

LEARNING
THE LANGUAGE
of
ADDICTION
COUNSELING

FIFTH EDITION

GERI MILLER

WILEY

Learning the Language of
ADDICTION
COUNSELING

Fifth Edition

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This book is dedicated to:

Ron Hood, my husband and best friend, who is there through it all. Gale, Abby, and Jason Miller; and Tom, Laura, Natalie, and Kate Prow—my family.

The women, my “sisters,” who were with me from the beginning—Pat Mitchell Anderson and Judy Retterath—and those sisters, Betty Gridley, Angela Wagner, and Joyce Reese who joined my journey along the way.

The addicted clients and their loved ones whom I had the honor of counseling; all those who have lived with and are living with the disease of addiction; and the counselors who remain committed to this important, sometimes miraculous, life-saving work.

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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 fifth 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 many years of working in the addiction counseling field, teaching undergraduate and graduate students in addiction counseling, and training mental health and addiction professionals, I have updated the "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, in relevant chapters, additional case studies and exercises have been added and at the end of each chapter there is an updated readings/resources/websites section that includes necessary information.

Fourth, there is a new chapter, Chapter 15, Supervision and Mentoring, that has been added.

Finally, for instructors, instructor resources have been updated, including videos, PowerPoint slides, test bank questions, and syllabi 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. 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. The compassion of these professionals—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, and clinical guidelines.

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 (disease model, addiction research, managed care, harm reduction, peer recovery) and models used to explain addiction. The chapter includes a summary of the current debate of language used in counseling this population. Also, there is an important notation at the end of the personal reflections section of Chapter 1 that discusses the rationale for the decisions I made regarding the inclusion of references throughout the book. The reader is encouraged to read this section carefully.
- Chapter 2, “Theories of Counseling Applied 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. Additional sections on the stages of change model, the assessment of DWI/DUI/OWI/OUIs, and diagnosis in terms of *DSM-5* criteria are referenced in this chapter.
- Chapter 4, “Co-Occurring Disorders and Behavioral Addictions,” provides an overview of co-occurring disorders with general assessment and treatment suggestions as well as an overview on behavioral addictions. Again, *DSM-5* criteria are referenced.
- Chapter 5, “The Core Treatment Process of Addictions,” provides an overview of four specific forms of addiction counseling: crisis intervention, individual, group, and family—with an initial overview of integrated treatment and the experience of the addict as it relates to treatment.
- Chapter 6, “Treatment-Related Issues and Counseling Approaches,” explores issues that may arise in relation to addiction counseling: sexual issues, HIV/AIDS, intimate partner violence (IPV), and homelessness. Recommendations for counseling in these related areas are provided. Specific counseling approaches, dialectical behavior therapy (DBT), Seeking Safety, and grief counseling, which may be used in addressing these issues, are discussed in this chapter. Also, because many clients have legal issues, there is a special section on drug court.
- 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, “Elaboration on Specific Therapies and Techniques Relevant to Addiction Counseling,” explores one core concept of counseling (client resilience), therapy approaches and techniques (positive psychology), the stages of change model, and evidence-based practice (EBP) as well as specific evidence-based practice and therapy approaches and techniques (motivational interviewing; brief therapy; behavioral/cognitive-behavioral-contingency-management/community reinforcement/behavioral coping skills).
- Chapter 10, “Culturally Sensitive Addiction Counseling,” examines issues that have an impact on addiction counseling. This chapter provides an overall perspective on multicultural counseling and techniques. In addition, it presents assessment, treatment, and aftercare issues as they relate to gender, ethnicity, sexual orientation, disability, and age (adolescents, older adults). It also includes information on socioenvironmental aspects of multicultural counseling, cultural competency, and the current issue of pronoun use in counseling.

- Chapter 11, “Chronic Pain Assessment and Treatment,” discusses the overlapping areas of substance abuse and pain in terms of: general concepts and issues, development of a general counseling approach with this population, and techniques that can be used in addressing pain management.
- Chapter 12, “Incorporating Spirituality into Addiction Counseling,” explores four areas related to the incorporation of spiritual perspectives in the addiction counseling field: the history; barriers and bridges; spiritual identity development; and counseling strategies—resources and techniques that include an overview of mindfulness interventions and techniques.
- Chapter 13, “Personal and Professional Development of the Counselor,” opens with a brief discussion of some concerns of technology’s impact on counseling and suggestions on how to address these concerns. It then explores general topic areas that affect the personal and professional development of the counselor [ethical dilemmas, testifying in court guidelines, working in difficult systems (including a new section on viewing it from a “weather pattern” perspective), working with addicts, and self-care].
- Chapter 14, “Obtaining Addiction Professional Credentials,” presents the different types of credentials, credentialing process stages, and helpful strategies to assist the reader in the credentialing process.
- Chapter 15: “Supervision and Mentoring,” provides an overview of the basic concepts of supervision and mentoring, the process of selecting the right professional for the role, and helpful suggestions regarding supervision and mentoring.

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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 life-saving work through your passion and commitment to it. Such wonderful times we have had together.

In addition, I want to thank the people who believed I could write such a book and supported me on the journey. Darren Lalonde, my editor at John Wiley & Sons, supported and assisted me throughout the writing of the book. He believed in the message of this book and in me: that belief sustained me through all the barriers we experienced.

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COMPANION WEBSITE

www.wiley.com/go/miller/addiction3e

This book has a comprehensive companion website that features a number of useful resources for instructors and students alike.

FOR INSTRUCTORS

Powerpoint Presentations

Test Banks

Annotated Syllabi

Please note that the resources for instructors are password protected and can only be accessed by instructors who register with the site.

INTRODUCTION

PERSONAL REFLECTIONS

As we approach addiction counseling, it is important that we as clinicians have as clear as possible an understanding of who we are personally and professionally in relation to addiction. We need to be brave enough to examine our own experiences with addictive tendencies, within ourselves and our loved ones as well as in 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 begin our 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 clients' lives. Such self-examination will also assist us in anchoring our work in the philosophy of this book: "compassionate accountability." In this philosophy, we have compassion for the person's story of addiction (i.e., how they became addicted) and yet we hold them accountable for their behavior.

I also need to comment on the terminology I have chosen to use throughout the text to describe those clients who struggle with addiction. I use the term addicts or addicted clients even though some readers may prefer other terms such as person(s) with substance use disorders in order to emphasize the "personhood" of the client (see Appendix 1A). I have chosen these terms because, in my addiction counseling experience, these terms clearly "name" the problem, "name the disease." By no means is the term meant to be disrespectful to the client. For example, in clinical meetings, I always insist that the person's name be used before their disorder is discussed because, as I tell my students, "They were a person before they developed the disease and their name is important. They are not their disease." My hope is that I do not offend the reader with my choice of terminology; rather, I encourage the reader to choose a term to discuss the addicted client that they believe is most respectful to their population. Our clients may not be aware of traumatizing terms, but they also may not care about the label—that is why counselors need to approach the discussion of client labels in an exploratory, respectful manner that encourages dialogue. Appendix 1A is a good example of the current controversies with language used in the field. Reactions to the Language of Recovery will vary on a continuum of responses from some professionals believing in the use of each of the alternative recovery terms to other professionals who believe in using none of them. During my years of working in the addiction counseling field, I have watched and participated in various "terminology debates." The current controversies of language are important; however, they are not new to the field. Therefore, the reader is encouraged to enter into these ongoing debates regarding language use in professional arenas (meetings, workshops, conferences, etc.) and choose terminology from a balanced perspective. That applies to this text in that I also hope that you will work with the language of this book as it describes the disease ("addiction") and the individuals it affects ("addicts") translating the language I use to the language that is most comfortable for your individual client, thereby serving their best interest. I believe that what is important, so critical and so necessary, is that we find terminology and an approach that powerfully invites our clients and their loved ones to heal from the destructive force of addiction.

Finally, a comment to the reader about my rationale for the inclusion of references throughout this book. I carefully chose references that I believe are helpful to the clinician; this means that references, on the surface, may appear to be outdated and unnec-

essary. However, the choice I made for reference inclusion throughout the book was oriented more clinically than academically. For example, the clinical choice for a reference dated in the 1980s was made for inclusion because I believe the information is still important in its historical anchoring clinically. Had I made a more academically oriented choice, I would have eliminated this important historical work.

I encourage you as a reader of this text to: (1) check with NIDA, NIAAA, and SAMHSA as well as your professional organizations to obtain the more current statistics and counseling approaches regarding the population with which you work, and (2) be aware that your own biases/wounds may be stirred in reading about these topics resulting in an emotionally charged reaction to information presented. I encourage you to only take information from this text that makes sense to you clinically and that fits your population.

My hope in this book is twofold: (1) that I have provided a broad, clinically useful overview of the topics, and (2) that I have been humane and compassionate to these populations of addicted individuals who already experience inhumane treatment.

OBJECTIVES

1. To learn the historical development of the field as well as the current issues regarding language use.
2. To understand the history of five influences on addiction counseling.
3. To explore how one's own models of addiction and understanding of influences impact the view of the addicted client, the cause of addiction, and treatment approaches.

Current statistics support the concern for alcohol and drug use in America. The 2016 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA]) found that 136.7 million Americans over age 12 drank alcohol, with 65.3 million people having a binge drinking experience at least once in the previous month, and 16.3 million reported being heavy drinkers in the last month. The survey also found that approximately 28.6 million Americans over age 12 had used an illicit drug during the month before being interviewed—this use consists primarily of marijuana and prescription pain reliever misuse.

Marijuana was the most common illicit drug used by individuals aged 12 or older (24.0 million)—higher than percentages from 2002 to 2015—especially in the age group of 26 or older. Another area of concern is opioid misuse (prescription opioid relievers or heroin); of the 11.8 million misusing opioids in 2016, 11.5 million were misusing pain relievers and 948,000 using heroin. For those age 12 or older, 6 people out of 10 misused them

to relieve physical pain and approximately half of those individuals received their last pain relievers from a friend or relative.

The Centers for Disease Control and Prevention (2013) reported that in 2010, the amount of prescribed painkiller medication could result in every American being medicated through an entire day for one month; while they were prescribed for medical reasons, they were misused or abused by others. Overdoses of the prescription painkillers (opioid or narcotic) have tripled in the past 20 years in the United States (SAMSHA, 2010, 2011). Their abuse/misuse has doubled in emergency room visits (SAMSHA, 2010) and teens and adults use them to experience a “high” or use them for other nonmedical reasons (SAMSHA, 2011).

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 the United States 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, because 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. Counselors may not be different from the American tendency, as pointed out by Greenbaum (2019), to view addiction as *both* a disease and a moral failing. Many helping professionals have negative personal as well as professional experiences working with addicted individuals. This may cause them to avoid or hesitate to work with this population. When working with addicts, counselors 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). Finally, countertransference may arise in the language the professional uses. Thombs and Osborn (2019) provide an overview of current concerns with regard to language usage. The authors state: “There are few labels today worse than that of *alcoholic* or *addict*” (p. 52) and proceed to describe the labeling as a “moral condemnation” (p. 52).

They also condense White and Kelly’s (2011) five reasons to stop using the terms “abuse” and “abuser” into four reasons (they view two of them as the same):

1. The terms are inaccurate because the individual does not abuse mood-altering substances, but rather treats them with respect/devotion.
2. Substance abuse is not a medical condition listed in the DSM-5 (American Psychiatric Association, 2013).
3. The terms contribute to stigma (both social and professional) that can keep individuals from getting help and experiencing interpersonal difficulties (i.e. being rejected, socially isolated).
4. The cause of the problem is anchored in the individual (choices, characteristics).

At the core of this professional climate encouraging a change of language use is an often cited study of Kelly and Westerhoff’s (2010). In this study, providers of mental health care who were attending a conference were given two versions of the same case: in one, the male client was described as a “substance abuser” while in the other he was described as having a “substance use disorder”. They found that the first description portrayed the person as more responsible for the condition and deserved punishing consequences. The researchers recommended that professionals hear recovering stories to help reduce the stigma. While this suggestion may be helpful, this author suggest that counselors, and other helping professionals, also examine their countertransference that stems from personal and/or professional experiences because such experiences can result in stigma towards the client. For example, by examining oneself for possible countertransference, the counselor may become aware of *how* their countertransference is communicated through their voice and eyes—*how* they say terms may sound harsh and judgmental, even when using the most “politically correct” terms. Such awareness can facilitate the counselor addressing the countertransference so

they are facilitating, not blocking, the therapy process.

In addition, Thombs and Osborn (2019) point out that the stigmas held by professionals may be related to a number of counselor factors. These factors may include: education (lack of a degree and/or specialized training); stressful work situations where routine and supervision are not provided as much as needed; and not seeing clients who successfully became and stayed sober.

Because language use appears to be critical in the counseling process (i.e. to reduce stigma and enhance the possibility of treatment), counselors need to clarify the language used in counseling (Richter and Foster, 2014). However, Thombs and Osborn (2019) state that even professional organizations do not agree on the terms to be used. Therefore, each counselor needs to clarify their language use during the current time of heated debates regarding language use *between and within* helping professional groups.

The prime directive guide in language choice recommended by the author is: welfare of the client. If the language *is* experienced as stigmatizing for the client, the counselor needs to examine their language use in sessions. However, if the language is *not* experienced as stigmatizing for the client (even though some experts say it is), the counselor may want to focus on helping the client stay sober rather than “pushing” the use of politically correct terms on the client. Such pressure by the counselor may result in: (1) the client becoming confused (“. . .but in my AA meetings the word ‘alcoholic’ is used when

people describe themselves.”), (2) a power struggle between the counselor and client, or (3) the client viewing the counselor as not being knowledgeable about the disease and the recovery process.

The reader may also want to refer to Appendix 1A that provides an example of language use recommendations. General suggestions regarding replacement of stigmatizing language are provided below with recommended language in brackets (Monitor on Psychology, 2019, p. 48):

- drug abuse/drug abuser [substance use/ person with a substance use disorder]
- addict/alcoholic/user [person with substance use disorder/person in recovery]
- clean/dirty drug screens [positive/negative drug screens]
- clean/dirty clients [clients “in recovery”, “abstinent”, or “resuming use of a substance”]
- medication-assisted treatment [medications for addiction treatment]

Finally, because these current debates may continue for years, this author suggests the reader stay in touch with their professional organizations regarding the controversies related to language use and engage in dialogue with professionals outside their professional identity as well as those with the same professional identity. Such an open-minded approach may enhance the counselor choosing language that serves the best interest of

CASE STUDY 1.1

Your client comes in to your first session and describes himself as an alcoholic who attends AA. You have strong feelings about the word “alcoholic” and believe that clients need to use nonstigmatizing language such as “person with a substance use disorder.” After a few times where you listen to your client label himself as an alcoholic, you suggest he consider using the term “person with a substance use disorder.” Your client rolls his eyes and says, “Oh, no. I got another one of those fancy, educated counselors.”

1. How would you respond to your client’s comment?
2. How would you invite a dialogue regarding the label he uses to describe himself?

EXERCISE 1.1

Discuss with colleagues your view of nonstigmatizing language with these questions guiding the discussion:

1. What language terms do I believe in using in addiction counseling?
2. What is my rationale for such usage?
3. What terms seem most fitting for my current or anticipated client population?

the client. Exercise 1.1 may assist the reader in exploring this area.

Finally, historically, 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. Up to the present day, different mental health professional groups have increasingly developed certification and licensure processes for addiction counselors. A general approach to certification and licensure is presented in Chapter 14.

This general expansion of the addiction field (effective treatment, research, certification/licensure) now allows for many routes of entry into addiction counseling. A professional may enter the field initially through research, a certification/licensure process, or additionally through a grassroots network experience of their own addiction recovery. As a result of various starting points of interest and involvement, there are numerous disagreements in the

field of addictions on applicable models and effective treatment approaches. For example, some addiction experts emphasize the strengths of the disease model of addiction and Alcoholics Anonymous (AA; Gragg, 1991), whereas other experts point out the weaknesses of the disease model and AA (G. A. Marlatt, 1985b). The influences on and models of addiction counseling are explored in the remainder of this chapter.

This chapter is intended to set the tone for the entire book and is divided into two sections. In the first section of this chapter, five addiction counseling influences that have and continue to shape the addiction counseling field are explored. These are the disease model of treatment, addiction research, managed care, harm reduction philosophy, and the peer recovery movement. This exploration is meant to expose the reader to the different forces that have shaped and continue to shape the field of addiction counseling. Before exploring these five influences, the reader needs to be aware of the distinction between managed care and integrated care. Managed care focuses on health care providers' efforts to provide quality care while reducing the costs of that care. In contrast, integrated care, discussed further in Chapter 5, is connected with health care systems such as hospitals where there is a multifaceted approach to care (i.e. physical, mental). However, it may be linked to the overarching umbrella of managed care because of its provision to have options that lower the cost of care. This overlap will also be discussed further in Chapter 5.

The second section presents a view of models used in understanding addiction; these models shape the view of the alcoholic, the cause of addiction, and the focus of treat-

ment. The model is like the foundation of the house, the theory (theories) makes up the structure of the house, and the different rooms in the house are the treatment intervention techniques.

ADDICTION COUNSELING INFLUENCES

Currently, there are at least **five** main influences in addiction counseling:

1. The traditional addiction counseling *disease model approach* 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. The *managed care approach* that confronts counselors with the question: What counseling approaches provide the greatest benefit for the least cost?
4. The *harm reduction approach* that asks: What reduces the harm of usage?
5. The *peer recovery approach* that poses the question: How may peers in recovery assist in the treatment process?

Each of these influences has an important impact on addiction counseling and because of their different orientations, there may be confusing messages sent to addiction counselors. 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, the managed care organizations may not be willing to pay for codependency treatment because of the disagreement among professionals, the harm reduction focus may view it as what harm comes to others as a result of the client's usage, and the peer recovery movement not having a uniform stance on the use of that term. To facilitate working within

these influences, it is important to understand the historical influences of the disease model of addiction treatment, addiction research, and managed care, harm reduction philosophy, and the peer recovery movement. Such understanding can enhance the treatment strategies of the counselor. Note that the section on the peer recovery movement is longer than the other sections due to the recent and ongoing influence of this movement on the addiction counseling field, its influence on the addiction counselor, and its potentially positive and negative impacts on the client.

Disease Model Approach in Relation to the Self-help Movement of Alcoholics Anonymous

Influence on Counseling: Is this approach healing for the addict within the scope of the disease model of addiction?

The addiction counseling field has two main root systems: a grassroots addiction recovery network and a research community base. The disease model approach, rooted in the research community base, is discussed further in the next influence section presented. Lay therapy with this population began in 1913, when Courtenay Baylor was hired by the clinic of Boston's Emmanuel Church (which opened 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* and *hope*: people CAN and DO recover from the disease.

Regarding the self-help movement in terms of the professional role, 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.

The role became one of a clinical professional. Two tendencies present in the field connected to the clinical professional need to be mentioned here. *First*, as stated earlier in this chapter, due to different routes of entry into the field, the clinical professional may or may not have advanced degrees. There may be a general mistrust between these two groups and a suspiciousness about the other's addiction knowledge base. At times such mistrust may be tempered by other factors, i.e. the degreed professional is also in addiction recovery. *Second*, there is a “twist” to this role as it has emerged in the recent upsurge of the peer recovery movement influence discussed at the end of this section. While the peer recovery movement reflects similarities to the grassroots model from which traditional 12-step programs originated, the role that has become a combination of a peer and a professional allowing the peer recovery role to have more freedom than that of a clinical profes-

sional (i.e. driving individuals to appointments, not having an office, sharing personal stories frequently etc.). Also, many peer recovery specialists may have a crossover between mental health and substance use disorder diagnoses that the clinical professional may or may not have.

Addiction Research Approach in Relation to the Disease Model

Influence on Counseling: Which addiction counseling approaches are supported in research findings?

Historically, 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). This model assisted in obtaining biomedical funding and reducing stigma and criminal approaches to addiction (Satel & Lilienfeld, 2017).

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 and 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. However, it is important to acknowledge some of the criticisms of the disease model approach that have been accruing for the last decade (Satel & Lilienfeld, 2017).

First, Thombs and Osborn (2019) point out that there are different disease models that vary according to: (1) the emphasis placed on various factors (physical, psychological, spiritual) and (2) the author's experience of the disease model professionally (training) and personally (in addiction recovery). They also state that AA's disease model incorporates the spiritual factor as both contributing to the addiction's cause and recovery while the medical community emphasizes the biological aspect (i.e. tolerance, withdrawal, genetic susceptibility). In addition, they state that AA uses the disease concept more metaphorically, in that the alcoholic's compulsive use *feels* like the hopelessness and powerlessness experienced by individuals with other diseases, whereas in the medical community it *is* a disease. Lewis (2017) points out the flaws of the disease model from a developmental-learning perspective (i.e. rewards) and Carter and Hall (2017) state that the disease model is *not* supported by neuroscience research *and* it may have resulted in reducing treatment-seeking as well as increasing stigma and focusing attention on medical treatment rather than harm reduction approaches.

Although it is critical to acknowledge such criticisms and to make such a distinction, this author chooses the Jellinek model of addiction and fuses the AA and medical community perceptions of alcoholism as a disease—not viewing them as dichotomous. This is consistent with Thomas and Osborn's (2019) view that each addicted person has a unique combination of genetic and environmental factors. Volkow et al. (2016) note, for example, that social environments as well as developmental stages and genetics are connected to vulnerability and recovery; they conclude that neuroscience supports the disease model of addiction. For the client, their view of addiction can shape: (1) their behavior, (2) their treatment collaboration with a team, and (3)

their willingness with regard to treatment (Jack et al., 2019).

Managed Care Approach

Influence on Counseling: What counseling approaches provide the greatest benefit for the least cost?

Austad and Berman (1991) 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 "prepaid 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. 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.

Although significant concerns abound in the addiction counseling field about this third influence, the managed care orientation is currently fused with service delivery. Whether one works at an agency or in a private practice, each treatment funding source increasingly asks for monitoring throughout treatment and has its own standards regarding treatment limits, accountability, audits, and reviews. Such momentous accountability is frustrating and overwhelming for addiction counselors. Also, there may be additional stress due to a behavioral focus, a sense of having to "do more with less" (G. Miller, 2001), and generally feeling dehumanized throughout the process (Sachs, 1996). 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).

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) point out that research over the past 30 years shows that people improve the longer they are in treatment, yet managed care plans emphasize less intense and shorter treatment duration (they 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. 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.

Because 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 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.

The responsibility of ethics falls to the counselor. The SAMHSA (1998b) makes five 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.

With regard to living within the realistic restraints of managed care, the counselor in this situation may feel like a worker at a fast-food franchise: Every burger gets the same ingredients no matter what. A three-component approach (self-care, professional organization involvement, a compassionate, collaborative approach toward managed care providers) can truly enhance the counselor's practice and client welfare. First, in terms of self-care, 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. Second, the counselor can become involved in state and national professional groups that advocate against the negative impact of managed health care (Pipal, 1995). Third, the counselor can 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 in order to encourage collaboration to provide for the client's best interests (Hood & Miller, 1997). 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: do what we can and let go of the rest.

This text's response to the increasing emphasis of cost containment where time-limited interventions are preferred over long-term counseling is: Chapter 7 focuses on relapse prevention; Chapter 8 focuses on self-help groups that are free and community-based; and Chapter 9 focuses on therapy approaches that may be a good match to this orientation.

CASE STUDY 1.2

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

EXERCISE 1.2

Reflect on any concerns you have in working with managed care organizations and discuss them with another individual to focus on ways to effectively manage any frustrations you anticipate experiencing.

Harm Reduction

Influence on Counseling: How can the problems related to usage be reduced?

The harm reduction philosophy is controversial within the addictions field—there is a continuum of reactions ranging from the view that it enables the addiction to the perspective that it is the only realistic approach to addressing addiction. Readers may need to examine their own reactions to this philosophy and let the welfare of the client guide the amount of influence of the harm reduction philosophy on the treatment of the addiction.

From the harm reduction perspective, the emphasis is on reducing problems with usage rather than the amount of alcohol/drugs the individual is using (Kinney, 2003; Shaw, Ritvo, & Irvine, 2005; Tiderington, Stanhope, & Henwood, 2013). 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). Osborn (2020) summarizes the five principles of harm reduction as:

1. consisting of a public health perspective
2. having the ideal of abstinence with acceptable alternatives that reduce harm

3. resulting from a local, grassroots approach in contrast to a federal mandate
4. focusing on meeting a client where they are in terms of what they want to change rather than the requirement of abstinence
5. maintaining a compassionate, practical approach

The harm reduction approach is based on public health principles avoiding judgment about using and focusing instead on reducing harm in practical ways (Cheung, 2000; Miller et al., 2017; Stancliff et al., 2015). 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; Wilson et al., 2015), Housing First programs (shelters for homeless with alcohol problems), naloxone (for opioid overdose reversal), and medication-assisted treatment (Thombs & Osborn, 2019). 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).

Historically, the harm reduction approach was used to guide policy in Europe and Australia in the early twentieth century (Thombs & Osborn, 2019), but in the United States it was present only in an underground

fashion in the 1960s and 1970s until it became formalized in the 1980s (Faupel, Horowitz, & Weaver, 2004). According to Denning (2005), 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. Amsterdam, Holland, and England in the 1970s and 1980s had increases in illicit drug use with limited effectiveness of abstinence-based treatment programs (Tatarsky & Marlatt, 2010). At the same time, the United Kingdom and Australia were beginning similar programs of needle exchange and methadone maintenance, and in the late 1980s these programs emerged in major US cities. Note that in England, there is currently movement from the harm reduction approach to an abstinence-based approach (Kemp, 2018).

There were three phases of the harm reduction approach 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 based on harm reduction or abstinence) (Erickson, 1999). Keep in mind that the United States has a long, entrenched history of using the disease model of addiction to treat alcoholism that has an emphasis on abstinence (Larimer et al., 2012) and abstinence is not necessarily a goal of addiction treatment from the harm reduction perspective (Tatarsky & Marlatt, 2010).

There are various controversies with regard to harm reduction. First, the struggle with harm reduction approaches intensifies with illegal drug use and specific populations such as adolescents and pregnant addicts. The type of drug and drug use population can elicit moralistic responses to usage that advocate prohibitionist or abstinence-based approaches to education/prevention and/or treatment. Second, there are concerns that a harm reduction approach will result in legalization of a drug ("Do Mainstream Treatment, Harm Reduction Mix?," 2001). As a result of

these concerns, harm reduction programs may face discrimination in the United States. A good example of this discrimination is with syringe exchange programs that often involve providing clean syringes, information on how to inject into and care for veins, warnings about bad drugs available, information on wound care and on social services available (Denning, 2005). Although syringe exchange programs are successful in reducing HIV as well as other infectious diseases (Phillips, Stein, Anderson, & Corsi, 2012; Vickerman, Martin, Turner, & Hickman, 2012, Stancliff et al., 2015; Wilson et al., 2015), these programs may be illegal in states and face threats from the police and raids by them (Denning, 2005). However, there are also groups that are pro harm reduction. One such group is the Harm Reduction Coalition (HRC), a peer-based, consumer-led organization that looks at policy and advocacy issues, street outreach, and treatment revision; it has newsletters, brochures, and conferences available (Denning, 2005). Contact information for this organization is included at the end of this chapter.

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 unconscious 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.
7. View addiction as a relationship providing support to the addict and that treatment, while it can provide support, cannot be as "consistently useful" (p. 493) as that relationship.

8. Remember that change is slow, relapse is common, and people need to stay connected in relationships throughout this process.
9. View success as any positive change.

Harm reduction therapy is unique to America and has been formally in existence for 12 years (Tatarsky & Marlatt, 2010). The harm reduction philosophy has a potential to be viewed as a barrier or bridge by addiction counselors. Although the harm reduction approach runs counter to the moral model of addiction, it can be a bridge with the psychological, sociocultural, medical, and biopsychosocial models of addiction discussed in this chapter. 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. The nine principles earlier can be used as guides for the counselor who wants to use them in treatment of the addicted client.

One of the benefits to this model is the pragmatic approach to addiction treatment. Lifelong abstinence may not be attainable for some clients, or the clients may not be motivated by abstinence (Rotgers, 2003); in the latter case, counselors face the ethical question of whether harm to self or others should be prevented (Miller et al., 2019). A harm reduction approach may assist the client in eventually achieving abstinence, but doing so in manageable steps (Rotgers, 2003; Miller et al., 2019); the counselor establishes goals collaboratively with the client to address the substance abuse problems (Rubin, 2003). This approach is a good match for the motivational interviewing and brief intervention approaches discussed in Chapter 9, as well as the stages of change model discussed throughout this book.

When adopting this type of approach, a counselor needs to be careful of two main dangers. First, there is the danger of going to an extreme and believing that all clients in all circumstances can be treated from a harm reduction perspective. Using the welfare of the client as a guide, a counselor may need to

take a direct stand or intervention of abstinence in order to act in the best interests of the client. Second, the counselor needs to continually monitor enabling behavior toward the client. This may be offset by dialogue with colleagues, supervisors, and/or mentors to ensure that assessment, treatment, and aftercare interventions are not reducing consequences to the using behavior and are keeping drug use as a primary focus. The question that faces the counselor is: "When is this approach reducing harm and when is it enabling?" (Shaw et al., 2005). The emphasis is on reduction of harm that can be done in a manner that fits a mainstream treatment model (e.g., letting people stay in treatment after a relapse or stay when on methadone). Scott's (2015) research study of practitioners found that the disease model and harm reduction approach could be integrated practically and compassionately. One example of the integration of the 12-step philosophy and methadone maintenance treatment, that includes discussion of the barriers and bridges in this integration, is provided by Ronel, Gueta, Abramsohn, Caspi, and Adelson (2011).

Eight recommendations for collaboration between blending mainstream addiction treatment and harm reduction approaches are ("Do Mainstream Treatment, Harm Reduction Mix?," 2001):

1. Respect the client (nonjudgmental).
2. Reduce consequences of drug abuse in the community.
3. Be creative in ways to reach potential clients.
4. Decrease consequences for those who use.
5. Provide treatment to clients and loved ones caught in the addiction cycle.
6. Do not view relapse as treatment failure.
7. Provide substance abuse treatment to clients receiving prescribed medication for medical/ psychiatric conditions.
8. Provide comprehensive services by working with other systems.