor may, for example, point out discrepancies between the client’s verbal and non-verbal behaviors, between two of

the client's statements, or between the client's past behavior and his behavior in the counseling sessions.

In confrontation, the counselor identifies contradictions that are outside the client's frame of reference, whereas paraphrasing, reflection of feelings and summarizing involve responding within the client's frame of reference. In using confrontation, the counselor gives honest feedback about what s/he perceives is actually happening with the client. Confrontation should not include accusations, evaluations or solutions to problems.

Sometimes the counselor may not know what to do after s/he attempts a confrontation. The following guidelines may be of help.

- ✚ If the client accepts the confrontation and agrees with the discrepancy pointed out, the counselor can use the opportunity to reinforce positive behavior.

'I am happy that you are able to see the problem from this angle. Let us plan what we can do about it.'

- ✚ If the client denies the confrontation, the counselor should return to an empathetic response.

'You are finding it difficult to see the problem the way your family members and I perceive it. It seems to be bothering you. Think about it. Let us talk about it later.'

The client may not be ready at that point of time to deal with the discrepancy and it would not be helpful to persist in the confrontations. It can however, be dealt with at the appropriate point in time.

- ✚ The client may simply act confused or ambivalent after confrontation. In that case, the counselor should focus on the current feeling.

'You seem to feel confused by my statement. Let me make myself clearer.'

An effective confrontation breaks down the defenses that s/he has consciously or unconsciously put up. It will enrich the condition of empathy in the counseling relationship if the client perceives the confrontation as stemming from the care and concern of the counselor.

Confrontation helps the client to:

- ✚ become more congruent (what he says corresponds with how he behaves)
- ✚ break down necessary defenses which the client has consciously or unconsciously put up
- ✚ focus on problems on which the client might take action or change his behavior.

Confrontation enables the counselor to:

- ✚ establish herself as a role model in using direct, honest and open communication.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Silence

Silence can be very powerful. It can be a time when things really ‘sink in’, and feelings are strongly felt and recognized. When combined with ‘attending cues’, it can serve to encourage the client to continue sharing. Silence can allow the client to experience the power of his/her own words.

Through commitment and experience, the counselor acquires skills to help the client in the process of achieving an addiction free, qualitatively better life.

Two Powerful Aspects of Counseling (Individual, Family, Couples & Group)

TRANSFERENCE

The client may consciously or unconsciously cast the counselor in the role of a parent or sibling (or other significant person from their life) in an effort to establish emotionally close ties, and to feel recognized and worthy of attention, in order to enhance self-esteem. In many cases transference can enhance the benefits of therapy. Being sensitive to transference issues and making it work therapeutically is the best course of action. Transference can be intensive, with a great deal of dependence coupled with hostile manipulative and testing behavior. When it progresses beyond an acceptable level and the client replays the conflicts and power struggles of his/her other relationships in the present counseling relationship, it can become unhealthy. Discussing these issues specifically and openly helps.

When it grows in an unhealthy direction especially with sexual connotations, transference interferes with therapy and it is best to transfer the client to another therapist.

Transference refers to clients’ placement of feelings originally directed towards significant others in their life onto the counselor (Wallin, 2007). For example, clients might project feelings related to their mother or father figure onto the counselor. In some cases this may lead to a belief that the counselor is nurturing and loving; in other situations feelings of anger and mistrust may arise. In the clients’ mind the counselor may also come to represent their ideal partner or friend; this may lead to platonic, romantic, or sexual attraction.

Depending upon the life history of the client, the counselor may also represent oppressive systems or an opposing cultural group (i.e. higher social class, an ethnic group the client may have had conflict with previously, etc). Due to the clients’ complicated thoughts, beliefs, and emotions entangled with the issue of transference developing ways to guide a counselor to work with these issues needs to be a regular part of clinical supervision. Increasing this



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

knowledge for the counselor will help the counselor help clients gain deeper insight and to preserve the therapeutic relationship.

COUNTER-TRANSFERENCE

Counter-transference can grow out of conscious or unconscious thought processes of the counselor. The counselor may project her/his own feelings or conflicts to the client and lose the professional objectivity that is necessary. Being sensitive to one's own feelings and behavior helps one become sensitive to the issue. Consider talking about it with the senior counselor, peers and, of course, seek your clinical supervisor's help. Being able to ask one why, and deal with it helps the counselor grow professionally. However, if the counter-transference is intensive, it would be best to terminate (with the guidance of your clinical supervisor) the relationship with the client.

There are scores of other special issues like counter-transference, that confront the counselor. Being aware of the specific issues that interfere with therapy, being open to new learning inputs from the team and senior counselors and clinical supervisor, help one deal with these problems. The depth of care one really feels for the client along with the professionalism that one brings into practice is what sets apart an effective and successful counselor from the rest of the crowd.

Additional definition & information on the all important subject of counter-transference:

Counter-transference occurs when counselors' emotions, beliefs, and biases are projected onto their client; as with transference this is typically related to the counselor's life history. Counter-transference involves an emotional connection with the client beyond what other counselors would deem as appropriate within the therapeutic relationship. The counselor's acceptance of the client's transference is another example of counter-transference (Gelso & Hayes, 2007). For example, when clients project feelings related to their parental figure onto their counselors, the counselors may find themselves wanting to protect the clients and reach beyond their boundaries to assist the clients. In such cases it is important to explore issues of both transference and counter-transference in order to rebalance the therapeutic relationship, reestablish boundaries, and promote client growth. There are many ways to recognize and respond to counter-transference during individual and group supervision. When not addressed, counter-transference can lead to violations of boundaries and potential harm to clients.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Instructor Note: In conclusion, I am hoping that in reading this chapter you all got the message, the purpose, the idea, the framework of who counselors are, who they can be, the importance of this role in people's lives. I am passionate about teaching and about helping others help themselves. I have allowed myself to be open to the process and over the years I have changed many many times in both my clinical practice and in personal life as a result. The journey has been and continues to be daunting, difficult, confusing, heartfelt, joyous, painful and outright wonderful.....I wouldn't change a single thing. It is my sincerest hope that you, the student open yourselves to the learning process, the clinical process and the self-discovery process. Enjoy the ride 😊



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Individual Counseling

Chapter 2

Competency: Encourage and reinforce client actions determined to be beneficial in progressing toward treatment goals.

Competency: Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress towards treatment goals.

Overview of Individual Addiction Counseling

Individual Counseling (IC) focuses on the symptoms of drug and alcohol addiction and related areas of impaired functioning. It also addresses the content and structure of the client's ongoing recovery program. This model of counseling is time limited and emphasizes behavioral change. It gives the client coping strategies, tools for recovery and in many programs, promotes 12-step philosophy and participation. The initial focus of addiction treatment is to assist the addicted person in achieving and maintaining abstinence from addictive chemicals and behaviors. Individual Counseling aids in helping the addicted person in their recovery and overall wellness.

One of the goals of IC is to help the addicted person acknowledge the damage that substances have caused in his or her life and instill the hope and belief that recovery is possible and that the client themselves have the ability to achieve long term health, wellness & recovery.

Within this counseling model, the client is the effective agent of change. It is the client who must take responsibility for working on and succeeding with a program of recovery. Although recovery is ultimately the client's responsibility, the client is encouraged to get a great deal of support from others, including counselors and other treatment staff, perhaps a sponsor, and family members and drug-free or recovering peers.

Overall, drug and alcohol dependence are thought to be a multi-determined, maladaptive way of coping with life's problems. It sometimes becomes compulsive and leads to a progressive deterioration in one's life circumstances.

Creating the Framework for Counseling

The frame refers to the structure and boundaries of the counseling within which the counseling and therapeutic relationship take place. Counselors should manage the therapeutic frame of the session with the utmost awareness, diligence and detail-mindedness.

People with substance use disorders can be exquisitely sensitive to deviations in the therapeutic frame, and can interpret deviations as a violation of trust. Of particular importance is counselor ability to start sessions punctually and hold them to a consistent duration, to provide sufficient notice for missed sessions, to manage the counselor's own feelings, to clearly communicate what and when material is discussed with the addiction treatment program staff members, and to negotiate contacts between sessions. Consistency and reliability are essential aspects to managing the therapeutic frame.

Operate within therapeutic margins of the therapeutic frame. Competent counseling takes place within a field bounded by 3 margins. Counseling outside of these relational or behavioral margins may be less effective. One margin is a counselor that is rushed, haphazard, disorganized or chaotic in conducting the session. The second margin is the counselor that is over-involved and too talkative or chatty, this therapist may cut the patient off, and in some cases use inappropriate self-disclosure. The third margin is the counselor that is cold, distant or preachy. A competent counselor works within the margins of this Therapeutic Triangle much like the tennis player strives to keep the ball within the white lines.

Stages of Individual Counseling in Addictions

The stages of IC treatment described here are:

1. Treatment Initiation
2. Early Abstinence
3. Maintenance of Abstinence
4. Advanced Recovery

As with other stage theories of development, the stage theory of addiction recovery is only a model. Individuals pass through the stages at their own pace, the stages are overlapping rather



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

than discreet, and individuals may slip back at points and need to rework issues from previous stages.

Appropriate treatment for addiction varies and is sensitive and responsive to the changing needs of the client throughout his or her recovery. The addiction counselor should understand that addiction treatment must be progressive, just as the client's recovery process is progressive. To provide optimal counseling, the counselor must be sensitive to the client's evolving needs in treatment. To ensure a progressive approach to addiction treatment, the counselor must be prepared to address different topics in recovery, use different kinds of interventions, and hold the client to a different level of responsibility as he or she works toward recovery.

As a guideline only:!!!!

In each session, the counselor should:

1. Find out how the client has been since last session.
2. Inquire whether the client has used drugs or alcohol since the last session. If the client has used, explore the relapse and help the client develop strategies to prevent future relapses.
3. Inquire whether there are any urgent problems that need attention and, if so, deal with them.
4. Discuss the progress or lack of progress related to the goals and objectives established in the treatment plan. Review the client's current stage in recovery and stage of change.

Goals and Objectives of Individual Drug Counseling – Traditional Approach

Competency: Work with the client to establish realistic, achievable goals consistent with achieving and maintaining recovery.

Competency: Facilitate the client's engagement in the treatment and recovery process.

Addiction counseling addresses (1) the symptoms of the drug addiction and areas of impaired functioning that are related to it and (2) the content and structure of the client's ongoing recovery program.

Throughout the course of individual addiction counseling the counselor will:



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

1. Help the client to admit that he or she suffers from the disease of chemical addiction. (if they haven't already)
2. Point out the signs and symptoms of addiction that are relevant to the client's experience.
3. Teach the client to recognize and re-channel urges to use drugs.
4. Encourage and motivate the client to achieve and sustain abstinence.
5. Monitor and encourage abstinence by using objective measures, such as urinalysis and Breathalyzer® tests.
6. Hold the chemically addicted person accountable for and discuss any episodes of use and strongly discourage further use.
7. Assist the client in identifying situations where drugs were used to cope with life's problems and in understanding that this process has prevented them achieving wellness in life.
8. Help the client to develop new, more effective problem-solving strategies.
9. Introduce the client to the 12-step philosophy and strongly encourage participation in a support peer based program.
10. Encourage the chemically addicted person to develop and continue with a recovery and wellness plan as a lifelong process.
11. Help the client to recognize and change defeating attitudes and behaviors that may stimulate a relapse.
12. Encourage the client to improve self-esteem by practicing newly acquired coping skills and problem-solving strategies at home and in the community.

The drug counseling sessions have a clear structure. Within the framework of that structure, the content of the discussion is largely up to the client. We make an effort to address effectively the client's individual needs at any point in treatment while also recognizing the commonality of many issues in addiction and recovery. People are indeed unique; however, the facets of a human problem like substance addiction usually follow familiar patterns. The validity of both realities should be respected.

Stages of Individual Counseling

A. Treatment Initiation

Clients often enter treatment with ambivalence about giving up their substance use. Counseling begins with helping the client decide to participate in treatment and accept abstinence as the basis / jumping off point of recovery work. The counselor can help the client recognize and



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

understand the damaging effects of addiction, address his or her denial of the problem, and support motivation toward recovery. In this progressive treatment model, the client's ambivalence is discussed specifically in the first 2 weeks of treatment (*Instructor comment: for some client's this work is needed throughout their entire treatment stay and after*), although motivation and commitment to recovery may be issues that are returned to throughout treatment. Depending on the treatment modality – residential, outpatient, intensive outpatient etc., the first two sessions of counseling should be devoted to introducing the treatment program to the client, obtaining a substance use and treatment history (completing a bio-psychosocial), and developing a therapeutic alliance.. In addition to the setting up of the framework for the treatment, the first two sessions are important in fostering the client's motivation.

Ambivalence and denial are likely to be relevant concerns in the early phase of treatment. Because they are so fundamental to the recovery process, the counselor should discuss them here or at any future point in the individual's treatment.

The counselor takes an active role, asking questions, offering guidance and direction, particularly during the early phases of treatment where immediate behavioral changes are required to establish and maintain abstinence.

The Therapeutic Alliance.....Yes Again!

Competency: Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness and empathy.

One of the most important aspects of the therapeutic alliance (TA) is the development of a cooperative relationship between client and counselor. Building a positive TA requires the counselor to start where the client is (i.e., to accept and work within the client's frame of reference). This stands in marked contrast to traditional approaches, which demand that the client submit to the counselor's (program's) frame of reference as the starting point of treatment. For example, if the client at first minimizes the seriousness of his or her drug use problem or rejects the idea that it is a problem at all, the counselor refrains from accusing the client of being in denial (a tactic likely to heighten rather than reduce the client's defensiveness) and instead asks the client to cooperate in a time-limited experiment (usually involving a trial period of abstinence) to assess the nature and extent of his or her involvement with psychoactive drugs.

Coerced or mandated clients pose the greatest challenge to getting a TA started. Typically, these clients appear for treatment angry, suspicious, mistrustful, and ready to do battle.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Building a relationship under these trying circumstances requires a great deal of clinical finesse on the part of the counselor, who makes every effort to:

- ✚ Empathize with the client's experience and the fact that no one likes to be told what to do.
- ✚ Accept without challenge the client's primary motivation for coming to treatment—to get the coercing agent (e.g., court, employer) "off my [the client's] back."
- ✚ Compliment the client for facing the realities of the situation by showing up at the session.
- ✚ Offer to help the client solve the problem or problems that led to the current situation.

Instructor Note: The process of Individual counseling has changed, just like the rest of addiction treatment. The idea of only viewing addiction as a disease and using a 12 step approach (which was the "new" approach to addiction treatment 25 yrs ago) is giving way to include a strengths based perspective on addiction and the client's. The counselor no longer needs to see the client as "sick" or "broken" somehow. Our approach is to see a human being with individual strengths, values, needs and issues; substance abuse is just one behavioral issue that needs to be addressed. When the counselor adopts an attitude of acceptance, non-judgment and caring the client is much more likely to respond in kind. Just remember be open to new clinical ideas and practices, be flexible enough to follow your client's lead but still remain on top of therapeutic session. An empowered client is more likely to believe they can be successful.

Crisis and Risk Assessment

Chapter 3

Competency: Apply crisis prevention and management skills.

As an addiction counselor you will be responsible for many things concerning the care and treatment of a client. One of the most important assessments and interventions you will be responsible for is crisis and risk assessment. In this chapter we will define crisis and risk and some interventions you can utilize to assess and/or de-escalate the client.

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 abusers 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)



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

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.?



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

- **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.

Instructor Note: I have only one thing to say.....GET YOUR SUPERVISOR.....IMMEDIATELY! EVEN IF YOU THINK THE CLIENT MAY NOT REALLY BE SUICIDAL. THIS IS AN ASSESSMENT AND DECISION THAT SHOULD BE MADE BY YOUR CLINICAL SUPERVISOR!

Therapeutic Approaches/Practices

Chapter 4

In this chapter we will review several theories and practice in brief and focus on an additional few that are the most common and statistically proven in working with the substance abusing client. Remember....It is important to use only Evidence Based Practices!!

Competency: Make constructive therapeutic responses when the client's behavior is inconsistent with stated recovery goals.

Competency: Promote client knowledge, skills, and attitudes consistent with the maintenance of health and prevention of HIV/AIDS, tuberculosis, sexually transmitted diseases, hepatitis C, and other infectious diseases.

Competency: Promote client knowledge, skills, and attitudes that contribute to a positive change in substance use behavior.

Competency: Encourage and reinforce client actions determined to be beneficial in progressing toward treatment goals.

Competency: Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress toward treatment goals.

Competency: Facilitate the development of basic and life skills associated with recovery.

Competency: Adapt counseling strategies to the individual characteristics of the client, including but not limited to disability, gender, sexual orientation, developmental level, culture, age and health status.

Competency: Facilitate the client's identification selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment progress and preventing relapse.

Theories of Counseling.....Briefly (and not all of them)

1. Analytic-oriented therapies

a. Psychoanalytic theory - Originator. Sigmund Freud

Focus of psychoanalytic theory - Resolving unconscious conflicts from the past.

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 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- is the processes of making problems seem less severe than they actually are.
- Compensation is developing positive traits to unconsciously mask weaknesses and mistakes.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Goal of psychoanalytic therapy – is 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.

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 - Originator. Alfred Adler

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).

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.).

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)

2. Experiential and relationship-oriented therapies

a. Existential therapy – Originators: Viktor Frankl and Rollo May



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Focus of existential therapy - 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.

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.

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 - Originator. Fritz Perls

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.

The Goal of gestalt therapy – is helping clients deal with unfinished (unresolved) business from the past in the here and now.

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.

What about unfinished business?

- Resentments
- Rage
- Hatred
- Unresolved grief



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Gestalt techniques include the infamous: empty chair exercise; letter writing (addressing unfinished business and reading aloud; role playing.

c. Person-centered therapy – Originator - Carl Rogers

Focus of person-centered therapy - The here and now.

View of human nature – is that 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

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.

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 – Originator - William Glasser

Focus of reality therapy - Helping clients to change in the here and now.

View of human nature – is that human beings have two basic needs:

- To love and be loved by others
- To feel worthwhile to self and others



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

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

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.

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 - Originator. Albert Ellis

Focus of rational emotive behavioral therapy - The here and now.

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.

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.

Some of the results of irrational beliefs are:

- Self criticism
- Isolation
- Self abuse
- Avoiding relationships
- Never striving to reach potential
- Drug use, etc.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

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.

The Big Three

The following are 3 of the many evidence based practices (EBP) used in addiction treatment/therapy. I chose these 3 as they are the most often utilized and have had documented success.

I have gone into more detail with these three.

Instructor Note: The order of the presentation does not reflect preference or benefit.

1. Cognitive Behavioral Therapy - An Overview

Originator – Aaron Beck

Focus of Therapy – is the Here and Now.

View of human nature – is that individuals with emotional problems often have faulty thinking as a result of having inadequate or incorrect information.

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



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

- 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.”)

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 with client’s having difficulty maintaining new behavioral practices.

Cognitive-behavioral coping skills treatment (CBT) is a short-term, focused approach to helping substance addicted individuals become abstinent from alcohol and other drugs. The underlying assumption is that learning processes play an important role in the development and continuation of drug and alcohol addiction. These same learning processes can be used to help individuals reduce their drug and alcohol use.

Very simply put, CBT attempts to help patients recognize, avoid, and cope. That is, RECOGNIZE the situations in which they are most likely to use cocaine, AVOID these situations when appropriate, and COPE more effectively with a range of problems and problematic behaviors associated with substance abuse.

Several important features of CBT make it particularly promising as a treatment for drug and alcohol addiction:

- ✚ CBT is a short-term, comparatively brief approach well suited to the resource capabilities of most clinical programs.
- ✚ CBT is structured, goal-oriented, and focused on the immediate problems faced by substance abusers entering treatment who are struggling to control their drug & alcohol use.
- ✚ CBT is a flexible, individualized approach that can be adapted to a wide range of clients as well as a variety of settings (inpatient, outpatient) and formats (group, individual).



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

CBT is compatible with a range of other treatments the client may receive, such as pharmacotherapy. CBT's broad approach encompasses several important common tasks of successful substance abuse treatment.

Skills Training

CBT can be thought of as a highly individualized training program that helps substance abusers unlearn old habits associated with drug & alcohol abuse and learn or relearn healthier skills and habits. By the time the level of substance use is severe enough to warrant treatment, clients are likely to be using substances as their single means of coping with a wide range of interpersonal and intrapersonal problems. This may occur for several reasons:

The individual may have never learned effective strategies to cope with the challenges and problems of adult life, as when substance use begins during early adolescence.

Although the individual may have acquired effective strategies at one time, these skills may have decayed through repeated reliance on substance use as a primary means of coping. These patients have essentially forgotten effective strategies because of chronic involvement in a drug-using lifestyle in which the bulk of their time is spent in acquiring, using, and then recovering from the effects of drugs.

The individual's ability to use effective coping strategies may be weakened by other problems, such as substance abuse with concurrent psychiatric disorders. Because substance abusers are a heterogeneous group and typically come to treatment with a wide range of problems, skills training in CBT are made as broad as possible. The first few sessions focus on skills related to initial control of substance misuse (e.g., identification of high-risk situations, coping with thoughts about drug/alcohol use). Once these basic skills are mastered, training is broadened to include a range of other problems with which the individual may have difficulty coping (e.g., social isolation, unemployment). In addition, to strengthen and broaden the individual's range of coping styles, skills training focuses on both intrapersonal (e.g., coping with craving) and interpersonal (e.g., refusing offers of drugs) skills. Clients are taught these skills as both specific strategies (applicable in the here and now to control drug/alcohol use) and general strategies that can be applied to a variety of other problems. Thus, CBT is not only geared to helping each patient reduce and eliminate substance use while in treatment, but also to imparting skills that can benefit the patient long after treatment.

Critical Tasks

CBT addresses several critical tasks that are essential to successful substance abuse treatment.

- ✚ Foster the motivation for abstinence. An important technique used to enhance the patient's motivation to stop cocaine use is to do a decisional analysis, which clarifies what the individual stands to lose or gain by continued cocaine use.
- ✚ Teach coping skills. This is the core of CBT - to help patients recognize the high-risk situations in which they are most likely to use substances and to develop other, more effective means of coping with them.
- ✚ Change reinforcement contingencies. By the time treatment is sought, many patients spend most of their time acquiring, using, and recovering from cocaine use to the exclusion of other experiences and rewards. In CBT, the focus is on identifying and reducing habits associated with a drug-using lifestyle by substituting more enduring, positive activities and rewards.
- ✚ Foster management of painful affects. Skills training also focus on techniques to recognize and cope with urges to use cocaine; this is an excellent model for helping patients learn to tolerate other strong affects such as depression and anger.
- ✚ Improve interpersonal functioning and enhance social supports. CBT includes training in a number of important interpersonal skills and strategies to help patients expand their social support networks and build enduring, drug-free relationships.

CBT, like most therapies, consists of a complex combination of common and unique factors. For example, in CBT mere delivery of skills training without grounding in a positive therapeutic relationship leads to a dry, overly didactic approach that alienates or bores most patients and ultimately has the opposite effect of that intended. It is important to recognize that CBT is thought to exert its effects through this intricate interplay of common and unique factors. A major task of the therapist is to achieve an appropriate balance between attending to the relationship and delivering skills training. For example, without a solid therapeutic alliance, it is unlikely that a patient will stay in treatment, be sufficiently engaged to learn new skills, or share successes and failures in trying new approaches to old problems. Conversely, empathic delivery of skills training as tools to help patients manage their lives more effectively may form the basis of a strong working alliance. (NIDA)

Research has established that cognitive behavioral therapies (CBT) are valuable tools in assisting clients reach their treatment goals. Implementing CBT effectively, however, requires skills and preparation. Too often counselors do not take the time necessary to prepare to guide clients through a learning process that can enhance their recovery, their relationships and their sense of self-efficacy. Pucci (2009) suggests that counselors are more likely to be effective using CBT when they use these strategies:

- ✚ Use a coherent systematic approach.

When a counselor uses a systematic approach to CBT s/he will have a therapeutic roadmap as a guide. Using a systematic approach to CBT ensures there is a focus point to each session that builds on the client's previous learning. Such approaches are typically published as manuals.

- ✚ Establish accurate empathy.

When a counselor establishes accurate empathy the client begins to feel understood. Accurate empathy creates a therapeutic bond with the client who begins to feel the therapist truly understands what s/he is experiencing. If a counselor offers an alternative unfamiliar way of thinking that is contrary to the client's beliefs, the client may begin to feel misunderstood. Therefore, it is best to establish an empathic relationship prior to helping the client examine and change self-defeating beliefs and assumptions.

- ✚ Recognize irrational thoughts.

One aspect of CBT is helping the client see the relationship between thoughts or beliefs and behavior. For example, most CBT approaches encourage the client to replace irrational beliefs about a situation ("This is awful, terrible and horrible") with a less severe, more rational statement ("This is unfortunate but it's not the end of the world"). The counselor's ability to distinguish rational from irrational beliefs in the context of the client's life and culture is one key to conducting effective CBT.

- ✚ Assist in creating rational replacement thoughts.

The counselor needs to help the client develop new rational replacements for exaggerated or irrational thoughts. Old beliefs do not easily give way to new ones. It is important to be patient at this stage of CBT.

✚ Focus on client assumptions.

CBT directs clients to focus on the assumptions underlying their thoughts or beliefs. For example, a client may state that her friends don't really appreciate her. A good therapeutic response might be, "Are you sure that there is evidence that they don't appreciate you? Remember that there are several other possible explanations to explore. Consider that your friends might have been distracted and forgot to thank you at that moment. It could be very helpful for you to explore other possibilities." Alternatively, the counselor could focus on the underlying assumption which may be contributing to the client's distress, encouraging the client to say something like, "It would be nice, but not essential, for my friends to acknowledge my efforts." When the underlying assumption is corrected and made for rational, the client is not likely to feel quite so distressed.

The Characteristics of Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is a good option for people who want to increase their self-confidence and move away from self-destructive behavior. This following list b let points the main features and effects of CBT:

- CBT helps develop flexible, self-enhancing beliefs and attitudes towards self, others and the world around.
- CBT is goal-directed.
- CBT offers skills and strategies for overcoming common problems such as anxiety, depression and more.
- CBT addresses the past with a view to understanding how personal history may be affecting present day beliefs and behaviors.
- CBT focuses on how problems are being perpetuated rather than searching for a singular reason or root cause.
- CBT encourages clients to try things out for themselves and practice new alternative ways of thinking and acting.
- CBT highlights prevention of relapse and personal development.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Dealing with Negativity through Cognitive Behavioral Therapy

As we saw earlier Cognitive Behavioral Therapy has all sorts of tools for helping clients help themselves. Simply thinking about this basic A-B-C structure can help clients understand and overcome negative thinking and start to deal with it constructively:

A is for activating events, or triggers – situations past, present, or future that trigger off thoughts and beliefs.

B stands for belief, representing thoughts and beliefs and includes the meanings attached to triggers and how client's think about themselves in relation to the trigger. **B** establishes how clients ultimately feel and act in response to a trigger.

C is for the consequences of the client's behaviors and emotions. They are what actions your client does and feels in response to a trigger (A) *because* of your thoughts and beliefs (B).

Setting Goals for Personal Problem Solving

It's important to help your clients be clear in their mind about their problems so that both of you can create specific attainable goals in relation to them. Try this acronym below – *SPORT* stands for *specific, positive, observable, realistic* and *timed*. Consider these five aspects when deciding treatment goals:

- **Specific:** Be precise about when, where, and with whom the client wants to feel and/or behave more constructively.
- **Positive:** State goals in positive and pro-active terms. What does the client want to achieve or work towards? What does the client want to strive to gain in their personal life?
- **Observable:** Consider how someone neutral could note that the client has changed. What positive changes might the client notice in their own thinking and actions?
- **Realistic:** Make goals clear, concrete and within the client's grasp. Focus on goals which involve changing personal reactions to life rather than on changing others or life events which the client has very little power over.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

- **Timed:** Create a timeframe to help you keep your goals in sight. Think about setting yourself clear times to carry out tasks along the way. Keeping a task-list with spotlighted times of when to do each task can help you to actually get on with what you need to do.

Cognitive Behavioral Therapy Techniques

Cognitive Behavioral Therapy exercises help in modifying a person's behavioral patterns. Behavioral patterns are modified for bringing about positive changes in the client's personality.

Cognitive Rehearsal - In this technique, the client is asked to recall a problematic situation from his/her past. The counselor and client work on the problem to find a solution for it. The counselor asks the client to rehearse positive thoughts in his/her mind; rehearsing positive thoughts helps in making appropriate changes to the client's thought processes. The power of imagination proves to be of great help when you are doing such type of exercises.

Validity Testing - In this technique, validity of thoughts of the client are tested by the counselor; the client is allowed to defend his/her viewpoint with the help of objective evidence. The faulty nature or invalidity of beliefs held by the client is exposed if he/she is unable to produce any kind of objective evidence.

Writing in a Journal - It is a practice of maintaining a diary to keep an account of the different situations encountered by clients in day-to-day life. Thoughts associated with these situations and behaviors exhibited in response are also mentioned in the diary. The counselor and client review what all is written in the diary and try to identify the client's maladaptive thought patterns. The discussion which takes place between client and counselor is helpful for finding the different ways in which behavior of the client gets affected.

Guided Discovery - The purpose behind using this technique is to help clients to understand their cognitive distortions. Clients are offered the necessary assistance and guidance by counselors to understand how they process information. It allows clients to alter the way they process of information. Upon completion of this treatment, the client's perception of the world undergoes a profound change and he/she starts seeing things with a new outlook. A change in perception enables the client to modify his/her behavioral patterns.

Modeling - It is one of the important cognitive behavioral therapy techniques wherein counselors perform role-playing exercises. These cognitive behavioral therapy exercises teach clients how to respond in difficult situations. The client sees the behavior of the counselor as a model to overcome his/her own behavioral problems.

Homework - 'Homework' is actually a set of assignments to be completed by clients. During their sessions with counselors, the clients are asked to take down notes, review audiotapes of these sessions and read articles/books related to this therapy.

Aversive Conditioning - In this technique the appeal of maladaptive behavior is lessened with the help of 'dissuasion'. The client is exposed to an unpleasant stimulus while he/she is engaged in a particular behavior for which treatment is needed. The end result of this exercise is that the client learns to associate the unpleasant stimulus with the maladaptive behavior in question; he/she becomes averse to behaving in such a manner.

Systematic Positive Reinforcement - It is one of the CBT techniques in which a certain kind of behavior (positive) is rewarded with positive reinforcement. A reward system is used to reinforce the importance of positive behavior in the minds of clients.

2. Motivational Interviewing

Motivation can be understood not as something one has but rather as something one does. It involves recognizing a problem, searching for a way to change, and then beginning and sticking with that change strategy. There are, as it turns out many ways to help people move toward such recognition and action.

Motivational interviewing is a way of being with a client, not just a set of techniques for doing counseling. Miller and Rollnick, 1991

Motivational interviewing is a technique in which you become a helper in the change process and express acceptance of your client. It is a way to interact with substance-using clients, not merely as an adjunct to other therapeutic approaches, and a style of counseling that can help resolve the ambivalence that prevents clients from realizing personal goals. Motivational interviewing builds on Carl Rogers' optimistic and humanistic theories about people's capabilities for exercising free choice and changing through a process of self-actualization. The therapeutic relationship for both Rogerian and motivational interviewers is a democratic partnership. Your role in motivational interviewing is directive, with a goal of eliciting self-motivational statements and behavioral change from the client in addition to creating client discrepancy to enhance motivation for positive change ([Davidson, 1994](#); [Miller and Rollnick, 1991](#)). Essentially, motivational interviewing activates the capability for beneficial change that everyone possesses ([Rollnick and Miller, 1995](#)). Although some people can continue change on



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

their own, others require more formal treatment and support over the long journey of recovery. Even for clients with low readiness, motivational interviewing serves as a vital prelude to later therapeutic work.

Motivational interviewing is a counseling style based on the following assumptions:

- Ambivalence about substance use (and change) is normal and constitutes an important motivational obstacle in recovery.
- Ambivalence can be resolved by working with your client's intrinsic motivations and values.
- The alliance between you and your client is a collaborative partnership to which you each bring important expertise.
- An empathic, supportive, yet directive, counseling style provides conditions under which change can occur. (Direct argument and aggressive confrontation may tend to increase client defensiveness and reduce the likelihood of behavioral change.)

Ambivalence

Individuals with substance abuse disorders are usually aware of the dangers of their substance-using behavior but continue to use substances anyway. They may want to stop using substances, but at the same time they do not want to. They enter treatment programs but claim their problems are not all that serious. These disparate feelings can be characterized as ambivalence, and they are natural, regardless of the client's state of readiness. It is important to understand and accept your client's ambivalence because ambivalence is often the central problem--and lack of motivation can be a manifestation of this ambivalence ([Miller and Rollnick, 1991](#)). If you interpret ambivalence as denial or resistance, friction between you and your client tends to occur.

The motivational interviewing style facilitates exploration of stage-specific motivational conflicts that can potentially hinder further progress. However, each dilemma also offers an opportunity to use the motivational style to help your client explore and resolve opposing attitudes. Examples of how these conflicts might be expressed at different stages of change.

Five Principles of Motivational Interviewing

Motivational interviewing has been *practical* in focus. The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative. The motivational interviewer must proceed with a strong sense of purpose, clear strategies and skills for pursuing that purpose, and a sense of timing to intervene in particular ways at incisive moments ([Miller and Rollnick, 1991, pp. 51-52](#)).

The clinician practices motivational interviewing with five general principles in mind:

1. Express empathy through reflective listening.
2. Develop discrepancy between clients' goals or values and their current behavior.
3. Avoid argument and direct confrontation.
4. Adjust to client resistance rather than opposing it directly.
5. Support self-efficacy and optimism.

Express Empathy

Empathy "is a specifiable and learnable skill for *understanding* another's meaning through the use of reflective listening. It requires sharp attention to each new client statement, and the continual generation of hypotheses as to the underlying meaning" ([Miller and Rollnick, 1991, p. 20](#)). An empathic style

- Communicates respect for and acceptance of clients and their feelings
- Encourages a nonjudgmental, collaborative relationship
- Allows you to be a supportive and knowledgeable consultant
- Sincerely compliments rather than denigrates
- Listens rather than tells
- Gently persuades, with the understanding that the decision to change is the client's
- Provides support throughout the recovery process

Empathic motivational interviewing establishes a safe and open environment that is conducive to examining issues and eliciting personal reasons and methods for change. A fundamental component of motivational interviewing is understanding each client's unique perspective, feelings, and values. Your attitude should be one of acceptance, but not necessarily approval or agreement, recognizing that ambivalence about change is to be expected. Motivational interviewing is most successful when a trusting relationship is established between you and your client.

Expressing Empathy

Reprinted with permission.

- Acceptance facilitates change.
- Skillful reflective listening is fundamental to expressing empathy.
- Ambivalence is normal.

Although empathy is the foundation of a motivational counseling style, it "should not be confused with the meaning of empathy as *identification* with the client or the sharing of common past experiences. In fact, a recent personal history of the same problem area...may compromise a counselor's ability to provide the critical conditions of change" ([Miller and Rollnick, 1991, p. 5](#)). The key component to expressing empathy is reflective listening.

If you are not listening reflectively but are instead imposing direction and judgment, you are creating barriers that impair the therapeutic relationship ([Miller and Rollnick, 1991](#)). The client will most likely react by stopping, diverting, or changing direction. Twelve examples of such non-empathic responses have been identified ([Gordon, 1970](#)):

1. **Ordering or directing.** Direction is given with a voice of authority. The speaker may be in a position of power (e.g., parent, employer) or the words may simply be phrased and spoken in an authoritarian manner.
2. **Warning or threatening.** These messages are similar to ordering but they carry an overt or covert threat of impending negative consequences if the advice or direction is not followed. The threat may be one the clinician will carry out or simply a prediction of a negative outcome if the client doesn't comply--for example, "*If you don't listen to me, you'll be sorry.*"

3. **Giving advice, making suggestions, or providing solutions prematurely or when unsolicited.** The message recommends a course of action based on the clinician's knowledge and personal experience. These recommendations often begin with phrases such as, "What I would do is...."
4. **Persuading with logic, arguing, or lecturing.** The underlying assumption of these messages is that the client has not reasoned through the problem adequately and needs help to do so.
5. **Moralizing, preaching, or telling clients their duty.** These statements contain such words as "should" or "ought" to convey moral instructions.
6. **Judging, criticizing, disagreeing, or blaming.** These messages imply that something is wrong with the client or with what the client has said. Even simple disagreement may be interpreted as critical.
7. **Agreeing, approving, or praising.** Surprisingly, praise or approval also can be an obstacle if the message sanctions or implies agreement with whatever the client has said. Unsolicited approval can interrupt the communication process and can imply an uneven relationship between the speaker and the listener. Reflective listening does not require agreement.
8. **Shaming, ridiculing, labeling, or name-calling.** These messages express overt disapproval and intent to correct a specific behavior or attitude.
9. **Interpreting or analyzing.** Clinicians are frequently and easily tempted to impose their own interpretations on a client's statement and to find some hidden, analytical meaning. Interpretive statements might imply that the clinician knows what the client's *real* problem is.
10. **Reassuring, sympathizing, or consoling.** Clinicians often want to make the client feel better by offering consolation. Such reassurance can interrupt the flow of communication and interfere with careful listening.
11. **Questioning or probing.** Clinicians often mistake questioning for good listening. Although the clinician may ask questions to learn more about the client, the underlying message is that the clinician might find the right answer to all the client's problems if enough questions are asked. In fact, intensive questioning can interfere with the

spontaneous flow of communication and divert it in directions of interest to the clinician rather than the client.

12. **Withdrawing, distracting, humoring, or changing the subject.** Although humor may represent an attempt to take the client's mind off emotional subjects or threatening problems, it also can be a distraction that diverts communication and implies that the client's statements are unimportant.

Ethnic and cultural differences must be considered when expressing empathy because they influence how both you and your client interpret verbal and nonverbal communications.

Develop Discrepancy

Motivation for change is enhanced when clients perceive discrepancies between their current situation and their hopes for the future. Your task is to help focus your client's attention on how current behavior differs from ideal or desired behavior. Discrepancy is initially highlighted by raising your clients' awareness of the negative personal, familial, or community consequences of a problem behavior and helping them confront the substance use that contributed to the consequences. Although helping a client perceive discrepancy can be difficult, carefully chosen and strategic reflecting can underscore incongruities.

Separate the behavior from the person and help your client explore how important personal goals (e.g., good health, marital happiness, financial success) are being undermined by current substance use patterns. This requires you to listen carefully to your client's statements about values and connections to community, family, and church. If the client shows concern about the effects of personal behavior, highlight this concern to heighten the client's perception and acknowledgment of discrepancy.

Once a client begins to understand how the consequences or potential consequences of current behavior conflict with significant personal values, amplify and focus on this discordance until the client can articulate consistent concern and commitment to change.

One useful tactic for helping a client perceive discrepancy is sometimes called the "Columbo approach" ([Kanfer and Schefft, 1988](#)). This approach is particularly useful with a client who prefers to be in control. Essentially, the clinician expresses understanding and continuously seeks clarification of the client's problems but appears unable to perceive any solution. A

stance of uncertainty or confusion can motivate the client to take control of the situation by offering a solution to the clinician ([Van Bilsen, 1991](#)).

Tools other than talking can be used to reveal discrepancy. For example, show a video and then discuss it with the client, allowing the client to make the connection to his own situation. Juxtaposing different media messages or images that are meaningful to a client can also be effective. This strategy may be particularly effective for adolescents because it provides stimulation for discussion and reaction.

You can help your client perceive discrepancy on a number of different levels, from physical to spiritual, and in different domains, from attitudinal to behavioral. To do this, it is useful to understand not only what an individual values but also what the community values. For example, substance use might conflict with the client's personal identity and values; it might conflict with the values of the larger community; it might conflict with spiritual or religious beliefs; or it might conflict with the values of the client's family members. Thus, discrepancy can be made clear by contrasting substance-using behavior with the importance the clients ascribe to their relationships with family, religious groups, and the community.

Developing Discrepancy

- Developing awareness of consequences helps clients examine their behavior.
- A discrepancy between present behavior and important goals motivates change.
- The client should present the arguments for change.

Avoid Argument

You may occasionally be tempted to argue with a client who is unsure about changing or unwilling to change, especially if the client is hostile, defiant, or provocative. However, trying to convince a client that a problem exists or that change is needed could precipitate even more resistance. If you try to prove a point, the client predictably takes the opposite side. Arguments with the client can rapidly degenerate into a power struggle and do not enhance motivation for beneficial change. When it is the client, not you, who voices arguments for change, progress can be made. The goal is to "walk" with clients (i.e., accompany clients through treatment), not "drag" them along (i.e., direct clients' treatment).

A common area of argument is the client's unwillingness to accept a label such as "alcoholic" or "*drug abuser*." Miller and Rollnick stated that

“There is no particular reason why the therapist should badger clients to accept a label, or exert great persuasive effort in this direction. Accusing clients of being *in denial or resistant or addicted* is more likely to increase their resistance than to instill motivation for change. We advocate starting with clients wherever they are, and altering their self-perceptions, not by arguing about labels, but through substantially more effective means” ([Miller and Rollnick, 1991, p. 59](#)).

Although this conflicts with some clinicians' belief that clients must be persuaded to self-label, the approach advocated in the "Big Book" of Alcoholics Anonymous (AA) is that labels are not to be imposed ([AA, 1976](#)). Rather, it is a personal decision of each individual.

Avoiding Arguments

Reprinted with permission.

- Arguments are counterproductive.
- Defending breeds defensiveness.
- Resistance is a signal to change strategies.
- Labeling is unnecessary.

Roll with Resistance

Resistance is a legitimate concern for the clinician because it is predictive of poor treatment outcomes and lack of involvement in the therapeutic process. One view of resistance is that the client is behaving defiantly. Another, perhaps more constructive, viewpoint is that resistance is a signal that the client views the situation differently. This requires you to understand your client's perspective and proceed from there. Resistance is a signal to you to change direction or listen more carefully. Resistance actually offers you an opportunity to respond in a new, perhaps surprising, way and to take advantage of the situation without being confrontational.

Adjusting to resistance is similar to avoiding argument in that it offers another chance to express empathy by remaining nonjudgmental and respectful, encouraging the client to talk

and stay involved. Try to avoid evoking resistance whenever possible, and divert or deflect the energy the client is investing in resistance toward positive change.

How do you recognize resistance? How do you avoid arguing and, instead, adapt to resistance? Miller and colleagues have identified and provided examples of at least seven ways to react appropriately to client resistance ([Miller and Rollnick, 1991](#); [Miller et al., 1992](#)). These are described below.

Four Types of Client Resistance

Arguing

The client contests the accuracy, expertise, or integrity of the clinician.

- *Challenging.* The client directly challenges the accuracy of what the clinician has said.
- *Discounting.* The client questions the clinician's personal authority and expertise.
- *Hostility.* The client expresses direct hostility toward the clinician.

Interrupting

The client breaks in and interrupts the clinician in a defensive manner.

- *Talking over.* The client speaks while the clinician is still talking, without waiting for an appropriate pause or silence.
- *Cutting off.* The client breaks in with words obviously intended to cut the clinician off (e.g., "Now wait a minute. I've heard about enough").

Denying

The client expresses unwillingness to recognize problems, cooperate, accept responsibility, or take advice.

- *Blaming.* The client blames other people for problems.
- *Disagreeing.* The client disagrees with a suggestion that the clinician has made, offering no constructive alternative. This includes the familiar "Yes, but...", which explains what is wrong with suggestions that are made.
- *Excusing.* The client makes excuses for his behavior.
- *Claiming impunity.* The client claims that she is not in any danger (e.g., from drinking).

- *Minimizing.* The client suggests that the clinician is exaggerating risks or dangers and that it really isn't so bad.
- *Pessimism.* The client makes statements about himself or others that are pessimistic, defeatist, or negative in tone.
- *Reluctance.* The client expresses reservations and reluctance about information or advice given.
- *Unwillingness to change.* The client expresses a lack of desire or an unwillingness to change.

Ignoring

The client shows evidence of ignoring or not following the clinician.

- *Inattention.* The client's response indicates that she has not been paying attention to the clinician.
- *Non-answer.* In answering a clinician's query, the client gives a response that is not an answer to the question.
- *No response.* The client gives no audible verbal or clear nonverbal reply to the clinician's query.
- *Sidetracking.* The client changes the direction of the conversation that the clinician has been pursuing.

Source: [Miller and Rollnick, 1991](#). Adapted from a behavior coding system by [Chamberlain et al., 1984](#). Reprinted with permission.

Simple reflection

The simplest approach to responding to resistance is with nonresistance, by repeating the client's statement in a neutral form. This acknowledges and validates what the client has said and can elicit an opposite response.

Client: I don't plan to quit drinking anytime soon.

Clinician: You don't think that abstinence would work for you right now.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Amplified reflection

Another strategy is to reflect the client's statement in an exaggerated form--to state it in a more extreme way but without sarcasm. This can move the client toward positive change rather than resistance.

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

Clinician: So your wife is worrying needlessly.

Double-sided reflection

A third strategy entails acknowledging what the client has said but then also stating contrary things she has said in the past. This requires the use of information that the client has offered previously, although perhaps not in the same session.

Client: I know you want me to give up drinking completely, but I'm not going to do that!

Clinician: You can see that there are some real problems here, but you're not willing to think about quitting altogether.

Shifting focus

You can defuse resistance by helping the client shift focus away from obstacles and barriers. This method offers an opportunity to affirm your client's personal choice regarding the conduct of his own life.

Client: I can't stop smoking reefer when all my friends are doing it.

Clinician: You're way ahead of me. We're still exploring your concerns about whether you can get into college. We're not ready yet to decide how marijuana fits into your goals.

Agreement with a twist

A subtle strategy is to agree with the client, but with a slight twist or change of direction that propels the discussion forward.

Client: Why are you and my wife so stuck on my drinking? What about all her problems? You'd drink, too, if your family were nagging you all the time.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Clinician: You've got a good point there, and that's important. There is a bigger picture here, and maybe I haven't been paying enough attention to that. It's not as simple as one person's drinking. I agree with you that we shouldn't be trying to place blame here. Drinking problems like these do involve the whole family.

Reframing

A good strategy to use when a client denies personal problems is reframing--offering a new and positive interpretation of negative information provided by the client. Reframing "acknowledges the validity of the client's raw observations, but offers a new meaning...for them" (Miller and Rollnick, 1991, p. 107).

Client: My husband is always nagging me about my drinking--always calling me an alcoholic. It really bugs me.

Clinician: It sounds like he really cares about you and is concerned, although he expresses it in a way that makes you angry. Maybe we can help him learn how to tell you he loves you and is worried about you in a more positive and acceptable way.

In another example, the concept of relative tolerance to alcohol provides a good opportunity for reframing with problem drinkers (Miller and Rollnick, 1991). Many heavy drinkers believe they are not alcoholics because they can "hold their liquor." When you explain that tolerance is a risk factor and a warning signal, not a source of pride, you can change your client's perspective about the meaning of feeling no effects. Thus, reframing is not only educational but sheds new light on the client's experience of alcohol.

Rolling With Resistance

Reprinted with permission.

- Momentum can be used to good advantage.
- Perceptions can be shifted.
- New perspectives are invited but not imposed.
- The client is a valuable resource in finding solutions to problems.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Siding with the negative

One more strategy for adapting to client resistance is to "side with the negative"--to take up the negative voice in the discussion. This is not "reverse psychology," nor does it involve the ethical quandaries of prescribing more of the symptom, as in a "therapeutic paradox." Typically, siding with the negative is stating what the client has already said while arguing against change, perhaps as an amplified reflection. If your client is ambivalent, your taking the negative side of the argument evokes a "Yes, but..." from the client, who then expresses the other (positive) side. Be cautious, however, in using this too early in treatment or with depressed clients.

Client: Well, I know some people think I drink too much, and I may be damaging my liver, but I still don't believe I'm an alcoholic or in need of treatment.

Clinician: We've spent considerable time now going over your positive feelings and concerns about your drinking, but you still don't think you are ready or want to change your drinking patterns. Maybe changing would be too difficult for you, especially if you really want to stay the same. Anyway, I'm not sure you believe you could change even if you wanted to.

Support Self-Efficacy

Many clients do not have a well-developed sense of self-efficacy and find it difficult to believe that they can begin or maintain behavioral change. Improving self-efficacy requires eliciting and supporting hope, optimism, and the feasibility of accomplishing change. This requires you to recognize the client's strengths and bring these to the forefront whenever possible. Unless a client believes change is possible, the perceived discrepancy between the desire for change and feelings of hopelessness about accomplishing change is likely to result in rationalizations or denial in order to reduce discomfort. Because self-efficacy is a critical component of behavior change, it is crucial that you as the clinician also believe in your clients' capacity to reach their goals.

Discussing treatment or change options that might still be attractive to clients is usually helpful, even though they may have dropped out of other treatment programs or returned to substance use after a period of being substance free. It is also helpful to talk about how persons in similar situations have successfully changed their behavior. Other clients can serve as role models and offer encouragement. Nonetheless, clients must ultimately come to believe that change is their responsibility and that long-term success begins with a single step forward. The AA motto, "one

day at a time," may help clients focus and embark on the immediate and small changes that they believe are feasible.

Education can increase clients' sense of self-efficacy. Credible, understandable, and accurate information helps clients understand how substance use progresses to abuse or dependency. Making the biology of addiction and the medical effects of substance use relevant to the clients' experience may alleviate shame and guilt and instill hope that recovery can be achieved by using appropriate methods and tools. A process that initially feels overwhelming and hopeless can be broken down into achievable small steps toward recovery.

Self-Efficacy

Reprinted with permission.

- Belief in the possibility of change is an important motivator.
- The client is responsible for choosing and carrying out personal change.
- There is hope in the range of alternative approaches available.

Instructor Note: I am happily including a small section on the most commonly stated myths about addiction and addicts. These beliefs and practice of these myths in addiction counseling has a predominantly negative effect. Not only are the myths negative but the impact of these myths on the client is negative as well. They can keep the client stuck, promote self-defeating thinking & behaviors and, in some cases, almost give permission to keep using. These myths have been around for a long time and many counselors who have been working in addictions for a while find it difficult to give them up and try new ways of seeing the client and working with the client. You, however, are students, so even if you are currently working in the field, your mind is open, ready to absorb new ideas and practices (these are 2 of the most important good counselor characteristics). So read, think, and challenge yourself, be honest with yourself. Do you currently believe/practice these myths????

Myths about Client Traits and Effective Counseling

Although the field is evolving toward a more comprehensive understanding of substance misuse and abuse, earlier views of addiction still persist in parts of our treatment system. Some of these are merely anachronisms (old fashioned, out of date); others may actually harm clients. Recent research has shown that some types of interventions that have been historically embedded within treatment approaches in the United States may paradoxically reduce

motivation for beneficial change. Other persisting stereotypes also interfere with the establishment of a helping alliance or partnership between the clinician and the client. Among the suppositions about clients and techniques that are being questioned and discarded are those discussed below.

Addiction stems from an addictive personality

Although it is commonly believed that substance abusers possess similar personality traits that make treatment difficult, no distinctive personality traits have been found to predict that an individual will develop a substance abuse disorder. The tendencies of an addictive personality most often cited are denial, projection, poor insight, and poor self-esteem. Research efforts, many of which have focused on clients with alcohol dependence, suggest there is no characteristic personality among substance-dependent individuals (Løberg and Miller, 1986; Miller, 1976; Vaillant, 1995). Rather, research suggests that people with substance abuse problems reflect a broad range of personalities. Nonetheless, the existence of an addictive personality continues to be a popular belief. One reason for this may be that certain similarities of behavior, emotion, cognition, and family dynamics do tend to emerge along the course of a substance abuse disorder. In the course of recovery, these similarities diminish, and people again become more diverse.

Resistance and denial are attributes of addiction

Engaging in denial, rationalization, evasion, defensiveness, manipulation, and resistance are characteristics that are often attributed to substance users. Furthermore, because these responses can be barriers to successful treatment, clinicians and interventions often focus on these issues. Research, however, has not supported the conclusion that substance-dependent persons, as a group, have abnormally robust defense mechanisms.

There are several possible explanations for this belief. The first is selective perception—that is, in retrospect, exceptionally difficult clients are elevated to become of usual responses. Moreover, the terms “denial” and “resistance” are often used to describe lack of compliance or motivation among substance users, whereas the term “motivation” is reserved for such concepts as acceptance and surrender (Kilpatrick et al., 1978; Nir and Cutler, 1978; Taleff, 1997). Thus, clients who disagree with clinicians, who refuse to accept clinicians’ diagnoses, and who reject treatment advice are often labeled as unmotivated, in denial, and resistant (Miller, 1985b; Miller and Rollnick, 1991). In other words, the term “denial” can be misused to describe disagreements, misunderstandings, or clinician expectations that differ from clients’ personal goals and may reflect counter-transference issues (Taleff, 1997).

Another explanation is that behaviors judged as normal in ordinary individuals are labeled as pathological when observed in substance-addicted populations (Orford, 1985). Clinicians and others expect substance users to exhibit pathological—or abnormally strong—defense mechanisms. A third explanation is that treatment procedures actually set up many clients to react defensively. Denial, rationalization, resistance, and arguing, as assertions of personal freedom, are common defense mechanisms that many people use instinctively to protect themselves emotionally (Brehm and Brehm, 1981). When clients are labeled pejoratively as alcoholic or manipulative or resistant, given no voice in selecting treatment goals, or directed authoritatively to do or not to do something, the result is a predictable—and quite normal—response of defiance. Moreover, when clinicians assume that these defenses must be confronted and “broken” by adversarial tactics, treatment can become counterproductive (Taleff, 1997). A strategy of aggressive confrontation is likely to evoke strong resistance and outright denial. Hence, one reason that high levels of denial and resistance are often seen as attributes of substance-dependent individuals as a group is that their normal defense mechanisms are so frequently challenged and aroused by clinical strategies of confrontation. Essentially, this becomes a self-fulfilling prophecy (Jones, 1977).

Confrontation is an effective counseling style

In contemporary treatment, the term “confrontation” has several meanings, referring usually to a type of intervention (a planned confrontation) or to a counseling style (a confrontational session). The term can reflect the assumption that denial and other defense mechanisms must be aggressively “broken through” or “torn down,” using therapeutic approaches that can be characterized as authoritarian and adversarial (Taleff, 1997). As just noted, this type of confrontation may promote resistance rather than motivation to change or cooperate. Research suggests that the more frequently clinicians use adversarial confrontational techniques with substance-using clients, the less likely clients will change (Miller et al., 1993), and controlled clinical trials place confrontational approaches among the least effective treatment methods (Miller et al., 1998).

There is, however, a constructive type of therapeutic confrontation. If helping clients confront and assess the reality of their behaviors is a prerequisite for intentional change, clinicians using motivational strategies focus on constructive confrontation as a treatment goal. From this perspective, constructive or therapeutic confrontation is useful in assisting clients to identify and reconnect with their personal goals, to recognize discrepancies between current behavior and desired ideals (Ivey et al., 1997), and to resolve ambivalence about making positive changes.

Five Opening Strategies

Clinicians who adopt motivational interviewing as a preferred style have found that the five strategies discussed below are particularly useful in the early stages of treatment. They are based on the five principles described in the previous section: express empathy, develop discrepancy, avoid argument, adjust to rather than oppose client resistance, and support self-efficacy. Helping clients address their natural ambivalence is a good starting point. These opening strategies ensure your support for your client and help the client explore ambivalence in a safe setting. The first four strategies, which are derived from client-centered counseling, help clients explore their ambivalence and reasons for change. The fifth strategy is specific to motivational interviewing and integrates and guides the other four.

In early treatment sessions, determine your client's readiness to change or stage of change (these will be discussed a little later in this chapter). Be careful to avoid focusing prematurely on a particular stage of change or assuming the client is at a particular stage because of the setting where you meet. As already noted, using strategies inappropriate for a particular change stage or forming an inaccurate perception regarding the client's wants or needs could be harmful. Therefore, try not to identify the goals of counseling until you have sufficiently explored the client's readiness.

Ask Open-Ended Questions

Asking open-ended questions helps you understand your clients' point of view and elicits their feelings about a given topic or situation. Open-ended questions facilitate dialog; they cannot be answered with a single word or phrase and do not require any particular response. They are a means to solicit additional information in a neutral way. Open-ended questions encourage the client to do most of the talking, help you avoid making premature judgments, and keep communication moving forward.

How To Ask Open-Ended Questions

Closed Question	Open Question
So you are here because you are concerned about	Tell me, what is it that brings you here



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

your use of alcohol, correct?	today?
How many children do you have?	Tell me about your family.
Do you agree that it would be a good idea for you to go through detoxification?	What do you think about the possibility of going through detoxification?
First, I'd like you to tell me some about your marijuana use. On a typical day, how much do you smoke?	Tell me about your marijuana use during a typical week.
Do you like to smoke?	What are some of the things you like about smoking?
How has your drug use been this week, compared to last: more, less, or about the same?	What has your drug use been like during the past week?
Do you think you use amphetamines too often?	In what ways are you concerned about your use of amphetamines?
How long ago did you have your last drink?	Tell me about the last time you had a drink.

Are you sure that your probation officer told you that it's only cocaine he is concerned about in your urine screens?	Now what exactly are the conditions that your probation officer wants you to follow?
When do you plan to quit drinking?	So what do you think you want

Listen Reflectively

Reflective listening, a fundamental component of motivational interviewing, is a challenging skill in which you demonstrate that you have accurately heard and understood a client's communication by restating its meaning. That is, you hazard a guess about what the client intended to convey and express this in a responsive statement, not a question. "Reflective listening is a way of checking rather than assuming that you *know* what is meant" ([Miller and Rollnick, 1991, p. 75](#)).

Reflective listening strengthens the empathic relationship between the clinician and the client and encourages further exploration of problems and feelings. This form of communication is particularly appropriate for early stages of counseling. Reflective listening helps the client by providing a synthesis of content and process. It reduces the likelihood of resistance, encourages the client to keep talking, communicates respect, cements the therapeutic alliance, clarifies exactly what the client means, and reinforces motivation ([Miller et al., 1992](#)).

This process has a tremendous amount of flexibility, and you can use reflective listening to reinforce your client's positive ideas ([Miller et al., 1992](#)). The following dialog gives some examples of clinician's responses that illustrate effective reflective listening. Essentially, true reflective listening requires continuous alert tracking of the client's verbal and nonverbal responses and their possible meanings, formulation of reflections at the appropriate level of complexity, and ongoing adjustment of hypotheses.

Clinician: What else concerns you about your drinking?

Client: Well, I'm not sure I'm concerned about it, but I do wonder sometimes if I'm drinking too much.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Clinician: Too much for...?

Client: For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel really awful, and I can't think straight most of the morning.

Clinician: It messes up your thinking, your concentration.

Client: Yes, and sometimes I have trouble remembering things.

Clinician: And you wonder if that might be because you're drinking too much?

Client: Well, I know it is sometimes.

Clinician: You're pretty sure about that. But maybe there's more...

Client: Yeah, even when I'm not drinking, sometimes I mix things up, and I wonder about that.

Clinician: Wonder if...?

Client: If alcohol's pickling my brain, I guess.

Clinician: You think that can happen to people, maybe to you.

Client: Well, can't it? I've heard that alcohol kills brain cells.

Clinician: Um-hmm. I can see why that would worry you.

Client: But I don't think I'm an alcoholic or anything.

Clinician: You don't think you're that bad off, but you do wonder if maybe you're overdoing it and damaging yourself in the process.

Client: Yeah.

Clinician: Kind of a scary thought. What else worries you?

Summarize

Most clinicians find it useful to periodically summarize what has occurred in a counseling session. Summarizing consists of distilling the essence of what a client has expressed and communicating it back. "Summaries reinforce what has been said, show that you have been listening carefully, and prepare the client to move on" ([Miller and Rollnick, 1991, p. 78](#)). A summary that links the client's positive and negative feelings about substance use can facilitate



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

an understanding of initial ambivalence and promote the perception of discrepancy. Summarizing is also a good way to begin and end each counseling session and to provide a natural bridge when the client is transitioning between stages of change.

Summarizing also serves strategic purposes. In presenting a summary, you can select what information should be included and what can be minimized or left out. Correction of a summary by the client should be invited, and this often leads to further comments and discussion. Summarizing helps clients consider their own responses and contemplate their own experience. It also gives you and your client an opportunity to notice what might have been overlooked as well as incorrectly stated.

Affirm

When it is done sincerely, affirming your client supports and promotes self-efficacy. More broadly, your affirmation acknowledges the difficulties the client has experienced. By affirming, you are saying, "I hear; I understand," and validating the client's experiences and feelings. Affirming helps clients feel confident about marshaling their inner resources to take action and change behavior. Emphasizing their past experiences that demonstrate strength, success, or power can prevent discouragement. For some clients, such as many African-Americans, affirmation has a spiritual context. Affirming their inner guiding spirit and their faith may help resolve their ambivalence. Several examples of affirming statements ([Miller and Rollnick, 1991](#)) follow:

- I appreciate how hard it must have been for you to decide to come here. You took a big step.
- I think it's great that you want to do something about this problem.
- That must have been very difficult for you.
- You're certainly a resourceful person to have been able to live with the problem this long and not fall apart.
- That's a good suggestion.
- It must be difficult for you to accept a day-to-day life so full of stress. I must say, if I were in your position, I would also find that difficult.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Elicit Self-Motivational Statements

Engaging the client in the process of change is the fundamental task of motivational interviewing. Rather than identifying the problem and promoting ways to solve it, your task is to help the client recognize how life might be better and choose ways to make it so.

Remember that your role is to entice the client to voice personal concerns and intentions, not to convince him that a transformation is necessary. Successful motivational interviewing requires that clients, not the clinician, ultimately argue for change and persuade themselves that they want to and can improve. One signal that the client's ambivalence and resistance are diminishing is the self-motivational statement.

Four types of motivational statements can be identified (Miller and Rollnick, 1991):

- Cognitive recognition of the problem (e.g., "I guess this is more serious than I thought.")
- Affective expression of concern about the perceived problem (e.g., "I'm really worried about what is happening to me.")
- A direct or implicit intention to change behavior (e.g., "I've got to do something about this.")
- Optimism about one's ability to change (e.g., "I know that if I try, I can really do it.")

The chart below illustrates how you can differentiate a self-motivational statement from a counter-motivational assertion. You can reinforce your client's self-motivational statements by reflecting them, nodding, or making approving facial expressions and affirming statements. Encourage clients to continue exploring the possibility of change. This can be done by asking for an elaboration, explicit examples, or more details about remaining concerns; questions beginning with "What else" are effective ways to invite further amplification. Sometimes asking clients to identify the extremes of the problem (e.g., "What are you most concerned about?") helps to enhance their motivation. Another effective approach is to ask clients to envision what they would like for the future. From there, clients may be able to begin establishing specific goals.

How To Recognize Self-Motivational Statements	
Self-Motivational Statements	Counter-motivational Assertions
I guess this has been affecting me more than I realized.	I don't have any problem with marijuana.
Sometimes when I've been using, I just can't think or concentrate.	When I'm high, I'm more relaxed and creative.
I guess I wonder if I've been pickling my brain.	I can drink all night and never get drunk.
I feel terrible about how my drinking has hurt my family.	I'm not the one with the problem.
I don't know what to do, but something has to change.	No way am I giving up coke.
Tell me what I would need to do if I went into treatment.	I'm not going into a hospital.

How To Recognize Self-Motivational Statements

I think I could become clean and sober if I decided to.

I've tried to quit, and I just can't do it.

If I really put my mind to something, I can do it.

I have so much else going on right now that I can't think about quitting.

Sample Questions To Evoke Self-Motivational Statements.

Problem Recognition

- What things make you think that this is a problem?
- What difficulties have you had in relation to your drug use?
- In what ways do you think you or other people have been harmed by your drinking?
- In what ways has this been a problem for you?
- How has your use of tranquilizers stopped you from doing what you want to do?

Concern

- What is there about your drinking that you or other people might see as reasons for concern?
- What worries you about your drug use? What can you imagine happening to you?
- How much does this concern you?

- In what ways does this concern you?
- What do you think will happen if you don't make a change?

Intention to Change

- The fact that you're here indicates that at least part of you thinks it's time to do something.
- What are the reasons you see for making a change?
- What makes you think that you may need to make a change?
- If you were 100 percent successful and things worked out exactly as you would like, what would be different?
- What things make you think that you should keep on drinking the way you have been? And what about the other side? What makes you think it's time for a change?
- I can see that you're feeling stuck at the moment. What's going to have to change?

Optimism

- What makes you think that if you decide to make a change, you could do it?
- What encourages you that you can change if you want to?
- What do you think would work for you, if you needed to change?

Source: Miller and Rollnick, 1991. Reprinted with permission.

3. Solution-Focused Therapy

Most of the work currently being done on substance abuse treatment uses a solution-focused approach. Solution-focused therapy is always brief, and to date there has not been a great deal of research comparing it to other models.

The solution-focused therapist believes that helping clients with substance abuse disorders to address any life problems they find significant will help them to reduce their substance use. What is important is finding a solution to the problems the client identifies as significant, then reinforcing the client's success in solving those problems. This procedure helps the client to recognize her own ability to solve her problems.

Research by Iguchi and colleagues supports some of the theoretical claims made by solution focused therapists (Iguchi et al., 1997). The study by Iguchi and colleagues compared the role of urine testing, traditional substance abuse counseling services, and the reinforcement of non-substance-use-related positive life changes and found that the latter resulted in the most significant reduction in substance use even after reinforcement contingencies ended.

The solution-focused therapy model has been used to respond to a range of problems and complaints. This model is a "complex and varied package of strategies that can be applied in an individualized, eclectic fashion to those seeking treatment" for a multifaceted and complex problem (Berg and Miller, 1992, p. xix).

Recovery starts when the client has made a decision (or have thoughts about it) to start the process: Recovery begins on the first day a person has the thought for the very first time, "I've got to do something about this drinking".

According to Berg & Ruess, 1998, "The field of substance abuse is the only professional health care discipline that does not trust an optimistic and positive client's self-report."

Key Concepts and Tools

All therapy is a form of specialized conversations. With SFBT, the conversation is directed toward developing and achieving the client's vision of solutions. The following techniques and questions help clarify those solutions and the means of achieving them.

Looking for previous solutions

SF therapists have learned that most people have previously solved many, many problems and probably have some ideas of how to solve the current problem. To help clients see these potential solutions they may ask, "Are there times when this has been less of a problem?" or "What did you (or others) do that was helpful?"



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Looking for exceptions

Even when a client does not have a previous solution that can be repeated, most have recent examples of exceptions to their problem. These are times when a problem could occur, but does not. The difference between a previous solution and an exception is small, but significant. A previous solution is something that the family has tried on their own that has worked, but later discontinued. An exception is something that happens instead of the problem, often spontaneously and without conscious intention. SF therapists may help clients identify these exceptions by asking, “What is different about the times when this is less of a problem?”

For example, in providing solution-focused brief therapy for a client with a substance abuse disorder, the therapist should direct the client's attention to periods when s/he was substance free. To identify these periods, the therapist must listen carefully to the client's responses, then ask the client to discuss those periods. The purpose is to help the client realize that s/he can maintain sobriety and has, in fact, done so in the past. The idea of focusing on the exception to any presenting problem is an aspect of strategic therapy that has particular relevance to the substance abuser because almost every substance abuser has had some period of abstinence-in many cases this period may have lasted months or years (Berg, 1995).

Exceptions to presenting problems may fall into two categories, deliberate exceptions and random exceptions. The more deliberate the behavior on the part of the client, the easier it will be for s/he to repeat it. But even substance-free periods that seemed to result from outside influences (i.e., random exceptions) can be used to help the client realize their own ability to stay sober.

Notes about Exceptions to Problems

All substance abuse problems have exceptions: Those the client creates by something he purposefully does and those that just seem to happen when the problem does not seem to be so much of a problem. It is the counselor's job to mine that exception for details asking questions that point our client in the direction of a workable solution:

When exceptions are not of our client's own, we use the miracle question to continue to develop our client's ideas.

✚ We use the word “suppose”



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

+ We do not refer specifically to any problem.

After we finish asking a question, we pause for a very long time.

+ We say, “guess”

We facilitate visualizations

+ Ask – “what will you be doing instead when you are not ...?”

+ “How will you know you are feeling (rested)?

Simply ask

+ “What else?”

+ “What will he notice is different about you?”

It is best to acknowledge this desire for a miracle.

+ “And on this miracle day when you noticed you were no longer HIV positive, what would you be doing? Could doing that help now?”

+ “How will that be helpful?”

The use of exception questions

+ “When was the most recent time when small pieces of this miracle were already happening?”

+ “What would you have to do more of to make even a small part of this miracle day come true?”

+ “What would have to happen more often for this miracle to take place?”

+ “When your husband stops drinking, what will he notice you doing differently? What will you have done, to do that?”

Try to limit the discussion to one miracle

Distinction between compliance and change

“How can your partner tell that you have learned your lesson and that you will never do it again?”



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Present and future-focused questions vs. past-oriented focus

The questions asked by SF therapists are usually focused on the present or on the future. This reflects the basic belief that problems are best solved by focusing on what is already working, and how a client would like their life to be, rather than focusing on the past and the origin of problems. For example, they may ask, “What will you be doing in the next week that would indicate to you that you are continuing to make progress?”

Compliments

Compliments are another essential part of solution focused brief therapy. Validating what clients are already doing well, and acknowledging how difficult their problems are encourages the client to change while giving the message that the therapist has been listening (i.e., understands) and cares. Compliments in therapy sessions can help to punctuate what the client is doing that is working. In SF therapy, compliments are often conveyed in the form of appreciatively toned questions of “How did you do that?” that invite the client to self-compliment by virtue of answering the question.

Inviting the clients to do more of what is working.

Once SF therapists have created a positive frame via compliments and then discovered some previous solutions and exceptions to the problem, they gently invite the client to do more of what has previously worked, or to try changes they have brought up which they would like to try – frequently called “an experiment.”

Miracle Question (MQ)

This unusual sounding tool is a powerful in generating the first small steps of 'solution states' by helping clients to describe small, realistic, and doable steps they can take as soon as the next day. The miracle question developed out of desperation with a suicidal woman with an alcoholic husband and four “wild” children who gave her nothing but grief. She was desperate for a solution, but that she might need a 'miracle' to get her life in order. Since the development of this technique, the MQ has been tested numerous times in many different cultures.

The most recent version is as follows:



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

T: I am going to ask you a rather strange question . . . that requires some imagination on your part . . . do you have good imagination?

C: I think so, I will try my best.

T: Good. The strange question is this; After we talk, you go home (go back to work), and you still have lots of work to do yet for the rest of today (list usual tasks here). And it is time to go to bed . . . and everybody in your household are sound asleep and the house is very quiet . . . and in the middle of the night, there is a miracle and the problem that brought you to talk to me about is all solved . But because this happens when you are sleeping, you have no idea that there was a miracle and the problems is solved . . . so when you are slowly coming out of your sound sleep . . .what would be the first small sign that will make you wonder . . .there must've been a miracle . . .the problem is all gone! How would you discover this?

C: I suppose I will feel like getting up and facing the day, instead of wanting to cover my head under the blanket and just hide there.

T: Suppose you do, get up and face the day, what would be the small thing you would do that you didn't do this morning?

C: I suppose I will say good morning to my kids in a cheerful voice, instead of screaming at them like I do now.

T: What would your children do in response to your cheerful "good morning?"

C: They will be surprised at first to hear me talk to them in a cheerful voice, and then they will calm down, be relaxed. God, it's been a long time that happened.

T: So, what would you do then that you did not do this morning?

C: I will crack a joke and put them in a better mood.

These small steps become the building block of an entirely different kind of day as clients may begin to implement some of the behavioral changes they just envisioned. This is the longest question asked in SFBT and it has a hypnotic quality to it. Most clients visibly change in their demeanor and some even break out in smiles as they describe their solutions. The next step is to identify the most recent times when the client has had small pieces of miracles (called exceptions) and get them to repeat these forgotten experiences.

Scaling Questions

Scaling questions (SQ) can be used when there is not enough time to use the MQ and it is also useful in helping clients to assess their own situations, track their own progress, or evaluate how others might rate them on a scale of 0 to 10. It is used in many ways, including with children and clients who are not verbal or who have impaired verbal skills. One can ask about clients' motivation, hopefulness, depression, confidence, and progress they made, or a host of other topics that can be used to track their performance and what might be the next small steps.

Scaling Questions:

Use numbers to replace the word description

A scaling question asks the client to evaluate either a problem or a solution on a scale of 1 to 10. It is useful when there is a disagreement between people.

✚ “How long do you need to stay here before you are ready to move to the next step?”

Scales can be used for assessment of client's progress in therapy.

✚ “What did you find helpful about AA? How have you been putting this to use in your daily life?”

Managed care companies accept scales.

The Nightmare Questions

Only after our attempts to build a solution using questions about the pre-session change, exceptions, and miracle days do we give ourselves the permission to ask the “nightmare” question.

Alcoholics see abstinence, not as a solution, but another “damn problem”.

✚ “What would you notice tomorrow morning that would let you know you were living a nightmare life?”

By using these, we are using problem talk to build a solution our client can live with.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

- ✚ “Are there times now, when small pieces of the nightmare are happening?”
- ✚ “What would it take to prevent this nightmare from happening?”
- ✚ “When she is living her nightmare, and you are living yours, what will you notice about each other?”

It is unethical waiting for the client to hit bottom. Helping him/her imagine ‘hitting bottom’ is safer.

“Denial” usually means the counselor and the client are in disagreement about the construction of the problem, or the best method to reach a solution.

Denial is in the theory of the counselor.

Coping Questions

This question is a powerful reminder that all clients engage in many useful things even in times of overwhelming difficulties. Even in the midst of despair, many clients do manage to get out of bed, get dressed, feed their children, and do many other things that require major effort. Coping questions such as “How have you managed to carry on?” or “How have you managed to prevent things from becoming worse?” open up a different way of looking at client’s resiliency and determination.

- ✚ “How have you managed to come this far without killing yourself with your booze?”

Not getting any worse takes a significant amount of effort.

Useful coping questions to ask about the seriousness of the problem.

These descriptions were never meant as an explanation or a prescription.

One day at a time

Consultation Break and Invitation to Add Further Information

Solution focused therapists traditionally take a brief consultation break during the 2nd half of each therapy session during which the therapist reflects carefully on what has occurred in the session. Some time prior to the break, the client is asked “Is there anything that I did not ask that you think it would be important for me to know?” During the break, the therapist or the therapist and a team reflect carefully on all that has occurred in the session. Following that, the



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

client is complimented and usually offered a therapeutic message based on the client's stated goal. Usually this takes the form of an invitation for the client to observe and experiment with behaviors that result in positive movement in the direction of the client's identified goal.

Client's Workable Solution:

- + The only solution that will work for a client is the one they create.
- + It is helpful to see family members as resources in building solutions.
- + There are many important things that problem drinkers do, that had nothing to do with the drinking.
- + Look at the bigger picture.

The decision of what is best for the client is made jointly: Hold off on making these good suggestions until after you have asked the client for their good ideas about making changes:

- + It is easy to burn out when you stop building solutions with your clients
- + Goals are what clients bring to the session; solutions are what we create cooperatively with our clients.
- + Guidelines for a well-formed solution.

Homework Works:

- + Homework is the treatment plan in action in the client's real-life environment.
- + To do more of what is already working.

When the homework has been a failure we simply apologize for leading the person astray.

- + "When that failed, what did you do that worked better?"
- + Change determined by a coin flip: Heads means they do the activity they described earlier.
- + Visitor type relationship – compliment success in therapeutic behavior
- + Customer type relationship – compliment the client on hanging in there.

Homework is our way of extending therapy to the client's natural living environment so that s/he can practice, experiment, and modify solutions to fit their natural way of living.

Agree with the client



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

- + Agree with client- goals
- + Use the client's language
- + Emphasize that this is a good time to come for therapy

Direct and indirect compliments

- + Help client feel successful

Simple, easy, doable homework tasks.

Relapse

Relapse is a normal learning experience. It means there was success.

- + "How did you know it was time to stop drinking again?"
- + "Who besides yourself was instrumental?"

Find the details of how client stayed sober before the relapse.

- + How is the client sober now?
- + What is different about this relapse and staying sober, compared with previous ones?

More Useful Questions

- + What is the goal of treatment?
- + What are the benchmarks that will let you know you are moving in the right direction?
- + What previous experiences do you have that will help?
- + What needs to be different when you return?

A counselor using a solution-focused approach works closely with the client to understand the client's own perspective on her problems. By focusing on those areas the client considers significant (e.g., relationships, work, and financial security), the counselor assists the client in understanding how her substance abuse affects those significant areas of concern. The counselor helps the client solve those significant problems while strongly reinforcing the client's success. After the initial session, the counselor keeps the client focused on how her situation is improving by asking, "What's better this time?"



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Instructor Note: So there you have it. Lots of clinical practices, approaches and techniques to get you started in counseling. The more knowledge you have in this area coupled with gathering practical experience you will begin to develop your own style. That style will blossom and grow with your confidence, with letting your authentic true self come to the forefront. When you begin to see yourself as a clinician and feel comfort in those shoes you will see how differently clients will respond to you and how you will feel about yourself and your clinical work. I am so excited for all of you knowing personally how self-fulfilling it is when you first realize you are thinking from a clinical brain.

OK, hang in there, just a couple more chapters to go. 😊

Involving Families, Couples and Significant Others in the Counseling Process

Chapter 5

Competency: Recognize how, when and why to involve the client's significant others in enhancing or supporting the treatment plan.

Competency: Understand the characteristics and dynamics of families, couples, and significant other affected by substance abuse.

Competency: Be familiar with and appropriately use models of diagnosis and intervention for families, couples and significant others, including extended, kinship, or tribal family structures.

Competency: Facilitate the engagement of selected members of the family or significant others in the treatment and recovery process.

Competency: Assist families, couples, and significant others in understanding the interaction between the family system and substance use behaviors.

Competency: Assist families, couples, and significant others in adopting strategies and behaviors that sustain recovery and maintain healthy relationships.

As we know addiction affects almost all areas of life – health, education, occupation, financial status, and particularly family & significant other relationships. It would be bad clinical practice to not address the impact of the client's addiction on his family/SO, it would also be remiss of the counselor not to involve the client's current SO & family members in their treatment (including preparing for the client to return home the family environment. However, like everything, timing & sensitivity to client's current readiness, it is just as important to know WHEN to bring these family members and/or SO's into the treatment process.

Family members can not only support the client in recovery, but can also provide details about the impact of addiction with clarity. Moreover, just knowing that his family is also actively participating in treatment will keep his denial level low.

Family members may also be as dysfunctional as the client. Hence, it is meaningful to involve them in counseling as the client will return to the family on completing treatment. Helping the family view the client positively and provide support is an essential part of treatment.

The client who is largely alienated from the family may resist the involvement of his family. Attempts to reintegrate may not be easy. These situations have to be handled judiciously. In the absence of family members, identifying other support people is essential.

For many individuals with substance abuse disorders, interactions with their family of origin, as well as their current family, set the patterns and dynamics for their problems with substances. Furthermore, family member interactions with the substance abuser can either perpetuate and aggravate the problem or substantially assist in resolving it. Family therapy is particularly appropriate when the client exhibits signs that his substance abuse is strongly influenced by family members' behaviors or communications with them.

Family involvement is often critical to success in treating many substance abuse disorders—most obviously in cases where the family is part of the problem.

Family therapy can be used to:

- ✚ Focus on the expectation of change within the family (which may involve multiple adjustments)
- ✚ Test new patterns of behavior
- ✚ Teach how a family system works--how the family supports symptoms and maintains needed roles
- ✚ Elicit the strengths of every family member
- ✚ Explore the meaning of the substance abuse disorder within the family

The Impact of Addiction of families, couples and significant others

Deutsch (1982) describes family dynamics as 'remarkably uniform in most addicted homes and significantly different from the conditions which govern most other households'. There are certain specific problems they face.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

- ✚ The family lives on an emotional roller coaster of embarrassment, guilt, hurt, anger and frustration.
- ✚ The addict becomes less predictable, less reliable, financial resources are diverted for alcohol / drugs, hence family becomes insecure.
- ✚ Constant demands, growing criticism, provocations, erode the family's self esteem.
- ✚ To protect the addict from external condemnation and to protect themselves from further embarrassment, the family may isolate itself from external contacts.

Reactions of family members and significant others to substance abuser

Denial - The family of the chemical dependent usually denies the existence of the problem in order to avoid humiliation and embarrassment. What is obvious to others is flatly denied by those who live on intimate terms with the dependent.

Preoccupation - The preoccupation of family members is similar to the addict's obsession for drugs. Their entire thinking usually revolves around the dependent and they forget to take care of their needs. Their lives are almost always modified to suit the needs of the chemical dependent.

Making Changes in Oneself - Most family members believe that the addict is taking drugs because of certain problems. As a result, the family takes responsibilities to deal with those problems. They try to establish a pleasant atmosphere at home hoping that it will help the addict to stay away from drugs. The family may go out of their way to please the addict and maintain a warm and caring attitude, etc.

Bargaining - The goal of bargaining is to offer the chemical dependent something in return for the desired behavior. But such bargaining does not work at all. Instead, it leads to frustration and depression.

Family in Recovery

Acceptance of treatment by the chemical dependent brings a great deal of relief to everyone concerned. Family members may hope that life is going to take a turn for the better at once. They may feel that all their tensions will disappear. In a supportive environment, the counselor should make them understand that it would be very unrealistic to expect that everything is going to be wonderful immediately. They should be made aware of the fact that there are

certain problems which they may face during the client's recovery. An understanding of this will help them handle the problems effectively.

Problems Experienced During Recovery

- ✚ During recovery, it is possible for family members to experience great relief over his abstinence and yet miss the old, familiar lifestyle. Although it was painful, there had always been some predictability. They knew how he was going to behave, and what situations they would be required to handle. But now the recovering person is likely to be more independent and more demanding. This can leave family members resentful. Earlier, the chemical dependent would not have reacted to anything happening at home. Now he may expect his wife to prepare tasty meals, keep the house clean and help the children in their studies. The family may not be able to view his expectations as justified.
- ✚ Friends and relatives may have all along admired the tolerance of the wife/mother and praised her for bearing the brunt all alone. When the chemical dependent stops taking drugs, the positive comments are likely to be transferred to him. They may even pick on her. 'Now that he has given up drugs, why don't you be more understanding? Why do you unnecessarily get angry and shout like this?' These remarks hurt her and it is very common for close family members to experience extreme bitterness and resentment, especially if they have coped with addiction by suppressing all their feelings.
- ✚ Certain actions that would not stir a second thought if displayed by others may set off alarms when exhibited by the recovering person. It is virtually impossible for the family not to harbor doubts when, for example, they find some cash missing or when they find the recovering person moody, tired or notice him remaining extra long behind a locked door or getting phone calls late in the night.
- ✚ Family members may tend to treat the recovering person as a 'brittle doll'. This is the result of a continuing fear and a prolonged belief that anything they might say could cause conflict and make him go back to drugs. As a result, there is no communication, no clarity of roles and the family works only according to his expectations. There is no chance of mutual trust developing in this kind of relationship because it continues to be dominated by fear. It will only result in more stress for the family.

- ✚ After many years of embarrassment and humiliation, the family may have few outside interests or friends. All other adjustment problems will be intensified by the family's lack of social contacts and shared pleasures.
- ✚ Family members will find it very difficult to listen to the recovering person or relate to him in a meaningful way. They may expect him to make changes according to their expectations. For instance, they may make plans for his future. They may ask him to go for work in the mornings or attend classes in the evenings, without discussing those issues with him. They are likely to feel that they have the solutions to all his problems.
- ✚ Family members may continue to harbor resentment. As a result, even though the addict may be making positive changes, they will be reluctant to acknowledge this. On the other hand, repeated remarks about money being wasted will be voiced.
- ✚ Members of the family may have conflicting views if it comes to the question of giving recovering person responsibilities. He may be willing to take up certain responsibilities. But the family members may not be able to trust him with the responsibilities he wants to carry out. They may find it more comfortable to assign him only menial or insignificant jobs and even after assigning jobs, they will be doubtful whether he will complete the tasks properly.

Educating the Family/Significant Other

Acceptance of treatment by the active addict brings a great deal of relief to everyone concerned. Family members may hope that life is going to take a turn for the better at once. They may feel that all their tensions will disappear. In a supportive environment, the counselor should make them understand that it would be very unrealistic to expect that everything is going to be wonderful immediately. They should be made aware of the fact that there are certain problems which they may face during the client's recovery. An understanding of this will help them handle the problems effectively.

The Need for Family Therapy

The interconnected relationships within a family are widely recognized as crucial elements in substance use disorder and its treatment. Family therapy focuses on family change (parenting practices, family environment and problem solving) and takes into account is also aimed to take place psychosocial environment in which the addict lives. In one situation, family therapy might refer to an educational session or a discussion of family problems with a substance abuse

counselor. In others, it might consist of a few family conferences with members of the treatment team present to explore what family members can do to help the user.

The broad goals of family therapy are:

- ✚ To provide information about addiction and its effects on the family system – It is essential to provide information about addiction being a disease, its impact on the family system, relapse symptoms and coping methodologies.
- ✚ To provide a safe and acceptable environment for the family to discuss their problems – Normally the family's attitude would be 'Once he gives up drugs, all our problems would disappear'. The counselor should focus the family's attention on the problems experienced by them as a result of addiction.

Some of the open-ended questions which can help them focus their attention on themselves and see a need to change their attitude and behavior are:

What would you like to work on?

What kind of help are you looking for?

What kind of changes do you think you should make?

- ✚ To improve interactions among family members – The intervention aims to bring about changes in the way family members relate to each other by examining the underlying causes of dysfunctional interaction and by encouraging new healthier ones.

The counselor helps family members appreciate how the values and perspective of each family member may differ, but those differences do not have to be a source of conflict. Helping family members solve problems together in the therapeutic setting enables them to learn strategies that can be applied with the addict in the home environment. Family members learn to listen to one another and solve problems through negotiation and compromise.

Another method of improving communication between family members is to introduce the concept of 'I' statements. 'I' statements focus on the effect of an action on the speaker rather than on the action itself. Instead of saying 'You always give us trouble', a family member would say, 'I feel sad when you behave in this manner'. These statements are often effective because

people can disagree about what they do, but it is difficult for them to dispute what someone else says she feels.

- ✚ To equip parents with the skills needed to deal with youngsters
Parents of youngsters who use substances typically aggravate small conflicts due to inadequate parenting practices (being permissive, authoritarian or inconsistent). The counselor should guide them towards improving parenting skills – appropriate monitoring (to know their friends, to know how they spend their time), setting limits, rebuilding emotional attachment and taking part in activities with the youngster.
- ✚ To provide optimism and a supportive environment – The counselor should help family members realize that the family support system surrounding the recovering person will require some change. They have to be guided to give up their preoccupation and obsession with the chemical dependent, and still be caring and help him in his recovery.
- ✚ Family can be helped even if the user is unwilling - Even if the chemical dependent does not seek help, it is imperative that family members should seek help. Breaking the silence about what they have been dealing with is the first step, followed by learning about enabling and co-dependency and methods to cope with addiction. Significant healing can begin to take place for families, even if the user's drug taking continues.

Intervene Through Significant Others

Considerable research shows that involvement of significant others (SOs) can help move substance users to contemplation of change, entry into treatment, retention and involvement in the therapeutic process, and successful recovery. An SO can play a vital role in enhancing an individual's commitment to change by addressing a client's substance use in the following ways:

- ✚ Providing constructive feedback to the client about the costs and benefits associated with his substance use behavior.
- ✚ Encouraging the resolve of the client to change the negative behavior pattern.
- ✚ Identifying the concrete and emotional obstacles to change.
- ✚ Alerting the client to social and individual coping resources that lead to a substance-free lifestyle.
- ✚ Reinforcing the client for using these social and coping resources to change the substance use behavior.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

In general, the SO helps to mobilize the client's inner resources to generate, implement, and sustain actions that subsequently lead to a lifestyle that does not involve substance use. The SO is expected to move the client toward generating their own solutions for change. Nevertheless, it is important to remember that the ultimate responsibility for change lies with the client.

A SO is typically a spouse, live-in partner, or other family member but can be any person who has maintained a close personal relationship with the client. ***Although a strong relationship is necessary, it is not sufficient for involving an SO in motivational counseling. Evidence indicates that a suitable candidate for SO-involved treatment is an individual who supports a client's substance-free life and whose support is highly valued by the client (Longabaugh et al., 1993).***

"I have found that actively involving an SO such as a spouse, relative, or friend in motivational counseling can really help facilitate a client's commitment to change. The SO can provide constructive input while the client is struggling with ambivalence about changing the addictive behavior. Feedback from the SO can help raise the client's awareness of the negative consequences of substance use. At the same time, the SO can provide the requisite support in sustaining the client's commitment to change. Before involving the SO, I routinely determine whether the SO has a positive relationship with the client and a genuine investment in contributing to the change process. SOs with strong ties to the client and an interest in helping the client change the substance-using behavior can make a valuable contribution toward change; those who lack these qualities can interfere with this process. Therefore, before involving the SO, I assess the interactions between the client and the SO. I am particularly interested in determining whether motivational statements made by the client are supported by the SO. Following this brief assessment, I employ a variety of commitment-enhancing strategies with the SO to help him facilitate the motivational process. I try to ask questions that will promote optimism on the part of the SO with regard to the client's ability to change. For example, I may ask the SO the following questions: Have you noticed what efforts Jack has made to change his drinking? What has been most helpful to you in helping Jack deal with the drinking? What is different now that leads you to feel better about Jack's ability to change? By using techniques such as eliciting self-motivational statements from the client, the SO can become a co-facilitator in the change process".

Allen Zweben, Consensus Panel Member

System of Dynamics of the Alcoholic Family

Role	Motivating Feeling	Identifying Symptom	Payoff for Individual	For Family	Possible Price
Dependent	Shame	Chemical Use	Relief of Pain	None	Addiction
Enabler	Anger	Powerlessness	Self-righteousness	Responsibility	Illness Martyrdom
Hero	In-adequacy Guilt	Over-achievement	Importance Attention(positive)	Self-worth	Compulsive Drive
Scapegoat	Hurt	Delinquency	Attention (negative)	Focus away from dependent	Self- destructive Addiction
Lost Child	Loneliness	Solitariness Shyness	Escape	Relief	Social Isolation
Mascot	Fear	Clowning Hyperactivity	Attention (amused)	Fun	Immaturity Emotional Illness

Instructor Note: Involving family members and/or significant others when the client is an adult (over age 18 by federal law) is important and useful (depending on the individual), however, you, the counselor cannot “force” the client to give consent to contact the family or the SO and the counselor cannot “force” the family member or SO to participate in the treatment of the client. It is most important to note that when working with adolescents (minors) the family/parents/legal guardian MUST be involved. First of all an adolescent (minor) cannot enter treatment or give consent to treat, only the parent/legal guardian are legally permitted to that. In addition, once treatment begins the counselor must involve the parents/legal guardian in family sessions at least once in brief treatment and more in lengthier stays. This is imperative!!! Why??? Typically the minor client will be returning to live with the parents/legal guardian, you cannot address clinical issues with the minor client like they live in a bubble, they are impacted by their families and they impact their families. The whole system needs to work through behaviors, practices, communications, and expectations. It is also of the utmost importance for the counselor to assess the stability and health of that family system. Perhaps the family members are active addicts or participate in criminal activities. If either or both of these examples are the case, the counselor will have to call in an abuse report (you are mandated reporters) and prepare to make alternative living arrangements for the minor client.

Systems Theory

Systems theory proposes that all systems like the maintain balance and harmony. The common expression, "Don't rock the boat" aptly describes a system's need to maintain balance. Therefore, every individual within any given system participates in the maintenance of that balance. However, if the natural balance (status quo) of a system is dysfunctional, then the system serves to maintain that dysfunction. In other words, it would "rock the boat" if we tried to improve the systems functioning. This is how some dysfunctional systems can promote and foster addictive behavior for some individuals in that system. With respect to addiction, the principal system of interest is the family system.

Like all systems, families operate to maintain a balance. Usually this entails activities and pressures to avoid conflict, hostility, aggression, or other things that leads to disharmony. The cost of maintaining this balance can be quite high. When someone in a family attempts to discontinue their addiction, it affects all the family members. In other words, recovery "rocks the boat."

Recovery involves family therapy that evaluates the family system. This evaluation serves to uncover hidden forces that serve to continue dysfunction. These forces have allowed addiction to flourish. Once these forces are identified, family members work together to foster a more functional family system that does not promote addiction.

The goals of family therapy are (broadly speaking)

- ✚ to provide information about addiction and its effects on the family system
- ✚ to provide a safe and acceptable environment for the family to discuss their problems
- ✚ to help the family members express their feelings of shame, guilt, fear and hurt
- ✚ to help them grow out of their dysfunctional coping behavior
- ✚ to help the family to clarify their problems and set realistic goals
- ✚ to help them improve their communication, so that they interact in a more constructive and helpful manner
- ✚ to guide the family to provide a supportive environment for the recovery of the substance addict.

Deeper Insight into the Family Dynamics

1. What is meant by 'the enabling behavior' of the families of addicts?

‘Enabling’ is a therapeutic term which in this context denotes a destructive form of helping. Any act that helps the addict to continue drug taking without suffering the consequences is considered ‘enabling behavior’. The ‘enabler’ is a person who may be impelled by his own anxiety and guilt to rescue the addict from his problems. This role is taken on by family members, friends, supervisors and colleagues at work.

Some examples of enabling behavior are:

- ✚ paying back the debts incurred by the user
- ✚ justifying his use of drugs – ‘He takes drugs because of problems at the workplace.’
- ✚ calling the manager and giving false reasons for his absence.

2. What should the family avoid doing?

- ✚ Do not hide alcohol bottles and do not search for drugs.
- ✚ Do not argue or quarrel with the person while he is under the influence of drugs. This will only lead to meaningless arguments.
- ✚ Do not look for reasons for his drug use. Some may be excuses and some, the consequences of his drug use.
- ✚ Do not attempt to punish, threaten, bribe, preach or try emotional appeal with the user. In the long run, none of these methods work.

3. What is ‘denial’ of the family?

Due to the social stigma attached to addiction, the family members deny the existence of any problem and gives excuses such as ‘going through a phase’ or ‘too much pressure’. The problem of addiction is either totally denied, minimized or rationalized.

4. Does a father’s addiction affect his children?

Yes, a father’s addiction leaves its impact on his children. Constant exposure to this environment leads to a lingering fear, and they are filled with feelings of shame and embarrassment. They see nothing other than fights, guilt, justification and they practically lose their childhood. As a result, they end up with a lot of emotional problems.

Support program



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

It is important that the chemical dependant has well-wishers or support persons who are willing to assist him in his recovery. Support people are those who have a keen interest in the welfare of the patient. They may be the family members – siblings, uncle, aunt or in-laws; personnel at his office – supervisors, managers, co-workers, family doctors or non-drug-taking friends.

Support people are those:

- ✚ who do not use alcohol or drugs
- ✚ who meet the patient frequently
- ✚ whom the patient respects and holds in high regard.

Group Counseling

Chapter 6

Competency: Describe, select, and appropriately use strategies from accepted and culturally appropriate models for group counseling with clients with substance use disorders.

Competency: Carry out the actions necessary to form a group, including but not limited to determining group type, purpose, size, and leadership; recruiting and selecting members; establishing group goals and clarifying behavioral ground rules for participating; identifying outcomes; and determining criteria and methods for termination or graduation from the group.

Competency: Facilitate the entry of new members and the transition of exiting members.

Competency: Facilitate group growth within the established ground rules and movement toward group and individual goals by using methods consistent with group type.

Competency: Understand the concepts of process and content, and shift the focus of the group when such a shift will help the group move toward its goals.

Competency: Describe and summarize the client's behavior within the group to document the client's progress and identify needs and issues that may require a modification in the treatment plan.

Group therapy has been acclaimed over the years as by far the most effective method of treatment for addiction. The gains of group therapy are now well established. The following are a few therapeutic gains that are unique to this treatment method:

- ✚ Provides an opportunity to share and identify with others who are going through similar problems. Groups help in developing a sense of belonging.
- ✚ Spontaneous sharing of older members, of their progress and the changes they have achieved, instills hope in the new skeptical members.
- ✚ Helps clients understand their own attitudes about drugs / alcohol abuse and their defenses against giving it up by identifying similar attitudes and defenses in others.
- ✚ Verbalization of thoughts and feelings, open feedback from others about positive and negative behavior and being a witness to successful conflict resolution, helps clients develop socialization skills.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

- ✚ Teaches members interdependence (in contrast to dependence on *chemicals*) and thus build a better social network. This also helps *chemical dependents* to work through isolation.
- ✚ Provides a congenial atmosphere to powerfully confront denial, and assess high-risk situations. Members utilize the group as a laboratory for developing new responses and new skills.
- ✚ Provides an opportunity to formulate realistic goals and plans.
- ✚ Sharing insights, offering suggestions and support gives an individual the pleasant feeling of helping another. This altruism aids in strengthening self-esteem.

These gains prove beyond doubt that group therapy can be effective. The task then for the counselor is to maximize the gains within the available timeframe. The following are a few basic guidelines that contribute to effective group therapy sessions.

Size of the Group

Five to ten members in a group is the acceptable range. When there are less than five members, it fails to function as a group; with more than ten, the group can become unwieldy – both making it less effective.

Duration of the Group Meeting

A minimum of one to an hour and a half is needed for the group to settle down and get to work on an issue. However, if a group session stretches beyond 90 minutes, fatigue sets in and diminishing gains are reported.

Frequency Of Meetings

This depends on the treatment modality. Residential settings have multiple groups in a day, day treatment programs have at least one group per day for the 4-6 days the client attends, and intensive outpatient and traditional outpatient settings use group as their main form of treatment.

After discharge and/or during follow-up, meetings may be held once or twice a week to strengthen changes made and offer support through the recovery process.

Physical Environment

A pleasant quiet room that ensures privacy is a pre-requisite for group meetings. The seats should be similar and placed in a circle that all are equal. Moreover, everybody is visible to the rest of the group; face-to-face interaction is made possible and non-verbal behavior can be easily observed.

Rules and Limit Setting

At the beginning of the session, the counselor has to clearly spell out basic rules like punctuality, regular attendance, staying for the entire session and not leaving midway, not attending under the influence of drugs.

The following norms are a requisite as they help members function appropriately.

Confidentiality

Any information gained about another group member in the group therapy setting is to be treated in strict confidence. In short, 'What happens in the group, stays within the group' should be repeatedly stressed.

Listening

Maintaining eye contact, willingness to listen to other person's feelings and words without interrupting, are important. Interruptions are not to be made unless

- ✚ the member is repetitious
- ✚ the member is rambling without focusing on issues relevant to the topic of discussion
- ✚ the listener has not understood and wishes to clarify his thoughts.

Using 'I' Statements

'We' and 'they' statements lead to superficial sharing on generalized issues. 'You' statements usually turn into critical, judgmental ones. 'I' statements, on the other hand, help the member speak only for himself and own responsibility for his feelings, thoughts and behavior. (Example: 'I feel ashamed. I have hurt my parents.')

Open, Honest, Spontaneous Sharing

Group therapy offers an unique opportunity for handling issues. It should be emphasized that to maximize gains, the wholehearted participation of the group is essential. Each member needs to remember that the more he puts into a group, the more he will benefit from the experience. All participants are considered equal, irrespective of their drinking or drug taking status, number of days they have stayed at the center, or nature of the damage. The counselor, as a facilitator of the group, need not share any details regarding her/him-self.

Feedback**Guidelines for Giving Feedback**

Feedback is an essential component of group therapy. Here are a few guidelines to be discussed with clients prior to entry into the group. These guidelines facilitate involvement in the session and help them relate appropriately to other group members. Members should talk about behavior they can see. The feedback should be specific and relevant.

I notice that you are late by 5-10 minutes everyday. So we are unable to start the group meeting on time.

Feedback should be given caringly and not by hurting or attacking another member. No judgmental statements should be made. For instance, the following should be avoided:

You have been lazy and irresponsible at work. You cannot be upset now with your boss for criticizing you. You just have to take it – you asked for it.

The proper feedback would be to say, ‘you talked about your repeated absences, delay in submitting reports and not meeting sales targets. Your work has definitely suffered due to addiction. You are now upset that your boss has expressed dissatisfaction. Considering your work pattern, this is not surprising and your boss’s reaction seems reasonable.

- ✚ Members should avoid sarcasm and condescending remarks while giving feedback. No advice is to be given – only responses.
- ✚ Members should be encouraged to share positive feedback also.

THE PROCESS OF GROUP THERAPY

During group therapy sessions, groups gradually move through a process of development. The early phase is the beginning of the group, particularly the first few meetings. The middle phase is the substance of the group, with the clients coming together, interacting, sharing, growing and changing in the counselor’s presence. The last phase is when the client completes the program and leaves the group.

Defining Therapeutic Groups in Substance Abuse Treatment

All groups can be therapeutic. Anytime someone becomes emotionally attached to other group members, a group leader, or the group as a whole, the relationship has the potential to influence and change that person. Identifying a group as “therapy” does not imply that other groups are not therapeutic.

Here are five models of group therapy currently used in substance abuse treatment:

- Psychoeducational groups, which teach about substance abuse.
- Skills development groups, which hone the skills necessary to break free of addictions.
- Cognitive–behavioral groups, which rearrange patterns of thinking and action that lead to addiction.
- Support groups, which comprise a forum where members can debunk each other’s excuses and support constructive change.
- Interpersonal process group psychotherapy (referred to hereafter as “interpersonal process groups” or “therapy groups”), which enable clients to recreate their pasts in the here-and-now of group and rethink the relational and other life problems that they have previously fled by means of addictive substances.

Treatment providers routinely use the first four models and various combinations of them. The last is not as widely used, chiefly because of the extensive training required to lead such groups and the long duration of the groups, which demands a high degree of commitment from both providers and clients. All the same, many people enter substance abuse treatment with a long history of failed relationships exacerbated by substance use. In these cases, an extended period of therapy is warranted to resolve the client's problems with relationships. The reality that extended treatment is not always feasible does not negate its desirability.

Advantages of Group Treatment

Treating adult clients in groups has many advantages, as well as some risks. Any treatment modality—group therapy, individual therapy, family therapy, and medication—can yield poor results if applied indiscriminately or administered by an unskilled or improperly trained therapist. The potential drawbacks of group therapy, however, are no greater than for any other form of treatment.

Some of the numerous advantages to using groups in substance abuse treatment are described below (Brown and Yalom 1977; Flores 1997; Garvin unpublished manuscript; Vannicelli 1992).

- *Groups provide positive peer support and pressure to abstain from substances of abuse.* Unlike AA, and, to some degree, substance abuse treatment program participation, group therapy, from the very beginning, elicits a commitment by all the group members to attend and to recognize that failure to attend, to be on time, and to treat group time as special disappoints the group and reduces its effectiveness. Therefore, both peer support and pressure for abstinence are strong.
- *Groups reduce the sense of isolation that most people who have substance abuse disorders experience.* At the same time, groups can enable participants to identify with others who are struggling with the same issues. Although AA and treatment groups of all types provide these opportunities for sharing, for some people the more formal and deliberate nature of participation in process group therapy increases their feelings of security and enhances their ability to share openly.
- *Groups enable people who abuse substances to witness the recovery of others.* From this inspiration, people who are addicted to substances gain hope that they, too, can maintain abstinence. Furthermore, an interpersonal process group, which is of long

duration, allows a magnified witnessing of both the changes related to recovery as well as group members' intra- and interpersonal changes.

- *Groups help members learn to cope with their substance abuse and other problems by allowing them to see how others deal with similar problems.* Groups can accentuate this process and extend it to include changes in how group members relate to bosses, parents, spouses, siblings, children, and people in general.
- *Groups can provide useful information to clients who are new to recovery.* For example, clients can learn how to avoid certain triggers for use, the importance of abstinence as a priority, and how to self-identify as a person recovering from substance abuse. Group experiences can help deepen these insights. For example, self-identifying as a person recovering from substance abuse can be a complex process that changes significantly during different stages of treatment and recovery and often reveals the set of traits that makes the system of a person's self as altogether unique.
- *Groups provide feedback concerning the values and abilities of other group members.* This information helps members improve their conceptions of self or modify faulty, distorted conceptions. In terms of process groups in particular, as specific themes emerge in a client's group experience, repetitive feedback from multiple group members and the therapist can chip away at those faulty or distorted conceptions in slightly different ways until they not only are correctable, but also the very process of correction and change is revealed through the examination of the group processes.
- *Groups offer family-like experiences.* Groups can provide the support and nurturance that may have been lacking in group members' families of origin. The group also gives members the opportunity to practice healthy ways of interacting with their families.
- *Groups encourage, coach, support, and reinforce as members undertake difficult or anxiety-provoking tasks.*
- *Groups offer members the opportunity to learn or relearn the social skills they need to cope with everyday life instead of resorting to substance abuse.* Group members can learn by observing others, being coached by others, and practicing skills in a safe and supportive environment.
- *Groups can effectively confront individual members about substance abuse and other harmful behaviors.* Such encounters are possible because groups speak with the

combined authority of people who have shared common experiences and common problems. Confrontation often plays a part of substance abuse treatment groups because group members tend to deny their problems. Participating in the confrontation of one group member can help others recognize and defeat their own denial.

- *Groups allow a single treatment professional to help a number of clients at the same time.* In addition, as a group develops, each group member eventually becomes acculturated to group norms and can act as a quasi-therapist himself, thereby ratifying and extending the treatment influence of the group leader.
- *Groups can add needed structure and discipline to the lives of people with substance use disorders, who often enter treatment with their lives in chaos.* Therapy groups can establish limitations and consequences, which can help members learn to clarify what is their responsibility and what is not.
- *Groups instill hope, a sense that “If he can make it, so can I.”* Process groups can expand this hope to dealing with the full range of what people encounter in life, overcome, or cope with.
- *Groups often support and provide encouragement to one another outside the group setting.* For interpersonal process groups, though, outside contacts may or may not be disallowed, depending on the particular group contract or agreements.

Fixed and Revolving Member Groups

The way groups are developed varies by the type of group. A wide range of therapeutic groups may be used with people who have substance use problems. For the purpose of this discussion, however, groups have been classified into two broad categories, each with the same two subcategories:

1. Fixed membership groups
 - A. Time-limited - in which the same group of people attend a specified number of sessions, generally starting and finishing together
 - B. Ongoing - in which new members fill vacancies in a group that continues over a long period of time

2. Revolving membership groups

- A. Time-limited - that members generally join for a set number of sessions
- B. Ongoing - that clients join until they accomplish their goals

ROLE OF THE COUNSELOR

Making group therapy a powerful source for change is an art and a skill. Here, as in an individual counseling relationship, the basic personality of the counselor, their professional training and experience can make a world of difference. The counselor has to maintain a relationship characterized by warmth, empathy, concern, acceptance and genuineness. An effective counselor will be sensitive and flexible to the needs of the group and flow with it, all the while making valuable interventions.

Helping members belong

The group therapy situation may be stressful for the newcomer. Members are strangers to each other and look to the counselor as the unifying force. By using this 'special member' status, the counselor goes on to create one physical entity, 'a group', from a collection of members with different experiences and problems. Being sensitive, accepting and supportive to all members and displaying this through appropriate verbal and non-verbal behavior, the counselor can create a sense of 'oneness' or togetherness.

Late coming, absenteeism, sub-grouping (two or three members carrying on interactions while actively excluding others) and 'scape-goating' (majority of the group making one member the target of their negative feelings) threaten cohesiveness. The counselor should act early and decisively to counteract these forces.

Encouraging 'feeling level' interaction

Shame, guilt, resentment and fear are the predominant negative emotions. Being able to talk about them in a supportive, caring environment to people who have actually experienced them, is what makes group therapy effective. Handling anger and resentment means coming to grips with the true underlying feelings. Members who are eloquent may find it easy to share on a superficial level. By encouraging and emphasizing 'feeling level' statements, the counselor can help them get in touch with their negative feelings, which they try to run away from. Separating thoughts from feelings and labeling feelings, helps and deal with them better. This exercise stands them in good stead in their future communication patterns and problem-solving efforts.

Facilitating growth

The counselor should never forget that her involvement is of prime importance in shaping the group norms. Too exacting behavior or being too passive – both can inhibit members. She needs to play her role with confidence and poise. Basic rules that are set at the start of the group process may sometimes need further strengthening. The counselor can draw attention to the norms through statements, observations, questions and display of appropriate non-verbal behavior. For example, to encourage member-to member communication, the following methods can be used:

- ❖ asking for other members' reactions
- ❖ refusing to answer questions directly

Nodding, smiling, verbal reinforcements and other good attending behavior help shape positive behavior among members. The counselor has to respond to unacceptable behavior like hushed or whispered conversations or late coming. Unhealthy practices like frequent interruptions or excessive criticism can grow quickly and it is the counselor's responsibility to guard against them.

The counselor should encourage feedback. When a member is criticized or confronted, caring questions like 'How do you feel about what was just said? help that member respond. When many suggestions or comments have been made in response to one member's sharing, asking him 'What did you find most helpful? How did you feel to receive so much?', helps the member give appropriate feedback.

The counselor is a 'model setting participant' in many ways. Good attending behavior displayed by the counselor is quickly copied by the members. By giving support and encouragement, the counselor invites members to follow suit. The counselor's handling of conflicts by permitting expression of negative feelings and working through them rather than suppressing them, helps members learn to do the same even in real life situations.

Recognizing the group's power

The primary therapeutic agent in a group is always the interaction between the members and not the counselor. As an effective counselor recognizes that the group's power is more than their own, and makes the group assume responsibility to make the interactions. If the counselor takes the responsibility, the members would sit back and wait for the counselor to make the interventions as if watching a movie. The counselor needs to resist the urge to quickly intervene with the right answers, and should wait for a discussion to follow and allow it to move slowly to a conclusion. The group values the decisions that they arrive at and does not look for quick fix answers from the counselor even if the solutions are just as, if not more, effective.

Recording

The progress or lack of it among each member in the group and the counselor's impressions need to be recorded. This will help the treatment professional to see and clarify the level of progress and plan further directions. In case a different counselor takes over, they will be able to

- ❖ assess the progress of each member
- ❖ set specific goals for each member
- ❖ identify and help him deal with negative factors so that they don't grow stronger and interfere with the recovery process
- ❖ use those facts to give appropriate feedback to members.

Recording is thus extremely useful and clearly necessary. But for the 'time pressed' counselor, if recording needs a lot of time, it can become stressful and poor compliance will result. To prevent this, recording should be structured, and carefully structured recording should not take more than 10 minutes.

If 5 sessions are held in a week, a weekly recording will suffice (in most agencies). If the session is once a week, recording can be done immediately. Changes initiated in group therapy may continue between sessions also. Recording helps the counselor keep tabs on the issues discussed and maintain continuity between sessions.

The ultimate goal of group therapy is to aid self-understanding and initiate change to the maximum level possible in each and every member of the group. Three factors contribute to this outcome.

1. The skill of the counselor
2. The openness of the members who constitute the group
3. The (genuine) interaction between the members

Therefore, the skill of the counselor needs to be sharpened periodically through frequent self-assessment, clinical reviews with peers, openness to new techniques and readiness to explore directions suggested by group therapy research studies. The counselor has some control over the second factor also in the sense that through a display of supportive care and concern, the counselor can facilitate the group to become open and honest in their sharing. This will lead to genuine 'feeling level' interaction and conflict resolution. To put it plainly, the counselor, even though a catalyst, is the key player and her skill is of prime importance.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

To Sum Up

The effectiveness of group therapy session depends on three major forces – the skill of the counselor, composition of the group and the interaction between the two. As the counselor is largely responsible for the first and the third, effectiveness is largely dependent on them. Maintaining group therapy records and inviting supervision by an experienced group counselor can help sharpen their skills. With experience and willingness to learn from one's own experience, one can emerge as a skillful group therapist.

Instructor Note: It is interesting how many students over the years have told me that running group is the scariest thing for them, much more so than individual counseling (which is strange to me since it is just you & the client in individual sessions). And, as you know, group is the main form of treatment practice in every addiction treatment facility, no matter what level of care. I recommend that if you are already working in a treatment facility to speak with your supervisor and ask to sit in on a few different type of groups, then after a couple of months of that, perhaps your supervisor will allow you to co-facilitate a few groups. After the groups you sit in on or co-facilitate are over please meet with the counselor who is running the groups for a de-briefing. This is the time you can ask a few questions about the group process and about how the group or particular situations were handled during group. All this adds up to great experience.

Counseling Client's with Co-Occurring Issues

Chapter 7

Maintaining a therapeutic alliance with clients who have co-occurring disorders (COD) is important—and difficult. This chapter describes techniques effective in counseling clients with COD. One is the use of motivational enhancement consistent with the client's specific stage of recovery. This strategy is helpful even for clients whose mental disorder is severe. Other strategies include contingency management, relapse prevention, and cognitive-behavioral techniques. For clients with functional deficits in areas such as understanding instructions, repetition and skill-building strategies can aid progress. Finally, 12-Step and other dual recovery mutual self-help groups have value as a means of supporting individuals with COD in the abstinent life. Clinicians often play an important role in facilitating the participation of these clients in such groups. This chapter will provide a basic overview of how counselors can apply each of these strategies to their clients who have COD. The purpose of this chapter is to describe for the addiction counselor how these guidelines and techniques, many of which are useful in the treatment of substance abuse or as general treatment principles, can be modified specifically and applied to people with COD.

Guidelines for Developing Successful Therapeutic Relationships with Clients with COD

- | |
|--|
| 1. Develop and use a therapeutic alliance to engage the client in treatment |
| 2. Maintain a recovery perspective |
| 3. Manage counter-transference |
| 4. Monitor psychiatric symptoms |
| 5. Use supportive and empathic counseling |

6. Employ culturally appropriate methods**7. Increase structure and support****Develop and Use a Therapeutic Alliance to Engage the Client in Treatment**

We have already discussed the importance of establishing a therapeutic alliance with clients; the same is true when working with COD clients, perhaps even more so. The clinician's ease in working toward a therapeutic alliance also is affected by his or her comfort level in working with the client. Substance abuse counselors may find some clients with significant mental illnesses or severe substance use disorders to be threatening or unsettling. It is therefore important to recognize certain patterns that invite these feelings and not to let them interfere with the client's treatment. This discomfort may be due to a lack of experience, training, or mentoring.

Clinicians who experience difficulty forming a therapeutic alliance with clients with COD are advised to consider whether this is related to the client's difficulties; to a limitation in the clinician's own experience and skills; to demographic differences between the clinician and the client in areas such as age, gender, education, race, or ethnicity; or to issues involving counter-transference. A consultation with a supervisor or peer to discuss this issue is important. Often these reactions can be overcome with further experience, training, supervision, and mentoring.

Individuals with COD often experience demoralization and despair because of the complexity of having two problems and the difficulty of achieving treatment success. Inspiring hope often is a necessary precursor for the client to give up short-term relief in exchange for long-term work with some uncertainty as to timeframe and benefit.

Challenges in working with clients with serious mental and substance use disorders –

- ✚ These individuals “present and maintain a less involved and more distant stance in relation to the therapist than do non-substance-abusing individuals with mental health disorders

- ✚ The presence or level of these deficits may vary widely for people living with mental health disorders, and also may vary significantly for that individual within the course of his illness and the course of his lifetime.

For all clients with co-occurring disorders, the therapeutic relationship must build on the capacity that does exist. These clients often need the therapeutic alliance to foster not only their engagement in treatment but as the cornerstone of the entire recovery process. Once established, the therapeutic alliance is rewarding for both client and clinician and facilitates their participation in a full range of therapeutic activities; documentation of these types of interactions provides an advantage in risk management.

Advice to the Counselor: Forming a Therapeutic Alliance

The following are recommended approaches for forming a therapeutic alliance with clients with COD:

- **Demonstrate an understanding and acceptance of the client.**
- **Help the client clarify the nature of his difficulty.**
- **Indicate that you and the client will be working together.**
- **Communicate to the client that you will be helping her to help herself.**
- **Express empathy and a willingness to listen to the client's formulation of the problem.**
- **Assist the client to solve some external problems directly and immediately.**
- **Foster hope for positive change.**

Varied meanings of “recovery”

The word “recovery” has different meanings in different contexts. Substance abuse treatment clinicians may think of a person who has changed his or her substance abuse behavior as being “in recovery” for the rest of his or her life (although not necessarily in formal treatment forever). Mental health clinicians, on the other hand, may think of recovery as a process in which the client moves toward specific behavioral goals through a series of stages. Recovery is assessed by whether or not these goals are achieved. Consumers with mental disorders may see recovery as the process of reclaiming a meaningful life beyond mental disorder, with symptom control and positive life activity.

While “recovery” has many meanings, generally, it is recognized that recovery does not refer solely to a change in substance use, but also to a change in an unhealthy way of living. Markers such as improved health, better ability to care for oneself and others, a higher degree of independence, and enhanced self-worth are all indicators of progress in the recovery process.

The recovery perspective generates at least two main principles for practice:

- **Develop a treatment plan that provides for continuity of care over time** . In preparing this plan, the clinician should recognize that treatment may occur in different settings over time (e.g., residential, outpatient) and that much of the recovery process is client-driven and occurs typically outside of or following professional treatment (e.g., through participation in mutual self-help groups) and the counselor should reinforce long-term participation in these constantly available settings.
- **Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process** . The use of treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process enables the clinician (whether within the substance abuse or mental health treatment system) to use sensible stepwise approaches in developing and using treatment protocols. In addition, markers that are unique to individuals—such as those related to their cultural, social, or spiritual context—should be considered. It is therefore important to engage the client in defining markers of progress that are meaningful to him and to each stage of recovery.

Maintaining a Recovery Perspective

The following approaches are recommended for maintaining a recovery perspective with clients who have COD:

- **Assess the client's stage of change.**
- **Ensure that the treatment stage (or treatment expectations) is (are) consistent with the client's stage of change.**
- **Use client empowerment as part of the motivation for change.**
- **Foster continuous support.**
- **Provide continuity of treatment.**
- **Recognize that recovery is a long-term process and that even small gains by the client should be supported and applauded.**

Monitor Psychiatric Symptoms

In working with clients who have COD, especially those requiring medications or who also are receiving therapy from a mental health services provider, it is especially important for the substance abuse counselor to participate in the development of the treatment plan and to monitor psychiatric symptoms. At a minimum, the clinician should be knowledgeable about the overall treatment plan to permit reinforcement of the mental health part of the plan as well as the part specific to recovery from addiction.

The clinician can ask such questions as, “How are your meds doing? Are you remembering to take them? Are you having any problems with them? Do you need to check in with the prescribing doctor?” It also is prudent to ask the client to bring in all medications and ask the client how he is taking them, when, how much, and if medication is helping and how. Clinicians



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

should help educate clients about the effects of medication, teach clients to monitor themselves (if possible), and consult with clients' physicians whenever appropriate.

A number of different tools are available to substance abuse treatment providers to help monitor psychiatric symptoms. Some tools are simply questions and require no formal instrument. For example, to gauge the status of depression quickly, ask the client: “On a scale of 0 to 10, how depressed are you? (0 is your best day, 10 is your worst).” This simple scale, used from session to session, can provide much useful information. Adherence to prescribed medication also should be monitored by asking the client regularly for information about its use and effect.

To identify changes, it is important to track symptoms that the client mentions at the onset of treatment from week to week. The clinician should keep track of any suggestions made to the client to alleviate symptoms to determine whether the client followed through, and if so, with what result. For example: “Last week you mentioned low appetite, sleeplessness, and a sense of hopelessness. Are these symptoms better or worse now?”

Suicidality is a major concern for many clients with COD. Persons with mental disorders are at 10 times greater risk for suicide than the general population, and the risk for suicidal behavior and suicide is increased with almost every major mental disorder. Of adults who commit suicide, 90 percent have a mental disorder, most frequently a major affective illness or posttraumatic stress disorder (PTSD). Alcohol and substance abuse often are associated with suicides and also represent major risk factors. Clients with COD—especially those with affective disorders—have two of the highest risk factors for suicide.

For clients who mention or appear to be experiencing depression or sadness, it is always important to explore the extent to which suicidal thinking is present. Similarly, a client who reports that he or she is thinking of doing harm to someone else should be monitored closely. The clinician always should ask explicitly about suicide or the intention to do harm to someone else when the client assessment indicates that either is an issue.

Use Supportive and Empathic Counseling

As in counseling with clients without COD a supportive and empathic counseling style is one of the keys to establishing an effective therapeutic alliance. The clinician's empathy enables clients to begin to recognize and own their feelings, an essential step toward managing them and learning to empathize with the feelings of others.

However, this type of counseling must be used consistently over time to keep the alliance intact. This caveat often is critical for clients with COD, who usually have lower motivation to address either their mental or substance abuse problems, have greater difficulty understanding and relating to other people, and need even more understanding and support to make a major lifestyle change such as adopting abstinence. Support and empathy on the clinician's part can help maintain the therapeutic alliance, increase client motivation, assist with medication adherence, model behavior that can help the client build more productive relationships, and support the client as he or she makes a major life transition.

Confrontation and empathy

In substance abuse treatment counseling, some tension always is felt between being empathic and supportive, and having to handle minimization, evasion, dishonesty, and denial. However, a counselor can be empathic and firm at the same time. This is especially true when working with clients with COD. The heart of confrontation is not the aggressive breaking down of the client and his or her defenses, but feedback on behavior and the compelling appeal to the client for personal honesty, truthfulness in interacting with others, and responsible behavior. A straightforward and factual presentation of conflicting material or of problematic behavior in an inquisitive and caring manner can be both “confrontative” and caring. The ability to do this well and with balance often is critical in maintaining the therapeutic alliance with a client who has COD.

Using Culturally Appropriate Methods

The consensus panel recommends the following approach for using culturally appropriate treatment methods with clients with COD:

- **Take cultural context, background, and experiences into account in the evaluation, diagnosis, and treatment of clients from various groups, cultures, or countries.**
- **Recognize the importance of culture and language, acknowledging the cultural strengths of a people.**
- **Adapt services to meet the unique needs and value systems of persons in all groups.**

- **Expand and update [the provider's/system's] cultural knowledge.**
- **Work on stigma reduction with a culturally sensitive approach.**

Source: Center for Mental Health Services 2001.

Key Techniques for Working with Clients Who Have COD

- 1. Provide motivational enhancement consistent with the client's specific stage of change.**
- 2. Design contingency management techniques to address specific target behaviors.**
- 3. Use cognitive-behavioral therapeutic techniques.**
- 4. Use relapse prevention techniques.**
- 5. Use repetition and skills-building to address deficits in functioning.**
- 6. Facilitate client participation in mutual self-help groups.**

Counseling techniques discussed and reviewed in earlier chapters (CBT, MI and Solution Focused etc.) can and should be used in conjunction with the approaches listed in this chapter to best work with COD clients.

Use Repetition and Skills-Building to Address Deficits in Functioning

Finally, in applying the approaches described above, keep in mind that clients with COD often have cognitive limitations, including difficulty concentrating. Sometimes these limitations are transient and improve during the first several weeks of treatment; at other times, symptoms



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

persist for long periods. In some cases, individuals with specific disorders (schizophrenia, attention deficit disorder) may manifest these symptoms as part of their disorder.

General treatment strategies to address cognitive limitations in clients include being more concrete and less abstract in communicating ideas, using simpler concepts, having briefer discussions, and repeating the core concepts many times. In addition, individuals often learn and remember better if information is presented in multiple formats (verbally; visually; or affectively through stories, music, and experiential activities).

When compared to individuals without additional disorders or disabilities, persons with COD and additional deficits often will require more substance abuse treatment in order to attain and maintain abstinence. A primary reason for this is that abstinence requires the development and utilization of a set of recovery skills, and persons with mental disorders often have a harder time learning new skills. They may require more support in smaller steps with more practice, rehearsal, and repetition. The challenge is not to provide more intensive or more complicated treatment for clients with COD, but rather to tailor the process of acquiring new skills to the needs and abilities of the client.

Instructor Note: Overall the addiction counselor will use the same therapeutic techniques with clients with COD as with clients without COD. There will be modifications of focus and a need for keen awareness of the mental status of the client as well on-going assessment of risk management. This is something a thorough, professional counselor does in a typical day. As we learn more and more about the co-existing relationship between mental health and substance abuse we will also learn new and more effective ways of assessing and working with these clients as well. Don't forget...as with everything we have discussed, when in doubt seek supervision.

Termination

Chapter 8

Instructor Note: The termination process begins the moment a client enters treatment. We, as counselors, know that our clients will be with us for a brief period of time in the client's life. And though it may be difficult to believe or visualize, especially in the first few days of treatment, many of our clients become attached (in a healthy way) to their counselor's and the treatment program. This is actually a good thing in many ways. When a client "buys" in to the treatment process and the treatment community they increase their likelihood of incorporating the new ways of living, thinking and behaving once they leave the treatment facility. The fact that this may be the first time the client has trusted anyone, connected to their emotions and incorporated new beliefs about themselves and their capabilities makes them vulnerable emotionally.

One of the goals for the counselor is to model healthy ways to end a relationship. Counselors teach the client that in life human beings have many different type of relationships, some will be long-lasting but some will be brief; if it was a good relationship the benefits, joys and sometimes love remain even after that relationship ends, brief does not mean that particular relationship was a "waste of time". It is not at all unusual for the client to express some level of anger or suddenly begin to act out. This is how some clients manage their hurt, fear and feelings of perceived rejection. The counselor needs to be prepared for this and be aware of signs of grief, yes I said grief, that is in effect what the client is experiencing, the sense of loss of someone important and meaningful in their lives.

The counselor needs to be sensitive to what's behind these feelings and thoughts, explore with the client their thoughts about leaving through statements like "wow you have done so well here, the thought of going back home must a little concerning or worrisome for you?", "so we are getting near the end of your time here, have you thought what leaving might feel like?" Any statement/question like these will hopefully generate an open self-exploration by the client. The counselor needs to assure the client that they can be equally as successful in the community as they have been in the treatment facility. The counselor can guide the client to sum up all they have achieved during their time in treatment so the client can own their hard work and the benefits of that hard work.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Another purpose of termination is preparing the client to grow so that s/he is not totally dependent on the counselor. When the counselor has repeatedly walked the client through the process of problem identification, goal setting and changing, the client learns these skills and can use them without the help of the counselor. Over a period of time, the client's social network gets strengthened and s/he is beginning to integrate into society. The counselor actively encourages the client to handle issues on their own and gradually withdraws involvement and support.

Termination is the logical conclusion to the process of counseling. The success of counseling does not end with resolution of their problems symptoms but should also ensure personality growth so that the client emerges as a stronger and more capable of handling his/her problems.

All through the stages of counseling, the counselor's skill is the primary force that keeps the client actively involved in therapy. In practice, however the client may not specifically progress from one stage to the other in a clear-cut manner as previously discussed in the power point about the stages of change. Instead, one stage merges into the other and the client may move back and forth on certain issues. The strength of the counselor lies in staying with the client, helping him stabilize and move forward. This process can be emotionally gratifying and professionally satisfying, but it can also be frustrating. The counselor's emotional maturity in dealing with setbacks by using the support of the treatment team members is of crucial importance.

Counseling calls for a lot of skill and much depends on the counselor's own personality style. To be effective, the counselor needs to be able to strike a balance between being stable and mature as well as being spontaneous. Commitment is expected, but with professional detachment. The suffering chemically addicted person who carries a low sense of self worth needs compassion, but he also needs the steadying hand of firmness and healthy boundaries to help them progress.

To play this role well with a fine sense of balance the counselor needs to be aware of her own potential as well as limitations. Counselors need to update their knowledge and fine tune their skills. Feedback from clients and other counselors should be received in the right perspective and changes need to be made. Self evaluation is also necessary. Asking oneself 'How did I handle this client during this session? Could I have done better?' are questions that counselors should ask themselves on a regular basis. With experience and willingness to evaluate oneself honestly, the counselor can develop skills of a high order.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

Instructor Closing Remarks: This course is chock full of information. It is a lot to have read and a lot to absorb. But make no mistake, ALL of it is important. There are many sections of information that you will be able to use long after you complete these courses, long after you take your CAP exam and pass with flying colors. Use the details given, use the example questions for clients, and use the good characteristics to check yourself, self-evaluate on a regular basis. Be honest; strive to grow in technique, assessment and most importantly as a professional. You will know if this field, this practice is the right one for you. You will know when all these things, these ways of practicing and being become of the utmost importance to you. When you cherish and respect the fact that other human beings are entrusting the well-being to you, their fears, their secrets and their vulnerabilities.

So I thank you in advance for your care, concern and consideration in these professional counseling matters. I will leave you with this brief questionnaire, not for school but for yourself.

Good Luck! 😊

WILL I MAKE A GOOD COUNSELOR?

Ask yourself the following questions:

1. Am I happy with myself?
2. Do I have confidence in my own abilities?
3. Am I happy not dominating or controlling others?
4. Do I take a liking to different types of people easily?
5. Do I feel that everyone can take his own decisions and assume his own responsibilities?
6. Do I find different types of people interesting?



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

7. Can I listen patiently when someone is talking in detail about his/her problems?

8. Do I have the well being of most people around me in my heart?

9. Am I tolerant towards religious and social beliefs that do not agree with mine?

10. Am I warm and loving towards new people who come in contact with me?

11. Can I talk easily and frankly about myself when the need arises?

12. Can I listen to a tragic circumstance without getting weighed down with sorrow?

If you can truthfully answer 'Yes' or 'I think I do' to most of the questions listed above, then you are the type of person who will make a good counselor. However, if you answer 'no' to a majority of the questions, you will either have to change your outlook, undergo more rigorous training, or accept the fact that you may not make an effective counselor.



6555 NW 9th Avenue, Ste. 210 | Fort Lauderdale, FL 33309
(954) 771-2091 – Fax (954) 771-2098

References:

1. Drug Treatment Program History and Continuing Controversy; Kolmac Clinic. Tuesday October 28, 2014
2. An Individual Drug Counseling Approach to Treat Cocaine Addiction; NIDA Archives
3. An Invitation to Counseling Work – Chapter 1; The Essential Counselor – Process, Skills & Techniques. 2nd Edition 2012.
4. Individual Addiction Counseling (IAC). Mark McGovern, Kim T. Mueser, Jessica L. Hamblen, Mary K. Jankowski – Dartmouth Medical School 2007.
5. Addiction Counseling: Examination of various Addiction Counseling and Therapy Approaches of Addictive Disorders. Journal of Addictive Disorders 2003.
6. The Licensed Chemical Dependency Counselor Written Exam: A Preparation Curriculum. Center for Substance Abuse Treatment State Systems Technical Assistance Project. October 2004
7. Enhancing Motivation for Change in Substance Abuse Treatment. SAMSHA TIP 35. Rockville (MD): [Substance Abuse and Mental Health Services Administration \(US\)](#); 1999.
8. http://www.integration.samhsa.gov/clinical-practice/sbirt/CBT_sbirt_part_2.pdf
9. Brief Interventions and Brief Therapies for Substance Abuse. SAMSHA TIP 34. Rockville (MD): [Substance Abuse and Mental Health Services Administration \(US\)](#); 1999.
10. Counseling for Drug Addiction: Individual, Family & Group. A Field Guide for Trainers Concepts Issues. Practical Tools and Resources. DR. SHANTHI RANGANATHAN, RUKMANI JAYARAMAN & V. THIRUMAGAL.
11. Berg & Ruess, 1998. Week 8: Solution Focus Interventions. University of Boston Massachusetts.
12. Substance Abuse Treatment: Group Therapy. SAMSHA TIP.
13. Substance Abuse Treatment for Persons With Co-Occurring Disorders. SAMSHA TIP