

THIRD EDITION



Learning the Language of

ADDICTION COUNSELING

Gerri Miller

THIRD EDITION

*LEARNING THE
LANGUAGE OF
ADDICTION COUNSELING*

THIRD EDITION

*LEARNING THE
LANGUAGE OF
ADDICTION COUNSELING*

Geri Miller



WILEY

JOHN WILEY & SONS, INC.

This book is printed on acid-free paper. ⊗

Copyright © 2010 by John Wiley & Sons, Inc. All rights reserved.

Published by John Wiley & Sons, Inc., Hoboken, New Jersey.

Published simultaneously in Canada.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, scanning, or otherwise, except as permitted under Section 107 or 108 of the 1976 United States Copyright Act, without either the prior written permission of the Publisher, or authorization through payment of the appropriate per-copy fee to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, (978) 750-8400, fax (978) 646-8600, or on the web at www.copyright.com. Requests to the Publisher for permission should be addressed to the Permissions Department, John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, (201) 748-6011, fax (201) 748-6008.

Limit of Liability/Disclaimer of Warranty: While the publisher and author have used their best efforts in preparing this book, they make no representations or warranties with respect to the accuracy or completeness of the contents of this book and specifically disclaim any implied warranties of merchantability or fitness for a particular purpose. No warranty may be created or extended by sales representatives or written sales materials. The advice and strategies contained herein may not be suitable for your situation. You should consult with a professional where appropriate. Neither the publisher nor author shall be liable for any loss of profit or any other commercial damages, including but not limited to special, incidental, consequential, or other damages.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering professional services. If legal, accounting, medical, psychological or any other expert assistance is required, the services of a competent professional person should be sought.

Designations used by companies to distinguish their products are often claimed as trademarks. In all instances where John Wiley & Sons, Inc. is aware of a claim, the product names appear in initial capital or all capital letters. Readers, however, should contact the appropriate companies for more complete information regarding trademarks and registration.

For general information on our other products and services please contact our Customer Care Department within the United States at (800) 762-2974, outside the United States at (317) 572-3993 or fax (317) 572-4002.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books. For more information about Wiley products, visit our website at www.wiley.com.

Library of Congress Cataloging-in-Publication Data:

Miller, Geraldine A., 1955–

Learning the language of addiction counseling / Geri Miller.—3rd ed.

p. cm.

Includes bibliographical references and indexes.

ISBN 978-0-470-50523-6 (paper/cd-rom)

1. Drug abuse counseling. 2. Substance abuse—Patients—Counseling of. 3. Drug addicts—Counseling of. I. Title.

RC564.M536 2010

362.29'186—dc22

2009054052

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

This book is dedicated to Ron Hood, my husband and friend, who was there through it all;
Gale, Abby, and Jason Miller; and Tom, Laura, Natalie, and Kate Prow; and my family.

The women who were with me from the beginning, Kathleen Kasprick, Pat Mitchell, and
Judy Retterath.

The addicted clients and their loved ones whom I had the honor of counseling.

CONTENTS

Preface	xi
Acknowledgments	xv
CHAPTER 1	
<i>INTRODUCTION</i>	1
Personal Reflections	1
Addiction Counseling Influences	2
Theories of Addiction	8
CHAPTER 2	
<i>THEORIES OF COUNSELING RELATED TO ADDICTION TREATMENT</i>	19
Personal Reflections	19
Development of a Theoretical Framework for Addiction Counseling	19
Dangers in Developing a Theoretical Framework and Recommendations	21
General Counseling Theories	24
CHAPTER 3	
<i>ASSESSMENT AND DIAGNOSIS OF ADDICTION</i>	37
Personal Reflections	37
Interviews	38
Behavioral Observations	45
Physiological Instruments	46
Psychometric Instruments	46
Diagnosis	55
Stages of Change	58
CHAPTER 4	
<i>ASSESSMENT, DIAGNOSIS, AND TREATMENT OF CO-OCCURRING DISORDERS</i>	63
Personal Reflections	63
Historical Struggles Between the Fields	65
General Guidelines	66
Problems with Diagnosing	67

Type of Co-Occurring Diagnoses	69
Related Issues	79
Screening	85
Recognition of Problems in Different Settings	85
Treatment Modifications and General Guidelines	86

CHAPTER 5***THE TREATMENT PROCESS FOR ADDICTIONS* 97**

Personal Reflections	97
Crisis Intervention	97
Individual Therapy	103
Group Therapy	110
Family Therapy	122
Specific Approaches	129

CHAPTER 6***TREATMENT-RELATED ISSUES* 145**

Personal Reflections	145
Sexual Issues	146
HIV/AIDS	154
Intimate Partner Violence	162

CHAPTER 7***RELAPSE PREVENTION* 183**

Personal Reflections	183
Counselor Approaches	183
Relapse-Prevention Models	187
Counseling Techniques	193
Case Studies of Special Populations	200
Co-Occurring Disorders	203

CHAPTER 8***SELF-HELP GROUPS* 209**

Personal Reflections	209
Suggestions for Counselors	209
12-Step Groups	211
Women for Sobriety	219
16 Steps	221
Rational Recovery	223
Secular Organizations for Sobriety	225
Self-Management and Recovery Training (Smart Recovery [®])	226

Matching Self-Help Groups to Meet Client Needs	228
Special Issues	234
Appendix Stories of Recovery	241

CHAPTER 9***CURRENT AND EVOLVING THERAPY APPROACHES AND TECHNIQUES* 243**

Personal Reflections	243
Positive Psychology	243
Client Resilience	246
Stages-of-Change Model	248
Motivational Interviewing	250
Brief Therapy	255
Evaluation of Effectiveness	267

CHAPTER 10***CULTURALLY SENSITIVE ADDICTION COUNSELING* 273**

Personal Reflections	273
Defining Multicultural	274
Social-Environmental Aspects	275
Breakdown of Communication	277
Multicultural Competence	277
Dialogue	278
General Counseling Suggestions	279
Assessment, Treatment, and Aftercare Issues	280

CHAPTER 11***INCORPORATING SPIRITUALITY INTO ADDICTION COUNSELING* 329**

Personal Reflections	329
Definition of Spirituality	329
The History of the Merger: Spirituality and Addiction Counseling	330
Bridges and Barriers	332
Influencing Factors	334
Assessment and Treatment	334
Counseling Resources and Techniques	336
Counselor Self-Care	339
Ethical Issues	342

CHAPTER 12***CHRONIC PAIN ASSESSMENT, TREATMENT, AND AFTERCARE* 345**

Personal Reflections	345
Definition of Pain	347

Issues of Living Sober with Chronic Pain	347
Assessment and Treatment	349

CHAPTER 13

PERSONAL AND PROFESSIONAL DEVELOPMENT OF THE COUNSELOR **359**

Personal Reflections	359
Ethical Issues	359
Testifying in Court	368
Working with Difficult Others	372
Self-Care	377
Working with Addicts	383

CHAPTER 14

*PREPARING FOR CERTIFICATION AND LICENSURE AS
AN ADDICTION PROFESSIONAL* **393**

Personal Reflections	393
Self-Care on the Journey	395
Supervision	397
Credentialing	399

References	407
Author Index	447
Subject Index	457

PREFACE

Learning the Language of Addiction Counseling emerged from a desire to summarize the clinical, theoretical, and research work in the addiction counseling field from a practitioner's point of view. The third edition of this book involves substantial changes that need to be highlighted at the onset. First, in order to present my views of addiction counseling that have evolved after working in the addiction counseling field for more than 30 years, teaching undergraduate and graduate students in addiction counseling for more than 20 years, and training mental health and addiction professionals for more than 15 years, I have added a "Personal Reflections" section at the beginning of each chapter.

Second, all of the chapters have been updated, with some having significant revisions, including sections with additional components to reflect changes in the field and sections being moved to more appropriate chapters. Third, two new chapters (Chapters 11 and 12) have been added that reflect common areas addressed in the field: spirituality and addiction counseling, and pain and substance abuse. Fourth, additional case studies and exercises and suggested readings/resources/websites sections have been expanded at the end of each chapter.

Finally, for instructors, instructor resources have been added that include PowerPoint slides and test bank questions for each chapter. These changes have been made because counselors and educators are increasingly being asked to "hit the ground running" when they begin their work. Syllabi for classes I have taught in the addictions area are included to also assist counselors and educators. It is hoped that this book will assist counselors and educators in more readily being able to do their work.

I have been blessed in my life to have been trained by numerous addiction counseling professionals who are deeply committed to the field, to helping people who are caught in a destructive cycle of addiction and who face horrific odds in life. Throughout my years of work in the addictions field, I have watched these professionals respect and care for individuals who have experienced, at a piercing level, a lack of respect and love both within themselves and from others. Their compassion for the suffering of both addicts and their loved ones and their hope for the healing of addiction recovery for all addicts and their loved ones led me to this field and has kept me in it all of these years.

This book provides a summary of addiction counseling based on practical application of both theory and research. It serves as a reference that can be used by two groups: (1) undergraduate and graduate students who are training to be direct service workers with addicted individuals and (2) clinicians who are new to the field of addiction counseling or who would like to review the state of the art of addiction counseling.

Although the book discusses techniques and approaches that are grounded in research, this book is focused on the practitioner. Throughout the text, interactive exercises, such as case studies and discussion exercises, are provided to assist the reader in applying the information

and to assist the teacher in integrating the material into the classroom discussion. Because of the different approaches in the addictions field, there are often controversies regarding theory and practice. This book does not reconcile these differences, but it does fuse theoretical and practical concerns into a pragmatic counseling framework, resulting in a helpful manual for counselors who work with addicts. *Learning the Language of Addiction Counseling* is a text that a practitioner can turn to for fundamental, practical, clinical guidelines.

Following are brief summaries of each chapter in the book:

- Chapter 1, “Introduction,” is a brief overview of addiction counseling that examines past and current influences on addiction counseling and theories of addiction.
- Chapter 2, “Theories of Counseling Related to Addiction Treatment,” explores theories of counseling as they apply to counseling addicted individuals.
- Chapter 3, “Assessment and Diagnosis of Addiction,” examines the assessment process with clients. Interviews, behavioral observations, physiological instruments, and psychometric instruments are discussed. Addiction diagnosis and American Society of Addiction Medicine (ASAM) Placement Criteria are also presented.
- Chapter 4, “Assessment, Diagnosis, and Treatment of Co-occurring Disorders,” explores the assessment process within the context of dual disorders. Specifically, principles of diagnosis and treatment, general guidelines, types of diagnosis, and treatment modifications are presented.
- Chapter 5, “The Treatment Process for Addictions,” provides an overview of addiction treatment with treatment plan guidelines. Four specific forms of addiction counseling are discussed: crisis intervention, individual, group, and family, as well as drug court, evidence-based therapy, dialectical behavior therapy, and seeking safety.
- Chapter 6, “Treatment-Related Issues,” explores issues that may arise in relation to addiction counseling. The chapter addresses the specific topics of rape and sexual abuse, HIV/AIDS, and partner violence. Recommendations for counseling in these related areas are provided.
- Chapter 7, “Relapse Prevention,” provides an overview of relapse prevention issues. Counselor approaches, models, and techniques are explored. Dual diagnosis issues are also discussed.
- Chapter 8, “Self-Help Groups,” addresses the national, abstinence-based self-help groups in the United States in terms of their historical development, basic concepts, use in counseling, and strengths and limitations. Information is also provided on how to assist clients in finding an appropriate group and sponsor/mentor and special issues related to self-help groups.
- Chapter 9, “Current and Evolving Therapy Approaches and Techniques,” presents information on positive psychology, resilience, the stages-of-change model, motivational interviewing, and brief therapy.
- Chapter 10, “Culturally Sensitive Addiction Counseling,” examines issues that have an impact on addiction counseling. These issues include multicultural counseling as it relates to gender, ethnicity, sexual orientation, disability, and age (e.g., adolescents, the elderly).
- Chapter 11, “Incorporating Spirituality into Addiction Counseling” presents information and suggestions on how to effectively incorporate spirituality into addiction counseling work.
- Chapter 12, “Chronic Pain Assessment, Treatment, and Aftercare” discusses the overlapping areas of pain and addiction and makes suggestions on counseling approaches and techniques in this area.

Chapter 13, “Personal and Professional Development of the Counselor,” explores areas of development that concern counselors—ethical issues, court testimony, working with difficult others, self-care, and issues related to working with addicts.

Chapter 14, “Preparing for Certification and Licensure as an Addiction Professional,” focuses on assisting counselors in preparing for certification and licensure.

ACKNOWLEDGMENTS

I cannot name all of the excellent professional role models I have encountered in the field, but I do acknowledge every one of you. You know who you are. You spent time explaining basic concepts of working in this field to me, you challenged me to be the best therapist, researcher, teacher, and person I could be, and you never settled for less in me or gave up on me. Thank you from the core of my being.

I also gratefully acknowledge the addicted clients I have worked with and their loved ones, who taught me through their amazing life stories about the destructive nature of addiction and the incredible capacity of the human spirit to survive and change. I thank these many people for showing me how to work in this field and how to live in this world. The courage and integrity of watching individuals struggle to break out of the pain of the addictive cycle is a powerful experience. To these people, I simply say, Thank you.

I also want to thank the many addiction professionals and graduate and undergraduate students I have trained over the years. You have taught me so much about the addictions field and have helped encourage my passion and commitment to this important work through your passion and commitment to it. Such wonderful times we have had together.

Additionally, I want to thank the people who believed I could write such a book and supported me on the journey. Marquita Flemming, my editor at John Wiley & Sons, Inc., supported and assisted me throughout the writing of the book. She showered me with enthusiasm and encouragement in the writing of this book that stayed me on the discouraging days; she believed in me and the importance of this book. I also want to acknowledge the other Wiley employees who worked so hard with me on this book: Judi Knott and Heather Dunphy in marketing, Kim Nir as production editor, and Fiona Brown as editorial assistant.

George Dennis, my computer teacher, helped me with my computer struggles, spending hours with me patiently wading through the technological advances that have occurred since the second edition was published. George is one of the kindest, smartest, most patient individuals I have ever known. Leila Weinstein worked with me on literature reviews, rewrites, and numerous other projects related to this book; she became my friend and colleague, who worked hard, efficiently, and reliably. My graduate assistant, Stephanie Kukich, came to my rescue in terms of the details of the manuscript.

Danny Graves, Lynn Jones, Bruce Kaplan, Leslie McCrory, Anna Misenheimer, Paul Nagy, and Kathy Norins, all busy professionals in the addictions field, took time to comment carefully and thoroughly on specific sections of the manuscript based on their expertise in the addictions field; such kindness and generosity each of you showed me. A special acknowledgment goes to Dr. Betty Gridley, my statistics teacher and mentor, who assisted in the development of test questions.

To Laurie Percival Oates, Rod and Marilou Steinmetz, and Betty Watson, who hold special places in my heart for their kindness, compassion, and amazing ability to create a safe space for

others in the world, including me, for providing support through the writing of this book. Also, I appreciate the support of my early-morning coffee-drinking buddy, who I adopted as a father, Ken Schmidt; as he was dying during the final stages of this edition, he told me encouragingly to “Just go write.” Ken, I still miss you, and I thank you for believing in me and teaching me how to work in a “man’s world.” I also appreciate the support from my Saturday-morning coffee-drinking buddies, who held me steadfast on this journey. I thank each of you.

To the employees of the Paul H. Broyhill Wellness Center—Jodi Cash (director), Paul Moore (assistant director), Michael Darling (personal trainer), Betty Watson (my friend) and all the rest of my buddies who encouraged and supported me every day with their friendship and laughter—“Thank you.” Michael Darling, thank you for being my teacher and friend.

Finally, to Ron Hood, my husband and my best friend, who demonstrated his love and support by painstakingly reading every word written in every draft of this book and previous editions: “Thank you, Ron, for being with me on this life path. I love you.”

INTRODUCTION

PERSONAL REFLECTIONS

As we approach addiction counseling, it is important, as clinicians, that we have as clear an understanding as possible of who we are both personally and professionally. We need to be brave enough to examine our own experiences with addictive tendencies within ourselves and our loved ones as well as our professional experiences with addicts. These experiences color and shape our work with our addicted clients. If we engage in a thorough self-exploration, we can enter encounters with addicts using a clear, balanced approach and avoid being thrown off balance by the intense force of addiction as it has expressed itself in our client's life. Following this self-awareness, a theoretical framework flows that stems from my view of counseling in general and addiction in particular; a theoretical framework that powerfully invites my clients and their loved ones to heal from the destructive force of addiction.

OBJECTIVES

1. To understand the history of influences on addiction counseling.
2. To learn the main theories of addiction counseling.
3. To apply the history and theoretical knowledge of addiction counseling to current issues in the field.

Current statistics support the concern for alcohol and drug use in America. The 2008 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA]) found that about 129 million Americans (51.6% of the total population over age 12) drank alcohol, with 23.3% having a binge drinking experience at least once in the previous month and 6.9% reporting being heavy drinkers. Also, about 12.4% drove while drinking alcohol at least once in the previous year. The survey also found that approximately 20.1 million Americans (8% of the total population over age 12) had used an illicit drug during the month before being interviewed. Marijuana was the most common illicit drug used.

These statistics underscore the importance of understanding the dynamics of alcohol and drug abuse and addiction. The high number of

individuals using alcohol and drugs in America also supports the need for counselors to understand the dynamics of addiction: It is highly likely that a counselor will work with individuals who are abusing alcohol or drugs in any counseling setting. Understanding the dynamics of addiction can help the mental health professional more effectively meet the needs of the client.

Working with the substance-abusing population, however, can be difficult. Mental health workers, both historically and currently, have not always liked working with alcoholics and addicts for at least two reasons: (1) the difficulty in treating them because of factors such as relapses, poor impulse control, emotional reactivity, and/or lying to protect their addiction; and (2) the lack of knowledge (techniques) on how best to treat them. However, openness to treating addicts grew as information on how to

treat addicts emerged and as additional funding for treatment became available. For example, addicts commonly deny the consequences of their usage to themselves and others (Levinthal, 1996). It became easier for counselors to deal with denial when the technique of intervention was introduced (Fields, 1995).

Counselors also have potential issues with countertransference. Many helping professionals have negative personal as well as professional experiences working with addicted individuals. This may cause them to avoid or hesitate working with this population. When working with addicts, they may be caught in familiar patterns of enabling or judging the addicted individual and their loved ones based on their own personal or professional experiences. Also, professionals can have concern they are being conned by addicts to enable their addiction and, as a result, may approach the addicted person in a manner that invites anger and manipulation from the client (Compton, 1999).

Changes in public policy also affected the work of counselors. In 1970, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was established to provide funding for alcoholism treatment and research, and in the 1970s, insurance companies began to reimburse agencies for providing addiction treatment (O'Dwyer, 1993). The Hughes Act (PL 91-616) established the NIAAA, funded states that established alcoholism divisions, and started alcohol treatment programs for federal employees (Fisher & Harrison, 1997). This policy change expanded the field of addiction counseling.

As a result, states started to create credentialing and licensing bodies to ensure quality addiction counseling (O'Dwyer, 1993); being a recovering addict no longer meant immediate entry into the addiction counseling field. Instead, addiction professionals needed to document a combination of credentials regarding both counseling experience and training. From 1993 to 1994, the Commission on Rehabilitation Counselor Certification (CRCC) developed another certification to complement the Certified

Rehabilitation Counselor (CRC) Certification: Certified Rehabilitation Counselor—Substance Abuse Counselor (CRC-SAC).

Certification of addiction professionals expanded in 1995, when the National Board of Certified Counselors (NBCC) established an addiction certification specialty for mental health counselors, and in 1996, the American Psychological Association (APA) established a proficiency certification for licensed psychologists. As of January 1, 1997, counselors who are certified as addiction counselors by the CRCC, the NBCC, or the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) can apply for their Master's in Addictions Counseling (MAC) certification ("New Credential for Addictions Counselors," 1996). Before January 1, 1997, CRC-SAC counselors could be grandfathered into the credential of CRC- MAC.

With the growth of research and treatment, there are now many routes of entry into addiction counseling. You may enter the field through a research, a grassroots network, or a certification/licensure process. As a result, there are numerous disagreements in the field of addictions on applicable theoretical models and effective treatment approaches. For example, some addiction experts emphasize the strengths of the disease model of addiction and Alcoholics Anonymous (AA; Gragg, 1995), whereas other experts point out the weaknesses of the disease model and AA (G. A. Marlatt, 1985b).

ADDICTION COUNSELING INFLUENCES

Currently, there are three main influences in addiction counseling:

1. The traditional addiction counseling approach of the *disease model* that asks: Is this approach healing for the addict within the scope of the disease model of addiction?
2. The *addiction research approach* that presents counselors with the question: Which addiction

counseling approaches are supported in research findings?

3. A final, and more recent, influence stems from *managed care organizations* that confront counselors with the question: What counseling approaches provide the greatest benefit for the least cost?

Each of these influences has an important impact on addiction counseling; as a result, numerous areas of conflict exist in the addictions field. For example, disease model counselors may advocate use of the term *codependency* for the partners and family members of addicts, but the research community may respond by stating that there is not enough research to warrant the use of such a diagnostic term, and the managed care organizations may not be willing to pay for codependency treatment because of the disagreement among professionals. It is important to understand the historical influences of both the disease model of addiction treatment and addiction research.

Disease Model of Addiction Treatment

The addiction counseling field has two main root systems: a grassroots addiction recovery network and a research community base. Lay therapy with this population began in 1913, when Courtenay Baylor was hired by the clinic of Boston's Emmanuel Church (that began in 1906) after receiving treatment there. Many lay counselors became sober before AA or without affiliation with it once it emerged in 1935 (W. L. White, 1999). AA looked at alcoholics as having an allergy to alcohol, which results in a craving and a loss of control (AA, 1939). Other than Thomas Trotter and Benjamin Rush—who, at the end of the 18th century, viewed alcoholism as a disease—alcoholism was typically viewed as a moral weakness (O'Dwyer, 1993). AA's view of alcoholism as an allergic reaction helped shift alcoholism from a moral problem to a physical or medical problem: The alcoholic was no longer

blamed for developing the addiction (G. A. Marlatt, 1985b).

The AA view of alcoholism as an allergic reaction affected treatment in a number of ways. First, defining addiction as a physical reaction (allergy, craving) allowed the addicted individual to feel less like a "bad person" and more like a "sick person," which preserved or restored self-esteem and self-respect. Second, viewing addicts as having an allergic reaction to mood-altering substances provided a simple, straightforward definition of their struggle that most people can readily grasp. Third, this grassroots model encouraged the use of self-help groups, thereby helping addicts develop a sense of community.

W. L. White (1999) describes the evolution of the professional addiction counselor role. With the birth of AA, members of AA began to be employed at treatment facilities. In the 1940s, boundaries between AA members and employers were clarified. The Minnesota model of treatment emerged from three programs in Minnesota that operated with an AA philosophy (Pioneer House established in 1948; Hazelden established in 1949; Willmar State Hospital established in 1950). In 1954, the Minnesota Civil Service Commission provided a title, Counselor on Alcoholism, that created a professional role for the addiction counselor.

Addiction Research

While the self-help group movement was growing, so was the research on addiction. About the same time as AA's development, the federal government began two drug treatment programs for prisoners, which facilitated research opportunities on addictions (O'Dwyer, 1993). Through his alcoholism research and the creation of the Yale School of Alcohol Studies in 1942, Jellinek developed the disease model of alcoholism (Bowman & Jellinek, 1941; Gragg, 1995; Jellinek, 1960). The disease model of alcoholism fit well with AA's model of an allergy, and a significant bridge developed between the self-help group movement and the research

community. In 1956, the American Medical Association (AMA) agreed that alcoholism was a disease (G. A. Marlatt, 1985b). Through the development of the disease model of alcoholism, both the self-help group movement and the research community guided mental health professionals in their work with addicts (Gragg, 1995).

In a manner similar to AA's view of addiction as an allergy, the disease model of addiction had an impact on treatment. The addict's self-esteem and respect is preserved or restored, because the problem is framed as physically, not morally, based. Also, the disease model provided information about the stages of the disease's development, thereby enhancing the diagnostic process. Finally, the model provided counselors with a framework and terminology to provide clients with information about the current and eventual progression of the disease.

Managed Care Organizations

Significant concerns about the third influence, managed care organizations, abound in the addictions field. Armstrong (1997) summarizes three common areas of focus in managed care: accessing care, containing costs, and ensuring quality. The logic of managed care is to make sure services provided are necessary and that monies are used thoughtfully (Kinney, 2003). However, Margolis and Zweben (1998) underscore some of the concerns with managed care in the addictions field. They point out that research over the past 30 years shows that people improve the longer they are in treatment, yet managed care emphasizes less intense and shorter treatment duration. For example, managed care plans may not cover individual sessions or focus on outpatient treatment.

Also, managed care plans may measure successful outcomes by "no immediate problems or complaints," which is a different treatment success measure than that used by an addiction counseling professional. Kinney adds two specific

problems that have occurred in the addictions field regarding managed care: (1) treatment is not individualized, so optimal care may not be obtained; and (2) contracts are based on reimbursement for certain diagnoses rather than actual costs. This results in services being limited. The Physician Leadership on National Drug Policy (PLNDP) reported that coverage of substance abuse has been limited in managed care plans for several reasons, such as (1) purchasers do not view themselves as able to negotiate for more comprehensive coverage; (2) both purchasers and health maintenance organizations (HMOs) may lack scientific data on substance abuse and not realize its cost effectiveness; and (3) insurers may view benefits as long term, so people would show the effectiveness of treatment after leaving their jobs and having different insurance ("Physician Group," 2002).

The primary impact of managed care on addictions treatment is a shortened length of treatment. Because of limited funding, counselors increasingly need to use briefer therapy models as well as assist clients in accessing community supports, such as self-help groups, to provide effective, comprehensive care. Although counselors may experience negative reactions to the treatment control of managed care, they have no choice but to work with the economic realities of the managed care philosophy (Hood & Miller, 1997).

Austad and Berman (1995) state that counselors cannot operate separately from their economic environments. One factor they attribute this shift to is increasing costs: ". . . employers, insurers, and individual consumers are no longer willing to pay unlimited amounts for health care without close scrutiny and accountability" (p. 3). Additionally, the authors state that mental health concerns became covered because of an awareness of the interaction between the mind and body. The counselor working in the area of addictions needs to find a balance between addressing the financial realities of managed care with the ethical commitment to client welfare. To work with this reality in the addictions

counseling field, the history of managed care needs to be examined in terms of its current impact on the field.

Austad and Berman (1995) describe the history of managed care development in the United States. Managed care systems came with two emphases: to provide quality care and to reduce costs. HMOs began in the 1900s as alternative forms of health care for poor people, laborers, and farmers who might be obliterated financially by intense, sudden medical costs. Initially, HMOs were opposed by medical professionals; however, acceptability for the concept of “pre-paid care” (health care is provided by specific individuals or groups for a specific fee predetermined in a contract) grew by the 1970s, as evidenced in the passing of the 1973 HMO Act, which decreased legal restrictions on these organizations and provided loans and grants. The basic models of HMOs are:

1. *Staff model.* Comprehensive medical services are provided by individuals (employees or contractors) who work out of a central location and receive a salary.
2. *Group model.* Group of practitioners who have a contract with an HMO to provide services (central location or private office).
3. *Independent practice model.* Practitioner provides specific service (private office).

The last two models have fees that are arranged previously or ones where the provider gives all necessary services for an agreed-upon fee. With a preferred provider organization (PPO), the clients have monetary incentives to use providers who have been previously approved by a panel, and the providers have an established agreement to provide services at a certain rate. Managed care models are changing, and HMOs are now part of this changing network. In terms of mental health services, this same 1973 act required HMOs to provide mental health services if they wanted federal assistance. In the 1980s, less money, growing costs, and

increased counseling demands by consumers resulted in an interest in more efficient and less costly counseling.

Because of the prevalence of managed health care, counselors need to work either within managed health care systems (as in the staff model described earlier) or with managed health care systems. An excellent resource for basic suggestions on general approaches in working with managed care in terms of practical realities is *The Elements of Managed Care* (S. R. Davis & Meier, 2001).

Counselors simply have less time to work with clients and need to practice under managed care directions (Whittinghill, Whittinghill, & Loesch, 2000). This reality raises concerns in areas such as confidentiality, reimbursement, and treatment needs that can impact the relationship between the counselor and the client (Hood & Miller, 1997). The responsibility of ethics falls to the counselor. The SAMHSA (1998b) makes some of the following recommendations:

1. Be aware of a commitment to both client and society.
2. Use the most effective and cost-effective treatment.
3. Promote the greatest good for the greatest number.
4. Use resources carefully.
5. Advocate for clients in terms of benefits in their best interest with the managed care company or through professional associations, noting that such advocacy involves a risk.

As to prevention of ethical dilemmas, Haas and Cummings (1992) recommend that eight issues be considered before entering a contract:

1. Know who carries the financial risk.
2. Anticipate how the plan might impact the therapeutic relationship.
3. Know if there is flexibility to the rules.

4. Understand alternatives to treatment (needs different treatment or benefits will run out).
5. Clarify if the plan will provide training or help to the provider that will enhance obtaining treatment goals.
6. Know if there are incentives for hospitalization.
7. Clarify if concerns or suggestions can be made to managed care.
8. Understand if clients know the limitations of their benefit plan.

The counselor needs to work with managed care organizations with a sensitivity that anchors itself in the best interests of the client yet includes an awareness of cost containment. This sensitivity requires an open discussion of the constraints and provisions of the managed care organization in the counseling agreement. An open dialogue at the beginning of the counseling process can reduce misunderstandings or negative impacts on the counseling process. Maintenance of this dialogue throughout counseling is critical. Hood and Miller (1997) raise the concern that counselors need to treat clients with an approach that combines integrity and compassion with the reality of a third party guiding treatment decisions based on cost.

At the same time, G. Miller (2001) states that there is additional stress for counselors because of a shift to a more behavioral focus and a sense of having to do more with less. Specific stresses may involve financially related struggles for some counselors in terms of their practice (i.e., service reimbursement, increased paperwork and accountability, and ethical dilemmas). Pital (1995) presents the danger of “distressed triangles,” where the counselor, client, and case manager show struggles with communication (indirect, secret), power, and emotions (anxiety, shame, confused loyalties). Sachs (1996) adds that the counselor can feel dehumanized in the process of working with these organizations; a contagion effect of dehumanization can then occur with clients. Van Wormer and Davis (2008) state

that managed care is more of a management of costs than care and has significantly limited substance abuse treatment in terms of type of treatments, shorter length of outpatient treatment, and emphasis on medication rather than individual therapy.

Langman-Dorwart, Wahl, Singer, and Dorwart (1992) encourage counselors to provide the best services possible with an awareness of cost. How can an addiction counselor do this? Whittinghill et al. (2000) state that addiction counselors need to diagnose accurately and effectively match clients to an appropriate treatment rather than a general one, such as practicing abstinence and working a 12-step program. Such interventions need to take into account the different levels of severity of addiction.

Counselors need to have knowledge and access to addiction treatment services offering different levels of care. They also need to consider briefer treatment modalities and become trained in these areas. Finally, counselors need to evaluate treatment outcomes and develop treatment goals that are measurable. The authors state that the reality for addiction counselors is that they may be operating under these managed care pressures within a system that is designed for more long-term, generic care with vague approaches.

C. Weisner (2001) also states that demographic factors such as gender, age, income, drug use type, and severity—along with motivation for treatment and abstinence—need to be examined for how they may affect treatment beginning (readiness for treatment, enhancement of motivation) and how the system brings them into treatment (i.e., intake process). Gorski (2003) recommends that treatment programs need to be expanded for people who are relapse-prone in order to encourage managed care payment of services for them. At this point, the managed care provider may say it did not work once, so why try again? However, if the condition is not effectively treated, there can be a worsening of the condition. It can be equally frustrating to have an agency set a flat number of

treatment sessions for a specific diagnosis. The counselor in this situation may feel like a worker at a fast-food franchise: Every burger gets the same ingredients no matter what. The counselor needs people or places to vent the frustration in working with such organizations so that the client does not hear such negative views from the therapist or experience negative consequences about reimbursement as a result of the conflict between the counselor and the managed care representative.

In addition, the counselor can become involved in state and national groups that advocate against the negative impact of managed health

Such an approach is an invitation to collaboration in an attempt to provide for the client's best interests. This three-pronged approach can truly enhance the counselor's practice within the reality of managed health care. The practice of self-care, involvement in professional organizations, and a compassionate approach to managed care personnel can help the counselor decide what can and cannot be done to help each client. Providing clients with such information in a professional manner can be a powerful role model for clients on dealing with life's realities: doing what we can do something about and letting go of the rest.

CASE STUDY 1.1

You are an experienced counselor with a specialty in addictions counseling. You are approached by a counselor who is new to addiction counseling for advice on working with managed care organizations. What three main suggestions would you make to this counselor to enhance his or her survival in the managed care world?

care (Pipal, 1995). Such action may positively impact the counselor's sense of empowerment. For example, Dorfman and Smith (2002) analyzed 54 prevention behavioral health intervention studies for effectiveness and reduced cost impact and made six recommendations for managed care practices in this area: (1) prenatal and infancy home visits, (2) cessation-of-smoking education and counseling, (3) short-term mental health therapy, (4) self-education for adults, (5) presurgical educational intervention with adults, and (6) brief counseling and advice to reduce alcohol use. Two of these, self-care education and brief counseling, are directly related to the substance abuse area. Counselors can use such research to advocate for their profession through their involvement with professional organizations.

Hood and Miller (1997) also suggest that the counselor use a compassionate approach with the managed care professional: Attempt to understand that individual's role and responsibilities with regard to providing services to the client.

As a result of the increasing emphasis of cost containment by these health organizations where time-limited interventions are preferred over long-term counseling (Whittinghill et al., 2000), Chapter 9 focuses on brief therapy as it applies to addiction counseling. Other counseling approaches presented are suggested, in part, because of their fit with the managed care philosophy. For example, Chapter 7 focuses on relapse prevention. For clinicians to work with clients who have addiction problems within a managed care framework, clinicians need to include relapse prevention information early in treatment because of a limited number of treatment sessions. Also, because managed care funding may encourage counselors to use community services for their clients to augment the limited number of therapy sessions, we emphasize community counseling approaches. Chapter 8 focuses on self-help groups that provide counselors with an opportunity both to learn about the philosophy of some of the national self-help groups and to assist their clients in making the best use of them.

THEORIES OF ADDICTION

Theories about addiction have changed. Some theories may be more popular in one area of the country than another. A counselor working with addicted individuals should find and become familiar with a model he or she is comfortable using for the assessment and treatment process. Also important are the theories of addiction advocated by the counselor's employer, the client's funding organization, and the state's addiction credentialing and licensing board. The theoretical models advocated by these organizations can have an impact on the counselor's employment, the client's treatment, and the counselor's liability, especially in court testimony. Because theoretical models vary, the standard classification of addiction found in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000)* can be used as common ground for discussion of addiction by professionals.

The *DSM-IV-TR* classifies mood-altering substances into 11 substance-related disorders: alcohol, amphetamine, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, phencyclidine (PCP), and sedatives, hypnotics, and anxiolytics.

Substance-Related Disorders in the *DSM-IV-TR* are divided into two categories: Substance Use (Dependence and Abuse) and Substance-Induced (intoxication, withdrawal, delirium, dementia, amnesic, psychotic, mood disorder, anxiety, sexual dysfunction, and sleep disorder). To meet the criteria for dependence, the client must have a maladaptive use pattern causing some type of impairment with at least three of the following occurring within one year: tolerance; withdrawal; more or longer use than planned; desire without ability to cut down or control usage; time spent on obtaining, using, or recovering from the substance; impact on activities that are social, occupational, or recreational (do less or not at all); and continued use in spite of physical or psychological problems related to use. Counselors need to refer to the

DSM-IV-TR to understand more thoroughly the complexities of a dependence diagnosis.

In terms of addiction theories, McHugh, Beckman, and Frieze (1979) provide a four-part framework (moral, psychological, sociocultural, and medical) that helps link theoretical models of addiction to the diagnosis of dependence. Each theoretical model includes a view of alcoholism, cause of alcoholism, and form of treatment, yet each emphasizes different addiction components. Some of these components are (Leigh, 1985):

1. *Cultural factors*, which influence how a person decides to take a drug, attitudes toward taking the drug, the practices of a group/subculture, and the drug's availability
2. *Environmental factors*, which include conditioning and reinforcement principles (drugs are taken to experience pleasure and reduce discomfort), learning factors (modeling, imitation, identification, etc.), and life events
3. *Interpersonal factors*, which include social influences (lifestyle choice, peer pressure, expectations of drug use, etc.) and family factors (system maintenance, genetic influences, etc.)
4. *Interpersonal factors*, which include human development, personality, affect/cognition, and sex differences

The following six models incorporate different aspects of these factors. One of the main concerns in managed health care is cost containment, which has an impact on developing specific therapeutic interventions (Austad & Berman, 1995). Some addiction theories are more amenable to this type of therapeutic framework than others and are highlighted in the following theoretical discussion.

Moral Model

The moral model views the alcoholic as a degenerate and sees alcoholism as a moral weakness

(M. Keller, 1976). Punishment is preferred over treatment, because a cure is not envisioned (McHugh et al., 1979).

Psychological Models

There are three main psychological theories: psychodynamic, personality trait, and behavior learning. Although each theory views the specific cause of alcoholism differently, they all share a similar outlook: The causal factors must be changed in order for treatment to be effective.

The psychodynamic theory focuses on the personal pathology of alcoholics. The goal in treatment is to uncover the unconscious conflicts. Because the conflicts are seen as fairly unchanging, treatment is not viewed as very effective. An example of such a conflict is parental rejection that results in dependency needs that cannot be met in reality (Zimberg, 1985).

The focus in the personality trait theory is on changing the personality traits of the alcoholic (e.g., treating high anxiety) (Barry, 1974). However, treatment is not very effective because of the stability of personality traits (McHugh et al., 1979). DiClemente (2003) states that although the personality of an addicted person has been examined, a clear or firm definition of such a personality does not exist. The behavior-learning theorists emphasize the changing of reinforcements, because alcohol is reinforcing for alcoholics. For instance, a change in reinforcers may occur by changing environments (J. Wallace, 1985). This theory offers the best prognosis of the three, because reinforcers can be readily changed.

Because the behavioral-learning theorists emphasize the reinforcements involved in alcohol/drug addiction, the counselor working within the framework of a managed care organization can use this theory in the treatment and recovery process (Tulkin & Frank, 1985). The counselor can develop a plan with the client that examines how the client is specifically reinforced by abusing alcohol/drugs. For example, if a client is psychologically addicted to marijuana because

it reduces stress, the counselor can use this information to help the client develop a treatment and recovery maintenance plan that includes relaxation coping skills.

Sociocultural Models

The sociocultural model emphasizes social forces and contexts that give birth to and feed alcoholism. Cultural attitudes (G. A. Marlatt, 1985a), family structure (Bowen, 1978), and crisis times (Bratter, 1985) need to be addressed in order to have an impact on alcoholism. Treatment focuses on changing the environmental contexts for the alcoholic. DiClemente (2003) adds peer pressure, social policies, and availability as factors to be considered in this model. The author also includes family influences such as nature-based in essence (genetics) and nurture-based (system dynamics).

One example of a sociocultural model is Cushman's (1990) empty self theory. In this model, industrialization, urbanization, and secularism are societal aspects that have resulted in the increasing loss of family, community, and tradition—those things that offer people shared meaning in their lives. The loss of these aspects results in an empty self, who views psychological boundaries as specific (“My mental health depends on me”), a locus of control as internal (“I am in charge of my life”), and a wish to manipulate the external world for personal ends (“I will be happy if I manage well”). Cushman (1990) believes that the active addict is using drugs to fight off feelings of alienation, fragmentation, worthlessness, and confusion (particularly around values). This theory can be readily applied in addiction counseling by assisting the client in recovering a lifestyle that involves a sense of family, community, and tradition, all supporting the addiction recovery.

Medical Model

The medical model looks at specific physiological dysfunctions such as endocrine dysfunction

(Gross, 1945). Although theories in the medical model may assist in defining and describing alcoholism, they fail to promote any specific treatments. The disease model of alcoholism is related to this category because of its basis in physiology (i.e., genetic predisposition, allergic reaction); however, it has a slightly different twist to it because of the individual's responsibility for future behavior and the need for spiritual help in recovery. Denning (2005) states that the addiction is seen as the primary disease that is caused by a loss of control and denial of having the disease; treatment requires abstinence.

The disease model views alcoholism as a progressive disease with symptoms. The two key elements in this model are loss of control over drinking and the progression of the disease, which ends in death. This view, a shift from the moral view, is more compassionate and open to treatment and insurance coverage (S. Goodman & Levy, 2003). This view is partially accepted by AA (McHugh et al., 1979): Alcoholism is an illness that is physical, mental, and spiritual in nature, and the alcoholic is not responsible for the development of the addiction but is responsible for future behavior. The alcoholic enters into recovery from addiction by admitting powerlessness over alcohol, as well as wrongs done to others, and receiving the help of a Higher Power—what might be called a spiritual solution.

This theory of addiction, according to AA, has been implemented in the Minnesota Model of treatment: Professional services are combined with the 12 steps of AA, using counselors who are often in addiction recovery themselves (O'Dwyer, 1993). This model involves the components of education, fellowship, and therapy (Schulz, Williams, & Galligan, 2009). It was developed at Minnesota's Hazelden guesthouse program for alcoholic men that had five simple expectations: (1) be responsible, (2) go to AA 12-step lectures, (3) interact with other clients, (4) make one's own bed, and (5) stay sober (Shaw, Ritvo, & Irvine, 2005). It shifted the treatment of alcoholics from custodial care to one based on dignity and respect of the alcoholic with an

emphasis on peer assistance, particularly in the sharing of personal stories (Shaw et al., 2005). This model, which was very strong in the 1960s and 1970s, encourages the treatment of the whole individual in terms of body, mind, and spirit (S. Goodman & Levy, 2003). Gragg (1995) highlights the benefits of using the disease model of alcoholism/addiction within an HMO framework: It reduces the client's guilt over the addiction, and it encourages community involvement to supplement managed care therapy.

Biopsychosocial Model

More recently, models of addiction have been presented as biopsychosocial (Perkinson, 1997). In this type of model, biogenetic traits and psychosocial factors are combined when addressing addiction in an attempt to provide an integrated, comprehensive model.

Ray and Ksir (2004) discuss the disease model argument as follows: While psychiatrists had viewed alcoholism as a secondary problem and focused on treating the primary mental health disorder (telling their patients to use alcohol less), AA viewed alcoholism as the main problem that required direct treatment. Allegiance to the disease model is based on this commitment to alcoholism being the primary problem that needs to be treated. The debate about alcoholism being a disease continues to the present day.

Some argue that alcoholism does not meet the criteria of being a disease because we cannot find the cause, directly treat it, or even know if there is a disease present. These critics also warn that the definition of the disease can be watered down by the view of seeing all excessive behaviors from this perspective. Some say it may be most appropriate to view the disease concept as a metaphor (G. A. Marlatt & Fromme, 1988). The biopsychosocial model of addiction may be a bridge across these conflicts. The biopsychosocial model (Figure 1.1) is holistic in that it views biological aspects impacting psychological aspects impacting social aspects of the individual in an ongoing, interactive manner (G. W.

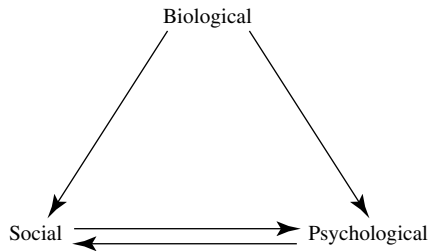


Figure 1.1 Biopsychosocial Model.

Lawson, Lawson, & Rivers, 2001). It looks at causality in a complicated way with regard to how the person becomes involved in addictive behavior, stays involved in addictive behavior, and stops the addictive behavior (DiClemente, 2003).

Kumpfer, Trunnell, and Whiteside (2003) describe the components of these three areas as follows: Biological includes genetic inheritance, in utero damage, and temperament or physiological differences. Psychological and social factors are combined into psychosocial, which includes an interaction between the individual and family, community, school, work, peer, and social factors.

There are some benefits to this perspective. First, it accounts for the complicating, contributing factors of addiction. This perspective encourages an individual assessment of the alcoholic or

addict that accounts for causes in varying amounts like pieces of a pie. For example, some alcoholics/addicts may have a significant biological component without much in the other two areas. The model encourages a complex yet individualized understanding of one's cause of addiction.

This broad assessment perspective also encourages a broader treatment perspective. As G. W. Lawson et al. (2001) report, treatment may then involve addressing more than one problem at a time. An example of this is when a woman in a domestic violence situation has a drinking/drug problem and needs to address both issues simultaneously because they impact each other. She can best protect herself if she is sober, and the experience of being battered may encourage or trigger her alcohol or drug usage. The model is one of the best practices, where the counselor looks for the best fit between the client's need and the available treatment (Addictions Foundation of Manitoba, 2000).

Yet, as DiClemente (2003) outlines, the drawbacks to the use of this model are threefold: (1) typically an emphasis is placed on one aspect of the model without a solid integration of the three aspects; (2) it is difficult to provide interventions on all aspects at the same time; and (3) some factors, such as risk and protective factors, cannot be changed. While DiClemente's concerns are important to consider, the use of the

CASE STUDY 1.2

Jacob is a 30-year-old male who came to your agency for an addiction assessment. At his first session, he was diagnosed as addicted (according to *DSM-IV-TR* criteria) to cocaine, his drug of choice. Jacob's HMO insurance coverage is limited to 5 days of inpatient treatment and 10 outpatient sessions with you. This is his first treatment for addiction. He tells you that all of his friends use cocaine and that his roommate started him on it. He says he likes cocaine because he does not feel depressed when he takes it. He also states that he feels like a failure because he became a drug addict like his father.

1. How would you use behavioral theories in terms of Jacob's recovery?
2. How would his culture be important to his recovery process?
3. What aspect of the disease model might be helpful to him?

biopsychosocial model in the treatment of addiction remains valid because of its emphasis on complicating factors interacting in order for an addiction to be born and live in an individual. Treatment and aftercare from this perspective invite a holistic, personalized approach.

Harm-Reduction Model

The harm-reduction model has a potential as a barrier or bridge with other theoretical models. Faupel, Horowitz, and Weaver (2004) provide a history of the harm-reduction approach. They state that although it was used to guide policy in Europe and Australia, in the United States it was present only in an underground fashion in the 1960s and 1970s, becoming formalized in the 1980s. Denning (2005) presents a history of the harm-reduction model. In the late 1970s and early 1980s, when Hepatitis B was killing intravenous drug users in Europe, the Netherlands implemented strategies to try to save people's lives. At the same time, the United Kingdom and Australia were beginning similar programs of needle exchange and methadone maintenance. In the late 1980s, these programs emerged in major U.S. cities.

Erickson (1999) describes three phases of the harm-reduction model in the United States: (1) in the 1960s, the first phase focused on health problems related to nicotine and alcohol; (2) in the 1990s, the second phase focused on HIV/AIDS prevention in injection drug users; and (3) the third phase, in which we are currently engaged, looks at legal and illegal drugs from a public health view (i.e., drug education to adolescents, programs that are harm reduction based or abstinence based). Although the harm-reduction model runs counter to the moral model of addiction, it can be a bridge with the psychological, sociocultural, medical, and biopsychosocial models of addiction. Given the prevalence of the biopsychosocial model of addiction, the harm-reduction model has the potential to enhance this model in terms of prevention, treatment, and aftercare of addiction.

In the harm-reduction model, the emphasis is on reducing problems with usage rather than the amount of alcohol/drugs the individual is using (Kinney, 2003; Shaw et al., 2005). It tries to approach use of drugs/alcohol as a reality that occurs; drug use is here to stay, so we need to focus on reducing its effects, and some forms of use are safer than others (Shaw et al., 2005). It is a benefit to the individual and society to reduce the harm connected to the using behavior; both individual and community quality of life is the most important, not necessarily abstinence (Shaw et al., 2005).

This model is based on public health principles avoiding judgment about using and focusing instead on reducing harm in practical ways (Cheung, 2000). It is a public health philosophy that involves many different strategies (Denning, 2005). Examples of a harm-reduction approach include programs for designated drivers and needle exchange programs (Kinney, 2003). In addition to the needle exchange programs (that reduce the transmission of HIV/AIDS and Hepatitis C), the other most familiar form of harm-reduction approaches is methadone maintenance that does not require abstinence, but focuses on reducing the dangers an addict faces in the street lifestyle (Shaw et al., 2005).

Denning (2005) outlines nine main principles of harm reduction:

1. Reduce the harm of drug use and prohibition of it.
2. Avoid punitive sanctions for what a person puts in their body.
3. View drugs as being used for many reasons and remember that all use is not abuse.
4. Remember that people can make rational life decisions while they are using.
5. Know that denial is conscious and a result of shame and punitive sanctions.
6. Work with people's ambivalence rather than confront it because resistance is normal in response to change.