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Alcoholism and Chemical Substance Abuse Dependency Continuing Education Course (15 Hours/Units)

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1. Introduction

Although much progress has been made in identifying people who misuse substances and who have substance use disorders (SUDs) as well as in using science-informed interventions such as motivational counseling approaches to treat them, the United States still faces many SUD challenges. For example, the National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration) reports that approximately:

- ✓ 140.6 million Americans ages 12 and older currently consume alcohol, 66.6 million report at least 1 episode of past-month binge drinking (defined as 5 or more drinks on the same occasion on at least 1 day in the past 30 days for men and 4 or more drinks on the same occasion on at least 1 day in the past 30 days for women), and 16.7 million drank heavily in the previous month (defined as binge drinking on 5 or more days in the past 30 days).
- ✓ 30.5 million people ages 12 and older have used illicit drugs in the past month.
- ✓ 11.4 million people ages 12 and older have misused opioids (defined as prescription pain reliever misuse or heroin use) in the past year.
- ✓ 8.5 million adults ages 18 and older (3.4 percent of all adults) have had both a mental disorder and at least 1 past-year SUD.
- ✓ 18.2 million people who need SUD treatment have not receive specialty treatment.
- ✓ One in three people who perceive a need for substance use treatment do not receive it because they lack healthcare coverage and are unable to afford treatment.
- ✓ Two in five people who perceive a need for addiction treatment do not receive it because they are not ready to stop using substances.

Perspectives on Addiction and Treatment

Historically, in the United States, different views about the nature of addiction and its causes have influenced the development of treatment approaches. For example, after the passage of the Harrison Narcotics Act in 1914, it was illegal for physicians to treat people with drug addiction. The only options for people with alcohol or drug use disorders were inebriate homes and asylums. The underlying assumption pervading these early treatment approaches was that alcohol and drug addiction was either a moral failing or a pernicious disease. By the 1920s, compassionate treatment of opioid addiction was available in medical clinics. At the same time, equally passionate support for the temperance movement, with its focus on drunkenness as a moral failing and abstinence as the only cure, was gaining momentum.

The development of the modern SUD treatment system dates only from the late 1950s. Even "modern" addiction treatment has not always acknowledged clinicians' capacity to support client motivation. Historically, motivation was considered a static client trait; the client either had it or did not have it, and there was nothing a clinician could do to influence it.

This view of motivation as static led to blaming clients for tension or discord in therapeutic relationships. Clients who disagreed with diagnoses, did not adhere to treatment plans, or refused to accept labels like "alcoholic" or "drug addict" were seen as difficult or resistant.

EXHIBIT 1.1. Models of Addiction

MODEL	UNDERLYING ASSUMPTIONS	TREATMENT APPROACHES
Moral/legal	Addiction is a set of behaviors that violates religious, moral, or legal codes.	Abstinence and use of willpower External control through hospitalization or incarceration
Psychological	Addiction results from deficits in learning, emotional dysfunction, or psychopathology.	Cognitive, behavioral, psychoanalytic, or psychodynamic psychotherapies
Sociocultural	Addiction results from socialization and sociocultural factors. Contributing factors include socioeconomic status, cultural and ethnic beliefs, availability of substances, laws and penalties regulating substance use, norms and rules of families and other social groups, parental and peer expectations, modeling of acceptable behaviors, and the presence or absence of reinforcers.	Focus on building new social and family relationships, developing social competency and skills, and working within a client's culture
Spiritual	Addiction is a spiritual disease. Recovery is predicated on a recognition of the limitations of the self and a desire to achieve health through a connection with that which transcends the individual.	Integrating 12-Step recovery principles or other culturally based spiritual practices (e.g., American Indian Wellbriety principles) into addiction treatment Linking clients to 12-Step, faith- and spiritual-based recovery, and other support groups
Medical	Addiction is a chronic, progressive disease. Genetic predisposition and neurochemical brain changes are primary etiological factors.	Medical and behavioral interventions including pharmacotherapy, education, and behavioral change advice and monitoring
Integrated treatment	Addiction is a chronic disease that is best treated by collaborative and comprehensive approaches that address biopsychosocial and spiritual components.	Integrated treatment with a recovery focus across treatment settings

SUD treatment has since evolved in response to new technologies, research, and theories of addiction with associated counseling approaches. Exhibit 1.1 above summarizes some models of addiction that have influenced treatment methods in the United States.

Regardless of professional identity or discipline, each treatment provider should have a basic understanding of addiction that includes knowledge of current models and theories, appreciation of the multiple contexts within which substance use occurs, and awareness of the effects of psychoactive drug use. Each professional must be knowledgeable about the continuum of care and the social contexts affecting the treatment and recovery process.

Each clinician should be able to identify a variety of helping strategies that can be tailored to meet the needs of individual clients. Each professional must be prepared to adapt to an ever-changing set of challenges and constraints. Although specific skills and applications vary across disciplines, the attitudinal components tend to remain constant. The development of effective practice in addiction counseling depends on the presence of attitudes reflecting openness to alternative approaches, appreciation of diversity, and willingness to change.

Clinicians who treat people with substance use disorders (SUDs) have diverse training experiences and skill levels. They include both credentialed counselors, clinicians, and peer support workers with lived experience. While this diversity can be a strength, a common foundation that guides the training and practice of SUD clinicians is crucial to providing clients with SUDs consistent, high-quality care for optimal recovery.

The Competency Model

SUD counselors need both core foundational competencies related to SUD treatment as well as more specific and extensive competencies that go beyond foundational knowledge. The Differentiated Competency Model provides a framework for understanding the relationship between these core and extended competencies. As illustrated by Exhibit 1, these foundational and extended skills can be thought of as a hub and its spokes, with the four transdisciplinary foundational competencies at the center (or hub) of a counselor's skill set, and the eight SUD-specific practice dimensions (the spokes) representing expanded competencies.

The Four Transdisciplinary Foundations

Providers with a broad range of backgrounds and in a wide variety of settings encounter clients with SUDs. This highlights the need for basic knowledge and understanding about substance-related factors that can interact with social and environmental contexts and contribute to medical and psychological comorbidities. The transdisciplinary foundations comprise four sets of competencies:

Understanding SUDs

- ✓ Understand a variety of models and theories of SUDs and other problems related to substance use
- ✓ Recognize the social, political, legal, economic, and cultural context within which SUDs exist, including risk and resiliency factors that characterize individuals and groups and their living environments
- ✓ Describe the behavioral, psychological, physical health, and social effects of psychoactive substances on the person using them and significant others
- ✓ Recognize the potential for SUDs to mimic a variety of medical and mental health conditions and the medical and mental health conditions that co-occur with SUDs

Treatment Knowledge

- ✓ Describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for SUDs and other substance-related problems
- ✓ Recognize the importance of family, social networks, and community systems in the treatment and recovery process
- ✓ Understand the importance of research and outcome data and their application in clinical practice
- ✓ Understand the value of an interdisciplinary approach to SUD treatment

Application to Practice

- ✓ Understand the established diagnostic criteria for SUDs and describe treatment modalities and placement criteria within the continuum of care
- ✓ Describe a variety of strategies to reduce the negative effects of substance use and SUDs
- ✓ Tailor strategies and treatment modalities to the client's stage of psychological and

Key Points

- ✓ Effective SUD counseling demands a comprehensive knowledge base of current research, principles, and methods for helping people with SUDs. Guidance framing the KSAs is critical to ensuring that clinicians feel confident in their ability to provide evidence-based, high-quality care to clients with SUDs.
- ✓ Provider competencies are focused around four foundational areas: (1) understanding SUDs, (2) knowledge of treatment approaches, (3) application to practice, and (4) professional readiness.
- ✓ Competencies are applied to a range of practice dimensions, including clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities.
- ✓ Working with clients in a culturally sensitive way is a key component emphasized across all foundational areas and practice dimensions.

physiological dependence, change, or recovery
- ✓ Provide treatment services appropriate to the personal and cultural identity and language of the client
- ✓ Adapt practice within the scope of treatment settings and modalities
- ✓ Be familiar with medical and pharmacological resources in the treatment of SUDs
- ✓ Understand the variety of insurance and health maintenance options available and the importance of helping clients access those benefits
- ✓ Recognize that crisis may indicate an underlying SUD and may represent an opportunity for change
- ✓ Understand the need for and the use of methods for measuring treatment outcome

Professional Readiness

- ✓ Understand diverse cultures and incorporate the relevant needs of culturally diverse groups as well as people with disabilities into clinical practice
- ✓ Understand the importance of self-awareness in one's personal, professional, and cultural life
- ✓ Understand the SUD professional's obligations to adhere to ethical and behavioral standards of conduct in the helping relationship
- ✓ Understand the importance of ongoing supervision and the requirements of continuing education in the delivery of client services
- ✓ Understand the obligation of the SUD professional to participate in both prevention and treatment activities
- ✓ Understand and apply setting-specific policies and procedures for handling crises or dangerous situations, including safety measures for clients and staff

The Eight Practice Dimensions

In addition to the general KSAs reflected in the four transdisciplinary foundations, it is essential that clinicians who specialize in the assessment and treatment of SUDs master the application of more specific and extensive KSAs that go beyond foundational knowledge to address various areas of routine clinical practice. The eight practice dimensions are:

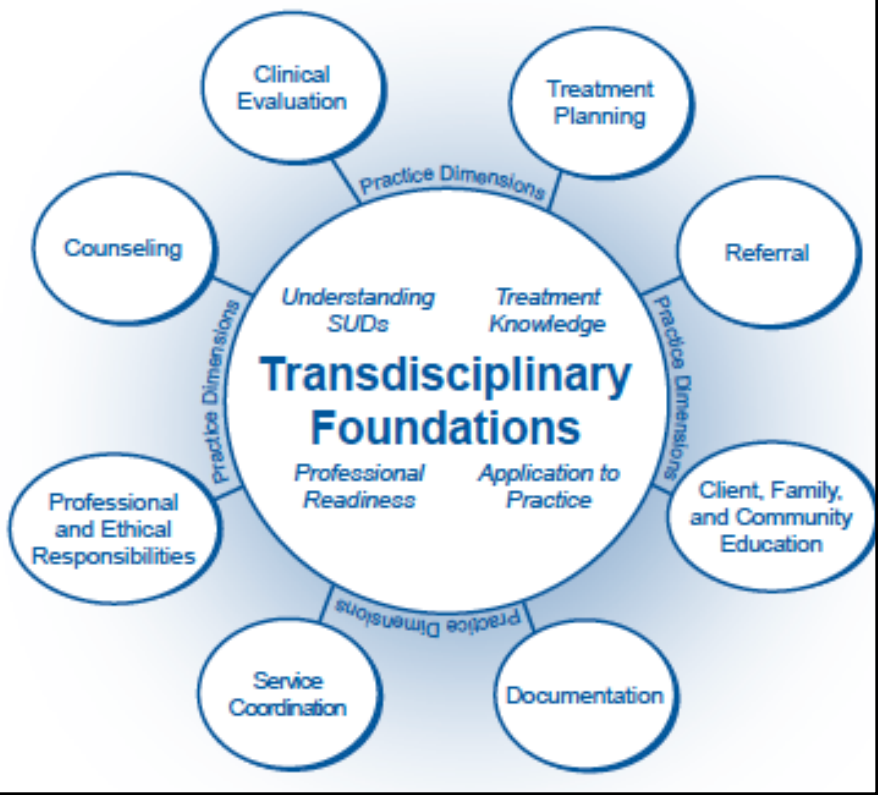
1) Clinical evaluation;
2) Treatment planning;
3) Referral;
4) Service coordination;
5) Counseling;

6) Client, family, and community education;
7) Documentation; and
8) Professional and ethical responsibilities.

Clinical Evaluation: Screening and Assessment

Clinical evaluation is a systematic approach to the screening and assessment of individuals thought to have an SUD, being considered for admission to SUD-related services, or presenting in a crisis situation. Examples of competencies in this dimension include establishing rapport; gathering data systematically from the client and other available sources; analyzing and interpreting the outcomes of standardized assessment data to determine treatment recommendations; determining the client's readiness for treatment and change, as well as the recovery environment and the needs of others involved in the current situation; reviewing the treatment options that are appropriate for the client's needs, characteristics, goals, and financial resources; and seeking appropriate supervision and consultation.

Exhibit 1. The Differentiated Competency Model



Treatment Planning

Treatment planning is a collaborative process in which professionals and the client develop a written document that identifies important treatment goals; describes measurable, time-sensitive action steps toward achieving those goals with expected outcomes; and reflects a verbal agreement between a counselor and client. Clinicians should be able to use relevant assessment information to guide the treatment planning process, to explain assessment findings to the client and significant others, to examine treatment options in collaboration with the client and significant others, to formulate mutually agreed-on and measurable treatment goals

The Importance of Culture

Cultural competency is defined as "the capacity of a service provider or organization to understand and work effectively in accord with the beliefs and practices of persons from a given ethnic/racial/religious/social group or sexual orientation. It includes the holding of knowledge, skills, and attitudes that allow the treatment provider and program to understand the full context of a client's current and past socioenvironmental situation". Clients from diverse racial, ethnic, and cultural groups often experience disparities in the healthcare system that negatively affect health outcomes (Healey et al.), highlighting the need for the recruitment and retention of providers who are trained in culturally competent, evidence-based approaches (Baffour).

Although cultural competency is an underlying theme throughout the counseling competencies and is woven into nearly all transdisciplinary foundations and practice dimensions, established competencies specifically encourages clinicians to adapt counseling strategies to the individual characteristics of the client, including but not limited to disability, gender, sexual orientation, developmental level, culture, ethnicity, age, and health status.

KSAs of Competency

Knowledge

- ✓ The effect of culture on substance use
- ✓ Cultural factors affecting responsiveness to various counseling strategies
- ✓ Current research concerning differences in drinking and substance use patterns based on the characteristics of the client
- ✓ SUD counseling strategies
- ✓ How to apply appropriate strategies based on the client's treatment plan
- ✓ The client's family and social systems and relationships between each
- ✓ The client's and social system's cultural norms, biases, and preferences
- ✓ Literature relating spirituality to SUDs and recovery

Skills

- ✓ Knowing how to individualize treatment plans
- ✓ Adapting counseling strategies to match unique client characteristics and circumstances
- ✓ Applying culturally and linguistically responsive communication styles and practices

Attitudes

- ✓ Recognition of the need for flexibility to meet the client's needs
- ✓ Willingness to adjust strategies in accordance with the client's characteristics
- ✓ A nonjudgmental, respectful acceptance of cultural, behavioral, and value differences

While a full exploration of each reference to cultural competency is beyond the scope of this course, a helpful introduction to this critical topic can be accessed through the course Improving Cultural Competence Unabridged – Online CE Course

and objectives, and to reassess the treatment plan at regular intervals or when indicated by changing circumstances.

Referral

This dimension refers to the process of facilitating the client's use of available support systems and community resources to meet needs identified in clinical evaluation or treatment planning. These competencies include continually assessing and evaluating referral resources to determine their appropriateness; arranging referrals to other professionals, agencies, community programs, or appropriate resources to meet the client's needs; explaining in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through; exchanging relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality rules and regulations and generally accepted professional standards of care; and evaluating the outcome of the referral.

Service Coordination: Implementing the Treatment Plan, Consulting, and Continuing Assessment and Treatment Planning

Service coordination involves the administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan. Clinicians who are competent in service coordination should be able to initiate collaboration with the referral source; to obtain, review, and interpret all relevant screening, assessment, and initial treatment planning information; to summarize the client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress to ensure quality of care, gain feedback, and plan changes in the course of treatment; to contribute as part of a multidisciplinary treatment team; to demonstrate respect and nonjudgmental attitudes toward clients in all contacts with community professionals and agencies; to maintain ongoing contact with the client and involved significant others to ensure adherence to the treatment plan; and to describe and document the treatment process, progress, and outcome.

Counseling: Individual Counseling, Group Counseling, and Counseling Families, Couples, and Significant Others

Counseling is described as a collaborative process that facilitates the client's progress toward mutually determined treatment goals and objectives. This dimension includes competencies such as facilitating the client's engagement in the treatment and recovery process; working with the client to establish realistic goals consistent with achieving and maintaining recovery; describing, selecting, and appropriately using strategies from accepted and culturally appropriate models for group counseling with clients with SUDs; facilitating group growth within the established ground rules and movement toward group and individual goals by using methods consistent with group type; understanding

the characteristics and dynamics of families, couples, and significant others affected by substance use; and assisting families, couples, and significant others in understanding the interaction between the family system and substance use behaviors.

Client, Family, and Community Education

This dimension refers to the process of providing clients, families, significant others, and community groups with information on risks related to psychoactive substance use, as well as available prevention, treatment, and recovery resources. Counselors should be able to provide culturally relevant formal and informal education programs that raise awareness and support SUD prevention and the recovery process; to sensitize others to issues of cultural identity, ethnic background, age, and gender in prevention, treatment, and recovery; to describe warning signs, symptoms, and the course of SUDs; to describe principles and philosophy of prevention, treatment, and recovery; and to teach life skills, including but not limited to stress management, relaxation, communication, assertiveness, and refusal skills.

Documentation

Documentation is the recording of the screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client-related data. Examples of competencies specific to documentation include the counselor's ability to demonstrate knowledge of accepted principles of client record management; to protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties; to prepare accurate and concise screening, intake, and assessment reports; to record progress of the client in relation to treatment goals and objectives; and to document treatment outcome, using accepted methods and instruments.

Professional and Ethical Responsibilities

The dimension of professional and ethical responsibilities encompasses the obligations of a counselor to adhere to accepted ethical and behavioral standards of conduct and continuing professional development. Counselors with an understanding of these obligations can adhere to established professional codes of ethics that define the professional context within which the counselor works to maintain professional standards and safeguard the client; to adhere to federal and state laws and agency regulations regarding the treatment of SUDs; to use a range of supervisory options to process personal feelings and concerns about clients; to conduct evaluations of professional performance applying ethical, legal, and professional standards to enhance self-awareness and performance; and to obtain appropriate continuing professional education.

Uses of the Competencies

Since they were drafted, one of the main uses of the competencies has been to support education and training of SUD clinicians across the country. The competencies have been integral to curriculum design and evaluation for continuing education and higher education, professional development programs, student assessment and supervision, and certification standards. The publication of a competency framework for clinicians who interact with SUD clients has promoted scientific knowledge in the real-world settings of mental and substance use disorder treatment.

2. DSM-5 Diagnostic Summary

Substance abuse is defined as "the overindulgence in and dependence of a drug or other chemical leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others. It is characterized by a pattern of continued pathological use of a medication, non-medically indicated substance, drug or toxin, that results in repeated adverse social consequences related to drug use, such as failure to meet work, family, or school obligations, interpersonal conflicts, or legal problems." According to the DSM-5, "The essential feature of substance use disorder is a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues using the substance despite significant substance related problems"

Substance-Related Disorders and the DSM-5

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) contains changes to addictions, substance-related disorders and alcoholism. According to the American Psychiatric Association, the most significant change includes the removal of the distinction between "abuse" and "dependence." The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. According to the DSM-5, "The essential feature of substance use disorder is a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues using the substance despite significant substance related problems"

The most significant changes to the DSM-5 criteria for substance use disorder include:

➢ “Recurrent legal problems” has been deleted

➢ "Craving or a strong desire or urge to use a substance" was added to the criteria

Severity from mild to severe is based on the number of criteria endorsed. Criteria for cannabis and caffeine withdrawal were added. New specifies were added for early and sustained remission along with new specifiers for "in a controlled environment" and "on maintenance therapy". According to the APA, “Criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant”.

Additions to the DSM-5 also includes Cannabis withdrawal as well as caffeine withdrawal

Severity of the DSM-5 substance use disorders include the following criteria changes:

- 2–3 criteria indicate a mild disorder
- 4–5 criteria, a moderate disorder
- 6 or more, a severe disorder

The DSM-5 deleted the physiological subtype and the diagnosis for “polysubstance dependence.”

According to the APA, “Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained re-mission is defined as at least 12 months without criteria (except craving). Additional new DSM-5 specifiers include “in a controlled environment” and “on maintenance therapy” as the situation warrants.”

DSM-5 Substance Related Disorders

The following includes a summary listing of the DSM-5 substance related disorders:

- ❖ Substance Induced Disorder
  - Substance Intoxication and Withdrawn

- ❖ Substance/Medication-Induced Mental Disorders
- ❖ Alcohol Related Disorders
  - Alcohol Use Disorder
  - Alcohol Intoxication
  - Other Alcohol Induced Disorders
  - Unspecified Alcohol Related Disorders
  - Alcohol Withdrawal

- ❖ Cannabis-Related Disorders

- Cannabis Use Disorder
- Cannabis Intoxication
- Cannabis Withdrawal
- Other Cannabis-Induced Disorders
- Unspecified Cannabis-Related Disorder

The following is a list with descriptions of the most common DSM 5 substance use disorders in the United States:

Alcohol Use Disorder (AUD): Excessive alcohol use can increase a person's risk of developing serious health problems in addition to those issues associated with intoxication behaviors and alcohol withdrawal symptoms. According to the Centers for Disease Control and Prevention (CDC), excessive alcohol use causes 88,000 deaths a year. Data from the National Survey on Drug Use and Health (NSDUH) — 2014 (PDF | 3.4 MB) show that slightly more than half (52.7%) of Americans ages 12 and up reported being current drinkers of alcohol. Most people drink alcohol in moderation. However, of those 176.6 million alcohol users, an estimated 17 million have an AUD. Many Americans begin drinking at an early age. About 24% of eighth graders and 64% of twelfth graders reported using alcohol in the past year. The definitions for the different levels of drinking include the following:

- **Moderate Drinking**—According to the Dietary Guidelines for Americans, moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men.
- **Binge Drinking**—SAMHSA defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 drinks for women and 5 drinks for men over a 2 hour period.
- **Heavy Drinking**—SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.
- **Excessive drinking** can put you at risk of developing an alcohol use disorder in addition to other health and safety problems. Genetics have also been shown to be a risk factor for the development of an AUD.

To be diagnosed with an AUD, individuals must meet certain diagnostic criteria. Some of these criteria include problems controlling intake of alcohol, continued use of alcohol despite problems resulting from drinking, development of a tolerance, drinking that leads to risky situations, or the development of withdrawal symptoms. The severity of an AUD —mild, moderate, or severe—is based on the number of criteria met.

Tobacco Use Disorder: According to the CDC, more than 480,000 deaths each year are caused by cigarette smoking. Tobacco use and smoking cause damage to nearly every organ in the human body, often leading to lung cancer, respiratory disorders, heart disease, stroke, and other illnesses. An estimated 66.9 million Americans aged 12 or older are current users of a tobacco product (25.2%). Young adults aged 18 to 25 had the highest rate of current use of a tobacco product (35%), followed by adults aged 26 or older (25.8%), and by youths aged 12 to 17 (7%). The prevalence of current use of a tobacco product is 37.8% for American Indians or Alaska Natives, 27.6% for whites, 26.6% for blacks, 30.6% for Native Hawaiians or other Pacific Islanders, 18.8% for Hispanics, and 10.2% for Asians.

Cannabis Use Disorder: Marijuana is the most used drug after alcohol and tobacco in the United States. Marijuana's immediate effects include distorted perception, difficulty with thinking and problem solving, and loss of motor coordination. Long-term use of the drug can contribute to respiratory infection, impaired memory, and exposure to cancer-causing compounds. Heavy marijuana use in youth has also been linked to increased risk for developing mental illness and poorer cognitive functioning.

Some symptoms of cannabis use disorder include disruptions in functioning due to cannabis use, the development of tolerance, cravings for cannabis, and the development of withdrawal symptoms, such as the inability to sleep, restlessness, nervousness, anger, or depression within a week of ceasing heavy use.

Stimulant Use Disorder: Stimulants increase alertness, attention, and energy, as well as elevate blood pressure, heart rate, and respiration. They include a wide range of drugs that have historically been used to treat conditions, such as obesity, attention deficit hyperactivity disorder and, occasionally, depression. Like other prescription medications, stimulants can be diverted for illegal use. The most commonly abused stimulants are amphetamines, methamphetamine, and cocaine. Stimulants can be synthetic (such as amphetamines) or can be plant-derived (such as cocaine). They are usually taken orally, snorted, or intravenously.

Symptoms of stimulant use disorders include craving for stimulants, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use stimulants, and withdrawal symptoms that occur after stopping or reducing use, including fatigue, vivid and unpleasant dreams, sleep problems, increased appetite, or irregular problems in controlling movement.

There are varying degrees of substance abuse involving many types of substances including:

➔ Narcotics
➔ Depressants
➔ Stimulants
➔ Hallucinogens
➔ Anabolic steroids

Hallucinogen Use Disorder: Hallucinogens can be chemically synthesized (as with lysergic acid diethylamide or LSD) or may occur naturally (as with psilocybin mushrooms, peyote). These drugs can produce visual and auditory hallucinations, feelings of detachment from one's environment and oneself, and distortions in time and perception. Symptoms of hallucinogen use disorder include craving for hallucinogens, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, use in risky situations like driving, development of tolerance, and spending a great deal of time to obtain and use hallucinogens.

Opioid Use Disorder*:* Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, nausea, constipation, and, depending upon the amount of drug taken, can depress respiration. Illegal opioid drugs, such as heroin and legally available pain relievers such as oxycodone and hydrocodone can cause serious health effects in those who misuse them. Some people experience a euphoric response to opioid medications, and it is common that people misusing opioids try to intensify their experience by snorting or injecting them. These methods increase their risk for serious medical complications, including overdose. Other users have switched from prescription opiates to heroin as a result of availability and lower price. Because of variable purity and other chemicals and drugs mixed with heroin on the black market, this also increases risk of overdose.

Symptoms of opioid use disorders include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.

3. Types of Substance Abuse

- More young Americans die from drugs than suicides, firearms, or school violence;
- The only disease that affects more people than substance abuse in America today is heart disease;

- Substance abuse is the single largest contributor to crime in the United States;
- In the latest year measured, the direct cost of drug abuse was estimated at 52 billion, with indirect costs of 128 billion.

Each class of substance abuse has distinguishing properties, and drugs within each class often produce similar effects. However, all controlled substances, regardless of class, share a number of common features. All controlled substances have abuse potential or are immediate precursors to substances with abuse potential. With the exception of anabolic steroids, controlled substances are abused to alter mood, thought, and feeling through their actions on the central nervous system (brain and spinal cord). Some of these drugs alleviate pain, anxiety, or depression. Some induce sleep and others energize.

Though some controlled substances are therapeutically useful, the "feel good" effects of these drugs contribute to their abuse. The extent to which a substance is reliably capable of producing intensely pleasurable feelings (euphoria) increases the likelihood of that substance being abused.

Drug Abuse

When drugs are used in a manner or amount inconsistent with the medical or social patterns of a culture, it is called drug abuse. The non-sanctioned use of substances controlled in Schedules I through V of the CSA is considered drug abuse. While legal pharmaceuticals placed under control in the CSA are prescribed and used by patients for medical treatment, the use of these same pharmaceuticals outside the scope of sound medical practice is drug abuse.

Dependence

In addition to having abuse potential, most controlled substances are capable of producing dependence, either physical or psychological.

Physical Dependence

Physical dependence refers to the changes that have occurred in the body after repeated use of a drug that necessitates the continued administration of the drug to prevent a withdrawal syndrome. This withdrawal syndrome can range from mildly unpleasant to life-threatening and is dependent on a number of factors, such as:

➔ The drug being used
➔ The dose and route of administration
➔ Concurrent use of other drugs
➔ Frequency and duration of drug use
➔ The age, sex, health, and genetic makeup of the user

Psychological Dependence

Psychological dependence refers to the perceived "need" or "craving" for a drug. Individuals who are psychologically dependent on a particular substance often feel that they cannot function without continued use of that substance. While physical dependence disappears within days or weeks after drug use stops, psychological dependence can last much longer and is one of the primary reasons for relapse (initiation of drug use after a period of abstinence).

Contrary to common belief, physical dependence is not addiction. While addicts are usually physically dependent on the drug they are abusing, physical dependence can exist without pain management or benzodiazepines to treat anxiety are likely to be physically dependent on that medication.

Addiction

Addiction is defined as compulsive drug-seeking behavior where acquiring and using a drug becomes the most important activity in the user's life. This definition implies a loss of control regarding drug use, and the addict will continue to use a drug despite serious medical and/or social consequences. Illicit drug use in America has been increasing.

Drugs within a class are often compared with each other with terms like potency and efficacy. Potency refers to the amount of a drug that must be taken to produce a certain effect, while efficacy refers to whether or not a drug is capable of producing a given effect regardless of dose. Both the strength and the ability of a substance to produce certain effects play a role in whether that drug is selected by the drug abuser. It is important to keep in mind that the effects produced by any drug can vary significantly and is largely dependent on the dose and route of administration. Concurrent use of other drugs can enhance or block an effect, and substance abusers often take more than one drug to boost the desired effects or counter unwanted side effects. The risks associated with drug abuse cannot be accurately predicted because each user has his/her own unique sensitivity to a drug. There are a number of theories that attempt to explain these differences, and it is clear that a genetic component may predispose an individual to certain toxicities or even addictive behavior.

Narcotics

Also known as "opioids," the term "narcotic" comes from the Greek word for "stupor" and originally referred to a variety of substances that dulled the senses and relieved pain. Though some people still refer to all drugs as "narcotics," today "narcotic" refers to opium, opium derivatives, and their semi-synthetic substitutes. A more current term for these drugs, with less uncertainty regarding its meaning, is "opioid." Examples include the illicit drug heroin and pharmaceutical drugs like OxyContin®, Vicodin®, codeine,

morphine, methadone, and fentanyl. What is their origin? The poppy papaver somniferum is the source for all natural opioids, whereas synthetic opioids are made entirely in a lab and include meperidine, fentanyl, and methadone. Semi-synthetic opioids are synthesized from naturally occurring opium products, such as morphine and codeine, and include heroin, oxycodone, hydrocodone, and hydromorphone. Teens can obtain narcotics from friends, family members, medicine cabinets, pharmacies, nursing homes, hospitals, hospices, doctors, and the Internet.

Street names for various narcotics/opioids include:
➔ Smack, Horse, Mud, Brown Sugar, Junk, Black Tat, Big H, Paregoric, Dover's Powder, MPTP (New Heroin), Hilbilly Heroin, Lean or Purple Drank, OC, Ox, Oxy, Oxycotton, Sippin Syrup

Narcotics/opioids come in various forms, including:
➔ Tablets, capsules, skin patches, powder, chunks in varying colors (from white to shades of brown and black), liquid form for oral use and injection, syrups, suppositories, and lollipops

Abuse:
➔ Narcotics/opioids can be swallowed, smoked, sniffed, or injected.

Legal Substances

Legal substances are approved by law for sale over the counter or by doctor's prescription. Some of these substances include caffeine, alcoholic beverages, nicotine, and inhalants such as nail polish, glue, inhalers, and gasoline. Prescription drugs such as tranquilizers, amphetamines, benzodiazepines, barbiturates, steroids, and analgesics can be knowingly or unknowingly overprescribed or otherwise used improperly. In many cases, new drugs prescribed in good conscience by physicians turn out to be a problem later. For example, Diazepam (Valium) was widely prescribed in the 1960s and 70s before its potential for serious addiction was realized. In the 1990s, sales of fluoxetine (Prozac) helped create a 3 billion antidepressant market (and still growing) in the United States, leading many people to criticize what they saw as the creation of a legal drug culture that discouraged people from learning other ways to deal with their problems. While herbal medicines have become increasingly popular, many are psychoactive to some degree, causing concerns of quality and safety. Prescription drugs are regulated by the Food and Drug Administration and the Drug Enforcement Administration.

Caffeine is an odorless, slightly bitter alkaloid found in coffee, tea, kola nuts, ilex plants, and cocoa. It can also be prepared synthetically from uric acid. While relatively harmless, it is the most commonly used mind altering drug in the world. When used in moderation,

caffeine acts as a mild stimulant to the nervous system, blocking the neurotransmitter adenosine and resulting in a feeling of well-being and alertness. It increases the heart rate, blood pressure, and urination and stimulates secretion of stomach acids. However, excessive intake can result in restlessness, insomnia, and heart irregularities. The effects of caffeine vary from person to person, as people excrete it at different rates. Physical dependence and unpleasant symptoms upon withdrawal (headache, fatigue, and depression) are common in regular caffeine users *(B. A Weinberg and B. K. Bealer, The World of Caffeine)*.

Alcohol

Alcohol Dependence is a condition characterized by the harmful consequences of repeated alcohol use, a pattern of compulsive alcohol use, and sometimes physiological dependence on alcohol (i.e., tolerance and/or symptoms of withdrawal). This disorder is only diagnosed when these behaviors become persistent and very disabling or distressing *(Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC: American Psychiatric Association)*.

Academic and/or work performance may deteriorate resulting from consequences including hangovers or from actual intoxication on the job or at school. Other examples include that child care or household responsibilities may be neglected, and alcohol-related absences may occur from school or work.

Alcohol may be used in physically hazardous circumstances such as drunk driving. Alcohol abuse may persist despite the knowledge that continued drinking poses significant social or interpersonal problems. Alcohol intoxication may cause significant intellectual impairment. Once a pattern of compulsive use develops, individuals may begin to devote significant time to obtaining and consuming alcoholic beverages. Alcohol use continues despite evidence of adverse psychological or physical consequences such as depression or blackouts. Individuals with this disorder are at increased risk for accidents, violence, and suicide. It is estimated that 1 in 5 intensive care unit admissions in some urban hospitals is related to alcohol and that 40% of people in U.S.A. experience an alcohol-related accident at some time in their lives, with alcohol accounting for up to 55% of fatal driving events. More than one-half of all murderers and their victims are believed to have been intoxicated with alcohol at the time of the murder. Severe Alcohol Intoxication also contributes to disinhibition and feelings of sadness and irritability, which contribute to suicide attempts and completed suicides *(Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC: American Psychiatric Association)*.

Only 5% of individuals with Alcohol Dependence ever experience severe complications of withdrawal such as delirium. However, repeated intake of high doses of alcohol can affect nearly every organ system, especially the gastrointestinal tract, cardiovascular

system, and the central and peripheral nervous system. Gastrointestinal effects include gastritis, stomach or duodenal ulcers, and, in about 15% of those who use alcohol heavily, liver cirrhosis and pancreatitis. There is also an increased rate of cancer of the esophagus, stomach, and other parts of the gastrointestinal tract. One of the most common associated general medical conditions is low-grade hypertension. There is an elevated risk of heart disease. Peripheral neuropathy may be evidenced by muscular weakness, paresthesias, and decreased peripheral sensation. Most persistent central nervous system effects include cognitive deficits, severe memory impairment, and degenerative changes in the cerebellum. One devastating central nervous system effect is the relatively rare Alcohol-Induced Persisting Amnesic Disorder (Wernicke-Korsakoff syndrome) in which there is a dramatic impairment in short-term memory. Men may develop erectile dysfunction and decreased testosterone levels. Repeated heavy drinking in women is associated with menstrual irregularities and, during pregnancy, with spontaneous abortion and fetal alcohol syndrome. Alcohol Dependence can suppress immune system mechanisms, predispose individuals to infections, and increase the risk for cancer. Individuals with Alcohol Dependence are at increased risk for Major Depressive Disorder, other Substance-Related Disorders, and Conduct Disorder in adolescents, Antisocial and Emotionally Unstable (Borderline) Personality Disorders, Schizophrenia, and Bipolar Disorder *(Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC: American Psychiatric Association)*.

An individual with a blood alcohol concentration of 100 mg of ethanol per deciliter of blood who does not show signs of intoxication can be presumed to have an acquired tolerance to alcohol. At 200 mg/dL, most non-alcoholic individuals would demonstrate severe intoxication. An elevation (> 30 units) of gamma-glutamyltransferase (GGT) is a sensitive laboratory test for heavy drinking. At least 70% of individuals with a high GGT level are persistent heavy drinkers (i.e., consuming 8 or more drinks daily on a regular basis). Another sensitive test for heavy drinking is an elevation (> 20 units) in carbohydrate deficient transferring (CDT). Both GGT and CDT levels return toward normal within days to weeks of stopping drinking, thus are useful tests to monitor abstinence. The combination of GGT and CDT may have even higher levels of sensitivity and specificity in diagnosing heavy drinking than either test used alone. Another useful laboratory test for heavy drinking is an elevated mean corpuscular volume (MCV). However, the MCV is a poor method of monitoring abstinence because it takes weeks to return to normal after the individual stops drinking. Liver function tests (e.g., alanine aminotransferase and alkaline phosphatase) can reveal liver injury that is caused by heavy drinking. High fat content in the blood also contributes to the development of fatty liver *(Source: National Clearinghouse for Drug & Alcohol Information)*.

Alcohol use is highly prevalent in most Western countries. However, in most Asian cultures, the overall prevalence of Alcohol-Related Disorders is relatively low. In Muslim

countries, the Islamic religion strictly prohibits alcohol (hence the rates of Alcohol-Related Disorders are very low). In the Western countries, this disorder occurs much more commonly in males (with a male-to-female ratio of 5:1). The lifetime risk of Alcohol Dependence is approximately 15% in the general population. In any year, 5% of the general population will actively be suffering from Alcohol Dependence *(Source: National Clearinghouse for Drug & Alcohol Information).*

Possible warning signs of advanced alcohol dependence include serious injuries sustained while under the influence, multiple blackouts, and multiple DUI's. Alcohol Dependence is frequently characterized by periods of remission and relapse. The first episode of alcohol intoxication is likely to occur in the mid-teens, with the age at onset of Alcohol Dependence peaking in the 20s to mid-30s. The large majority of those who develop Alcohol Dependency do so by their late 30s. Alcohol Dependence often has a familial pattern, and it is estimated that 40%-60% of the variance of risk is explained by genetic influences. The risk for Alcohol Dependence is 3 to 4 times higher in close relatives of people with Alcohol Dependence. Most studies have found a significantly higher risk for Alcohol Dependence in the monozygotic twin than in the dizygotic twin of a person with Alcohol Dependence. Adoption studies have revealed a 3- to 4-fold increase in risk for Alcohol Dependence in the children of individuals with Alcohol Dependence when these children were adopted away at birth and raised by adoptive parents who did not have this disorder. Follow-up studies of the typical person with an Alcohol Use Disorder show a higher than 65% 1-year abstinence rate following treatment. Even among less functional and homeless individuals with Alcohol Dependence who complete a treatment program, as many as 60% are abstinent at 3 months, and 45% at 1 year. Some individuals (perhaps 20% or more) with Alcohol Dependence achieve long-term sobriety even without treatment *(Source: National Clearinghouse for Drug & Alcohol Information).*

Tranquilizers

One of the many functions of tranquilizers is to calm the central nervous system and decreasing emotional agitation. Tranquilizing drugs differ from hypnotic drugs such as barbiturates in that they do not act on the brain's cortical areas but rather on its lower portions, e.g., the hypothalamus. They have been found helpful in the treatment of tension and mental illness. Reserpine, which appeared on the market in 1952, was the first tranquilizer to be used in modern Western medicine. Other drugs used as tranquilizers include the phenothiazines, meprobamate, certain muscle relaxants and anticonvulsants, and lithium carbonate. See also psychopharmacology *(American Psychiatric Association. Substance-related disorders. In Diagnostic and Statistical Manual of Mental Disorders, 5th ed., Washington, DC: American Psychiatric Association).*

Amphetamines

Amphetamines are any one of a group of drugs that are powerful central nervous system stimulants. Amphetamines have stimulating effects opposite to the effects of depressants such as alcohol, narcotics, and barbiturates. They raise the blood pressure by causing the body to release epinephrine, postpone the need for sleep, and can reverse, partially and temporarily, the effects of fatigue. Amphetamines enhance mental alertness and the ability to concentrate, and also cause wakefulness, euphoria, and talkativeness. Benzedrine is the trade name for the drug amphetamine; dextroamphetamine is marketed as Dexedrine. Methamphetamine, a potent stimulant marketed as Desoxyn, is the most rapidly acting amphetamine. They are available by prescription for limited uses; illegal sources include stolen or diverted supplies or clandestine laboratories *(American Psychiatric Association. Substance-related disorders. In Diagnostic and Statistical Manual of Mental Disorders, 5th ed., Washington, DC: American Psychiatric Association).*

Inhalants

Inhalants are a diverse group of volatile substances whose chemical vapors can be inhaled to produce psychoactive (mind-altering) effects. While other abused substances can be inhaled, the term "inhalants" is used to describe substances that are rarely, if ever, taken by any other route of administration. A variety of products common in the home and workplace contain substances that can be inhaled to get high; however, people do not typically think of these products (e.g., spray paints, glues, and cleaning fluids) as drugs because they were never intended to induce intoxicating effects. Yet young children and adolescents can easily obtain these extremely toxic substances, and are among those most likely to abuse them. In fact, more 8th graders have tried inhalants than any other illicit drug *(American Psychiatric Association. Substance-related disorders. In Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC: American Psychiatric Association).*

Inhalants fall into the following categories:

Volatile solvents—liquids that vaporize at room temperature

- Industrial or household products, including paint thinners or removers, degreasers, dry-cleaning fluids, gasoline, lighter fluid
- Art or office supply solvents, including correction fluids, felt-tip marker fluid, electronic contact cleaners, glue

Aerosols—sprays that contain propellants and solvents

- Household aerosol propellants in items such as spray paints, hair or deodorant sprays, fabric protector sprays, aerosol computer cleaning products, and vegetable oil sprays

Gases—found in household or commercial products and used as medical anesthetics

- Household or commercial products, including butane lighters and propane tanks, whipped cream aerosols or dispensers (whippets), and refrigerant gases
- Medical anesthetics, such as ether, chloroform, halothane, and nitrous oxide ("laughing gas")

Nitrites—a special class of inhalants that are used primarily as sexual enhancers

- Organic nitrites are volatiles that include cyclohexyl, butyl, and amyl nitrites, commonly known as "poppers." Amyl nitrite is still used in certain diagnostic medical procedures. When marketed for illicit use, they are often sold in small brown bottles labeled as "video head cleaner," "room odorizer," "leather cleaner," or "liquid aroma."

These various products contain a wide range of chemicals such as:

- toluene (spray paints, rubber cement, gasoline),
- chlorinated hydrocarbons (dry cleaning chemicals, correction fluids)
- hexane (glues, gasoline),
- benzene (gasoline),
- methylene chloride (varnish removers, paint thinners),
- butane (cigarette lighter refills, air fresheners), and
- nitrous oxide (whipped cream dispensers, gas cylinders).

Adolescents tend to abuse different products at different ages. Among new users aged 12–15, the most commonly abused inhalants were glue, shoe polish, spray paints, gasoline, and lighter fluid. Among new users aged 16 or 17, the most commonly abused products were nitrous oxide or whippets. Nitrites are the class of inhalants most commonly abused by adults. Inhalants can be breathed in through the nose or mouth in a variety of ways, such as sniffing or snorting fumes from a container, spraying aerosols directly into the nose or mouth, or placing an inhalant-soaked rag in the mouth ("huffing"). Users may also inhale fumes from a balloon or a plastic or paper bag that contains an inhalant. The intoxication produced by inhalants usually lasts just a few minutes; therefore, users often try to extend the "high" by continuing to inhale repeatedly over several hours *(American Psychiatric Association. Substance-related disorders. In Diagnostic and Statistical Manual of Mental Disorders, 5th ed.,Washington, DC: American Psychiatric Association).*

The effects of inhalants are similar to those of alcohol, including slurred speech, lack of coordination, euphoria, and dizziness. Inhalant abusers may also experience lightheadedness, hallucinations, and delusions. With repeated inhalations, many users feel

less inhibited and less in control. Some may feel drowsy for several hours and experience a lingering headache. Chemicals found in different types of inhaled products may produce a variety of additional effects, such as confusion, nausea, or vomiting. By displacing air in the lungs, inhalants deprive the body of oxygen, a condition known as hypoxia. Hypoxia can damage cells throughout the body, but the cells of the brain are especially sensitive to it. The symptoms of brain hypoxia vary according to which regions of the brain are affected: the hippocampus, for example, helps control memory, so someone who repeatedly uses inhalants may lose the ability to learn new things or may have a hard time carrying on simple conversations. Long-term inhalant abuse can also break down myelin, a fatty tissue that surrounds and protects some nerve fibers. Myelin helps nerve fibers carry their messages quickly and efficiently, and when damaged can lead to muscle spasms and tremors or even permanent difficulty with basic actions like walking, bending, and talking *(American Psychiatric Association. Substance-related disorders. In Diagnostic and Statistical Manual of Mental Disorders, 5th ed., Washington, DC: American Psychiatric Association)*.

Addiction to inhalants can occur with repeated abuse. According to the *Treatment Episode Dataset*, inhalants were reported as the primary substance abused by less than 0.1 percent of all individuals admitted to substance abuse treatment. However, of those individuals who reported inhalants as their primary, secondary, or tertiary drug of abuse, nearly half were adolescents aged 12 to 17. This age group represents only 8 percent of total admissions to treatment. Sniffing highly concentrated amounts of the chemicals in solvents or aerosol sprays can directly induce heart failure and death within minutes of a session of repeated inhalations. This syndrome, known as “sudden sniffing death,” can result from a single session of inhalant use by an otherwise healthy young person. Sudden sniffing death is particularly associated with the abuse of butane, propane, and chemicals in aerosols. High concentrations of inhalants may also cause death from suffocation by displacing oxygen in the lungs, causing the user to lose consciousness and stop breathing. Deliberately inhaling from a paper or plastic bag or in a closed area greatly increases the chances of suffocation. Even when using aerosols or volatile products for their legitimate purposes (i.e., painting, cleaning), it is wise to do so in a well-ventilated room or outdoors.

- Hearing loss—spray paints, glues, dewaxers, dry-cleaning chemicals, correction fluids
- Peripheral neuropathies or limb spasms—glues, gasoline, whipped cream dispensers, gas cylinders
- Central nervous system or brain damage—spray paints, glues, dewaxers
- Bone marrow damage—gasoline
- Liver and kidney damage—correction fluids, dry-cleaning fluids

➡ Blood oxygen depletion—varnish removers, paint thinners

(American Psychiatric Association. Substance-related disorders. In Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Washington, DC: American Psychiatric Association).

Benzodiazepines

Benzodiazepines are any of a class of drugs prescribed for their tranquilizing, anti-anxiety, sedative, and muscle-relaxing effects. Benzodiazepines are also prescribed for epilepsy and alcohol withdrawal. Introduced in the early 1960s with chlordiazepoxide (Librium), benzodiazepines were heralded as a safer alternative to barbiturates and meprobamate because they were relatively non–habit forming and were less lethal in overdose.

There has been considerable debate over their side effects, addictiveness, and abuse, beginning with negative media attention given to diazepam (Valium) in the late 1960s and continuing with debate over triazolam (Halcion), which culminated in its withdrawal from the market in Britain and several other countries. All benzodiazepines appear to have amnesic side effects. Triazolam has been associated with depression, increased daytime anxiety in poor sleepers, and some cases of psychosis. Physical dependence on benzodiazepines is seen predominantly in patients who have taken the medications over long periods. Upon withdrawal the original symptoms often recur, and patients may experience anxiety, insomnia, perceptual changes, hallucinations, and seizures. These symptoms can be lessened by slowly tapering off the dose *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread).*

Abuse of benzodiazepines occurs most often in young white males who also abuse other substances. In this group benzodiazepines, especially diazepam and alprazolam (Xanax), are used, sometimes nasally, to ameliorate the unwanted effects of street drugs, such as cocaine. Flunitrazepam (Rohypnol), a prescription benzodiazepine sedative not approved in the United States, is increasingly being abused by teen-agers in some areas of the country. While many doctors feel benzodiazepines are safe and effective, especially for short-term relief of anxiety and insomnia, others feel that they mask underlying problems and invite dependence. There are 12 benzodiazepines now on the market, including clonazepam (Clonopin) and temazepam (Restoril) *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread).*

Barbiturates

Barbiturates are any one of a group of drugs that act as depressants on the central nervous system. High doses depress both nerve and muscle activity and inhibit oxygen consumption in the tissues. In low doses barbiturates act as sedatives, i.e., they have a tranquilizing effect; increased doses have a hypnotic or sleep-inducing effect; still larger doses have anticonvulsant and anesthetic activity. The mechanism of action on the central nervous system is not known. The barbiturates are all derivatives of barbituric acid, which was first prepared in 1864 by the German organic chemist Adolf von Baeyer. The drugs differ widely in the duration of their action, which depends on the rapidity with which they are distributed in body tissues, degraded, and excreted. Ultrashort-acting barbiturates such as thiopental sodium (Pentothal) are often used as general anesthetics. Secobarbital (Seconal) and pentobarbital sodium (Nembutal) are short-acting barbiturates, amobarbital (Amytal) is intermediate in duration of action, and phenobarbital (Luminal) is a long-acting derivative. Barbiturates are used to relax patients before surgery, as anticonvulsants, and as sleeping pills. They also are commonly abused. Taken regularly, barbiturates can be psychologically and physically addictive. Barbiturate addicts must be withdrawn from the drug gradually to avoid severe withdrawal symptoms such as convulsions. Overdose can cause coma or death. In the United States the manufacture and distribution of barbiturates were brought under federal control by the 1965 Drug Abuse and Control Act, and they are legally available only by prescription. See publications of the Drugs & Crime Data Center and Clearinghouse, the Bureau of Justice Statistics Clearinghouse, and the National Clearinghouse for Alcohol and Drug Information.

Steroids

Steroids are a class of lipids having a particular molecular ring structure called the cyclopentanoperhydro-phenanthrene ring system. Steroids differ from one another in the structure of various side chains and additional rings. Steroids are common in both plants and animals. In humans, steroids are secreted by the ovaries and testes, the adrenal cortex, and the placenta.

The range of steroids is diverse, including several forms of vitamin D, digitalis, sterols (e.g., cholesterol), and the bile acids. Many steroids are biologically active hormones that control a number of the body's metabolic processes. This group includes the male sex hormone testosterone and the female sex hormones estrogen and progesterone. The steroid hormones of the adrenal cortex include glucocorticoids such as cortisone and cortisol (see also corticosteroid drug) and mineralocorticoids such as aldosterone.

Natural or synthetic steroids are used in oral contraceptives and in the treatment of arthritis, Addison's disease, and certain skin ailments. Side effects, related to dosage and length of treatment, can be serious and include high blood pressure, edema, unwanted hair growth, and menstrual cycle disruption. Anabolic steroids, male hormones given to

build up strength in seriously ill patients, have been abused by bodybuilders and athletes in an attempt to increase muscle mass and strength.

Analgesics

Analgesics are any of a diverse group of drugs used to relieve pain. Analgesic drugs include the non-steroidal anti-inflammatory drugs (NSAIDs) such as the salicylates, narcotic drugs such as morphine, and synthetic drugs with morphinelike action such as meperidine (Demerol) and propoxyphene (Darvon). Aspirin and other NSAIDs (e.g., acetaminophen, ibuprofen, and naproxen) reduce fever and inflammation as well as relieve pain. Narcotic analgesics and the morphinelike synthetic drugs depress the central nervous system and alter the perception of pain. They are used to alleviate pain not relieved by the NSAIDs. NSAIDs and other analgesics are also used in combination, as in Tylenol with codeine and Darvocet (Darvon and acetaminophen). Recently, patient-controlled analgesic techniques have been introduced, in which patients have the option of injecting small quantities of narcotic type analgesics to control their own pain. Microprocessor-controlled injections may be made through intravenous catheters, or through a catheter into the epidural (covering of the spinal cord) area. In addition to analgesic drugs, various techniques, such as acupuncture, hypnosis (see hypnotism), and biofeedback, are used to alleviate pain *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread).*

Illegal Substances

Prescription drugs are considered illegal when diverted from proper use. Some people shop until they find a doctor who freely writes prescriptions; supplies are sometimes stolen from laboratories, clinics, or hospitals. Morphine, a strictly controlled opiate, and synthetic opiates, such as fentanyl, are most often abused by people in the medical professions, who have easier access to these drugs. Other illegal substances include cocaine and crack, marijuana and hashish, heroin, hallucinogenic drugs such as LSD, PCP (phencycline or “angel dust”), “designer drugs” such as MDMA (Ecstasy), and “party drugs” such as GHB (gamma hydroxybutyrate) *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread).*

Opiates

An Opiate drug is any of a group of drugs derived from opium. Used medicinally to relieve pain and induce sleep, they include codeine, morphine, the morphine derivative heroin, and, formerly, laudanum. Sometimes included in the group are certain synthetic drugs that have morphinelike pharmacological action. All opiates are considered controlled substances by U.S. law and are available only by prescription. Heroin is not available legally at all in the United States *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread).*

Cocaine

Cocaine is an alkaloid drug derived from the leaves of the coca shrub. A commonly abused illegal drug, cocaine has limited medical uses, most often in surgical applications that take advantage of the fact that, in addition to its anesthetic effect, it constricts small arteries, lessening bleeding. There are many street names for cocaine, including coke, C, toot, flake, and snow.

Modes of Administration; "Crack" Cocaine

Cocaine is either snorted (sniffed), swallowed, injected, or smoked. Habitual snorting can result in serious damage to the nasal mucous membranes; shared needles put the user at increased risk of HIV infection. The street drug comes in the form of a white powder, cocaine hydrochloride. The hydrochloride salt and the cutting agents are removed to create the pure base product "freebase." Freebase is smoked and reaches the brain in seconds. "Crack" cocaine, also called "rock," is a form of freebase that comes in small lumps and makes a crackling sound when heated. It is relatively inexpensive, but must be repeated often.

Crack cocaine magnifies the effects of cocaine and is considered to be more highly and more quickly addictive than snorted cocaine. It causes a very abrupt increase in heart rate and blood pressure that can lead to heart attack and stroke even in young people with no history of vascular disease, sometimes the first time the drug is used. It also crosses the placental barrier; babies born to crack-addicted mothers go through withdrawal and are at a higher risk of stroke, cerebral palsy, and other birth defects *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread)*.

Marijuana

Marijuana is a drug obtained from the flowering tops, stems, and leaves of the hemp plant, *Cannabis sativa* or *indica;* the latter species can withstand colder climates. It is one of the most commonly used drugs in the world, following only caffeine, nicotine, and alcoholic beverages in popularity. In the United States, where it is usually smoked, it also has been called weed, grass, pot, or reefer.

The effects of marijuana vary with its strength and dosage and with the state of mind of the user. Typically, small doses result in a feeling of well-being. The intoxication lasts two to three hours, but accompanying effects on motor control last much longer. High doses can cause tachycardia, paranoia, and delusions. Although it produces some of the same effects as hallucinogens like LSD and mescaline (heightened sensitivity to colors, shapes, music, and other stimuli and distortion of the sense of time), marijuana differs chemically and pharmacologically.

The primary active component of marijuana is delta-9-tetrahydrocannabinol (THC), although other cannabinol derivatives are also thought to be intoxicating. In 1988 scientists discovered receptors that bind THC on the membranes of nerve cells. They reasoned that the body must make its own THC-like substance. The substance, named anandamide, was isolated from pig brains by an American pharmacologist, William A. Devane.

Marijuana use carries a higher risk for developing lung cancer than nicotine use. Marijuana typically remains in the bloodstream longer than alcohol. Marijuana lowers testosterone levels and sperm counts in men and raises testosterone levels in women. In pregnant women it affects the fetus and results in developmental difficulties in the child. There is evidence that marijuana affects normal maturation of preadolescent and adolescent users and that it affects short-term memory and comprehension. Heavy smokers often sustain lung damage from the smoke and contaminants. Regular use can result in dependence *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread).*

Hashish

Hashish is a resin extracted from the flower clusters and top leaves of the hemp plant, *Cannabis sativa,* and *C. indica.* Hashish, called charas in India, is the most potent grade of cannabis and is obtained from cultivated plants grown in hot, moist climates. Marijuana, a cheaper and less potent substance, is usually obtained from the cut tops of plants grown in cooler climates. Like marijuana, hashish is usually smoked, but in a pipe or water pipe; in N Africa it is also eaten. Hash oil is an extract of hashish that can be smoked or added to the tobacco in a cigarette. Hashish is an intoxicant, producing euphoria and exaggerations of sensations. It is an illegal substance in the United States with no accepted medical use. Like marijuana, its active ingredient is delta-9-tetrahydrocannabinol (THC). See publications of the Drugs & Crime Data Center and Clearinghouse, the Bureau of Justice Statistics Clearinghouse, and the National Clearinghouse for Alcohol and Drug Information *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread).*

Heroin

Heroin is an opiate drug synthesized from morphine. Originally produced in 1874, it was thought to be not only nonaddictive but useful as a cure for respiratory illness and morphine addiction, and capable of relieving morphine withdrawal symptoms. Later it was discovered to have the same pharmacologic effects as morphine and to be just as addictive. In many parts of the world, it is used as an analgesic (for relief of pain), particularly for the terminally ill. Although in the United States the manufacture and importation of the drug are prohibited and it is not used medically, heroin predominates

in illicit narcotics traffic because it Heroin is a central nervous system depressant that relieves pain and induces sleep. It produces a dreamlike state of warmth and well-being. It may also cause constricted pupils, nausea, and respiratory depression, which in its extremes can result in death. Heroin activates brain regions that produce euphoric sensations and brain regions that produce physical dependence. Hence, its notorious ability to produce both psychological and physical addiction. Its addictiveness is characterized by persistent craving for the drug, tolerance, and painful and dangerous withdrawal. Withdrawal symptoms include panic, nausea, muscle cramps, chills, and insomnia. Heroin use during pregnancy increases the risk of miscarriage and stillbirth. Infants exposed to heroin in the womb go through withdrawal at birth and exhibit various developmental problems. Besides the danger of overdose, addicts are susceptible to malnutrition, hepatitis, pneumonia, and AIDS *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread)*.

Hallucinogens

Hallucinogens are any of a group of substances that alter consciousness; also called psychotomimetic (i.e., mimicking psychosis), mind-expanding, or psychedelic drug. The group includes mescaline, or peyote, which comes from the cactus *Lophophora williamsii*; psilocin and psilocybin, from the mushrooms *Psilocybe mexicana* and *Stropharia cubensis*; and LSD, synthesized from lysergic acid, found in the fungus *Claviceps pursuer* (see ergot). These alkaloids have also been produced synthetically. Newer hallucinogens, such as PCP (phencyclidine, or “angel dust”), a drug originally used as an anesthetic, and MDMA (“Ecstasy”), an amphetamine derivative, were common in the 1980s. Marijuana has hallucinogenic properties but is pharmacologically distinct. Hallucinogens have been used for centuries by certain peoples. The Hindus and the Aztecs used them to facilitate meditation, cure illness, and enhance mystical powers. Many North American tribal peoples still use hallucinogenic mushrooms and peyote in tribal rituals *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread)*.

4. Screening and Assessment for Substance Use Disorders

The goal of substance abuse screening is to identify individuals who have or are at risk for developing alcohol or drug related problems, and within that group, identify clients who need further assessment to diagnose their substance use disorders and develop plans to treat them.

Primary care clinicians should periodically and routinely screen all clients for substance use disorders. Deciding to screen some clients and not others opens the door for cultural,

racial, gender, and age biases that result in missed opportunities to intervene with or prevent the development of alcohol or drug related problems. Visual examination alone cannot detect intoxication, much less more subtle signs of alcohol and drug-affected behavior.

A major advantage of conducting substance abuse screening as part of the ongoing process of primary care is that positive screens can be followed up at subsequent visits. In many practices, clinicians' long-standing relationships with patients give them the opportunity to conduct preliminary assessments also known as *brief assessments*. Depending on the clinician's experience and training and the resources available within a community, he may either develop a treatment plan or refer the patient for assessment by a skilled substance abuse specialist. In larger practices or clinics where provider-patient relationships are not as close, clear documentation of screening results will help ensure appropriate follow up.

Negative screens for substance abuse also warrant discussion. They allow clinicians to play a health promotion and prevention role by reinforcing the wisdom of abstinence from illicit drugs and maintenance of safe levels of alcohol use. If a clinician does not have the time (or the expertise) for a face-to-face discussion of the problem, she can give the patient lists of resources for additional help and a handout or brochure on the effects of alcohol or the other relevant drug.

4.1 Warning Signs and Risk Factors for Alcohol and Illicit Drug Use

It is important for primary care clinicians to know clients' drinking levels in order gauge their potential risk for developing problems.

Physical Signs: General

- Dental caries
- Swollen hands or feet
- Swollen parotid glands
- Leukoplakia in mouth
- Gingivitis
- Perforated septum
- Needle track marks
- Skin abscesses, burns on inside of lips
- Disrupted menstrual cycle

Physical Signs: Neurological

- Dilated or constricted pupils
- Slurred, incoherent, or too rapid speech
- Inability to focus (both visually and mentally)
- Unsteady gait
- "Nodding off"
- Blackouts or other periods of memory loss
- Insomnia or other sleep disturbances
- Withdrawal symptoms
- Agitation

Psychiatric

- Depression
- Anxiety
- Low self-esteem
- Low tolerance for stress
- Other mental health disorders
- Feelings of desperation
- Feelings of loss of control over one's life
- Feelings of resentment

Behavioral

- Use of other substances
- Aggressive behavior in childhood
- Conduct disorders; antisocial personality
- Impulsiveness and risk taking
- Alienation and rebelliousness

School-based academic or behavioral problems

- Involvement with criminal justice system
- Poor interpersonal relationships
- Social and Sexual History
- Legal status (minor, in custody)
- Alcohol or drug use by friends
- Level of education

Occupation/work history

- Sexual orientation
- Number of sexual relationships
- Types of sexual activity engaged in

- Whether the client practices safe sex

Family

- Use of drugs and alcohol by parents, siblings
- Inherited predisposition to alcohol or drug dependence
- Family dysfunction
- Family trauma
- Marital/cohabitation status
- Domestic violence and other abuse history

Demographic

- Male gender
- Inner city or rural residence combined with low-socioeconomic status
- Lack of employment opportunities

Low-Risk and At-Risk

Low-risk drinkers consume less than an average of one to two drinks per day, do not drink more than three or four drinks per occasion, and do not drink in high risk situations (i.e. while pregnant, driving a car, etc.).

At-risk drinkers occasionally exceed recommended guidelines for use. While they are at risk for alcohol related problems, they may never experience negative consequences as a result of their drinking and represent a prime target for preventive, educational efforts by primary care clinicians.

4.2 Factors To Consider in Selecting a Screening Instrument

In the primary care setting, substance abuse screening is done using brief written, oral, or computerized questionnaires, referred to throughout this section as *screening instruments*. A number of factors must be considered in determining the suitability of a screening instrument for this setting. These include sensitivity and specificity, cost, ease of administration, and patient acceptance.

Sensitivity and Specificity

Sensitivity is a screening instrument's capacity to identify true cases of the target condition in a given population. The closer to 100 percent of those with alcohol and other drug problems that a screen identifies as positive for that condition, the more sensitive the test. *Specificity* refers to an instrument's ability to identify people who do *not* have the disorder. *False positives* (identifying people who do not have the disorder as having it) tend to increase as sensitivity increases, and *false negatives* (missed cases) tend to

increase as specificity increases. Because screening instruments are imperfect, balancing sensitivity against specificity is a situation-specific issue. Generally, for screening in primary care, sensitivity should be emphasized over specificity -- that is, it is more important not to *miss true cases* than it is to assess further some patients who ultimately turn out not to have a substance use disorder. A positive screen can usually be confirmed or refuted with further history taken on the spot or, if necessary, evaluation by a substance abuse specialist. The screening instruments recommended by the Consensus Panel achieve a reasonable balance between sensitivity and specificity.

Most screening instruments have been designed for substance abuse treatment populations, not primary care populations. The four-question CAGE questionnaire (Ewing, 1984) and the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al., 1992), however, have been extensively tested in primary care settings, and a number of other studies of outpatient, substance abuse treatment populations support the practice of applying substance abuse screening instruments to primary care populations. The CAGE questionnaire is reproduced in this section.

Cost

Costs of administering a screen depend on who does the screening (e.g., physician, nurse, nurse practitioner, or physician assistant), how long it takes, and what special training (if any) is required; whether the instrument can be self-administered by the patient via pencil and paper or computer; and how long it takes to score the instrument.

Ease of Administration

The written questionnaire format is self-explanatory; the interview format consists of a clinician's asking the patient a set of predetermined questions. Computerized versions of validated paper questionnaires such as the CAGE are growing in popularity, and preliminary studies on the effectiveness of this approach are promising. A study of adolescents found that when 15-year-olds were asked about past-week alcohol use, 10 percent responded positively to a computerized questionnaire, but only 5 percent to a paper questionnaire. Across populations, however, studies have shown that similar results were obtained regardless of the form of the test.

Computers also can reduce the time needed for manual scoring and keep track of who has been screened and when. In addition, some computerized screens like the Diagnostic Interview Schedule format will automatically ask selected assessment questions if the score on screening is positive.

Client Acceptance

Simply raising the subject of substance abuse with patients can be useful. Evidence indicates that asking questions about alcohol or other drugs "primes" patients to disclose information and results in a two- to threefold increase in their stated intention to discuss substance abuse problems with their health care provider in the future.

While opinions vary about whether to integrate substance abuse screening into a standard history, asking potentially sensitive questions about substance abuse in the context of other behavioral and lifestyle questions appears to be less threatening to patients. Studies have found that screening for alcohol-related disorders is more acceptable to patients if it is part of a comprehensive health-risk evaluation that covers topics like exercise, diet, weight control, and medication use. Placing the questions within the larger context of preventive health care can help both patient and clinician feel more comfortable, reduce any perceived stigma or bias about the questions, and decrease anxiety in the client. This finding holds true when screening for use of illicit drugs as well. Primary care clinicians with experience in substance use screening also report that discussing problematic use can help foster the ongoing relationship between client and clinician.

4.3 Screening Instruments

To expedite screening and increase the likelihood of honest answers, clinicians should ask questions sequentially, beginning with the legal drug alcohol. Typically people with substance use disorders drink, so asking, "Please tell me about your drinking" serves as an effective filter. If the patient replies that he does not drink, the clinician should ask, "What made you decide not to drink?" If the answer is that the patient is a life-long abstainer or has been in recovery for 5 years or more, the clinician can conclude the screening process. There are a few exceptions. Even if they don't admit to drinking, adolescents should be asked about drug use, particularly marijuana. Pregnant women and women older than 60, as well as women who have experienced a major life transition (e.g., death of a spouse or retirement), should be queried about their psychoactive prescription drug use and use of over-the-counter sleep aids. See TIPs 3 *(Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents)* and 4 *(Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents)* for a full discussion of assessing and treating adolescents and TIP 2 *(Pregnant, Substance-Using Women)* for information about that population (CSAT). Substance abuse among people over 60 is covered in a forthcoming TIP, *Substance Abuse Among Older Adults*.

Alcohol Screening Instruments

Alcohol screening instruments question patients about how much and how often they drink and/or the consequences of their drinking. Answers to quantity/frequency questions

indicate whether a patient was, is, or may be at risk for becoming a problem drinker, a binge drinker, and/or an alcoholic, distinctions important in determining the clinician's response. A hallmark of alcoholism (and drug addiction) is continued use of a substance despite adverse consequences. Questionnaires focusing on consequences generally are quite successful in detecting dependent users; without quantity/frequency questions, however, these instruments tend to miss early stage problem drinkers and at-risk drinkers. Since no single screening instrument can be used with all primary care patients, clinicians will want to select those options that best meet the needs of their patient population. For patients with low literacy skills, face-to-face interviews where the clinician asks the questions and documents answers will best elicit information. Regardless of the information-gathering technique, however, clinicians are relying on self-reports with no assurance that answers are truthful. At this time, there is no viable alternative to self-reports in the primary care setting, although urine tests (discussed further below) can often detect recent use of some common illicit drugs, and liver function tests may show liver damage, suggesting excessive alcohol consumption. Since denial is a major symptom of dependence, the validity of self-reports is frequently an issue for those patients with alcohol or drug problems. In this situation, when the clinician suspects that a patient is not responding honestly, she may, with the patient's permission, seek information from such collateral sources as the patient's spouse, parents, and siblings. To assist primary care clinicians with screening instrument decisions, the Consensus Panel recommends the following widely used instruments for the primary care setting.

To screen for alcohol problems using a self-administered written questionnaire, a brief instrument like the AUDIT is appropriate, particularly where the expected reading level and comprehension of written English are not likely to be problematic. The AUDIT takes about 2 minutes to answer and about 15 seconds to score. If the screen will be administered by a clinician, the CAGE, supplemented by the first three quantity/frequency questions from the AUDIT, is recommended. This combination will increase sensitivity for detection of both problem drinking and alcohol dependence because it includes questions about both alcohol consumption and its consequences. Self-administering the CAGE alone takes about 30 seconds.

Drug Screening Instruments

Although screening for drug use in the primary care setting can make patients and clinicians uncomfortable, asking about illicit drug use is as important as asking about other personal practices (such as sexual practices that put patients at higher risk for sexually transmitted diseases) that can affect a patient's health.

Of the drug abuse screening instruments, CAGE-AID (CAGE Adapted to Include Drugs) is the only tool that has been tested with primary care patients. Like the CAGE, CAGE-

AID, reproduced below, focuses on lifetime use. While those patients who are drug dependent may screen positive, adolescents and those who have not yet experienced negative consequences as a result of their drug use may not. For this reason, the Consensus Panel recommends asking patients, "Have you used street drugs more than five times in your life?" In Panelists' experience, a positive answer indicates that drugs may be a problem and suggests the need for in-depth screening and possibly assessment. Because the questions were originally developed for alcohol, the CAGE-AID will not apply to every illicit drug or drug user. It is, however, a useful starting point. As with the CAGE, the Panel recommends that one positive answer prompt further evaluation.

It is recommended that clinicians treating client populations at high risk for drug abuse ask their screening questions regarding alcohol and drug use in combination. (This high-risk group includes those with psychiatric, behavioral, demographic, familial, social, or genetic risk factors that increase the likelihood of drug abuse. Red flags include work-related, marital and family, or legal problems.) Clients may view questions about drug use paired with questions about alcohol as less onerous than questions about drug use alone.

Supplementary Laboratory Tests

Although several laboratory tests can detect alcohol and other drugs in urine and blood, these tests measure recent substance use rather than chronic use or dependence. At this time, there is no test like the blood sugar test for diabetes or the blood pressure test for hypertension to identify substance use disorders.For some adolescents, a drug test may be a useful supplement to the screening instrument, especially if changes have occurred in school performance, sleep patterns, weight, mood, or social group. Again, depending on the clinician's expertise and available resources, urine tests can be done in the primary care setting or can be referred out to a drug treatment specialist.

Matching Screens With Clients

Certain screening instruments may work better for different age, gender, racial, and ethnic groups. There is some concern that cultural, gender, and age issues are not addressed adequately by the instruments currently available and that the instruments cannot detect the particular problems that may occur within different populations. No instrument has been shown to be consistently culturally sensitive with all ethnic populations, although some instruments work better with some subpopulations of patients and are less culturally biased than others.

The CAGE has been found to have a higher sensitivity for identifying alcohol dependence in African Americans compared to Whites, while the AUDIT identifies

alcohol dependence at roughly the same rate of sensitivity in both races. AUDIT has been validated in six countries with disparate cultures, although not across the various cultures in the United States.

To assess the effectiveness of a given screening instrument with a given population, a clinician must evaluate, among other factors, patients' understanding of the questions, their emotional responses to them, and the instrument's psychometric properties in the given patient population. Further studies in multiple populations are necessary to build on the current research and validate experiential knowledge. There is insufficient evidence at this time to support a recommendation for specific alternative screening instruments for different cultural groups. Nor do existing data suggest that special tools are necessary to screen different populations. Nevertheless, some points can be made about some specific populations.

Pregnant Women

It is generally accepted that quantity/frequency criteria should be lower for females than males and that pregnant women should abstain from all alcohol and other drug use. Fetal alcohol syndrome is the most common preventable cause of mental retardation (Centers for Disease Control and Prevention). Opiates and cocaine have been implicated in intrauterine growth retardation, premature births, neurobehavioral and neurophysical dysfunction, birth defects, cardiovascular problems in mother and fetus, spontaneous abortion and fetal compromise, vascular disruptions, and increased risk for infectious diseases including human immunodeficiency virus (HIV).

Because of the potential risk to the fetus, primary care clinicians should ask all pregnant patients about their drug use. The Panel recommends asking directly, "Do you use street drugs?" If the patient answers yes, advise her about possible negative effects on the fetus and recommend abstinence.

Of the alcohol screening instruments that have been modified for pregnant women, the TWEAK (a phonetic acronym for its five questions: "tolerance," "worried," "eye-openers," "amnesia," "cut down") has been found to be the most effective for this population, for whom any use is relevant. Based on best clinical judgment, the Panel recommends the use of the TWEAK (reproduced below) for pregnant patients in the primary care setting.

Older Adults

A recent study found that for patients age 65 and older, the prevalence of hospitalizations for alcohol-related medical conditions and for myocardial infarctions are similar. As high as the numbers are now, projections of the future prevalence of alcohol-related problems

indicate that the problems among older adults will increase appreciably, especially when the Baby Boom generation turns age 60. To ensure that older adults receive needed intervention services, stepped-up identification efforts by primary care clinicians are essential. Since warning signs of substance abuse (e.g., sleep problems, falls, and confusion) can be easily confused with or masked by other concurrent illnesses and chronic conditions associated with aging, the Consensus Panel recommends that all adults age 60 and older be screened for alcohol and prescription drug abuse as part of their regular physical examination. At the very least, those older adults undergoing key life transitions (e.g., death of a spouse, retirement, moving, or cessation of caretaker responsibilities) should be screened.

The CAGE and the Michigan Alcoholism Screening Test -- Geriatric Version (MAST-G) (Blow et al., 1992) are alcohol screening instruments that have been validated for use with older adults. The Consensus Panel recommends the use of the CAGE, again with a cutoff score of 1. The lower threshold is particularly important for this population because "age-related physical changes . . . can cause older people to develop more severe intoxication and subsequent problems at lower levels of consumption". There is also "some evidence of increased neural sensitivity to single doses of alcohol with age".

Since the MAST-G was developed specifically for older adults, it provides a sound screening option for clinicians willing to spend the time required to administer this 24-item test. Although the AUDIT has not been evaluated for use with older adults, it has been validated cross-culturally. Since there are few culturally sensitive screening instruments, the AUDIT may prove useful for identifying alcohol problems among older members of ethnic minority groups.

Individuals with chronic health problems also may be using a large number of prescription drugs, which can cause complications when combined with alcohol and other drugs. To screen for prescription drug use, a clinician can ask questions such as:

- "Do you see more than one health care provider regularly? Why? Have you switched doctors recently? Why?"
- "What prescription drugs are you taking? Are you having any problems with them?"
- "Where do you get your prescriptions filled? Do you go to more than one pharmacy?"
- "Do you use any other nonprescription medications? If so, what, why, how much, how often, and how long have you been taking them?"

If the clinician suspects that prescription drug abuse may be occurring and the older patient is confused about her prescriptions, seeing more than one doctor, using more than one pharmacy, or seems reluctant to discuss her use, assessment is warranted.

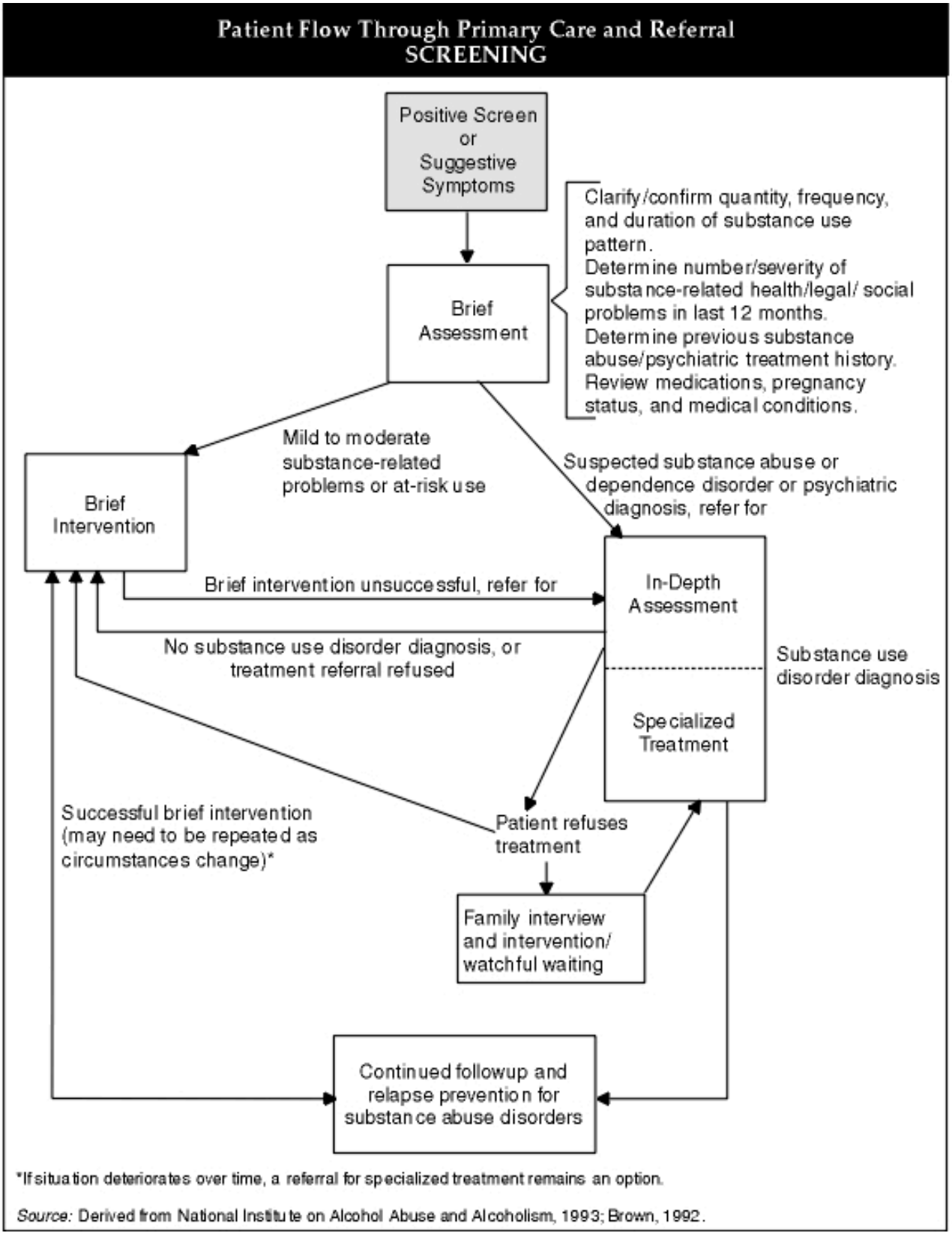
Health Care Professionals

Health care professionals are not exempt from substance abuse problems and should be screened according to the same protocols applied to the larger primary care population. Limited histories should be obtained from all, and a thorough screening done if the provider is being prescribed a mood-altering drug -- especially when anxiety, depression, and generalized physical complaints are presented. Interventions with this population may be challenging because health care professionals may be convinced that they know about substance use, which they think somehow makes them immune to this problem. While the incentive to complete treatment is compelling -- a license and professional reputation are in jeopardy -- the high stakes may also make it unlikely that they will admit to alcohol or drug abuse on a simple screening. Providers also should watch for physical or psychological signs of substance abuse or behaviors like excessive prescribing or personal use among their colleagues.

Adolescents and Young Adults

Because epidemiological evidence indicates high risk among adolescents and young adults and since early intervention among this group can greatly reduce future health and other social costs, primary care clinicians should routinely screen these patients. According to the American Medical Association's *Guidelines for Adolescent Preventive Services* (GAPS), all adolescents should be asked annually about their use of alcohol, tobacco, and illicit drugs and about their use of over-the-counter and prescription drugs for non-medical purposes, including anabolic steroids. However, since many teens do not receive annual physical examinations, the Panel recommends that screening occur every time they seek medical services, including visits necessitated by acute illness and accidents or other injuries.

Although the routine use of urine toxicology as part of the screening process of adolescents is not recommended, there are important exceptions. When there is a clinical reason to suspect a substance abuse problem (e.g., recent onset of an emotional or behavioral disorder, a change in school performance, or unexplained need for large sums of money), urine tests can be a prudent adjunct to the screening questions. Adolescents should not be tested without their knowledge and consent, except in a medical emergency. The knowledge that a test will be conducted sometimes prompts more honest replies, although this is not always the case.



If any of the following risk factors or "red flags" are revealed during questioning and examination, the adolescent should be referred to a substance abuse treatment specialist with expertise in adolescent issues for a comprehensive assessment.

Risk Factors

- ✓ Physical or sexual abuse
- ✓ Parental substance abuse
- ✓ Parental incarceration
- ✓ Dysfunctional family relationships
- ✓ Peer involvement with drugs or alcohol or with serious crime
- ✓ Smoking tobacco

Red Flags

- ✓ Marked change in physical health
- ✓ Deteriorating performance in school or job
- ✓ Dramatic change in personality, dress, or friends
- ✓ Involvement in serious delinquency or crimes
- ✓ HIV high-risk activities (e.g., injection drug use or sex with injection drug user)
- ✓ Serious psychological problems (e.g., suicidal ideation or severe depression)

Detailed information about screening, assessing, and treating alcohol- and other drug-abusing adolescents is provided in TIPs 3 *(Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents)* and 4 *(Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents)*. The Consensus Panel that developed those documents recommends using the Problem Oriented Screening Instrument (POSIT) because it covers 10 potentially problematic areas, takes only 20 minutes to self-administer, requires no training, is easy to score and interpret, is available in Spanish, and can be obtained free of charge from the National Clearinghouse for Alcohol and Drug Information.
The POSIT does, however, require literacy.

Common Screening Instruments

CAGE-AID

Asking the following questions of every adult routinely and periodically is a cost-effective way of screening for substance abuse and detecting possible problems at an early stage in their development

1) Have you ever felt you ought to **cut down** on your drinking or drug use?
2) Have people **annoyed** you by criticizing your drinking or drug use?
3) Have you felt bad or **guilty** about your drinking or drug use?
4) Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**eye-opener**)?

Scoring: Item responses on the CAGE are scored 0 for "no" and 1 for "yes" answers. Consider con-ducting a brief intervention with any client who scores a one or higher.

Asking potentially sensitive questions about sub-stance abuse in the context of other behavioral lifestyle questions appears to be less threatening to patients.

The AUDIT Questionnaire

The AUDIT is designed to be used as a brief structured interview or self-report survey that can easily be incorporated into a general health interview, lifestyle questionnaire, or medical history. Patients tend to answer it most accurately when the interviewer is friendly and nonthreatening.

- ➡ The purpose of the questions is clearly related to a diagnosis of their health status
- ➡ The client is alcohol and drug-free at the time of the screening
- ➡ The information is considered confidential
- ➡ The questions are easy to understand

How To Use AUDIT

Screening with AUDIT can be conducted in a variety of primary care settings by persons who have different kinds of training and professional backgrounds. The core AUDIT is designed to be used as a brief structured interview or self-report survey that can easily be incorporated into a general health interview, lifestyle questionnaire, or medical history. When presented in this context by a concerned and interested interviewer, few patients will be offended by the questions. The experience of the WHO collaborating investigators (Saunders and Aasland) indicated that AUDIT questions were answered accurately regardless of cultural background, age, or gender. In fact, many patients who drank heavily were pleased to find that a health worker was interested in their use of alcohol and the problems associated with it.

In some clients, the AUDIT questions may not be answered accurately because they refer specifically to alcohol use and problems. Some patients may be reluctant to confront their alcohol use or to admit that it is causing them harm. Individuals who feel threatened by revealing this information to a health worker, who are intoxicated at the time of the interview, or who have certain kinds of mental impairment may give inaccurate responses. Patients tend to answer most accurately when

- ✶ The interviewer is friendly and nonthreatening
- ✶ The purpose of the questions is clearly related to a diagnosis of their health status
- ✶ The patient is alcohol- and drug-free at the time of the screening
- ✶ The information is considered confidential
- ✶ The questions are easy to understand

Clinicians should try to establish these conditions before the AUDIT is given. Answers should be recorded carefully. In addition to these general considerations, the following interviewing techniques should be used:

- ✓ Try to interview patients under the best possible circumstances
- ✓ Look for signs of alcohol or drug intoxication– clients who have alcohol on their breath or appear intoxicated may be unreliable respondents
- ✓ It is important to read the questions as written and in the order indicated
- ✓ Circle the number that comes closest to the patient's answer.
- ✓ It is important to read the questions as written and in the order indicated. By following the exact wording, better comparability will be obtained between your results and those obtained by other interviewers.
- ✓ Most of the questions in AUDIT are phrased in terms of "how often" symptoms occur. It is useful to offer the patient several examples of the response categories (for example, "Never," "Several times a month," "Daily") to suggest how he might answer. When he has responded, it is useful to probe during the initial questions to be sure that the patient has selected the most accurate response (for example, "You say you drink several times a week. Is this just on weekends or do you drink more or less every day?"). If responses are ambiguous or evasive, continue asking for clarification by repeating the question and the response options, asking the patient to choose the best one. At times, answers are difficult to record because the patient may not drink on a regular basis. For example, if the client was drinking intensively for the month prior to an accident, but not before or since, then it will be difficult to characterize the "typical" drinking sought by the question. In these cases it is best to record the amount of drinking and related symptoms for the heaviest drinking period of the past year, making note of the fact that this may be atypical or transitory for that individual. Record answers carefully, using the comments section of the interview brochure to explain any special circumstances, additional information, or clinical inferences. Often patients will provide the interviewer with useful comments about their drinking that can be valuable in the interpretation of the total AUDIT score.

How often to do you have a drink containing alcohol?

(0) Never
(1) Monthly or less
(2) Two to four times a month
(3) Two to three times a week
(4) Four or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

[Code number of standard drinks.*]
*In determining the response categories it has been assumed that one drink contains 10 g of alcohol. In countries where the alcohol content of a standard drink differs by more than 25 percent from 10 g, the response category should be modified accordingly.
(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7 to 9
(4) 10 or more

How often do you have six or more drinks on one occasion?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

Have you or someone else been injured as a result of your drinking?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Has a relative or friend or a doctor or other health worker been concerned about your drink-ing or suggested you cut down?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Procedures for scoring AUDIT

Question 1:
Never = 0
Monthly or less = 1
Two to four times per month = 2
Two to three times per week = 3
Four or more times per week = 4

Question 2:
1 or 2 = 0
3 or 4 = 1
5 or 6 = 2
7 to 9 = 3

10 or more = 4

Questions 3–8:
Never = 0
Less than monthly = 1
Monthly = 2
Weekly = 3
Daily or almost daily = 4

Questions 9–10:
No = 0
Yes, but not in the last year = 2
Yes, during the last year = 4

The minimum score (for non-drinkers) is 0 and the maximum possible score is 40. A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption.

TWEAK Test

Use the TWEAK test to screen pregnant women.

- **T Tolerance**: How many drinks can you hold?
- **W** Have close friends or relatives **worried** or complained about your drinking in the past year?
- **E Eye-opener**: Do you sometimes take a drink in the morning when you first get up?
- **A Amnesia**: Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
- **K** Do you sometimes feel the need to **cut down** on your drinking?

Scoring: A 7-point scale is used to score the test. The "tolerance" question scores 2 points if a woman reports she can hold more than five drinks without falling asleep or passing out. A positive response to the "worry" question scores 2 points, and a positive response to the last three questions scores 1 point each. A total score of 2 or more indicates a woman is likely to be a risky drinker.

Short Michigan Alcoholism Screening Test (SMAST)

PATIENT NAME: _____		
DATE OF BIRTH: _____		
DATE OF ADMINISTRATION: _____		
1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people)	**YES**	**NO**
2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	**YES**	**NO**
3. Do you ever feel guilty about your drinking?	**YES**	**NO**
4. Do friends or relatives think you are a normal drinker?	**YES**	**NO**
5. Are you able to stop drinking when you want to?	**YES**	**NO**
6. Have you ever attended a meeting of Alcoholics Anonymous?	**YES**	**NO**
7. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?	**YES**	**NO**
8. Have you ever gotten into trouble at work or school because of drinking?	**YES**	**NO**
9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	**YES**	**NO**
10. Have you ever gone to anyone for help about your drinking? If YES: was this other than Alcoholics Anonymous or a hospital? (If YES, code as YES; if NO, code as NO)	**YES**	**NO**
11. Have you ever been in a hospital because of drinking? If YES: Was this for (a) detox; (b) alcoholism treatment; (c) alcohol-related injuries or medical problems, e.g., cirrhosis or physical injury incurred while under the influence of alcohol (car accident, fight, etc.)?	**YES**	**NO**
12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?	**YES**	**NO**
13. Have you ever been arrested, even for a few hours, because of other drunken behavior?	**YES**	**NO**

Michigan Alcoholism Screening Test–Geriatric Version (MAST-G)

The following are yes or no questions:

1) After drinking have you ever noticed an increase in your heart rate or beating in your chest?
2) When talking with others, do you ever underestimate how much you actually drink?
3) Does alcohol make you so sleepy that you often fall asleep in your chair?
4) After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
5) Does having a few drinks help decrease your shakiness or tremors?
6) Does alcohol sometimes make it hard for you to remember parts of the day or night?
7) Do you have rules for yourself that you won't drink before a certain time of the day?
8) Have you lost interest in hobbies or activities you used to enjoy?

9) When you wake up in the morning, do you ever have trouble remembering part of the night before?
10) Does having a drink help you sleep?
11) Do you hide your alcohol bottles from family members?
12) After a social gathering, have you ever felt embarrassed because you drank too much?
13) Have you ever been concerned that drinking might be harmful to your health?
14) Do you like to end an evening with a nightcap?
15) Did you find your drinking increased after-someone close to you died?
16) In general, would you prefer to have a few drinks at home rather than go out to a social event?
17) Are you drinking more now than in the past?
18) Do you usually take a drink to relax or calm your nerves?
19) Do you drink to take your mind off your problems?
20) Have you ever increased your drinking after experiencing a loss in your life?
21) Do you sometimes drive when you have had too much to drink?
22) Has a doctor or nurse ever said they were worried or concerned about your drinking
23) Have you ever made rules to manage your drinking?
24) When you feel lonely does having a drink help?

Scoring: 5 or more "yes" responses are indicative of an alcohol problem.

Suggestions for Screening

All adolescents should be asked about alcohol and drug use, particularly marijuana.

Risk Factors for Adolescent Drug Use

- Physical or sexual abuse
- Parental substance abuse
- Parental incarceration
- Dysfunctional family relationships
- Peer involvement with drugs or alcohol
- Smoking tobacco

Red Flags

- ✶ Marked change in physical health
- ✶ Deteriorating performance in school or job
- ✶ Dramatic change in personality, dress, or friends
- ✶ Involvement in serious delinquency or crimes
- ✶ HIV high-risk activities
- ✶ Serious psychological problems

Pregnant women and women older than 60, as well as women who have experienced a major life transition, should be queried about their psychoactive prescription drug use and use of over-the-counter sleep aids. Clinicians will want to use the screening instrument that best meets the needs of their patient population. When treating patient populations at high risk for drug abuse, ask questions regarding alcohol and drug use at the same time.

4.4 Screening Techniques

Asking the Questions

The Consensus Panel believes that both physicians and non-physicians can reliably screen for alcohol problems. Expanding the pool of people who screen to include nurse practitioners and physician assistants increases the likelihood that patients who should be screened are. Regardless of their professional positions, the clinicians should have proven screening skills: Early screening by unqualified people can lead to false reporting, which becomes part of the patient's record. Those screening should be familiar with the questionnaire and its interpretation, demonstrate considerable interviewing skills, be able to establish rapport with the primary care patient population, and be sensitive to the potentially stigmatizing nature of screening for alcohol and drug problems.

How the questions are asked tends to be more important than who is asking. One study demonstrated, for example, that the sensitivity of the CAGE questionnaire is dramatically enhanced by an open-ended introduction: "Please tell me about your drinking". Some problem drinkers and illegal drug users may feel embarrassed and guilty about their use; others may respond with hostility to questions raising the possibility of an alcohol or drug problem. To overcome discomfort with alcohol and drug screening questions and increase the likelihood of honest answers, clinicians should pose screening questions and accept patient responses matter-of-factly without judgment. Some clinicians report that assumptive questioning yields more accurate responses: "When was the last time you were high?" for example, is a better question than "Do you drink?" Other helpful questions are, "At what age did you first use?", "At what age did you use most frequently?", and "How many times did you use last month?" Ensuring privacy during the screening also reassures patients that the information they provide will be kept confidential and enhances the rapport between patients and clinicians.

Since screening also can reveal that a member of the patient's family has problems with alcohol or other drug use, clinicians should be sensitive to this possibility. The ongoing, long-standing contact with patients and their families that many primary care clinicians enjoy presents a unique opportunity to support non-using family members who are upset by a spouse's, child's, parent's, or sibling's substance abuse problem, confused about how to proceed, and exhausted from covering up or attending to the problem on their own.

These relationships also smooth the way for clinicians to discuss possible substance abuse among other family members and devise a plan for intervening with all those who may be involved. In discussions like these, it is important to assure the patient that confidentiality will be maintained.

Effective implementation of a screening system will require ongoing training, monitoring, training supervision, and attention to issues of reliability, empathy, appropriate responsiveness, and consistency over time. Use of a well-validated screening questionnaire reduces the risk of personal bias in interpretation.

Documenting Screening

It is important to remember that a positive screen does not constitute a diagnosis, even if the screen suggests a high probability of risky alcohol- or drug-related behavior. If and when the positive screen is confirmed by further assessment *and* discussed with the patient, clinicians should then explain the implications of including positive screening results in the medical record. While medical records are confidential, patients routinely waive confidentiality in order to provide information to insurers. Patients should be apprised of their right to deny insurers access to their medical records but warned that such a refusal could make it more difficult to obtain insurance coverage later. The Consensus Panel recommends that clinicians flag charts with positive results, but because of confidentiality concerns, chart reminders should remain neutral and not identify the problem being flagged.

Following Up on Screening

All clients who undergo screening for alcohol or drug use should be told the results of the screen. Clients with positive results to a screen will need some type of followup. Assessment questions should cover severity of the suspected alcohol or drug involvement, the types and frequency of problems connected with the client's use, and other special medical and psychiatric considerations.

If a client's response to a brief assessment suggests a diagnosis of substance abuse or dependence, the clinician should initiate a referral for an in-depth assessment.
The clinician can initiate a brief, office-based therapeutic intervention in these situations:

- ✓ Screening reveals only mild to moderate substance abuse problems
- ✓ The client appears to be at risk for experiencing negative consequences as a result of current patterns
- ✓ Co-existing illness or conditions may be worsened by continued drinking or other medications
- ✓ Client refuses referral for further assessment or treatment

Responding to Screens

Negative Screens

Even if the screen is negative, the Consensus Panel recommends periodic rescreening for substance abuse because problematic use of alcohol, illicit drug use, and their consequences can vary over an individual's lifetime. Since there is no clear scientific evidence to define appropriate intervals for screening in asymptomatic patients, the Panel recommends that clinical considerations govern the frequency of rescreening. Indications might include presentation of medical conditions that are often alcohol- or drug-related such as hypertension or insomnia; diabetes or ulcers that do not respond to treatment; persistent requests for prescription drugs; unexplained weight loss; staph infection on face, arms, or legs; frequent falls; repeated fractures, lacerations, or burns; repeated trauma that suggests domestic violence; depression; and sexually transmitted diseases.

Positive Screens

Clinicians should present results of positive screens in a nonthreatening manner. For example, a clinician might say, "After reviewing your answers on the screening questionnaire, there are some things I'd like to follow up with you," or, "Your answers to this questionnaire are similar to the answers of people who may be having a problem with alcohol."

Clinicians must make some quick decisions at the time of screening to determine the appropriate clinical response. Three possible approaches are suggested based on severity of the problem and possible risk (none of the three is appropriate for an intoxicated patient, who may require an immediate response):

1) The clinician can follow up immediately with a brief assessment during the initial visit.
2) The clinician can schedule a subsequent visit for assessment if the screening results are inconclusive.
3) The clinician can decide to refer to another source for assessment.

In areas where specialized substance abuse resources are available, the Consensus Panel recommends that high-risk patients be referred for assessment. The following sections provide information on the next steps: conducting brief assessments and brief interventions and referring and following up on patients who need specialized assessments and treatment.

Assessment

The first step to understanding local substance abuse treatment resources is to collect information about the specialized services in your area and have a contact person at each one.
In-depth substance abuse assessment requires specialized skills and consumes a substantial amount of time. However, even clinicians who will not perform substance abuse assessments should have a basic understanding of their elements and objectives so they can:

- ✓ Initiate appropriate referrals
- ✓ Participate effectively as a member of the treatment team, if required
- ✓ Better fulfill a monitoring responsibility with respect to patient progress
- ✓ Carry out needed medical case management functions as appropriate

What assessment does

- ✓ Examines problems related to use (e.g., med-ical, behavioral, social, and financial)
- ✓ Provides data for a formal diagnosis
- ✓ Establishes severity of an identified problem
- ✓ Helps to determine appropriate level of care
- ✓ Guides treatment planning

Goals and Effectiveness of Treatment

While each individual in treatment will have specific long and short-term goals, all specialized substance abuse programs have three similar generalized goals:

- ✓ Reducing substance abuse or achieving a sub-stance-free life
- ✓ Maximizing multiple aspects of life functioning
- ✓ Preventing or reducing the frequency and severity of relapse

For most patients, the primary goal of treatment is attainment and maintenance of abstinence. However, until the patient accepts that abstinence is necessary, treatment programs try to minimize the effects of continuing use and abuse through education

Counseling

Self-help groups that stress reducing risky behavior, building new relationships with drug-free friends, changing recreational activities and lifestyle patterns, substituting substances used with less risky ones, etc. All the long-term studies find that "treatment works"–the majority of substance-dependent patients eventually stop compulsive use and have less frequent and severe relapse episodes.

Some important things to remember about alcohol and other drug treatment are
No single approach is effective for all persons with alcohol problems
Treatment of other life problems associated with drinking improves outcomes
Therapists and patient (and problem) characteristics, treatment process, post-treatment adjustment factors and the interactions among these variables also determine outcomes
Patients who significantly reduce alcohol consumption or become totally abstinent usually improve their functioning.

5. Substance Abuse Intervention and Treatment

Treatment of substance abuse depends upon several variables including the severity and nature of the addiction, client motivation, and the availability of services. While some users may come into treatment voluntarily and have the support of family, friends, and workplace; others may be sent to treatment by the courts against their will and have virtually no support system. Most people in drug treatment have a history of criminal behavior; approximately one third are sent by the criminal justice system.

Both pharmacological and behavioral treatments are used, often augmented by educational and vocational services. Treatment may include detoxification, therapy, and support groups, such as the 12-step groups Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous. Nonresidential programs serve the largest number of patients. Residential facilities include hospitals, group homes, halfway houses, and therapeutic communities, such as Phoenix House and Daytop Village; most of the daily activities are treatment-related. Programs such as Al-Anon, CoAnon, and Alateen, 12-step programs for family and friends of substance abusers, help them to break out of codependent cycles.

Co-Occurring Disorders is the co-morbid condition of a person considered to be suffering from a mental illness and a substance use disorder. The concept can be used broadly, for example depression and an alcohol use disorder, or it can be restricted to specify severe mental illness (e.g. psychosis, schizophrenia) and substance use disorder (e.g. cannabis abuse). Co-Occurring Disorders is also a term used for people with an intellectual disability and diagnosed with a mental illness.

Some treatment programs use medicines that neutralize the effects of the drug. Antabuse is a medicine used in the treatment of alcohol dependency. It causes severe and sudden reaction (nausea, vomiting, headache) when alcohol is present. Naltrexone, to treat alcohol and heroin abuse, and acamprosate, used to treat alcoholism, both reduce cravings. Other programs use stabilizing medications, e.g., methadone or buprenorphine maintenance programs for heroin addiction. Acupuncture has been successful in treating the cravings that accompany cocaine withdrawal and is being used with pregnant substance abusers to improve the health of their babies.

For every person in drug treatment there is an estimated three or four people who need it. Many who attempt to get treatment, especially from public facilities, are discouraged by waits of over a month to get in. Evaluating the effectiveness of treatment is difficult because of the chronic nature of drug abuse and alcoholism and the fact that the disease is usually complicated by personal, social, and health factors.

5.1 Interventions

Brief Intervention

Brief interventions as secondary prevention tools have the potential to help an estimated 15 to 20 million heavy drinkers in the U.S. by minimizing serious adverse consequences such as costly emergency room visits, domestic violence, or road accidents.

Selecting Appropriate Clients for Brief Intervention

In response to screening questionnaires patients can be categorized into one of three groups:

1) Clients who do not appear to have any alcohol-or drug-related problems. These patients require no further intervention.
2) Clients with positive but low scores on any screening tests or who occasionally use marijuana. These patients may be appropriate candidates for brief intervention.
3) Clients with several positive responses to screening questionnaires and suspicious drink-ing or drug use histories, symptoms of sub-stance dependence, or current use of illicit drugs. These patients need further assessment.

Conducting Brief Interventions

1) **Give feedback about screening results, impairment and risks while clarifying the findings**
   - ➡ Give prompt feedback to the screening.
   - ➡ Present results in a straightforward, non-judgmental manner and in terms a patient can readily understand.
   - ➡ Concerns about potential or actual health effects should be stressed. For example, "At this level of consumption, you are at increased risk for some health problems as well as accidents."
   - ➡ Avoid being adversarial and pay attention to semantics. For example, the phrase "people for whom substance abuse is creating a problem" is less off-putting then the labels "alcoholic" or "addict."
   - ➡ Remain tolerant of the range of client reactions, including astonishment, embarrassment, hostility, and denial.

- ➡ Try to avoid arguments or discussions about how much others can drink without adverse consequences.
- ➡ Be reassuring that alcohol and drug problems are not anyone's "fault" and can certainly be addressed during visits.

2) Inform the patient about safe consumption limits and offer advice about change

- ➡ Explain what acceptable and safe use levels are for the relevant substance. Low-risk drinking is no more than two drinks per day for men and one drink per day for women.
- ➡ Clients should understand concepts of tolerance and metabolism.
- ➡ Abstinence from illegal drugs is always the ultimate goal. For example, "Thank you for being honest with me about your marijuana use. One concern of mine is your asthma, because marijuana smoke does affect your lungs. Why don't we work out a plan to help you quit?"
- ➡ Clearly state recommendations about consumption goals, keeping these in the context of lifestyle issues and living habits. For example, "In reviewing your response to our screening questionnaire, I notice that you are drinking a lot of beer on weekends. You don't seem to have any direct problems as a result, but I'm concerned that driving while intoxicated is not safe and you have a young family to consider."
- ➡ Clinician authority in offering advice can be strongly motivating.

3) Assess the patient's readiness to change A patient's reaction to initial feedback about screening results offers strong clues about readiness to change. People with substance abuse disorders generally fall into one of five stages along a continuum that provides a useful framework for monitoring progress:

1) *Pre-contemplation:* Not seeing the behavior as a problem or not wanting to change the behavior.
2) *Contemplation:* Beginning to understand that the behavior is causing difficulties in living or taking a toll on their health and happiness.
3) *Preparation/Determination*: Considering various options for change.
4) *Action:* Taking concrete steps to change the behavior in a specific way.
5) *Maintenance*: Avoiding relapse into problem behavior.

Be prepared for resistance and setbacks. Avoid the temptation to regard resistance as a challenge to authority or to react in an authoritarian way. Have an emphatic and

supportive attitude and create an atmosphere that the patient will be comfortable returning to even if goals are not successfully achieved.

4) Negotiate goals and strategies for change

- ➡ With alcohol, suggest that the client reduce consumption to below unsafe or potentially hazardous levels. For example, "Can we set a specific date to reduce your alcohol use? Could you cut back, beginning this week?"
- ➡ If a client who is using illegal drugs does not feel ready to discontinue use, suggest a taper-ing schedule. The clinician can only remind the client that reducing or stopping alcohol use or abstaining from other drug use will eliminate the health or social problems substance use is causing: Ultimately the client must choose the goal.
- ➡ Suggest that clients keep track of consumption in a daily diary to make them more aware of how much they consume. Even clients who are not ready to change their behavior may be willing to keep a diary.
- ➡ Clients will be more motivated to change if they are helping to set goals and develop strategies for change. Some studies have found that self-help manuals can be a helpful adjunct for planning change.
- ➡ A written contract is a good idea since sometimes clients forget what they agreed to do.

5) Arrange for followup treatment

- ➡ Monitor any health problems or abnormal physical markers.
- ➡ Express trust in the client.
- ➡ Confront the client if he or she is not honest about reporting substance use.
- ➡ The use of any form of objective monitoring beyond self-reports of substance abuse must be negotiated between the clinician and the client.
- ➡ Tell clients exactly who will see their medical charts and what information about screening and intervention will be recorded.

One researcher found that reduction of alcohol consumption correlated with the number of practitioner intervention sessions that were delivered.

Deciding to Refer for Further Assessment or Treatment

Clinicians should be prepared for the brief intervention to fail: The patient may not be able to achieve or maintain the mutually established goal of reducing or stopping use after one, or even several, tries. Clinicians cannot force a patient to undergo further assessment. However, if problem use persists after a brief intervention, those discussions should serve as a springboard for a more in-depth assessment or specialized treatment.

The Role of the Primary Care Clinician Throughout Treatment
Learn about treatment resources in the community that offer appropriate services
Keep in touch with the specific treatment pro-gram where the patient is enrolled to ascertain its quality and understand the approach and services offered
Request formal reports regarding the treatment plan and progress indicators from the program on a periodic basis (with the patient's explicit permission)
Clarify the clinician's role in continued care of the patient (e.g. treating specific medical conditions, writing prescriptions, and monitoring compliance through urine or other testing)

5.2 Treatment Models and Approaches

The three historical orientations that still underlie different treatment models are
A medical model, emphasizing biological/genetic or physiological causes of addiction that require treatment by a physician utilizing pharmacotherapy to relieve symptoms.
A psychological model, focusing on an individual's maladaptive motivational learning or emotional dysfunction as the primary cause of sub-stance abuse. The approach includes psychotherapy or behavioral therapy directed by a mental health professional.
A sociocultural model, stressing deficiencies in the social and cultural milieu or socialization process that can be ameliorated by changing the physical and social environment, particularly through involvement in self-help fellowships or spiritual activities and supportive networks. Treatment authority is often vested in persons who are in recovery themselves and whose experiential knowledge is valued.

The four major treatment approaches now prevalent in public and private programs are:

The Minnesota Model of Residential Chemical Dependency Treatment incorporates a biopsycho-social model for addiction that focuses on abstinence as the primary treatment goal and uses the Alcoholics Anonymous 12-Step pro-gram as a major tool for recovery and relapse prevention. This approach evolved from earlier precursors and initially required 28 to 30 days to complete. More recent models have shortened inpatient stays considerably and substituted intensive outpatient treatment followed by less intensive continuing care.

Drug-free Outpatient Treatment uses a variety of counseling and therapeutic techniques, skills training, and educational supports and little or no pharmacotherapy to address the specific needs of individuals moving from active sub-stance abuse to abstinence. This is the least standardized treatment approach and varies considerably in both intensity, duration of care, and staffing patterns. Most of these programs see patients only once or

twice weekly and use some combination of counseling strategies, social work, and 12-Step or self-help meetings.

Methadone Maintenance or Opioid Substitution Treatment specifically targets chronic heroin or opioid addicts who have not benefited from other treatment approaches. The methadone or other long-acting opioid, when administered in adequate doses, reduces drug craving, blocks euphoric effects from continued use of heroin or other illegal opioids, and eliminates the rapid mood swings associated with short-acting and usually injected heroin. The approach, which allows patients to function normally, focuses on rehabilitation and the development of a productive lifestyle.

Therapeutic Community Residential Treatment is best suited to patients with a substance abuse dependence diagnosis who also have serious psychosocial adjustment problems and require re-socialization in a highly structured setting. Treatment generally focuses on negative pat-terns of thinking and behavior that can be changed through reality-oriented individual and group therapy, and participation in a therapeutic milieu with hierarchical roles, privileges, and responsibilities. Tutorials, remedial and formal education, and daily work assignments in the communal setting or conventional jobs are usually required.

Pharmacotherapy

The use of medication to manage alcohol and drug abuse falls into four categories:

1) ***Medications to manage withdrawal*** replaces the abused drug with another, safer drug. The latter can be gradually tapered until physiological homeostasis is restored.
2) ***Medications to discourage substance use***, can precipitate an unpleasant reaction or diminish the euphoric effects of alcohol and other drugs.
3) ***Agonist substitution therapy*** replaces an illicit drug with a prescribed medication. Opioid maintenance treatment, currently the only type of this therapy available, both prevents withdrawal symptoms from emerging and reduces craving among opioid-dependent patients.
4) ***Medications to treat comorbid psychiatric conditions*** are used for persons with co-occur-ring mental health and substance abuse problems. Prescribing medications for these patients requires extreme caution, partly due to difficulties in making accurate differential diagnosis and due to the dangers of intentional or unintentional overdose.

Family Systems

The Importance of Family therapy in Substance Use Disorder Treatment

Involving family members in substance use disorder (SUD) treatment can positively affect client engagement, retention, and outcomes. Positive social/family support is related to long-term abstinence and recovery, whereas negative social/family support (e.g., interpersonal conflict, social pressure to use) is related to increased risk for relapse (Brown et al.; Cavaiola et al.; Moos & Moos; Worley et al.). In addition, when compared to non-family-based models of counseling, family-based treatments aimed at reducing SUDs are associated with lower delivery costs (Morgan et al.).

This section is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocol (TIP) 39, *Substance Use Disorder Treatment and Family Therapy*. It surveys basic factors for programs and providers to consider when implementing family-related therapy approaches, goals and processes for conducting effective family counseling, and resources for further learning about family therapy techniques and models.

Goals of Integrated Family Therapy

Key Points

- Although family involvement in SUD treatment has been shown to improve outcomes with certain clients, providers should consider client factors, such as withdrawal status, co-occurring disorders, legal involvement, or history of violence in the family, before implementing a family-based approach.
- "Family" is a broad term and can mean different things to different people (i.e., blended families, children living with grandparents, same-sex families, military families, and living with unrelated persons). Providers should allow the client to define whom they consider to be their family.
- Approaches to family counseling need to adapt to scheduling, travel, and/or ambivalence issues that can arise when involving members of a family (as opposed to individual sessions).
- Family counseling should be based on a thorough family assessment that examines patterns of family interaction as well as strengths and challenges in the family dynamic.
- Culture and diversity are vital aspects of effective family counseling. Awareness of these factors will help providers "meet clients where they are" in treatment.

The overall focus of family counseling in SUD treatment is on the roles, relationships, and communication patterns within the family system (van Wormer & Davis, 2018). Understanding these dynamics and, when necessary, modifying them can help family members both support an individual's SUD recovery, while also altering relational behavior patterns that could trigger future substance use. Specific core objectives include:

- ✓ **Leveraging the family to influence change.** Providers should encourage family members to support each other to increase the client's motivation to make important lifestyle changes, including shifting away from substance misuse.
- ✓ **Involving families in SUD treatment.** Providers should create inviting, diverse, and easily accessible programs to engage family members in the treatment environment. This might include many families or a single family member attending a psychoeducational activity or participating in a structured family-based counseling intervention. Providers should also consider developing multifamily groups to take advantage of the support, connections, and mutually beneficial effects that can come from families with lived experience interacting.
- ✓ **Changing family behaviors that support SUDs.** Providers should help the family recognize behavioral, cognitive, and emotional responses that unintentionally support the client's SUD.
- ✓ **Preventing SUDs across generations.** Providers should help families recognize how family patterns that promote SUDs can be passed from generation to generation.

Assessing the Appropriateness of Integrated Family Counseling

Before beginning family therapy, providers should screen for circumstances in which family-based interventions and counseling approaches would be inadvisable, inappropriate, or counterproductive. Several factors can influence the decision to involve family members in treatment.

- **Domestic violence:** Joint counseling for couples in which intimate partner violence has occurred is generally not recommended (New York State Office for the Prevention of Domestic Violence). Family members can learn how to express anger appropriately and safely via structured family counseling, but extreme anger or threats of violence rule out family counseling.
- **Abuse:** Do not include children, spouses, or elderly family members in family sessions if there is any current abuse or risk of abuse by family members (see box, "Mandatory Reporting of Abuse").
- **Substance use withdrawal:** Given the intensity of physical and emotional instability experienced by people in withdrawal, it is not practical to attempt integrated family counseling during this process.
- **Co-occurring mental health issues:** Family counseling is generally appropriate for clients with SUDs and mental disorders. Some family-based interventions are

particularly effective for specific co-occurring mental disorders, including severe adult anxiety disorders (Gehart).

Significant cognitive impairment: For clients who have significant cognitive impairment, family counseling can be helpful if the client is not overly disruptive, is also involved in individual counseling or other rehabilitation treatment, and is stabilized on appropriate medications as needed.

Mandated participation

One or more family members, particularly those with SUDs, may be mandated to treatment by the criminal justice system, Child Protective Services, or an employer. A provider's first priority should be to form an alliance with the mandated client without "taking sides" with the client regarding the need for treatment. Motivational interviewing strategies can help providers build a therapeutic alliance and help the client and family members resolve their ambivalence about participating in family counseling (Lloyd-Hazlett et al.).

In mandated counseling, providers should clarify that the primary concern is the family's well-being, and share any requirements that must be followed regarding release of information to the referring organization. Providers should inform all family members about their rights and responsibilities as clients, and the provider's legal and ethical responsibilities. Providers also should have family members sign all pertinent releases as part of the informed consent process.

Who Participates: Defining "Family"

It is up to clients to identify whom they would like to include in family counseling. Providers should make their best efforts to include anyone the client thinks is significant: relatives or nonrelatives, extended family (e.g., grandparents, a cousin), friends, significant others, or "family of choice" (i.e., supportive members of a community the client identifies with). Providers can offer ideas about why it might be important or helpful to include specific family members, but they should always honor the clients' autonomy and right to decide for themselves what constitutes their family and decide which family members to include in treatment. Once family is identified, providers should be prepared to address obstacles that can hinder family participation:

Geographic constraints: Some clients have no significant family members close enough to attend family sessions in person. Using secure teleconferencing or videoconferencing technology is one strategy for including family members in important conversations with the client. Another is to hold longer family sessions (e.g., 2 hours) or multiple sessions over consecutive days with family members who are able to travel and attend family counseling.

Work and scheduling conflicts: Overcoming work and scheduling obstacles can necessitate holding multiple sessions outside of normal work hours or offering phone or video consultation.

Disruptive behavior: Providers may need to exclude a family member who is continually angry, blaming, or disruptive. Address this issue with the family and the individual separately, and explore options for addressing that family member's needs (e.g., individual counseling, referral to other support services). Reinvolve the individual in family sessions when the needs have been addressed.

Family subsystems: All families include subsystems — the interpersonal relationships among clusters of people within the family system. Providers may need to work with individuals or different subsets of family members before the whole family can address its overall treatment goals.

Address the Impact of Stigma

When working with families in SUD treatment, it is important to recognize that feelings of stigma can affect willingness to participate in therapy. Families affected by SUDs often feel isolated and struggle with stigma, shame, and confusion. Providers should be aware of this and work to educate family members about the nature of addiction (Lancaster et al.)

Refusal to attend counseling sessions: Strategies to include relatives who refuse to attend sessions include arranging an empty chair in the room to represent that family member and addressing the absent family member metaphorically, or calling the family member who is not present during the family session (after securing his or her permission) to enlist his or her help in answering a question that has come up in the session.

Conducting Appropriate Screening and Assessment

Assessment is an important component of any SUD treatment program. Assessment moves through several stages that are designed to identify the client's family resources and strengths to best position the client and family to achieve positive treatment outcomes.

Individual assessment

Comprehensive assessments are usually conducted at intake and are often required for an individual entering SUD treatment. To ensure effective family involvement, the assessment should:

- ✓ Yield a thorough and accurate family history.
- ✓ Confirm and clarify information about the client.

- ✓ Establish the context in which substance misuse most often occurs and in which it may have started or accelerated.
- ✓ Set a tone for a continuing focus on the family.
- ✓ Identify family resources to help plan long-term care.
- ✓ Document specific information that can determine treatment goals.
- ✓ Help the clinician determine which family members should be involved.

If the client agrees to family involvement in treatment, providers should obtain privacy/confidentiality releases and then schedule an initial family interview.

Family interview

Although family members may feel ambivalent about becoming involved in treatment, they are often willing to attend at least an initial interview either individually or as a group. The primary focus is to engage the family and begin to develop an alliance with each family member. Providers can also use this initial interview to determine how the family functions, identify major family problems, and identify the family's perception of how the client's SUD has affected the family and each member (Schumm & O'Farrell). Because safety is paramount, providers should also make a preliminary determination of any current family violence and physical or sexual abuse or abuse history.

Family and strengths assessment

Once the family is actively involved in treatment sessions, the provider has an opportunity to assess current family functioning, the history of SUDs over time and across generations, and the role of SUDs in the development of family problems (Schumm & O'Farrell). Providers can also explore the history of the individual's SUD over time, but they should always link this history to the development of family system SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. The primary assessment task is to observe family interactions during sessions to determine alliances and conflicts among family members, interpersonal boundaries, and communication styles.

Providers can also assess the strengths of the client and all family members involved in treatment. The goal is to identify: the family's current coping skills and abilities; family, social, and recovery supports; motivation and commitments to change; and self-efficacy. In other words, providers are assessing recovery capital— the internal and external resources that the client can draw on to begin and sustain recovery. Doing so will give providers a baseline of family coping skills and client-centered knowledge, values, and resources to build on in helping the family develop a treatment and recovery plan. It is also critical to maintain a strengths-focused lens throughout counseling to set a positive

tone and enhance family members' motivation to address challenging problems (Tuerk et al.).

Optimizing initial family counseling sessions

After the family interview and assessment process, initial family counseling sessions should focus on building relationships with all family members and giving each member time to share his or her frustrations, challenges, and hopes. The identified client should always be part of family sessions. The only times to exclude someone are if he or she is intoxicated or under the influence of drugs, has severe psychiatric symptoms (e.g., hallucinations, suicidality, delusions, severe mania), has threatened violence, or a combination of these.

Initial sessions should focus on:

- ✓ Establishing a working relationship with members of the family.
- ✓ Orienting participants to the family counseling process.
- ✓ Continuing the assessment of how the SUD has affected each family member.
- ✓ Reframing SUDs from a character flaw or moral failing to a biochemical and behavioral problem they can work on together to remove from their lives.
- ✓ Continuing the assessment of family strengths and strategies they have previously used to lessen the impact of the SUD on the family.
- ✓ Exploring family goals and expectations for the future and each family member's ideas on how counseling can help.

Addressing Common Challenges

The following approaches can help overcome common challenges, myths, and obstacles hindering engagement and treatment of families.

"Family counseling is secondary." When a provider views family therapy as an add-on to individual or group counseling, it sends a message to clients and family members that family counseling is not important. Providers should evaluate their attitudes about family involvement and be champions for integrating family-based interventions as an important part of SUD treatment.

"Family counseling is too painful." Although family counseling may temporarily shake up the family system and activate intense feelings, these feelings are a normal part of counseling. A provider's task is to help the client and family members discover new ways of coping with intense emotions instead of reverting to old behaviors (e.g., blaming and shaming the family member with the SUD).

Two Family-Based models for Treating SUD: An Overview

Behavioral Couples Therapy (BCT) is designed for married or cohabiting individuals seeking help for an SUD (O'Farrell & Fals-Stewart). BCT is a structured approach that focuses on improving partners' patterns of interaction, building more cohesive relationships to reduce risk of return to use for the partner with an SUD, supporting abstinence, and improving relationship functioning. BCT has also been adapted for use with families (O'Farrell et al.).

Appropriate participants are generally couples, with the following characteristics:

- Partners are married or living together.
- Neither partner has a significant co-occurring mental disorder.
- Only one member has an SUD.
- There is no indication of risk of any intimate partner violence.

Interventions in BCT focus on reducing substance misuse and (in some cases) promoting abstinence in support of recovery from an SUD (e.g., developing a recovery contract), addressing relationship concerns (e.g., increasing positive activities and improving communication), and preventing relapse (e.g., developing plans for continued recovery and relapse prevention).

BCT can yield desirable treatment outcomes, including reductions in substance use, legal and family problems, and hospitalizations. It is also linked with increased abstinence and treatment adherence (O'Farrell & Clements; Rowe).

Risk Reduction Through Family Therapy (RRFT) is an integrative approach that addresses co-occurring posttraumatic stress disorder (PTSD) symptoms (or other mental health problems), SUDs, and other risk behaviors in trauma-exposed adolescents. In RRFT, clients intentionally recall specific feelings, thoughts, cues, and memories of traumatic experiences.

Appropriate participants are trauma-exposed adolescents ages 13–18 who experience co-occurring trauma-related mental health problems (e.g., PTSD, depression), substance use problems, and other risk behaviors (e.g., risky sexual behavior, nonsuicidal self-injury) and parents/caregivers. RRFT is individualized to each family and adolescent.

The goals of RRFT include reducing symptoms of trauma-related mental health issues, reducing substance use and substance use risk factors, increasing protective factors, improving family communication and cohesion, and reducing risk factors for revictimization.

RRFT can lead to reductions in drug use, drug use-related risks, PTSD symptoms, and sexual behaviors that increase risk for HIV and other sexually transmitted infections (Hahn et al., 2020).

Coordination of family services. It is challenging to provide family-oriented case management or referral and coordination of services while doing family counseling, but providers can actively link individual family members to case management services or peer providers who can collaborate with them to coordinate the multiple service needs of the family. It can also be helpful to connect a family with other persons with lived experience of recovery to help them navigate coordinated care.

Keeping family secrets. A provider should not hold family secrets. The provider should let everyone know during the initial family interview that he or she will bring up information a family member reveals outside of family sessions and will do so during the next family session. The only exception is if a family member tells the provider privately of violence or abuse that needs to be addressed separately.

SUD client or family member is in precontemplation. The term "denial" has been used to describe people who do not see an SUD as a problem. This label is judgmental; avoid using it and let family members know that using labels to confront each other can lead to conflict or family members closing down emotionally. Providers can also reframe "denial" as precontemplation, an indication that the family member is not quite ready to change.

Family's adjustment to abstinence. Families tend to adjust to SUDs, and family members may act differently (and not always positively) when the client with the SUD enters recovery, as long-standing problems finally come to light and roles within the family realign. The provider's task is to help family members adapt to these changes, find ways to support the client's recovery, learn new relationship and coping skills, and find healthier ways to function as a family.

The client being treated for opioid use disorder (OUD) with buprenorphine and methadone. Common myths of medication treatment for OUD include the false belief that people taking it are simply replacing one addiction with another, and that people cannot truly be in recovery while taking these medications. Family members need to be educated about what medication treatment for OUD is, as well as its effectiveness and safety, so they can be a source of emotional and practical support for clients.

The client on other medication. When clients stop taking medications, symptoms of mental disorders or previous substance use behaviors can reemerge, causing families to return to patterns of dysfunction. The provider's task is to raise this issue in family sessions. Once all family members have accurate information about the importance of medication adherence, the conversation can shift to the family's working as a team to

support the client in taking medication as prescribed or safely tapering off (under medical supervision and when appropriate).

Financial/logistical barriers. For many families or family members, financial and/or travel resources may be limited. Offering bus tokens, transit cards, or similar transportation incentives can help increase the ability of the family (or other members) to participate.

Eight Cultural Questions To Consider When Offering SUD Treatment for Families

1) How is this family structured?
2) What is the role of the extended family?
3) What is the role of religion or spirituality within this family?
4) What is the family's immigration/ nativity status? How does this affect family members' level of acculturation?
5) Are there culture-specific family values to be aware of?
6) How does the family's culture affect their communication style?
7) How does this family experience racism and discrimination? How do those experiences, along with historical trauma, affect the family?
8) Has the family experienced any periods of separation (particularly between parent and child)?

Responding to Cultural Differences

Truly comprehensive, evidence-based SUD treatment cannot be offered if the culture of the family with whom the provider is working is not considered. Although a comprehensive discussion of culture and diversity in family-based treatment is beyond the scope of this *Advisory,* providers can consider the following steps to embrace cultural differences:

- ✓ Engage aspects of the family's culture or religion that promote healing.
- ✓ Consider the role that drugs and alcohol may play in the culture.
- ✓ Be flexible and meet families where they are.
- ✓ Be continuously aware of and sensitive to the differences between the provider and the members of the group he or she is counseling.
- ✓ Is the family a homogeneous group or one that represents different backgrounds? Does the family live in one community or several different communities? Are those communities different from the one in which the provider lives? These considerations and responsiveness to the specific cultural norms of the family in treatment must be respected from the start of counseling. Family members may also identify or affiliate with multiple cultures (e.g., ethnic origin but also religion or sexual identity). If these factors are not apparent or explicitly explained by the clients and families, the provider should ask.
- ✓ Providers should be aware of and sensitive to their own family culture. Providers may bring their own cultural issues to treatment. A provider's age, gender, ethnicity, local community, and levels of health literacy and education, as well as other traits, may affect therapeutic processes.

Adolescents

Research shows that adolescents use drugs and alcohol for various reasons:

- They are often readily available.
- They provide a quick, easy and frequently cheap way to feel good.
- They offer a means of gaining acceptance in a peer group.
- They may help modify unpleasant feelings, reduce disturbing emotions, alleviate depression.

Additional factors that contribute to adolescent drug abuse, especially alcohol dependence:

- **Biological Risk**: Increasing evidence points to a genetic predisposition to chemical dependency. If a parent is a substance abuser, one study indicates that chances are increased by 25% that his/her child will also be a substance abuser *(Conroy)*.
- **Lack of Supervision**: Parents who travel or who both work all day create an environment that allows for unsupervised activities which may involve drinking.
- **Parental Attitudes**: Children develop perceptions about drugs and alcohol based on what they see at home.
- **Life Crises**: Death in the family, divorce, illness, and moving to a new community are all examples of life stressors. A significant positive correlation exists between the number of problems reported in the family and the number of different types of drugs abused by the adolescent offspring *(National Youth Polydrug Study)*.
- **Peer Pressure**: One study indicates that an adolescent's chance of problem or heavy drinking is five times greater if a best friend is also a drinker.
- **Early Beginnings:** The earlier a child learns to sedate anxiety with a substance, the greater the problem. Proportionately, younger children in drug-abusing families are heavier users and require more treatment than their older counterparts.
- **Parenting Style:** Parents intent on being buddies, rather than functioning from an adult executive position, have problems confronting the child and setting limits around substance use. Alcohol is the drug of first choice of American teenagers. It is considered a gateway drug, one that leads to abuse of other substances. Alcohol abuse is blamed for the dramatic increase in teen traffic fatalities, suicides, and homicides. (The National Council on Alcoholism and Drug Dependency (NCADD)).

There is a strong correlation between adolescent substance abuse, unsatisfactory family relationships, and inadequate emotional support by parents. A family systems idea of the adolescent substance abuse problem might be stated as follows: a family experiencing discord, detachment or loss without stabilizing coping mechanisms results in an emotional climate which is conducive to the development of an adolescent substance

abuser. In a vicious cycle, this drug-abusing behavior then leads to an intensification of the pre-existing dysfunctional family patterns. This unresolved situation leads to more acting-out behavior and increased use of drugs by the adolescent.

Kaufman and Kaufman have compiled the following list of the seven most frequently asserted clinical and theoretical speculations regarding the systemic characteristics of families with adolescent drug abuse members.

- ➡ The drug addict is the symptom carrier of the family.
- ➡ The addict helps to maintain the family homeostasis.
- ➡ The addicted member reinforces the parental need to control and continue parenting, yet finds such parenting inadequate for his or her needs.
- ➡ The addict provides a displaced battlefield, so that implicit and explicit parental strife can continue to be denied.
- ➡ Parental drug and alcohol abuse is common and is directly transmitted to the addict or results in inadequate parenting.
- ➡ The addict is involved in cross-generational alliances with parents separated from each other.
- ➡ Generational boundaries are diffuse. There is frequent competition between parents. Frequently, the crisis created by the drug dependent member is the only way the family gets together and attempts some problem solving, or is the only opportunity for a "dead" family to experience emotions.

Adolescents in such families may accurately perceive that the drug abuse ensures ongoing family crises and, if discontinued, may result in neglect by the family or a decrease in the adolescent's importance and centrality in the family. The turmoil created by the drug abuser who comes home stoned, gets into trouble at school, steals, overdoses, or gets arrested may represent an attempt, albeit negative, to secure and maintain family interest and involvement.

Summary Points from a Family Counselor Point of View

- ➡ If background and training are largely within the family therapy tradition, develop an ever−deepening understanding of the subtleties and pervasiveness of denial. If background and training are largely within the substance abuse treatment field, develop an ever−deepening understanding of the subtleties and impact of family membership and family dynamics on the client and the members of the client’s family.
- ➡ When the going gets tough, get help. Both substance abuse counselors and family therapists are likely to need help from each other with different situations. Consultations and collaboration are key elements in ensuring clients’ progress.
- ➡ Develop thorough and effective assessment processes.

➡ Consider specialized training on one or more specific family therapy techniques or approaches.
➡ Match techniques to stage of change and phase of treatment.

Specialized Treatment

There are common themes in treating all addictions. The client's physical, psychological and spiritual needs must be incorporated into treatment. Medically supervised detoxification followed by inpatient treatment and outpatient treatment is a routine treatment approach. Treatment often lasts for over a year. Involvement in community based self-help groups is often a life-long activity for recovering people. Therapists working with chemically dependent persons need to involve a variety of supportive services to provide the most effective treatment. Medical, financial, occupational, legal, psychological, and family problems are some of the areas that should be integrated into the treatment plan in order to assist the chemically dependent person in obtaining abstinence and becoming sober. Random urinalysis is another important aspect of treatment planning for persons with substance abuse problems.*(National Center on Addiction and Substance Abuse at Columbia University (CASA). Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse, New York: CASA)*

Cocaine Treatment

Current treatment approaches are similar to those used for alcohol abuse. The most effective are those that adapt to the specific problems associated with cocaine abuse. Treatment should include management of withdrawal symptoms, engagement, abstinence and relapse prevention.

Individual therapy, group therapy, and community based self-help groups should all be integrated into the treatment plan. Once the drug abuser is stabilized in treatment, family therapy is recommended. Family members may choose individual therapy, group therapy, and community based self-help groups to address their own needs. Due to the high financial cost of a cocaine addiction, persons with a history of cocaine dependency may also need counseling to address financial problems and occupational needs *(NIDA; Galanter and Kleber).*

Amphetamines Treatment

The person addicted to amphetamines may need medically supervised detoxification. Inpatient treatment may also be necessary. Outpatient treatment for amphetamine abuse often includes a combination of individual and/or group therapies, as well as, participation in a peer support group such as Cocaine Anonymous. Family therapy would

be recommended once the substance abuser is stabilized in his or her recovery. Individual therapy for family members could be utilized until family therapy is recommended. This previously described treatment approach could be utilized for most substance abusers and their family members *(Baron; National Clearinghouse for Drug & Alcohol Information; Galanter Kleber)*.

Opiod Treatment

Treatment is similar to the previously mentioned treatment planning for alcohol and cocaine. However, in working with a person who is abusing opioids, methadone or some other drug, treatment is usually incorporated into the treatment process to assist the person in successfully obtaining completed abstinence from all substances *(Galanter & Kleber; NIDA)*.

Sedative, Hypnotic or Anxiolytic Treatment

Medically supervised detoxification is necessary to safely assist a person in obtaining abstinence. Inpatient treatment may follow successful detoxification. Patients previously addicted to any depressant or sedative are at increased risk of becoming dependent if prescribed the same class of drugs at a future time. Education, relaxation training, stress management, recreational alternatives, self-help groups, and individual therapy are coping strategies that proves useful instead of pharmaceutical interventions *(Baron; Galanter & Kleber)*.

Marijuana Treatment

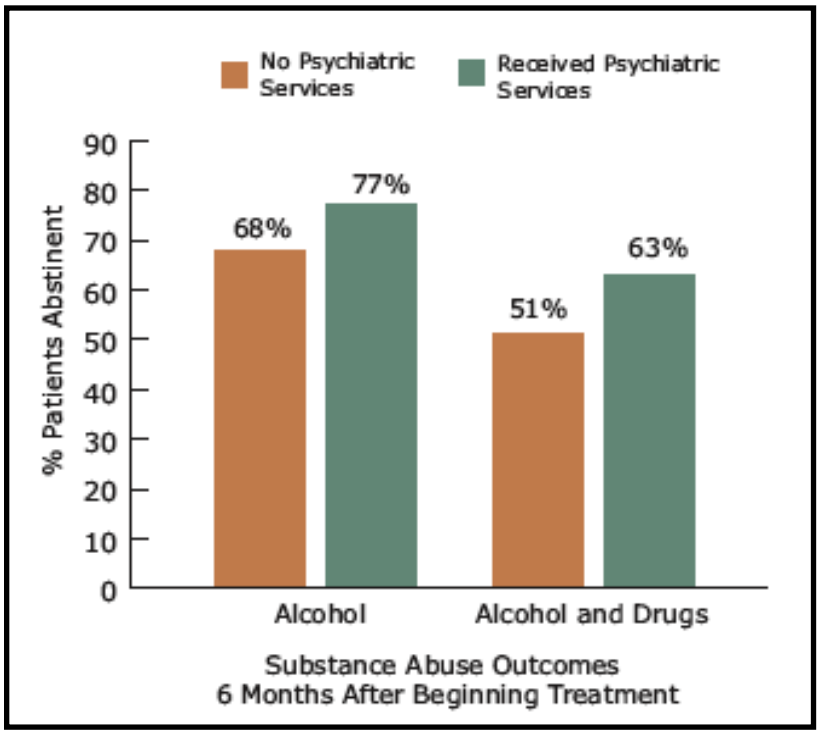
Modern therapy for marijuana addiction embraces a multi-disciplinary approach. Education, group and individual counseling, and peer support groups are often used to facilitate recovery. Community based self-help groups such as Marijuana Anonymous or Narcotics Anonymous should be utilized for continuing recovery. (Baron; *Matrix Center*; *National Council on Alcoholism*; *National Clearinghouse for Drug & Alcohol Information*; *Whitebread)*.

Hallucinogen Treatment

In treating a person with hallucinogen abuse or dependency problems, relaxation exercises and behavioral therapy may be helpful. Individual therapy, group therapy and community based self-help groups are recommended. Family involvement in therapy is also beneficial for all family members. For some clients, flashbacks may have to be addressed in treatment. (*National Clearinghouse for Drug & Alcohol Information*; *Whitebread)*.

Inhalants Treatment

Treatment would be similar to the previously mentioned treatment processes. It is always important to remember when working with a person with substance abuse problems to make the treatment plan drug-specific and to individualize the psychotherapy to better meet the person's needs (*Source: Espeland*; *National Institute on Drug Abuse Capsule Series*).



Cognitive Behavioral Therapy (CBT) of Substance Abuse

According to Aaron Beck, PhD, there are many different ways of conceptualizing substance abuse *(Beck et al.)*. Although the disease model and 12-step programs are dominant throughout treatment literature and practice, several authors have developed social learning, or cognitive-behavioral, approaches for understanding and treating substance abuse disorders *(e.g., Abrams and Niaura)*. Alternative efforts even have included rational emotive (RET) approaches to treating substance abuse *(e.g., Ellis et al.)*.

According to Aaron Beck, PhD., Cognitive Therapy is "an active, collaborative, focused form of psychotherapy developed from the findings that psychological disturbances frequently involve habitual errors in thinking" *(Beck et al.)*.

Similarly, the cognitive model of substance abuse outlines that certain individuals have developed a "cognitive vulnerability" to drug abuse. Under particular circumstances, specific beliefs are activated that increase the likelihood of substance use *(Beck et al.)*. Beliefs and subsequent self-talk such as, "I cannot socialize without getting high," are activated in certain provocative situations, leading to increased risk of succumbing to drug use.

According to the CBT model, various circumstances can trigger drug-related beliefs and, consequently, drug use. Beck has researched a series of events that occur between the external/internal circumstances and the actual drug use. The sequence of conditions is as follows: the high-risk external/internal circumstance is followed by the activation of a basic drug-related belief, which in turn leads to associated automatic thoughts and further to craving/urges. This in turn leads to the activation of facilitating beliefs about drug use, which directs attention to instrumental strategies for obtaining the drugs, this in turn leads to use. At this point, drug use can serve as an additional external/internal circumstance that triggers other drug-related beliefs (e.g., "Since I have broken my abstinence, I might as well go on a binge"), resulting in a vicious cycle *(Beck et al.)*.

Behavioral treatment researchers have explored the efficacy of numerous behavioral interventions for drug dependent individuals and have made considerable progress. Research studies on behavioral treatments for drug dependence were presented by scientists who do state-of-the-art research in this area: Drs. Stitzer, Childress, Grabowski, and Higgins. She wrote with Drs. Iguchi, Kildorf, and Bigelow, Dr. Stitzer reviewed the research on the use of positive versus negative contingencies with methadone maintenance patients and presented the advantages of using positive incentives. Cognitive therapy for substance abuse was clearly described by Dr. Wright at the technical review and again in the chapter written by Drs. Wright, Beck, Newman, and Liese. Dr. Childress reviewed the work she has done on cue exposure with opiate and cocaine addicts. In her chapter, she and her coauthors, Drs. Hole, Ehrman, Robbins, McLellan, and O'Brien, alert the field to the need for providing patients with active strategies for managing their drug problems in addition to the passive cue exposure strategies used in the laboratory. Dr. Grabowski pointed out that even when clinics do not define them as such, all clinics use clinic wide behavioral interventions, commonly thought of as the rules of the clinic. Dr. Grabowski and his coauthors, Drs. Rhoades, Elk, Schmitz, and Creson, reviewed the ways in which these clinic wide and individualized contingencies can impact positively on drug dependence treatment. Dr. Higgins showed how community reinforcement, an approach that controls and utilizes reinforcers in multiple aspects of the cocaine-dependent individual's life, can increase the ability to achieve and maintain cocaine abstinence. Dr. Higgins' approach, described in the chapter by Drs. Higgins and Budney and originally developed by Hunt and Azrin for use with

alcoholics, holds great promise for the treatment of cocaine addiction. The work of behavioral treatment researchers at the technical review has, in many ways, set the standard for behavioral drug dependence treatment research *(Beck, A.T.; Wright, F.D.; Newman, C.F.; and Liese, B.S. Cognitive Therapy of Substance Abuse. New York: The Guilford Press).*

12 Step

A twelve-step program is a set of guiding principles outlining a course of action for recovery from addiction, compulsion, or other behavioral problems. Originally proposed by Alcoholics Anonymous (AA) as a method of recovery from alcoholism, the Twelve Steps were first published in the book, *Alcoholics Anonymous: The Story of How More Than One Hundred Men Have Recovered From Alcoholism* in 1939. The method was then adapted and became the foundation of other twelve-step programs such as Narcotics Anonymous, Overeaters Anonymous, Co-Dependents Anonymous and Debtors Anonymous. The process of twelve-step recovery has been characterized by Dr. Bob - one of AA's co-founders - as "Trust God, clean house, help others". As summarized by the American Psychological Association, the process involves the following:

- ✓ Admitting that one cannot control one's addiction or compulsion;
- ✓ Recognizing a greater power that can give strength;
- ✓ Examining past errors with the help of a sponsor (experienced member);
- ✓ Making amends for these errors;
- ✓ Learning to live a new life with a new code of behavior;
- ✓ Helping others that suffer from the same addictions or compulsions.

(Source: Alcoholics Anonymous. "Sponsorship Q&A (pamphlet)". Alcoholics Anonymous World Services)

Twelve-step methods have been adopted to address a wide range of substance abuse and dependency problems. Over 200 self-help organizations, known as fellowships, with a worldwide membership of millions, now employ twelve-step principles for recovery. Narcotics Anonymous was formed by people who did not relate to the specifics of alcohol dependency. Similar groups now exist for sufferers of cocaine addiction: Cocaine Anonymous, as well as other specific drug addictions, such as Crystal Meth Anonymous and Marijuana Anonymous. Behavioral issues such as compulsion with and/or addiction to gambling, food, and sex are addressed in fellowships such as Gamblers Anonymous, Overeaters Anonymous and Sexual Compulsives Anonymous. Fellowships such as Al-Anon - for families and friends of the person with the addiction - are responses to what is identified by some mental health professionals as the problem of addiction as a disease that flourishes in and is enabled by family systems. Other groups address problems with

certain types of behaviors, including Clutterers Anonymous, Debtors Anonymous, and Workaholics Anonymous.

Twelve Steps

These are the original Twelve Steps as published by Alcoholics Anonymous.

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His Will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

In some cases, where other twelve-step groups have adapted the AA steps as guiding principles, they have been altered to emphasize principles important to those particular fellowships, to remove gender-biased or specific religious language *(Alcoholics Anonymous, June 2001. Alcoholics Anonymous, 4th edition ed., Alcoholics Anonymous World Services)*.

Twelve Traditions

The Twelve Traditions accompany the Twelve Steps, the Traditions provide guidelines for group governance. They were developed in AA in order to help resolve conflicts in the areas of publicity, religion and finances. Most twelve-step fellowships have adopted these principles for their structural governance. The Twelve Traditions of Alcoholics Anonymous are as follows.

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

(Source: Alcoholics Anonymous, Alcoholics Anonymous, 4th edition ed. Alcoholics Anonymous World Services).

Understanding 12 Step Programs

Family therapists would benefit from attendance at 12 Step programs to understand the concepts and to see in action the principles that might be helpful to their clients. Anyone can attend an open 12 Step meeting (see a local telephone directory or AA's Web site at www.aa.org, and click on "contact local AA"), and therapists who attend meetings and process the information with knowledgeable supervisors or colleagues are able to converse with clients about meeting attendance, problems, benefits, and methods of utilizing 12 Step meetings in conjunction with the therapeutic process. Experience with attendance at 12 Step meetings helps therapists to address issues of resistance when clients say that the meetings are not appropriate for them (e.g., "everyone is different from me," or "they make me tell things I don't want to talk about.") Another benefit of

therapists' attendance at meetings is the ability to prepare a client for attendance. The therapist can give an overview of what to expect; for example, it is not necessary to put a donation in the basket as it is passed; it is okay to say "pass" if people are taking turns talking by going around the room, seat by seat; how people use sponsors, and so on.

Considering how common substance abuse is in our society, all family therapists need to understand the philosophy behind the disease concept of substance abuse; the concepts of 12 Step programs (such as powerlessness and surrender); the signs, symptoms, and stages of substance abuse; and the specific issues, problems, and needs of children. Some evidence suggests that these ties are already strong. For example, *Northey* found in a recent survey that 89 percent of family therapists do refer clients to self−help groups. Family therapists also need to understand the language and terminology of the substance abuse treatment field and

Substance abuse treatment providers recognize the importance that spirituality (regardless of the particular faith or spiritual path chosen) can have in recovery. The use of spirituality and self help principles may seem foreign to some family therapists' conception of treatment, but these ideas are widely used and accepted within the substance abuse treatment community. Family therapists can use spirituality by recommending that families connect (or reconnect) with their spiritual traditions or discuss spiritual beliefs.

Some self help ideas, such as sponsorship (a mentoring component for clients), can also be applied within a family therapy setting. Connecting a family who is new to treatment with another more experienced family in treatment can help both, encouraging the new family to see the possible gains and helping the more experienced family reaffirm its commitment to treatment and the difference it has made.

12 Step groups are the mutual self help modality most commonly used, but there are other self-help groups that go beyond the substance abuse field. In fact, some of these groups are called mutual aid groups because they go beyond the traditional AA self−help 12 Step programs. Examples include Deaf and Hard of Hearing 12 Step Recovery Resources (www.dhh12s.com), Depression and BiPolar Support Alliance (www.dbsalliance.org), and the National Alliance for the Mentally Ill (www.nami.org). The Internet can serve as a good point for finding out local information about these kinds of groups. A listing of various mutual aid resources by the Behavioral Health Recovery Management project can be found at www.bhrm.org. See also the National Mental Health Consumer's Self−Help Clearinghouse at www.mhselfhelp.org.

AA Effectiveness

Alcoholics Anonymous is the largest of all the twelve-step programs followed by Narcotics Anonymous, meaning a large majority of twelve-step members are recovering from addiction to drugs or alcohol. The majority of twelve-step programs, however, address illnesses other than addiction. For example, the third largest twelve-step program, Al-Anon, treats codependence. About twenty percent of twelve-step programs are for addiction recovery, the other eighty percent address a variety of problems from debt to depression. It would be an error to assume the effectiveness of twelve-step methods at treating problems in one domain translates to all or to another domain, therefore readers are directed to relevant sections in each group's articles *(Source: Alcoholics Anonymous, Alcoholics Anonymous (4th edition ed.). Alcoholics Anonymous World Services).*

Common Treatment Modalities

A variety of treatment modalities are widely used in substance abuse treatment. Family therapists should be familiar with at least the most common of these modalities in order to be able to make effective referrals and understand other components of clients' treatment regimens. When referring a client to a particular substance abuse treatment program, however, a number of factors must be considered in addition to the necessary intensity of treatment and the specific services available. Some main considerations are:

- The client's expressed needs and desires
- A recommendation from a substance abuse treatment professional (if there is any doubt about the treatment modality to which the client should be referred)
- The client's insurance or other available funding sources and the types of treatment they cover
- The client's work setting and family arrangements, especially whether they allow the client to leave for an extended period of time

Nonetheless, the consensus panel believes that family therapy (as distinguished from family education programs or visiting programs) has a place in all treatment modalities. The panel has highlighted ways to use family interventions in most of the treatment settings described here.

Short-term Residential

Short-term residential programs provide intensive treatment to clients who live onsite for a relatively short period (usually 3 to 6 weeks). The majority of these programs provide multiple treatment interventions, including group and individual counseling, assessments, the development of a strong connection with self-help groups and instruction in its principles, psycho-educational groups, and pharmacological interventions to reduce craving and discourage use.

Short Term Inpatient Treatment (SIT)

SIT is the therapeutic approach predominantly used in programs oriented toward insured populations. SIT is a highly structured 3 to 6 week inpatient program. Patients receive psychiatric and psychological evaluations, assist in developing a recovery plan based on the tenets of AA, attend educational lectures and groups, meet individually with counselors and other professionals, and participate in family or codependent therapy. Patients also receive intensive follow−up care lasting from 3 months to 2 years, with less intensive follow-up after that.

Many short-term residential programs feature some sort of treatment intervention for clients' family members. The Hazelden Family Center, for example, is a 5 to 7 day residential family program that explores relationship issues common among families with a member who abuses substances. A majority of the family programs used in short-term residential treatment involve psychoeducational family groups. Most such programs do not provide traditional family therapy, even if they offer some other form of family oriented treatment.

There is no reason family therapy cannot be integrated into short-term residential programs, though the short duration of therapy may require more intensive and longer (than 1 hour) sessions because work with a family will often end when the client with the substance use disorder leaves treatment. Unfortunately, clients may have to become engaged in an entirely different system for their continuing care, as funding for services may not carry over. Further, family therapy would need to be highly structured (as other activities in these programs are) and the therapist would need to work around a schedule of other activities in the treatment program. If family therapy is being added to an inpatient residential program, it should not take the place of family visiting hours. Clients also need recreational time with their families.

Some short-term residential programs may intentionally refrain from including family therapy because providers believe that clients in early recovery are unable to manage painful issues that often arise in family therapy. That may be true in some cases, but even if a client is unable to deal simultaneously with the cessation of substance use and family issues, the family of the client can still benefit from family therapy.

Long-term Residential Treatment (or therapeutic community)

A long-term residential (LTR) program will provide round the clock care (in a non-hospital setting), along with intensive substance abuse treatment for an extended period (ranging from months to 2 years). Most LTR programs consider themselves a form of therapeutic community (TC), but LTRs can make use of additional treatment models and approaches, such as cognitive–behavioral therapy, 12 Step work, or relapse prevention.

The traditional TC program provides residential care for 15 to 24 months in a highly structured environment for groups ranging from 30 to several hundred clients. According to the TC model, substance abuse is a form of deviant behavior, so the TC works to change the client's entire way of life. In addition to helping clients abstain from substance abuse, TCs work on eliminating antisocial behavior, developing employment skills, and instilling positive social attitudes and values.

TC treatment is not limited to specific interventions, but involves the entire community of staff and clients in all daily activities, including group therapy sessions, meetings, recreation, and work, which may involve vocational training and other support services. Daily activities are highly structured, and all participants in the TC are expected to adhere to strict behavioral rules. Group sessions may sometimes be quite confrontational. A TC ordinarily also features clearly defined rewards and punishments, a specific hierarchy of responsibilities and privileges, and the promise of mobility through the client hierarchy and to staff positions. The TC has become a treatment option for incarcerated populations (see the forthcoming TIP *Substance Abuse Treatment for Adults in the Criminal Justice System* [CSAT in development *j*]) and a modified version of the TC has been demonstrated to be effective with clients with co-occurring substance use and other mental disorders (for more information on the modified TC, see the forthcoming TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT in development *k*], a revision of TIP 9).

Clients in TCs often lack basic social skills, come from broken homes and deprived environments, have participated in criminal activity, have poor employment histories, and abuse multiple substances. For these reasons, the TC process is more a matter of providing habilitation than rehabilitation. As Gerstein notes, the TC environment in many ways "simulates and enforces a model family environment that the patient lacked during developmentally critical preadolescent and adolescent years". Family therapy is not generally an intervention provided in TCs (at least not in the United States), but TC programs can use family therapy to assist clients, especially when preparing them to return to their homes and communities.

Outpatient Treatment

Outpatient treatment is the most common modality of substance abuse treatment. It is also the most diverse, and the type of treatment provided, as well as its frequency and intensity, can vary greatly from program to program. Some, such as those that offer walk-in services, may offer only psycho-education, while intensive day treatment can rival residential programs in range of services, assessment of client needs, and effectiveness *(National Institute on Drug Abuse)*.

The most common variety of outpatient program is one that provides some kind of counseling or therapy once or twice a week for 3 to 6 months. Many of these programs rely primarily on group counseling, but others offer a range of individual counseling and therapy options, and some do offer family therapy. Some outpatient programs offer case management and referrals to needed services such as vocational training and housing assistance, but rarely provide such services onsite, not because they do not see the need, but because funding is unavailable. The services are often offered in specialized programs for clients with co-occurring substance use and other mental disorders.

Outpatient treatment has distinct advantages. Compared to inpatient treatment, it is less costly and allows more flexibility for clients who are employed or have family obligations that do not allow them to leave for an extended period of time. Research has demonstrated, as with many other modalities, that the longer a client is in outpatient treatment the better are his chances for maintaining abstinence for an extended period of time. Studies of outpatient treatment have documented high drop−out rates in this modality, so many clients do not remain in treatment long enough to receive the optimal benefit. For this reason, exit planning, resource information, and community engagement should start in the beginning of treatment.

Because of the great diversity in services offered by outpatient treatment programs it is difficult to generalize about the use of family therapy. Certainly, however, family therapy can be implemented in this setting, and a number of outpatient treatment programs offer various levels of family intervention for their clients. (For more information see the forthcoming TIP *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* [CSAT in development *c*].)

6. Co-Occuring Disorders

What is health? The World Health Organization (WHO) considers healthy states ones characterized by “complete physical, mental, and social well-being and not merely the absence of disease or infrmity” (WHO, n.d.). The Department of Health and Human Services’ (HHS) Healthy People 2020 initiative also supports a broad definition of optimal health, reflected by its overarching goals of (Centers for Disease Control and Prevention [CDC]):

- ✓ Helping people achieve high-quality, long lives free of preventable disease, disability, injury, and premature death.
- ✓ Establishing health equity, eliminating disparities, and improving the health of all groups.

✓ Promoting quality of life, healthy development, and healthy behaviors across all life stages.

The concept of "well-being" extends beyond one's physical condition and includes other important areas of functioning and quality of life, such as mental illness and SUDs. Healthy People 2020 policy and prevention goals include reducing substance use among all Americans (especially children) and decreasing the prevalence of mental disorders (particularly suicidality and depression) while increasing treatment access (Office of Disease Prevention and Health Promotion).

SUDs and mental disorders are detrimental to the health of individuals and to society as a whole. The tendency of these disorders to co-occur can make the damage they cause more extensive and complex. As knowledge of CODs continues to evolve, new challenges have arisen: What is the best way to manage CODs and reduce lags in treatment? How do we manage especially vulnerable populations with CODs, such as people experiencing homelessness and those in our criminal justice system? What about people with addiction and serious mental illness (SMI), such as bipolar disorder or schizophrenia? What are the best treatment environments and modalities? How can we build an integrated system of care?
The main purpose of this section is to attempt to answer these and related questions by providing current, evidence-based, practice-informed knowledge about the rapidly advancing field of COD research.

KKEY MESSAGES

Key Points

- ➡ People with mental illness are likely to have comorbid substance use disorders (SUDs) and vice versa. Clinicians should expect to encounter mental illness in their client population.
- ➡ Co-occurring disorders (CODs) are burdensome conditions that have significant physical, emotional, functional, social, and economic consequences for the people who live with these disorders and their loved ones. Society as a whole is also affected by the prevalence of CODs.
- ➡ Over the past two decades, the behavioral health field's knowledge of the outcomes, service needs, and treatment approaches for individuals with CODs has expanded considerably. But gaps remain in ready access to services and provision of timely, appropriate, effective, evidence-based care for people with CODs.
- ➡ CODs are complex and bidirectional. They can wax and wane over time. Providers, supervisors, and administrators should be mindful of this when helping clients make decisions about treatment and level of care.

The behavioral health field has used many terms to describe the group of individuals who have CODs. Some of these terms do not appear in this TIP, which attempts to reflect a "person-frst" approach (see the "Person-Centered Terminology" section). Providers and other

professionals working with people who have CODs need to understand that **some terms that have been commonly related to CODs may now be outdated and, in certain cases, pejorative.** Such terms include:

- Dual diagnosis.
- Dually diagnosed.
- Dually disordered.
- Mentally ill chemical abuser.
- Mentally ill chemically dependent.
- Mentally ill substance abuser.
- Mentally ill substance using.
- Chemically abusing mentally ill.
- Chemically addicted and mentally ill.
- Substance abusing mentally ill.

All of these terms have their uses, but many have connotations that are unhelpful or too broad or varied in interpretation to be useful. For example, "dual diagnosis" also can mean having both mental and developmental disorders. Outside of this TIP, readers should not assume that these terms all have the same meaning as CODs and should clarify the client characteristics associated with a particular term. Readers should also realize that the term "co-occurring disorder" is not always precise. As with other terms, it may become distorted over time by common use and come to refer to other conditions; after all, clients and consumers may have a number of health conditions that "co-occur," including physical illness. Nevertheless, for the purpose of this section, CODs refers only to SUDs and mental disorders.

Some clients' mental illness symptoms may not fully meet strict definitions of co-occurring SUDs and mental disorders or criteria for diagnoses in DSM-5 categories. However, many of the relevant principles that apply to the treatment of CODs will also apply to these individuals. Careful assessment and treatment planning to take each disorder into account will still be important.

Complications of CODs

CODs can complicate treatment and, if poorly managed, can hinder recovery. Further, rates of mental disorders appear to increase as the number of SUDs increases, meaning people with polysubstance use are especially vulnerable to CODs.

Epidemiologists have observed increasing rates of SUD treatment admissions among people with multiple SUDs. Analyses of TEDS data (SAMHSA, CBHSQ, 2019) reveal tha more than 25 percent of people ages 12 and older admitted for SUD treatment reported both alcohol and other substance misuse. This could partially account for the

increase in clients with CODs in SUD treatment settings, as it appears that having multiple mental disorders increases the odds of having multiple SUDs or vice versa. In the NESARC-III (McCabe, West, Jutkiewicz, & Boyd), people with one lifetime mental disorder had more than three times the odds of having multiple past-year SUDs compared with people with no lifetime mental disorders. **But people with multiple mental disorders (particularly mood disorders, PDs, and PTSD) are nearly nine times more likely to have multiple past-year SUDs.** Individuals with multiple previous SUDs were also less likely to experience remission from substance misuse than were people with a single SUD.

SUD treatment facilities are increasingly seeing non-alcohol substances as the primary substance of misuse among people entering treatment.

CODs can be an obstacle to addiction recovery, especially when untreated. Data from the TEDS-Discharges show that, of people admitted to SUD treatment, 28 percent had a co-occurring psychiatric condition (Krawczyk et al). Prevalence rates of CODs varied across individual states and ranged from 8 percent to 62 percent. People with a psychiatric comorbidity were significantly more likely than those without a psychiatric comorbidity to report using three or more substances (27 percent vs. 17 percent). Of people who did not complete treatment, 42 percent had a COD, versus 36 percent without. This translated to about a 1.3 increase in odds of not completing treatment and a 1.1 increase in odds of earlier time to attrition for people with CODs compared with those with an SUD only.

CODs are strongly associated with socioeconomic and health factors that can challenge recovery, such as unemployment, homelessness, incarceration/criminal justice system involvement, and suicide. According to SAMHSA's *Mental Health Annual Report*, **29 percent of people with CODs were unemployed and 50 percent were not in the labor force** (e.g., disabled, retired, student) (SAMHSA). The current national unemployment rate at the time of this publication is 3.8 percent (Bureau of Labor Statistics).

Of people 12 and older with CODs, 7.5 percent experience homelessness, including 8.3 percent of people with an SUD and schizophrenia or other psychotic disorder, 6.9 percent with an SUD and bipolar disorders, and 7.8 percent with an SUD and depressive disorders (SAMHSA, 2019d). Rates of lifetime and past-year homelessness in the general community per NESARC-III (Tsai) are about 4 percent and 1.5 percent, respectively. The *Annual Homeless Assessment Report to Congress* (Henry, Watt, Rosenthal, & Shivji) found that almost 23 percent of adults in permanent supportive housing programs had transferred from an SUD treatment center; 15 percent, from a mental health services facility. Furthermore, of the 552,830 total individuals experiencing homelessness, about

20 percent had an SMI and about 16 percent (86,647) had a chronic SUD (U.S. Department of Housing and Urban Development).

Of people incarcerated in U.S. state prisons (Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017), about 48 percent have a history of mental illness (of whom 29 percent had an SMI), 26 percent, a history of an SUD. Of those with mental illness, 49 percent also have a co-occurring SUD.

Mental disorders that commonly co-occur with SUDs—including depression, anxiety disorders, bipolar disorders, schizophrenia, and PTSD—are highly prevalent in people who have completed suicide, (Stone, Chen, Daumit, Linden, & McGinty). Suicide is also a well-known risk factor in SUDs and a leading cause of death for people with addiction (Center for Substance Abuse Treatment; Yuodelis- Flores & Ries). In CDC's National Vital Statistics System dataset (Stone et al.), 46 percent of all individuals in the United States who died by suicide between 2014 and 2016 had a known mental condition, and 28 percent misused substances, and of this 28 percent almost one-third (32 percent) also had a known mental health condition.

In addition to inducing a mental disorder, substance misuse can sometimes mimic a mental disorder. Thus, it is important to use thorough screening and assessment approaches to help disentangle all symptoms and make an accurate diagnosis.

These figures reflect the need for specifically tailored COD assessments, interventions, treatment approaches, and clinical considerations (e.g., COD programming specific to people without stable housing; COD interventions designed for implementation in criminal justice settings).

The Complex, Unstable, and Bidirectional Nature of CODs

Clinicians working with clients who have CODs often want to know which disorder developed first. The answer is not always clear because the temporal nature of CODs can be inconsistent and nuanced. In some cases, a mental disorder may obviously have led to the development of an SUD. An example would be someone with long-standing major depressive disorder who starts using alcohol excessively to cope and develops AUD. In other instances, substance use clearly precipitated the mental disorder—such as when someone develops a cocaine-induced psychotic disorder. In many cases, it will be uncertain which disorder occurred first.

Furthermore, CODs can be bidirectional. For some clients, there may be a third condition that is influencing both or either of the two comorbid disorders (e.g., HIV, chronic pain).

Environmental factors, like homelessness or extreme stress, can also affect one or both disorders. Thus, even when it is clear which disorder developed frst, the causal relationship may be unknown. Regardless of the temporal-causal relationship between a client's SUD and mental illness, the two are likely to affect, and possibly exacerbate, one another. This means that both need to be treated with equal seriousness.

CODs are not necessarily equal in severity. Often, one disorder is more severe, distressing, or impairing than the other. Recognizing this is important for treatment planning and requires a person-centered rather than cookie-cutter approach to determining diagnosis, comorbidities, functioning, treatment and referral needs, and stage of change. Models are available to help counselors make such decisions based on the severity and impact of each disorder. For instance, the Four Quadrants Model (National Association of State Mental Health Program Directors & National Association of State Alcohol and Drug Abuse Directors) classifies clients in four basic groups based on relative symptom severity, not diagnosis:

- ✓ Category I: Less severe mental disorder/less severe substance disorder
- ✓ Category II: More severe mental disorder/less severe substance disorder
- ✓ Category III: Less severe mental disorder/more severe substance disorder
- ✓ Category IV: More severe mental disorder/more severe substance disorder

SUDs, Mental Illness, and "Self- Medicating"

The notion that SUDs are caused, in whole or in part, by one's attempts to "self-medicate" symptoms with alcohol or illicit drugs has been a source of debate. The consensus panel cautions that the term "self-medication" should not be used, as it equates drugs of misuse (which usually worsen health) with true medications (which are designed to improve health). Although some people with mental conditions may misuse substances to alleviate their symptoms or otherwise cope (Sarvet et al., Simpson, Stappenbeck, Luterek, Lehavot, & Kaysen), this is not always the case. Counselors should not assume self-medication is the causal link between a client's mental disorder and SUD.

Conclusion

The COD recovery trajectory often has pitfalls, but our understanding of CODs and COD-specific service delivery has improved over the past 20 years. Despite these advances, signifcant gaps remain in the accurate and timely assessment, diagnosis, and treatment of people with CODs. To achieve lower cost mental health services and SUD treatment, better client outcomes, and a more positive treatment experience, providers and administrators must collectively place more focus on CODs in their work. By better understanding the risks and responding to the service needs of people with CODs, behavioral health service providers can help make long-term recovery an attainable goal for all clients with CODs.

7. Strategies for Working with Clients with Co-Occurring Disorders

Guiding Principles for Working With People Who Have Co-Occurring Disorders

Many treatment providers and agencies recognize the need to provide quality care to people with CODs but see it as a daunting challenge beyond their resources. Programs that already have incorporated some elements of integrated services and want to do more may lack a clear framework for determining priorities. Addiction counselors might recognize the need to be able to effectively treat clients with CODs but not fully understand the best approaches to doing so. As clinicians and programs look to improve their effectiveness in treating this population, what should they consider? How could the experience of other agencies or counselors inform their planning process? Are resources available that could help turn such a vision into reality? This chapter is designed to help both providers and agencies that want to improve services for their clients with CODs, whether that means establishing services where there currently are none or learning to improve existing ones.

The section is designed for clinicians, other treatment/service providers, supervisors, and administrators and begins with a review of general guiding principles derived from proven models, clinical experience, and the growing base of empirical evidence. Building on these guiding principles, the chapter turns to the specific core components for effective service delivery for addiction counselors and other providers and for administrators and supervisors, respectively. For providers, this includes addressing in concrete terms the challenges of providing access, screening and assessment, appropriate level of care, integrated treatment, comprehensive services, and continuity of care. For supervisors and administrators, effective service delivery requires staff to develop essential core competencies and take advantage of opportunities for professional development. Achieving optimal COD programming means integrating research into clinical services to ensure that practices are evidence based, establishing essential services to meet the varied needs of people with CODs, and conducting program assessments to gauge whether services adequately fulfill clients' access and treatment needs.

The following includes a list of guiding principles to serve as fundamental building blocks for working with clients who have CODs. These principles are derived from a variety of sources: conceptual writings, well-articulated program models, a growing understanding of the essential features of CODs, elements common to separate treatment

models, clinical experience, and available empirical evidence. These principles may be applied at both a program level (e.g., providing literature for people with cognitive impairments) or at the individual level (e.g., addressing the client's basic needs).
and the related field experience underlying each one.

Use a Recovery Perspective

The recovery perspective has two main features: It acknowledges that recovery is a long-term process of internal change, and it recognizes that these internal changes proceed through various stages.

The recovery perspective applies to clients with CODs and generates two main practice principles:

- Develop a treatment plan that provides for continuity of care over time.
- In preparing this plan, the provider should recognize that treatment may occur in different settings over time (e.g., residential, outpatient) and that much of the recovery process typically occurs outside of or following treatment (e.g., through participation in mutual-support programs, through family, peer, and community support, including the faith community).
- The provider needs to reinforce long-term participation in these continuous care settings.
- Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process. Whether within the substance use disorder (SUD) treatment or mental health services system, the provider is advised to use sensible stepwise approaches in developing and using treatment protocols. In

KEY POINTS

- ✓ General guiding principles of good care for people with co-occurring disorders (CODs) ensure that counselors and other providers, administrators, and supervisors fully meet clients' comprehensive needs—effectively and ethically.
- ✓ Clinicians should offer clients full access to a range of integrated services through the continuum of recovery.
- ✓ Administrators and supervisors are responsible for the training, professional development, recruitment, and retention of qualifed counselors and other professional staff working with people who have CODs. Failure to attend to these workforce matters will only further inhibit client access to care.
- ✓ Several core essential services exist for clients with comorbid conditions, and supervisors and administrators should regularly evaluate their program's capacity and performance to monitor its effectiveness in providing these services and correct course when needed.

addition, markers that are unique to individuals—such as those related to their cultural, social, or spiritual context—should be considered.

- ✤ The provider needs to engage the client in defining markers of progress that are meaningful to him or her and to each stage of recovery.

Adopt a Multiproblem Viewpoint

People with CODs generally have an array of mental, medical, substance use, family, and social problems. Most need substantial rehabilitation and habilitation (i.e., initial learning and acquisition of skills). Treatment should address immediate and long-term needs for housing, work, health care, and a supportive network. Therefore, services should be comprehensive to meet the multidimensional problems typically presented by clients with CODs.

Six Guiding Principles in Treating Clients With CODs

- ➡ Use a recovery perspective.
- ➡ Adopt a multi-problem viewpoint.
- ➡ Develop a phased approach to treatment.
- ➡ Address specific real-life problems early in treatment.
- ➡ Plan for the client's cognitive and functional impairments.
- ➡ Use support systems to maintain and extend treatment effectiveness.

Develop a Phased Approach to Treatment

Using a staged or phased approach to COD treatment helps clinicians optimize comprehensive, appropriate, and effective care for all client needs. Generally, three to five phases are identified, including engagement, stabilization/ persuasion, active treatment, and continuing care or continuing care/relapse prevention (Mueser & Gingerich; Substance Abuse and Mental Health Services Administration [SAMHSA]). These phases are consistent with, and parallel to, stages identified in the recovery perspective. The use of these phases enables the provider (whether within the SUD treatment or mental health services system) to develop and use effective, stage-appropriate treatment protocols.

Address Specific Real-Life Problems Early in Treatment

Growing recognition that CODs arise in a context of personal and social problems, with disruption of personal and social life, has prompted approaches that address specifc life problems early in treatment. These approaches may incorporate case management and intensive case management to help clients surmount bureaucratic hurdles or handle legal

and family matters. Specialized interventions that target important areas of client need, such as housing-related support services (Clark, Guenther, & Mitchell), can also help. Vocational services help clients with CODs make concrete improvements in career goal setting, job seeking, work attainment, and earned wages (Luciano & Carpenter-Song; Mueser, Campbell, & Drake).

For people in recovery from mental disorders or SUDs, workforce participation is not only valuable because of its economic contributions; it can also enhance individual self-effcacy, improve self-identity (e.g., help people feel "normal" as opposed to "like a patient"), offer a sense of belonging with society at large, provide a way for people to build relationships with others, and improve quality of life (Charzynska, Kucharska, & Mortimer; Walsh & Tickle). A review of the effects of employment interventions for people with SUDs found that employment was associated with reduced substance use and more stable housing (Walton & Hall).

Solving financial, housing, occupational, and other problems of everyday living is often an important first step toward achieving client engagement in continuing treatment. Engagement is a critical part of SUD treatment generally and of treatment for CODs specifically, because remaining in treatment for an adequate length of time is essential to achieving behavioral change.

Plan for Clients' Cognitive and Functional Impairments

Services for clients with CODs, especially those with more serious mental disorders, must be tailored to individual needs and functioning. Clients with CODs often display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks (Duijkers, Vissers, & Egger). The manner in which interventions are presented must be compatible with client needs and functioning. Such impairments frequently call for relatively short, highly structured treatment sessions that are focused on practical life problems. Gradual pacing, visual aids, and repetition are often helpful. Even impairments that are comparatively subtle (e.g., certain learning disabilities) may still have significant impact on treatment success. Careful assessment of such impairments and a treatment plan consistent with the assessment are therefore essential.

Use Support Systems To Maintain and Extend Treatment Effectiveness

The mutual-support movement, the family, peer providers, the faith community, and other resources that exist within the client's community can play an invaluable role in recovery. This can be particularly true for clients with CODs, many of whom have not enjoyed a consistently supportive environment for decades. In some cultures, the stigma surrounding SUDs or mental disorders is so great that the client and even the entire family may be ostracized by the immediate community. For instance, some mutual-

support programs are not very accepting of members with CODs who take psychiatric medication. Furthermore, the behaviors associated with active substance use may have alienated the client's family and community. The provider plays a role in ensuring that the client is aware of available support systems and motivated to use them effectively.

Benefits of SUD Treatment

Researchers also have clearly demonstrated that substance abuse treatment of clients with co-occurring mental illness and substance use disorders can be beneficial—even for clients with serious mental disorders. For example, the National Treatment Improvement Evaluation Study (NTIES) found marked reductions in suicidality the year following substance abuse treatment compared to the year prior to treatment for adults, young adults, adolescents, and subgroups of abused and non-abused women. Of the 3,524 adults aged 25 and over included in the study, 23 percent reported suicide attempts the year prior to treatment, while only 4 percent reported suicide attempts during the year following treatment. Twenty-eight percent of the 651 18- to 24-year-old young adults had a suicide attempt the year before treatment, while only 4 percent reported suicide attempts during the 12 months following treatment. Similarly, the 236 adolescents (13 to 17 years of age) showed a decline in pre- and post-treatment suicide attempts, from 23 percent to 7 percent, respectively. For the group as a whole (4,411 persons), suicide attempts declined about four-fifths both for the 3,037 male clients and for the 1,374 female clients studied (Karageorge). A subset of women (aged 18 and over) were identified as either having reported prior sexual abuse (509 women) or reporting no prior sexual abuse (667 women). Suicide attempts declined by about half in both of these groups (Karageorge), and both groups had fewer inpatient and outpatient mental health visits and less reported depression (Karageorge).

Therapeutic Alliance

Maintaining a therapeutic alliance with clients who have co-occurring disorders (COD) is important—and difficult. The first part of the following section reviews guidelines for addressing these challenges. It stresses the importance of the clinician's ability to manage feelings and biases that could arise when working with clients with COD (sometimes called countertransference). Together, clinicians and clients should monitor the client's disorders by examining the status of each disorder and alerting each other to signs of relapse. The consensus panel recommends that clinicians use primarily a supportive, empathic, and culturally appropriate approach when working with clients with COD. With some clients who have COD, it is important to distinguish behaviors and beliefs that are cultural in origin from those indicative of a mental disorder. Finally, clinicians should increase structure and support to help their clients with COD make steady progress throughout recovery.

The second part of the following section describes techniques effective in counseling clients with COD. One is the use of motivational enhancement consistent with the client's specific stage of recovery. This strategy is helpful even for clients whose mental disorder is severe. Other strategies include contingency management, relapse prevention, and cognitive-behavioral techniques. For clients with functional deficits in areas such as understanding instructions, repetition and skill-building strategies can aid progress. Finally, 12-Step and other dual recovery mutual self-help groups have value as a means of supporting individuals with COD in the abstinent life. Clinicians often play an important role in facilitating the participation of these clients in such groups. This section will provide a basic overview of how clinicians can apply each of these strategies to their clients who have COD. The material in this chapter is consistent with national or State consensus practice guidelines for COD treatment, and consonant with many of their recommendations.

The purpose of the following section is to describe for the clinician and other practitioners how these guidelines and techniques, many of which are useful in the treatment of substance abuse or as general treatment principles, can be modified specifically and applied to people with COD. These guidelines and techniques are particularly relevant in working with clients in quadrants II and III.

Develop and Use a Therapeutic Alliance to Engage the Client in Treatment

Research suggests that a therapeutic alliance is "one of the most robust predictors of treatment outcome" in psychotherapy (*Najavits et al*.). Some studies in the substance abuse treatment field also have found associations between the strength of the therapeutic alliance and counseling effectiveness. One research team found that both clinician and client ratings of the alliance were strong predictors of alcoholic outpatients' treatment participation in treatment, drinking behavior during treatment, and drinking behavior at a 12-month follow-up, even after controlling for a variety of other sources of variance.

Challenges for the Clinician

The clinician's ease in working toward a therapeutic alliance also is affected by his or her comfort level in working with the client. Substance abuse counselors may find some clients with significant mental illnesses or severe substance use disorders to be threatening or unsettling. It is therefore important to recognize certain patterns that invite these feelings and not to let them interfere with the client's treatment. This discomfort may be due to a lack of experience, training, or mentoring. Likewise, some mental health clinicians may feel uncomfortable or intimidated by clients with substance use disorders. Clinicians who experience difficulty forming a therapeutic alliance with clients with COD are advised to consider whether this is related to the client's difficulties; to a limitation in the clinician's own experience and skills; to demographic differences between the clinician and the client in areas such as age, gender, education, race, or

ethnicity; or to issues involving countertransference (see the discussion of countertransference below). A consultation with a supervisor or peer to discuss this issue is important. Often these reactions can be overcome with further experience, training, supervision, and mentoring.

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

Challenges in working with clients with serious mental and substance use disorders. Achieving a therapeutic alliance with clients with serious mental illness and substance use disorders can be challenging. According to Ziedonis and D'Avanzo, many people who abuse substances also may have some antisocial traits. Such individuals are "less amenable to psychological and pharmacological interventions and avoid contact with the mental health treatment staff." Therefore, it is reasonable to conclude that "the dually diagnosed are less likely to develop a positive therapeutic alliance than non-substance-abusing patients with schizophrenia…".

Forming a Therapeutic Alliance

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

Individuals with both schizophrenia and a substance use disorder may be particularly challenging to treat. These individuals "present and maintain a less involved and more distant stance in relation to the therapist than do non-substance-abusing individuals with schizophrenia" (*Ziedonis and D'Avanzo*). The presence or level of these deficits may vary widely for people living with schizophrenia, and also may vary significantly for that individual within the course of his illness and the course of his lifetime. While "this configuration of interpersonal style suggests that developing a therapeutic alliance can be difficult," Ziedonis and D'Avanzo insist, "working with the dually diagnosed requires a primary focus on the therapeutic alliance"

For all clients with co-occurring disorders, the therapeutic relationship must build on the capacity that does exist. These clients often need the therapeutic alliance to foster not only their engagement in treatment but as the cornerstone of the entire recovery process. Once established,

the therapeutic alliance is rewarding for both client and clinician and facilitates their participation in a full range of therapeutic activities; documentation of these types of interactions provides an advantage in risk management.

Maintain a Recovery Perspective

The word "recovery" has different meanings in different contexts. Substance abuse treatment clinicians may think of a person who has changed his or her substance abuse behavior as being "in recovery" for the rest of his or her life (although not necessarily in formal treatment forever). Mental health clinicians, on the other hand, may think of recovery as a process in which the client moves toward specific behavioral goals through a series of stages. Recovery is assessed by whether or not these goals are achieved. For persons involved with 12-Step programs, recovery implies not only abstinence from drugs or alcohol but also a commitment to "work the steps," which includes changing the way they interact with others and taking responsibility for their actions. Consumers with mental disorders may see recovery as the process of reclaiming a meaningful life beyond mental disorder, with symptom control and positive life activity.

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

Implications of the recovery perspective

The recovery perspective as developed in the substance abuse field has two main features: (1) It acknowledges that recovery is a long-term process of internal change, and (2) it recognizes that these internal changes proceed through various stages. The recovery perspective generates at least two main principles for practice:

- ***Develop a treatment plan that provides for continuity of care over time***. In preparing this plan, the clinician should recognize that treatment may occur in different settings over time (e.g., residential, outpatient) and that much of the recovery process is client-driven and occurs typically outside of or following professional treatment (e.g., through participation in mutual self-help groups) and the counselor should reinforce long-term participation in these constantly available settings.
- ***Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process***. The use of treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process enables the clinician (whether within the substance abuse or mental health treatment system) to use sensible stepwise approaches in

developing and using treatment protocols. In addition, markers that are unique to individuals—such as those related to their cultural, social, or spiritual context—should be considered. It is therefore important to engage the client in defining markers of progress that are meaningful to him and to each stage of recovery.

Stages of change and stages of treatment

Working within the recovery perspective requires a thorough understanding of the interrelationship between stages of change and stages of treatment. De Leon has developed a measure of motivation for change and readiness for treatment—The Circumstances, Motivation and Readiness Scales—and provided scores for samples of persons with COD (De Leon et al.). De Leon has demonstrated the relationship between these scales and retention in treatment for general substance abuse treatment populations and programs (De Leon). It is important that the expectation for the client's progress through treatment stages (e.g., outreach, stabilization, early-middle-late primary treatment, continuing care, and long-term care/cycles into and out of treatment) be consistent with the client's stage of change.

Maintaining a Recovery Perspective

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

Client empowerment and responsibility

The recovery perspective also emphasizes the empowerment and responsibility of the client and the client's network of family and significant others. As observed by the American Association of Community Psychiatrists (AACP), the strong client empowerment movement within the mental health field is a cornerstone for recovery:

Pessimistic attitudes about people with COD represent major barriers to successful system change and to effective treatment interventions … recovery is defined as a process by which a person with persistent, possibly disabling disorders, recovers self-esteem, self-worth, pride, dignity, and meaning, through increasing his or her

ability to maintain stabilization of the disorders and maximizing functioning within the constraints of the disorders. As a general principle, every person, regardless of the severity and disability associated with each disorder, is entitled to experience the promise and hope of dual recovery, and is considered to have the potential to achieve dual recovery (AACP).

Continuous support

Another implication of the recovery perspective is the need for continuing support for recovery. This means the provider encourages clients to build a support network that offers respect, acceptance, and appreciation. For example, an important element of long-term participation in Alcoholics Anonymous (AA) is the offering of a place of belonging or a "home." AA accomplishes this supportive environment without producing over-dependence because the client is expected to contribute, as well as receive, support.

Continuity of treatment

An emphasis on continuity of treatment also flows from a recovery perspective. Continuity of treatment implies that the services provided by the program are constant, and a client might remain a consumer of substance abuse or mental health services indefinitely. Treatment continuity for individuals with COD begins with proper and thorough identification, assessment, and diagnosis. It includes easy and early access to the appropriate service providers "…through multiple episodes of acute and subacute treatment … independent of any particular setting or locus of care" (AACP).

Manage Countertransference

Though somewhat dated and infrequently used in the COD literature, the concept of "countertransference" is useful for understanding how the clinician's past experience can influence current attitudes toward a particular client. "Transference" describes the process whereby clients project attitudes, feelings, reactions, and images from the past onto the clinician. For example, the client may regard the clinician as an "authoritative father," "know-it-all older brother," or "interfering mother."

Once considered a technical error, countertransference now is understood to be part of the treatment experience for the clinician. Particularly when working with multiple and complicated problems, clinicians are vulnerable to the same feelings of pessimism, despair, anger, and the desire to abandon treatment as the client. Inexperienced clinicians often are confused and ashamed when faced with feelings of anger and resentment that can result from situations where there is a relative absence of gratification from working with clients with these disorders (Cramer 2002). Less experienced practitioners may have more difficulty identifying countertransference, accessing feelings evoked by interactions with a client, naming them, and working to keep these feelings from interfering with the counseling relationship.

Both substance use disorders and mental disorders are illnesses that are stigmatized by the general public. These same attitudes can be present among clinicians. Mental health clinicians who usually do not treat persons with substance abuse issues may not have worked out their own response to the disorder, which can influence their interactions with the client. Similarly, substance abuse treatment clinicians may not be aware of their own reactions to persons with specific mental disorders and may have difficulty preventing these reactions from influencing treatment. The clinician's negative attitudes or beliefs may be communicated, directly or subtly, to the client. For example: “I was depressed too, but I never took medications for it—I just worked the steps and got over it. So why should this guy need medication?”

Such feelings often are related to burnout and are exacerbated by the long time required to see progress in many clients with COD. For example, one study found that therapists' attitudes toward their substance abuse clients tended to become more negative over time, though the increasing negativity was found to be less extreme for substance abuse counselors without graduate degrees who used the 12 steps to inform their counseling approach than for psychotherapists with graduate training who participated in the study

Cultural issues also may arouse strong and often unspoken feelings and, therefore, generate transference and countertransference. Although counselors working with clients in their area of expertise may be familiar with countertransference issues, working with an unfamiliar population will introduce different kinds and combinations of feelings.

Managing Countertransference

- The clinician should be aware of strong personal reactions and biases toward the client.
- The clinician should obtain further supervision where countertransference is suspected and may be interfering with counseling.
- Clinicians should have formal and periodic clinical supervision to discuss countertransference issues with their supervisors and the opportunity to discuss these issues at clinical team meetings.

The clinician is advised to understand and be familiar with some of the issues related to countertransference and strategies to manage it. Such countertransference issues are particularly important when working with persons with COD because many people with substance abuse and mental disorders may evoke strong feelings in the clinician that could become barriers to treatment if the provider allows them to interfere. The clinician may feel angry, used, overwhelmed, confused, anxious, uncertain how to proceed with a case, or just worn out.

Monitor Psychiatric Symptoms

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

It is equally important that the client participate in the development of the treatment plan. For example, for a client who has both bipolar disorder and alcoholism, and who is receiving treatment at both a substance abuse treatment agency and a local mental health center, the treatment plan might include individual substance abuse treatment counseling, medication management, and group therapy. In another example, the substance abuse treatment clinician may assist in medication monitoring of a person taking lithium. The clinician can ask such questions as, “How are your meds doing? Are you remembering to take them? Are you having any problems with them? Do you need to check in with the prescribing doctor?” It also is prudent to ask the client to bring in all medications and ask the client how he is taking them, when, how much, and if medication is helping and how. Clinicians should help educate clients about the effects of medication, teach clients to monitor themselves (if possible), and consult with clients' physicians whenever appropriate.

Status of symptoms

Clinicians need to have a method by which to monitor changes in severity and number of symptoms over time. For example, most clients present for substance abuse treatment with some degree of anxiety or depressive symptoms. As discussed earlier, these symptoms are referred to as substance induced if caused by substances and resolved within 30 days of abstinence. Substance-induced symptoms tend to follow the “teeter totter” principle of “what goes up, must come down,” and vice versa—so that after a run of amphetamine or cocaine the individual will appear fatigued and depressed, while after using depressants such as alcohol or opioids, the individual more likely will appear agitated and anxious. These “teeter totter” symptoms are substance withdrawal effects and usually are seen for days or weeks. They may be followed by a substance-related depression (which can be seen as a neurotransmitter depletion state), which should begin to improve within a few weeks. If depressive or other symptoms persist, then a co-occurring (additional) mental disorder is likely, and the differential diagnostic process ensues. These symptoms may be appropriate target symptoms for establishing a diagnosis or determining treatment choices (medication, therapy, etc.). Clients using methamphetamines may present with psychotic symptoms that require medications.

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

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

Monitoring Psychiatric Symptoms

- ✓Obtain a mental status examination to evaluate the client's overall mental health and danger profile. Ask questions about the client's symptoms and use of medication and look for signs of the mental disorder regularly.
- ✓Keep track of changes in symptoms.
- ✓Ask the client directly and regularly about the extent of his or her depression and any associated suicidal thoughts.

Potential for harm to self or others

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

For clients who mention or appear to be experiencing depression or sadness, it is always important to explore the extent to which suicidal thinking is present. Similarly, a client who reports that he or she is thinking of doing harm to someone else should be monitored closely. The clinician

always should ask explicitly about suicide or the intention to do harm to someone else when the client assessment indicates that either is an issue.

In addition to asking the client about suicidal thoughts and plans as a routine part of every session with a suicidal or depressed person, Blumenthal stresses that *the clinician should immediately follow up appointments missed by an acutely suicidal person.* Management of the suicidal client requires securing an appropriate mental health professional for the client and having the client monitored closely by that mental health professional. The counselor also should have 24-hour coverage available, such as a hotline for the client to call for help during off hours. However, there are effective ways of managing individuals who have suicidal thoughts but no immediate plan, and are willing and able to contact the counselor in the event these thoughts become too strong, prior to action.

Use Supportive and Empathic Counseling

Definition and importance

A supportive and empathic counseling style is one of the keys to establishing an effective therapeutic alliance. According to Ormont, empathy is the ability to "experience another person's feeling or attitude while still holding on to our own attitude and outlook"; it is the foundation adults use for relating to and interacting with other adults (Ormont). The clinician's empathy enables clients to begin to recognize and own their feelings, an essential step toward managing them and learning to empathize with the feelings of others.

However, this type of counseling must be used consistently over time to keep the alliance intact. This caveat often is critical for clients with COD, who usually have lower motivation to address either their mental or substance abuse problems, have

Using an Empathic Style

Empathy is a key skill for the counselor, without which little could be accomplished. The practice of empathy "requires sharp attention to each new client statement, and a continual generation of hypotheses as to the underlying meaning" (Miller and Rollnick). An empathic style:

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

greater difficulty understanding and relating to other people, and need even more understanding and support to make a major lifestyle change such as adopting abstinence. Support and empathy on the clinician's part can help maintain the therapeutic alliance, increase client motivation, assist with medication adherence, model behavior that can help the client build more productive relationships, and support the client as he or she makes a major life transition.

Confrontation and empathy

The overall utility of confrontational techniques is well accepted in the substance abuse literature. It is used widely in substance abuse treatment programs, including those surveyed in the Drug Abuse Treatment Outcomes Study in which the effectiveness of such programs was demonstrated. Confrontation is a form of interpersonal exchange in which individuals present to each other their observations of, and reactions to, behaviors and attitudes that are matters of concern and should change (De Leon).

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

Employ Culturally Appropriate Methods

Understanding the client's cultural background

It is well known that population shifts are resulting in increasing numbers of minority racial and ethnic groups in the United States. Each geographic area has its own cultural mix, and providers are advised to learn as much as possible about the cultures represented in their treatment populations. Of particular importance are the backgrounds of those served, conventions of interpersonal communication, understanding of healing, views of mental disorder, and perception of substance abuse.

To work effectively with persons of various cultural groups, the provider should learn as much as possible about characteristics of the cultural group such as communication style, interpersonal interactions, and expectations of family. For example, some cultures may tend to somaticize symptoms of mental disorders, and clients from such groups may expect the clinician to offer relief for physical complaints. The same client may be offended by too many probing, personal questions early in treatment and never return.

Similarly, understanding the client's role in the family and its cultural significance always is important (e.g., expectations of the oldest son, a daughter's responsibilities to her parents, grandmother as matriarch).

At the same time, the clinician should not make assumptions about any client based on his or her perception of the client's culture. The level of acculturation and the specific experiences of an individual may result in that person identifying with the dominant culture, or even other cultures. For example, a person from India adopted by American parents at an early age may know little about the cultural practices in his birth country. For such clients, it is still important to recognize the birth country and discover what this association means to the client; however, it may exert little influence on his beliefs and practices.

Clients' perceptions of substance abuse, mental disorders, and healing

Clients may have culturally driven concepts of what it means to abuse substances or to have a mental disorder, what causes these disorders, and how they may be "cured." Clinicians are encouraged to explore these concepts with people who are familiar with the cultures represented in their client population. Counselors should be alert to differences in how their role and the healing process are perceived by persons who are of cultures other than their own.

Wherever appropriate, familiar healing practices meaningful to these clients should be integrated into treatment. An example would be the use of acupuncture to calm a Chinese client or help control cravings, or the use of traditional herbal tobacco with some American Indians to establish rapport and aid emotional balance.

Cultural perceptions and diagnosis

It is important to be aware of cultural and ethnic bias in diagnosis. For example, in the past some African Americans were stereotyped as having paranoid personality disorders, while women have been diagnosed frequently as being histrionic. American Indians with spiritual visions have been misdiagnosed as delusional or as having borderline or schizotypal personality disorders.

Using Culturally Appropriate Methods

- ✓Take cultural context, background, and experiences into account in the evaluation, diagnosis, and treatment of clients from various groups, cultures, or countries.
- ✓Recognize the importance of culture and language, acknowledging the cultural strengths of a people.
- ✓Adapt services to meet the unique needs and value systems of persons in all groups.
- ✓Expand and update [the provider's/system's] cultural knowledge.
- ✓Work on stigma reduction with a culturally sensitive approach.

Some clinicians would be likely to over diagnose obsessive-compulsive disorder among Germans or histrionic disorder in Hispanic/Latino populations. The diagnostic criteria should be tempered by sensitivity to cultural differences in behavior and emotional expression and by an awareness of the clinician's own biases and stereotyping.

Cultural differences and treatment: Empirical evidence on effectiveness

Studies related to cultural differences and treatment issues among clients with COD are scarce. However, one study that compared nonwhite and white clients with COD who were treated in mental health settings suggests issues that deserve providers' attention. Researchers found that African-American, Asian-American, and Hispanic/Latino clients tended to self-report a lower level of functioning and to be "viewed by clinical staff as suffering from more severe and persistent symptomatology and as having lower psychosocial functioning." Researchers noted "this was due in part to the chronicity of their mental disorders and persistent substance abuse, but also was magnified by cross-cultural misperceptions; for example, system bias, countertransference, or inadequate support systems" - Jerrell and Wilson

The study also found that nonwhite clients tended to have fewer community resources available to them than white clients, and that clinicians had more difficulty connecting them with needed services.

Increase Structure and Support

To assist clients with COD, clinicians should provide an optimal amount of structure for the individual. Free time is both a trigger for substance use cravings and a negative influence for many individuals with mental disorders; therefore it is a particular issue for clients with COD. Strategies for managing free time include structuring one's day to have meaningful activities and to avoid activities that will be risky. Clinicians often help clients to plan their time (especially weekends). Creating new pleasurable activities can both help depression and help derive "highs" from sources other than substance use. Other important activities to include are working on vocational and relationship issues. In addition to structure, it is also important that the daily activities contain opportunities for receiving support and encouragement. Counselors should work with clients to create a healthy support system of friends, family, and activities. Increasing support, time organization, and structured activities are strategies in cognitive-behavioral therapies (see section below) for both mental disorders and substance abuse treatment.

Techniques for Working with Clients with COD

The following section reviews techniques, mainly from the substance abuse field, that have been found to be particularly helpful in the treatment of clients with substance abuse and that are being adapted for work with clients with COD (see text box).

Key Techniques for Working with Clients who Have COD

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

Provide Motivational Enhancement Consistent with the Client's Specific Stage of Change

Definition and Description

Motivational Interviewing (MI) is a "client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller and Rollnick). MI has proven effective in helping clients clarify goals and make commitment to change (CSAT; Miller; Miller and Rollnick; Rollnick and Miller). This approach shows so much promise that it is one of the first two psychosocial treatments being sponsored in multisite trials in the National Institute on Drug Abuse (NIDA) Clinical Trials Network program. As Miller and Rollnick have pointed out, MI is "a way of being with a client, not just a set of techniques for doing counseling" (Miller and Rollnick). This approach involves *accepting* a client's level of motivation, whatever it is, as the only possible starting point for change. For example, if a client says she has no interest in changing her drinking amounts or frequency, but only is interested in complying with the interview to be eligible for something else (such as the right to return to work or a housing voucher), the clinician would avoid argumentation or confrontation in favor of establishing a positive rapport with the client—even remarking on the positive aspect of the client wishing to return to work or taking care of herself by obtaining housing. The clinician would seek to probe the areas in which the client does have motivation to change. The clinician is interested in eventually having an impact on the client's drinking or drug use, but the strategy is to get to that point by working with available openings.

A variety of adaptations of MI have emerged. Examples include brief negotiation, motivational consulting, and motivational enhancement therapy (MET). MET combines

the clinical style associated with MI with systematic feedback of assessment results in the hope of producing rapid, internally motivated change. Rollnick and other practitioners of MI find that the many variants differ widely in their reliance on the key principles and elements of MI.

The four principles outlined below guide the practice of MI. In this section, each principle is summarized. For each principle, some of the related strategies that practitioners use when applying this principle to client interactions are highlighted.

Guiding Principles of Motivational Interviewing

1. Express empathy	• Acceptance facilitates change.
	• Skillful reflective listening is fundamental.
	• Ambivalence is normal.
2. Develop discrepancy	• The client rather than the counselor should present the arguments for change.
	• Change is motivated by a perceived discrepancy between present behavior and important personal goals or values.
3. Roll with resistance	• Avoid arguing for change.
	• Resistance is not opposed directly.
	• New perspectives are invited but not imposed.
	• The client is a primary resource in finding answers and solutions.
	• Resistance is a signal to respond differently.
4. Support self-efficacy	• A person's belief in the possibility of change is an important motivator.
	• The client, not the counselor, is responsible for choosing and carrying out change.
	• The counselor's own belief in the person's ability to change becomes a self-fulfilling prophecy.

(Source: Miller and Rollnick)

1. Expressing empathy

Miller and Rollnick state that “an empathic counseling style is one fundamental and defining characteristic of motivational interviewing” (Miller and Rollnick 2002, p. 37). The counselor refrains from judging the client; instead, through respectful, reflective listening, the counselor projects an attitude of acceptance. This acceptance of the person's perspectives does not imply agreement. It “does not prohibit the counselor from differing with the client's views and expressing that divergence” (Miller and Rollnick 2002, p. 37). It simply accepts the individual's ambivalence to change as normal and expected behavior in the human family. Practitioners find that projecting acceptance rather than censure helps free the client to change (Miller and Rollnick 2002).

2. Developing discrepancies

While recognizing the client's ambivalence to change as normal, the counselor is not neutral or ambivalent about the need for change. The counselor advances the cause of change not by insisting on it, but by helping the client perceive the discrepancy between the current situation and the client's personal goals (such as a supportive family, successful employment, and good health). The task of the counselor is to call attention to this discrepancy between “the present state of affairs and how one wants it to be,” making it even more significant and larger in the client's eyes. The client is therefore more likely to change, because he sees that the current behavior is impeding progress to *his* goals—not the counselor's (Miller and Rollnick 2002, p. 39).

3. Rolling with resistance

Practitioners believe that “the least desirable situation, from the standpoint of evoking change, is for the counselor to advocate for change while the client argues against it” (Miller and Rollnick). The desired situation is for the clients themselves to make the argument for change. Therefore, when resistance is encountered, the counselor does not oppose it outright. Instead, the counselor offers new information and alternative perspectives, giving the client respectful permission to “take what you want and leave the rest” (Miller and Rollnick).

The counselor's response to resistance can defuse or inflame it. Miller and Rollnick describe a number of techniques the skillful clinician can use when resistance is encountered. For example, the counselor may use various forms of reflection, shift the focus of discussion, reframe the client's observation, or emphasize the client's personal choice or control.

4. Supporting self-efficacy

The final principle of Motivational Interviewing recognizes that an individual must believe he or she actually can make a change before attempting to do so. Therefore, the counselor offers support for the change and communicates to the client a strong sense that change is possible. Self-efficacy also can be enhanced through the use of peer role models, as well as by pointing out past and present evidence of the client's capacity for change.

One way practitioners put this principle into action is by evoking "confidence talk" in which the client is invited to share "ideas, experiences, and perceptions that are consistent with ability to change" (Miller and Rollnick). This could involve reviewing past successes, discussing specific steps for making change happen, identifying personal strengths, and acknowledging sources of support.

"Change talk"

Clients' positive remarks about change, or "change talk," are the opposite of resistance. The counselor responds to any expression of desire to change with interest and encourages the client to elaborate on the statement. For example in a person with combined alcohol dependence and PTSD, the clinician might ask, "What are some other reasons why you might want to make a change?" (Miller and Rollnick 2002, p. 87). The counselor also can use reflective listening to clarify the client's meaning and explore what is being said. It is important, however, to do this in a way that does not appear to be taking a side in the argument. This sometimes results in resistance and the client may begin to argue with the counselor instead of continuing to think about change.

"Decisional balance"

Practitioners of MI have coined the term "decisional balance" to describe a way of looking at ambivalence. Picture a seesaw, with the costs of the status quo and the benefits of change on one side, and the costs of change and the benefits of the status quo on the other (Miller and Rollnick 2002). The counselor's role is to explore the costs and benefits of substance use with the aim of tipping the balance toward change. That change will be stronger and more likely to endure if it is owned by the client's perception that the benefits of change are greater than the costs.

Matching motivational strategies to the client's stage of change

The motivational strategies selected should be consistent with the client's stage of change. Clients could be at one stage of recovery or change for the mental disorder and another for the substance use disorder; to complicate things further, a client may be at one stage of change for one substance and another stage of change for another substance. For example, a client with combined alcohol and cocaine dependence with co-occurring panic disorder may be in the *contemplation stage* (i.e., aware that a

problem exists and considering overcoming it, but not committed to taking action) in regard to alcohol, *precontemplation* (i.e., unaware that a problem exists, with no intention of changing behavior) in regard to cocaine, and *action* (i.e., actively modifying behavior, experiences, or environment to overcome the problem) for the panic disorder.

Stages of Change

Stage	Characteristics
Precontemplation	No intention to change in the foreseeable future; may be unaware or under-aware of problems.
Contemplation	Aware that a problem exists and thinking seriously about overcoming it, but have no commitment to take action yet made; weighing pros and cons of the problem and its solution.
Preparation	Combines intention and behavior—action is planned within the next month, and action has been taken unsuccessfully in the past year; some reductions have been made in problem behaviors, but a criterion for effective action has not been reached.
Action	Behavior, experiences, or environment are modified to overcome the problem; successful alteration of the addictive behavior for anywhere between 1 day to 6 months (note that action does not equal change).
Maintenance	Working to prevent relapse and consolidate gains attained during the Action stage; remaining free from addictive behavior and engaging consistently in a new incompatible behavior for more than 6 months.

(*Source:* Adapted from Prochaska et al.)

In each case, the clinician examines the internal and external leverage available to move the client toward healthy change. For example, a client may want to talk about her marriage, but not about the substance abuse problem. The clinician can use this as an opening; the marriage doubtless will be affected by the substance abuse, and the motivation to improve the marriage may lead to a focus on substance abuse. Evaluating a client's motivational state necessarily is an ongoing process. It should be recognized that court mandates, rules for clients engaged in group therapy, the treatment agency's operating restrictions, or other factors may place some barriers on how this strategy is implemented in particular situations.

The above figure illustrates approaches that a clinician might use at different stages of readiness to change to apply MI techniques when working with a substance

abuse client showing evidence of COD. For a thorough discussion of MI and the stages of change, the reader is referred to Miller and Rollnick.

Motivational Enhancement Approaches

Stage of Readiness	Motivational Enhancement Approaches
Precontemplation	• Express concern about the client's substance use, or the client's mood, anxiety, or other symptoms of mental disorder.
	• State nonjudgmentally that substance use (or mood, anxiety, self-destructiveness) is a problem.
	• Agree to disagree about the severity of either the substance use or the psychological issues.
	• Consider a trial of abstinence to clarify the issue, after which psychological evaluation can be reconsidered.
	• Suggest bringing a family member to an appointment.
	• Explore the client's perception of a substance use or psychiatric problem.
	• Emphasize the importance of seeing the client again and that you will try to help.
Contemplation	• Elicit positive and negative aspects of substance use or psychological symptoms.
	• Ask about positive and negative aspects of past periods of abstinence and substance use, as well as periods of depression, hypomania, etc.
	• Summarize the client's comments on substance use, abstinence, and psychological issues.
	• Make explicit discrepancies between values and actions.
	• Consider a trial of abstinence and/or psychological evaluation.
Preparation	• Acknowledge the significance of the decision to seek treatment for one or more disorders.
	• Support self-efficacy with regard to each of the COD.
	• Affirm the client's ability to seek treatment successfully for each of the COD.
	• Help the client decide on appropriate, achievable action for each of the COD.
	• Caution that the road ahead is tough but very important.
	• Explain that relapse should not disrupt the client-clinician relationship.

Stage of Readiness	Motivational Enhancement Approaches
Action	• Be a source of encouragement and support; remember that the client may be in the action stage with respect to one disorder but only in contemplation with respect to another; adapt your interview approach accordingly.
	• Acknowledge the uncomfortable aspects of withdrawal and/or psychological symptoms.
	• Reinforce the importance of remaining in recovery from both problems.
Maintenance	• Anticipate and address difficulties as a means of relapse prevention.
	• Recognize the client's struggle with either or both problems, working with separate mental health and substance abuse treatment systems, and so on.
	• Support the client's resolve.
	• Reiterate that relapse or psychological symptoms should not disrupt the counseling relationship.
Relapse	• Explore what can be learned from the relapse, whether substance-related or related to the mental disorder.
	• Express concern and even disappointment about the relapse.
	• Emphasize the positive aspect of the effort to seek care.
	• Support the client's self-efficacy so that recovery seems achievable.

Source: Reproduced from Samet et al.

Although MI is a well-accepted and commonly used strategy in the substance abuse treatment field, the issue of when it is appropriate to avoid or postpone addressing the client's substance use is the subject of some debate. MI does make a distinction between agreeing with a client's denial system (which is counterproductive) and sidestepping it in order to make some progress. As shown above, these motivational strategies are employed to help both clinician and client work together toward the common goal of helping the client. With practice and experience, the clinician will come to recognize when to sidestep disagreements and pursue MI and when to move forward with traditional methods with clients who are motivated sufficiently and ready for change. The details of these strategies and techniques are presented in TIP 35 and in Miller and Rollnick.

Motivational strategies have been shown to be helpful with persons who have serious mental disorders. Most programs designed for persons with such disorders recognize “that the majority of psychiatric clients have little readiness

for abstinence-oriented substance use disorder (SUD) treatments"; therefore, they "incorporate motivational interventions designed to help clients who either do not recognize their SUD or do not desire substance abuse treatment to become ready for more definitive interventions aimed at abstinence" *(Drake and Mueser)*.

A four-session intervention has been developed specifically to enhance readiness for change and treatment engagement of persons with schizophrenia who also abuse alcohol and other substances *(Carey et al)*. This intervention is summarized in Figure 5-3. In a pilot study of the intervention, 92 percent of the 22 participants completed the series of sessions, all of whom reported that intervention was both positive and helpful. A range of motivational variables showed post-intervention improvements in recognition of substance use problems and greater treatment engagement, confirmed by independent clinician ratings. Those who began the intervention with low problem recognition made gains in that area; those who began with greater problem recognition made gains in the frequency of use and/or involvement in treatment. Although these data are preliminary, the technique is well articulated. It shows promise and warrants further research, including efforts to determine its efficacy among clients with COD who have mental disorders other than schizophrenia.

A Four-Session Motivation-Based Intervention

Goals	Therapeutic Activities	Purpose
Session 1—Introduction, Assessment, and Information Feedback		
Establish therapeutic alliance and collaborative approach	Introduce intervention	• To elicit reasons and motivations for attending
Begin to develop discrepancy (raise awareness of the extent of use and negative consequences)		• To establish understanding of the nature and purpose of the intervention
	Assess and discuss readiness to change	• To establish mutual understanding of attitudes toward substance use and prospects for change
		• To convey respect for the client's attitudes
		• To evaluate using open-ended and structured techniques
	Feedback of current use, consequences, and risks	• To foster client's awareness of extent of use, comparison to norms, negative consequences, and risks of pattern of use

Goals	Therapeutic Activities	Purpose
Session 2—Decisional Balance		
Continue emphasis on therapeutic alliance and collaborative approach	Review Session 1 and introduce Session 2	• To let the client know what to expect (alleviates anxiety)
Place more emphasis on developing discrepancy		• To help the client remember insights/reactions to reinforce gains
	Decisional balance	• To help the client identify and verbalize salient cons of using and pros of quitting
		• To foster dissatisfaction with use, and interest in quitting, clarifying barriers to change
Session 3—Strivings and Efficacy		
Continue emphasis on developing discrepancy	Review Session 2 and introduce Session 3	• To reorient the client to the treatment process and reinforce past gains
Place more emphasis on self-efficacy	Assess and discuss expectancies with regard to behavior change	• To monitor changes in perceived importance and self-efficacy to change substance use
		• To shore up motivation for change or address reasons for low motivation
	Strivings list	• To develop discrepancy between a future with and without change in substance use by verbalizing personal aspirations, likely negative effects of use to achieving goals, and potential facilitative effects of abstinence
Session 4—Goals and Action Plan		
Reinforce motivational gains (in perceived importance of change, self-efficacy)	Review treatment	• To reinforce motivational changes
		• To extend the principle of providing periodic summaries of discussion throughout the course of each session
		• To use repetition to compensate for deficits in attention and memory
To leave the client with a clear plan of action	Elicit goals and develop written plan of action	• To help identify and clarify specific, realistic goals around substance use reduction
		• To help develop a plan of action, including mobilizing external supports and internal resources

Goals	Therapeutic Activities	Purpose
		• To help the client anticipate barriers and solve problems around him

Assessment of readiness to change could differ markedly between the client and the clinician. *Addington et al.* found little agreement between self-report of stage of readiness to change and the assessment of stage of readiness determined by interviewers for their 39 outpatients with diagnoses of both schizophrenia and a substance use disorder. In view of these observations, clinicians should be careful to establish a mutual agreement on the issue of readiness to change with their clients.

To date, motivational interviewing strategies have been applied successfully to the treatment of clients with COD, especially in

- Assessing the client's perception of the problem
- Exploring the client's understanding of his or her clinical condition
- Examining the client's desire for continued treatment
- Ensuring client attendance at initial sessions
- Expanding the client's assumption of responsibility for change

Future directions include

- Further modification of MI protocols to make them more suitable for clients with COD, particularly those with serious mental disorders
- Tailoring and combining MI techniques with other treatments to solve the problems (e.g., engagement, retention, etc.) of all treatment modalities

Case Study: **Using MET With a Client Who Has COD**

Gloria M. is a 34-year-old African-American female with a 10-year history of alcohol dependence and 12-year history of bipolar disorder. She has been hospitalized previously both for her mental disorder and for substance abuse treatment. She has been referred to the outpatient substance abuse treatment provider from inpatient substance abuse treatment services after a severe alcohol relapse.

Over the years, she sometimes has denied the seriousness of both her addiction and mental disorders. Currently, she is psychiatrically stable and is prescribed valproic acid to control the bipolar disorder. She has been sober for 1 month.

At her first meeting with Gloria M., the substance abuse treatment counselor senses that she is not sure where to focus her recovery efforts—on her mental disorders or her addiction. Both have led to hospitalization and to many life problems in the past. Using motivational strategies, the counselor first attempts to find out Gloria M.'s own evaluation of the severity of each disorder and its consequences to determine her stage of change in regard to each one.

Gloria M. reveals that while in complete acceptance and an active stage of change around alcohol dependence, she is starting to believe that if she just goes to enough recovery meetings she will not need her bipolar medication. Noting her ambivalence, the counselor gently explores whether medications have been stopped in the past and, if so, what the consequences have been. Gloria M. recalls that she stopped taking medications on at least half a dozen occasions over the last 10 years; usually, this led her to jail, the emergency room, or a period of psychiatric hospitalization. The counselor explores these times, asking: Were you feeling then as you were now—that you could get along? How did that work out? Gloria M. remembers believing that if she attended 12-Step meetings and prayed she would not be sick. In response to the counselor's questions, she observes, “I guess it hasn't ever really worked in the past.”

The counselor then works with Gloria M. to identify the best strategies she has used for dual recovery in the past. “Has there been a time you really got stable with both disorders?” Gloria M. recalls a 3-year period between the ages of 25 and 28 when she was stable, even holding a job as a waitress for most of that period. During that time, she recalls, she saw a psychiatrist at a local mental health center, took medications regularly, and attended AA meetings frequently. She recalls her sponsor as being supportive and helpful. The counselor then affirms the importance of this period of success and helps Gloria M. plan ways to use the strategies that have already worked for her to maintain recovery in the present.

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Use Cognitive-Behavioral Therapeutic Techniques

Cognitive-behavioral therapy (CBT) is a therapeutic approach that seeks to modify negative or self-defeating thoughts and behavior. CBT is aimed at both thought and behavior change (i.e., coping by thinking differently and coping by acting differently). One cognitive technique is known as "cognitive restructuring." For example, a client may think initially, "The only time I feel comfortable is when I'm high," and learn through the counseling process to think instead, "It's hard to learn to be comfortable socially without doing drugs, but people do so all the time" CBT includes a focus on overt, observable behaviors—such as the act of taking a drug—and identifies steps to avoid situations that lead to drug taking. CBT also explores the interaction among beliefs, values, perceptions, expectations, and the client's explanations for why events occurred.

An underlying assumption of CBT is that the client systematically and negatively distorts her view of the self, the environment, and the future. Therefore, a major tenet of CBT is that the person's thinking is the source of difficulty and that this distorted thinking creates behavioral problems. CBT approaches use cognitive and/or behavioral strategies to identify and replace irrational beliefs with rational beliefs. At the same time, the approach prescribes new behaviors the client practices. These approaches are educational in nature, active and problem-focused, and time-limited.

CBT for substance abuse

CBT for substance abuse combines elements of behavioral theory, cognitive social learning theory, cognitive theory, and therapy into a distinctive therapeutic approach that helps clients recognize situations where they are likely to use substances, find ways of avoiding those situations, and learn better ways to cope with feelings and situations that might have, in the past, led to substance use.

CBT for people with substance use disorders also addresses "coping behaviors." Coping "refers to what an individual does or thinks in a relapse crisis situation so as to handle the risk for renewed substance use". The approach assumes that "substance abusers are deficient in their ability to cope with interpersonal, social, emotional, and personal problems. In the absence of these skills, such problems are viewed as threatening, stressful, and potentially unsolvable. Based on the individual's observation of both family members' and peers' responses to similar situations and on their own initial experimental use of alcohol or drugs, the individual uses substances as a means of trying to address these problems and the emotional reactions they create" (CSAT). The clinician seeks to help the client increase his coping skills so he will not use drugs in high-stress situations.
CBT and COD

Distortions in thinking generally are more severe with people with COD than with other substance abuse treatment clients. For example, a person with depression and an alcohol use disorder who has had a bad reaction to a particular antidepressant may claim that all antidepressant medication is bad and must be avoided at all costs. Likewise, individuals may use magnification and minimization to exaggerate the qualities of others, consistently presenting themselves as "losers" who are incapable of accomplishing anything. Clients with COD are, by definition, in need of better coping skills. The Substance Abuse Management Model in the section on Relapse Prevention Therapy later in this chapter provides a pertinent example of how to increase behavioral coping skills.

Grounding

Some clients with COD, such as those who have experienced trauma or sexual abuse, can benefit from a particular coping skill known as "grounding" (Najavits). Many such clients frequently experience overwhelming feelings linked to past trauma, which can be triggered by a seemingly small comment or event. Sometimes, this sets off a craving to use substances. Grounding refers to the use of strategies that soothe and distract the client who is experiencing tidal waves of pain or other strong emotions, helping the individual anchor in the present and in reality. These techniques work by directing the mental focus outward to the external world, rather than inward toward the self. Grounding also can be referred to as "centering," "looking outward," "distraction," or "healthy detachment" (Najavits).

Grounding "can be done anytime, anywhere, by oneself, without anyone else noticing it. It can also be used by a supportive friend or partner who can guide the patient in it when the need arises" (Najavits). It is used commonly for PTSD, but can be applied to substance abuse cravings, or any other intense negative feeling, such as anxiety, panic attacks, and rage. Grounding is so basic and simple that it gives even the most impaired clients a useful strategy. However, it must be practiced frequently to be maximally helpful. For a lesson plan and other materials on grounding, see Najavits.

Roles of the client and clinician

CBT is an active approach that works most effectively with persons who are stabilized in the acute phase of their substance use and mental disorders. To be effective, the clinician and the client must develop rapport and a working alliance. The client's problem is assessed extensively and thorough historical data are collected. Then, collaboratively, dysfunctional automatic thoughts, schemas, and cognitive distortions are identified. Treatment consists of the practice of adaptive skills within the therapeutic environment and in homework sessions. Booster sessions are used following termination of treatment to assist people who have returned to old maladaptive patterns of thinking.

Case Study: Using CBT With a Client With COD

Jack W. is referred to the substance abuse treatment agency for evaluation after a positive urine test that revealed the presence of cocaine. He is a 38-year-old African American. Initially, Jack W. engages in treatment in intensive outpatient therapy three times weekly, has clean urine tests, and seems to be doing well. However, after 2 months he starts to appear more depressed, has less to say in group therapy sessions, and appears withdrawn. In a private session with the substance abuse treatment counselor, he says that, "All this effort just isn't worth it. I feel worse than I did when I started. I might as well quit treatment and forget the job. What's the point?" The counselor explores what has changed, and Jack W. reveals that his wife has been having a hard time interacting with him as a sober person. Now that he is around the house more than he used to be (he was away frequently, dealing drugs to support his habit), they have more arguments. He feels defeated.

In the vocabulary of CBT, Jack W. demonstrates "all or nothing" thinking (I might as well lose everything because I'm having arguments), overgeneralization, and discounting the positive (he is ignoring the fact that he still has his job, has been clean for 2 months, looks healthier and, until recently, had an improved outlook). His emotionally clouded reasoning is blackening the whole recovery effort, as he personalizes the blame for what he sees as failure to improve his life.

Clearly, Jack W. has lost perspective and seems lost in an apparently overwhelming marital problem. The counselor, using a pad and pencil, draws a circle representing the client and divides it into parts, showing Jack that they represent physical health, his work life, his recovery, risk for legal problems, and family or marriage. He invites Jack to review each one, comparing where he is now and where he was when he first arrived at the clinic in order to evaluate the whole picture. Jack observes that everything is actually getting better with the exception of his marriage. The counselor helps Jack gain the skills needed to stand back from his situation and put a problem in perspective. He also negotiates to determine the kind of help that Jack would see as useful in his marriage. This might be counseling for the couple or an opportunity to practice and rehearse ways of engaging his wife without either of them becoming enraged.

If Jack's depression continues despite these interventions, the counselor may refer him to a mental health provider for evaluation and treatment of depression.

Adapting CBT for Clients with COD

✓Use visual aids, including illustrations and concept mapping (a visual presentation of concepts that makes patterns evident).
✓Practice role preparation and rehearse for unexpected circumstances.
✓Provide specific *in vivo* feedback on applying principles and techniques.
✓Use outlines for all sessions that list specific behaviorally anchored learning objectives.
✓Test for knowledge acquisition.
✓Make use of memory enhancement aids, including notes, tapes, and mnemonic devices.

Source: Adapted from Peters and Hills.

The client with COD is an active participant in treatment, while the role of the clinician is primarily that of educator. The clinician collaborates with the client or group in identifying goals and setting an agenda for each session. The counselor also guides the client by explaining how thinking affects mood and behavior. Clients with COD may need very specific coping skills to overcome the combined challenges of their substance abuse and their mental disorder. For example, Ziedonis and Wyatt (1998, p. 1020) address the need to target "the schizophrenic's cognitive difficulties (attention span, reading skills, and ability to abstract)." Their approach for these clients includes role-playing to help build communication and problem solving skills. Some specific CBT strategies for programs working with clients with COD are described below. See also the text box above for a case example.

Use Relapse Prevention Techniques

Marlatt defines relapse as "a breakdown or setback in a person's attempt to change or modify any target behavior". NIDA elaborates this definition by describing relapse as "any occasion of drug use by recovering addicts that violates their own prior commitment and that often they regret almost immediately" (NIDA), and adds Relapse Prevention Therapy (RPT) to its list of effective substance abuse treatment approaches. Relapse can be understood not only as the event of resuming substance use, but also as a process in which indicators of increasing relapse risk can be observed prior to an episode of substance use, or lapse.

A variety of relapse prevention models are described in the literature (e.g., Gorski 2000; Marlatt et al; NIDA; Rawson et al.). However, a central element of all clinical approaches to relapse prevention is anticipating problems that are likely to arise in maintaining change and labeling them as high-risk situations for resumed substance use, then helping

clients to develop effective strategies to cope with those high-risk situations without having a lapse. A key factor in preventing relapse is to understand that relapses are preceded by triggers or cues that signal that trouble is brewing and that these triggers precede exposure to events or internal processes (high-risk situations) where or when resumed substance use is likely to occur. A lapse will occur in response to these high-risk situations unless effective coping strategies are available to the person and are implemented quickly and performed adequately. Clinicians using relapse prevention techniques recognize that lapses (single episodes or brief returns to drug use) are an expected part of overcoming a drug problem, rather than a signal of failure and an indication that all treatment progress has been lost. Therapy sessions aimed at relapse prevention can occur individually or in small groups, and may include practice or role-play on how to cope effectively with high-risk situations.

According to Daley and Marlatt, approaches to relapse prevention have many common elements. Generally they focus on the need for clients to

1) Have a broad repertoire of cognitive and behavioral coping strategies to handle high-risk situations and relapse warning signs.
2) Make lifestyle changes that decrease the need for alcohol, drugs, or tobacco.
3) Increase healthy activities.
4) Prepare for interrupting lapses, so that they do not end in full-blown relapse.
5) Resume or continue to practice relapse prevention skills even when a full-blown relapse does occur by renewing their commitment to abstinence rather than giving up the goal of living a drug-free life.

In Marlatt's model of RPT, lapses are seen as a “fork in the road” or a “crisis.” Each lapse contains the dual elements of “danger” (progression to full-blown relapse) and “opportunity” (reduced relapse risk in the future due to the lessons learned from debriefing the lapse). The goal of effective RPT is to teach clients to recognize increasing relapse risk and to intervene at earlier points in the relapse process in order to encourage clients to progress toward maintaining abstinence from drugs and living a life in which lapses occur less often and are less severe. Specific aspects of RPT might include:

- ✳ Exploring with the client both the positive and negative consequences of continued drug use (“decisional balance,” as discussed in the motivational interviewing section of this chapter)
- ✳ Helping clients to recognize high-risk situations for returning to drug use
- ✳ Helping clients to develop the skills to avoid those situations or cope effectively with them when they do occur
- ✳ Developing a “relapse emergency plan” in order to exercise “damage control” to limit the duration and severity of lapses
- ✳ Learning specific skills to identify and cope effectively with drug urges and craving

Clients also are encouraged to begin the process of creating a more balanced lifestyle to manage their COD more effectively and to fulfill their needs without using drugs to cope with life's demands and opportunities. In the treatment of clients with COD, it often is critical to consider adherence to a medical regimen required to manage disruptive and disorganizing symptoms of mental disorder as a relapse issue. In terms of medication adherence, a "lapse" is defined as not taking the prescribed drugs one needs rather than the resumption of taking illicit drugs for self-medication or pleasure seeking.

Adaptations for clients with COD

Several groups have developed relapse prevention interventions aimed at clients with different mental disorders or substance use diagnoses (see Evans and Sullivan). Weiss and colleagues developed a 20-session relapse prevention group therapy for the treatment of clients with co-occurring bipolar and substance use disorders. This group stressed concepts of importance to both disorders—for example, it contrasts "may as well" thinking, which allows for relapse and failure to take medication, with "it matters what you do." It also teaches useful skills relevant to both disorders, such as coping with high-risk situations and modifying lifestyle to improve self-care (p. 49). Ziedonis and Stern have developed a dual recovery therapy, which blends traditional mental health and addiction treatments (including both motivational enhancement therapy and relapse prevention) for clients with serious mental illness.

Substance abuse management module

Roberts et al. developed *The Substance Abuse Management Module* (SAMM) based on the previously described RPT approach of Marlatt and his colleagues. SAMM originally was designed to be a component of a comprehensive approach to the treatment of co-occurring substance use dependence and schizophrenia. This detailed treatment manual illustrates many RPT techniques and focuses on the most common problems encountered by clients with severe COD. SAMM offers a detailed cognitive-behavioral strategy for each of several common problems that clients face. Each strategy includes both didactics and detailed skills training procedures including role-play practice. Emphasis is placed on rehearsing such key coping behaviors as refusing drugs, negotiating with treatment staff, acting appropriately at meetings for mutual self-help, and developing healthy habits. Both counselor and client manuals are available.

The text box below describes the SAMM protocol (Roberts et al. 1999) shows how a clinician might work with a substance abuse treatment client with COD to help the client avoid drugs.

Overview of SAMM Concepts and Skills

How to Avoid Drugs (Made Simple)

The concepts and skills taught in this module are designed to help clients follow these four recommendations:

• If you slip, quit early.

• When someone offers drugs, say no.

• Don't get into situations where you can't say no.

• Do things that are fun and healthy.

Overview of Module Concepts and Skills

Clients learn how to follow these recommendations by learning key concepts and the skills. Here are four recommendations restated in terms of the module's key concepts:

Plain English	**Module Concepts**
If you slip, quit early.	Practice damage control.
When someone offers drugs, say no.	Escape high-risk situations.
Don't get into situations where you can't say no.	Avoid high-risk situations.
Do things that are fun and healthy.	Seek healthy pleasures.

Concepts and Skills Associated With Each Recommendation

Practice damage control

Main point: If you slip and use drugs or alcohol again, stop early and get right back into treatment. This will reduce damage to your health, relationships, and finances.

Concepts: Maintain recovery, slip versus full-blown relapse, risk reduction, abstinence violation effect, bouncing back into treatment.

Skills: Leaving a drug-using situation despite some use; reporting a slip to a support person.

Escape high-risk situations

Main point: Some situations make it very hard to avoid using drugs. Be prepared to escape from these situations without using drugs. Realize that it would be much better to avoid these situations in the first place.
Concepts: High-risk situations.
Skills: Refusing drugs from a pushy dealer; refusing drugs offered by a friend.
Avoid high-risk situations
Main point: Avoid high-risk situations by learning to recognize the warning signs that you might be headed toward drug use.
Concepts: Drug habit chain (trigger, craving, planning, getting, using), warning signs, U-turns, removing triggers, riding the wave, money management, representative payee.
Skills: Getting an appointment with a busy person; reporting symptoms and side effects; getting a support person.
Seek healthy pleasures
Main point: You can avoid drugs by focusing on the things that are most important and enjoyable to you. Do things that are fun and healthy.
Concepts: Healthy pleasures, healthy habits, activities schedule.
Skills: Getting someone to join you in a healthy pleasure; negotiating with a representative payee.
Additional Recommendations and Concepts
Understand how you learned to use drugs.
Main point: Drug abuse is learned and can be unlearned.
Concepts: Habits, reinforcement, craving, conditioning, extinction, riding the wave.
Know why you decided to quit.
Main point: Make sure you can always remember why you decided to quit using drugs.

Concepts: Advantages and disadvantages of using drugs and of not using drugs.
Carry an emergency card.
Main point: Make an emergency card that contains vital information and reminders about how and why to avoid drugs. Carry it with you at all times.
Concepts: Support person, coping skills, why quit.

Source: Adapted from Roberts et al.

Integrated Treatment

RPT and other cognitive-behavioral approaches to psychotherapy and substance abuse treatment allow clinicians to treat COD in a integrated way by

1) Doing a detailed functional analysis of the relationships between substance use, Axis I or II symptoms, and any reported criminal conduct
2) Evaluating the unique and common high-risk factors for each problem and determining their interrelationships
3) Assessing both cognitive and behavioral coping skills deficits
4) Implementing both cognitive and behavioral coping skills training tailored to meet the specific needs of an individual client with respect to all three target behaviors (i.e. substance use, symptoms of mental disorder, and criminal conduct)

Summary of RP strategies for clients with COD

Daley and Lis summarize RP strategies that can be adapted for clients with COD, some of which are listed below:

➡ Regardless of the client's motivational level or recovery stage, relapse education should be provided and related to the individual's mental disorder. The latter is important, particularly because the pattern typically followed by clients with COD begins with an increase in substance use leading to lowered efficacy or discontinuation of psychiatric medication, or missed counseling sessions. As a consequence, symptoms of mental disorders reappear or worsen, the client's tendency to self-medicate through substance use is exacerbated, and the downward spiral is perpetuated.

➡ Clients with COD need effective strategies to cope with pressures to discontinue their prescribed psychiatric medication. One such strategy simply is to prepare clients for external pressure from other people to stop taking their medications. Rehearsing circumstances in which this type of pressure is applied, along with anticipating the possibility, enables clients with COD to react appropriately. Reinforcing the difference between substances of abuse—getting “high”—and taking psychiatric medication to treat an illness is another simple but effective strategy.

Case Study: **Preventing Relapse in a Client with COD**

Stan Z. is a 32-year-old with diagnoses of recurrent major depression, antisocial personality disorder, crack/cocaine dependence, and polysubstance abuse. He has a 15-year history of addiction, including a 2-year history of crack addiction. Stan Z. has been in a variety of psychiatric and substance abuse treatment programs during the past 10 years. His longest clean time has been 14 months. He has been attending a dual-diagnosis outpatient clinic for the past 9 months and going to Narcotics Anonymous (NA) meetings off and on for several years. Stan Z. has been clean from all substances for 7 months. Following is a list of high-risk relapse factors and coping strategies identified by Stan Z. and his counselor:

High-Risk Factor 1

Stan Z. is tired and bored "with just working, staying at home and watching TV, or going to NA meetings." Recently, he has been thinking about how much he "misses the action of the good old days" of hanging with old friends and does not think he has enough things to do that are interesting.

Possible coping strategies for Stan Z. include the following: (1) remind him of problems caused by hanging out with people who use drugs and using drugs by writing out a specific list of problems associated with addiction; (2) challenge the notion of the "good old days" by looking closely at the "bad" aspects of those days; (3) remind him of how far he has come in his recent recovery, especially being able to get and keep a job, maintain a relationship with one woman, and stay out of trouble with the law; (4) discuss current feelings and struggles with an NA sponsor and NA friends to find out how they handled similar feelings and thoughts; and (5) make a list of activities that will not threaten recovery and can provide a sense of fun and excitement and plan to start active involvement in one of these activities.

High-Risk Factor 2

Stan Z. is getting bored with his relationship with his girlfriend. He feels she is too much of a "home body" and wants more excitement in his relationship with her. He also is having increased thoughts of having sex with other women.

Possible coping strategies for Stan Z. include the following: (1) explore in therapy sessions why he is really feeling bored with his girlfriend, noting he has a long-standing pattern of dumping girlfriends after just a few months; (2) challenge his belief that the problem is mainly his girlfriend so that he sees how his attitudes and beliefs play a role in this problem; (3) talk directly with his girlfriend in a nonblaming fashion about his desire to work together to find ways to instill more excitement in the relationship; (4) remind him of potential dangers of casual sex with a woman he does not know very well and that he cannot reach his goal of maintaining a meaningful, mutual relationship if he gets involved sexually with another woman. His past history is concrete proof that such involvement always leads to sabotaging his primary relationship.

High-Risk Factor 3

Stan Z. wants to stop taking antidepressant medications. His mood has been good for several months and he does not see the need to continue medications.

Possible coping strategies include the following: (1) discuss his concern about medications with his counselor and psychiatrist before making a final decision; (2) review with his treatment team the reasons for being on antidepressant medications; (3) remind him that because he had several episodes of depression, even during times when he has been drug-free for a long period, medication can help "prevent" the likelihood of a future episode of depression.

- ➡ An integral component of recovery is the use of mutual self-help and dual recovery groups to provide the support and understanding of shared experience. To maximize the effectiveness of their participation, clients with COD usually need help with social skills (listening, self-disclosure, expressing feelings/desires, and addressing conflict).
- ➡ Clients can use daily self-ratings of persistent psychiatric symptoms to monitor their status. Use of the daily inventory and symptom review should be encouraged to help clients with COD to track changes and take action before deteriorating status becomes critical. See the text box below for a case study applying RP strategies.

Use Repetition and Skills-Building To Address Deficits in Functioning

In applying the approaches described above, keep in mind that clients with COD often have cognitive limitations, including difficulty concentrating. Sometimes these limitations are transient and improve during the first several weeks of treatment; at other times, symptoms persist for long periods. In some cases, individuals with specific disorders (schizophrenia, attention deficit disorder) may manifest these symptoms as part of their disorder. General treatment strategies to address cognitive limitations in clients include being more concrete and less abstract in communicating ideas, using simpler concepts, having briefer discussions, and repeating the core concepts many times. In addition, individuals often learn and remember better if information is presented in multiple formats (verbally; visually; or affectively through stories, music, and experiential activities). Role-playing real-life situations also is a useful technique when working with clients with cognitive limitations. For example, a client might be assigned to practice "asking for help" phone calls using a prepared script. This can be done individually with the counselor coaching, or in a group, to obtain feedback from the members. When compared to individuals without additional disorders or disabilities, persons with COD and additional deficits often will require more substance abuse treatment in order to attain and maintain abstinence. A primary reason for this is that abstinence requires the development and utilization of a set of recovery skills, and persons with mental disorders often have a harder time learning new skills. They may require more support in smaller steps with more practice, rehearsal, and repetition. The challenge is not to provide more intensive or more complicated treatment for clients with COD, but rather to tailor the process of acquiring new skills to the needs and abilities of the client.

Using Relapse Prevention Methods

- ➡Provide relapse prevention education on both mental disorders and substance abuse and their interrelations.
- ➡Teach skills to help the client handle pressure for discontinuing psychotropic medication and to increase medication adherence.
- ➡Encourage attendance at dual recovery groups and teach social skills necessary for participation.
- ➡Use daily inventory to monitor psychiatric symptoms and symptoms changes.
- ➡If relapse occurs, use it as a learning experience to investigate triggers with the client. Reframe the relapse as an opportunity for self-knowledge and a step toward ultimate success.

Case Study: Using Repetition and Skills Building With a Client With COD

In individual counseling sessions with Susan H., a 34-year-old Caucasian woman with bipolar disorder and alcohol dependence, the counselor observes that often she is forgetful about details of her recent past, including what has been said and agreed to in therapy. Conclusions the counselor thought were clear in one session seem to be fuzzy by the next. The counselor begins to start sessions with a brief review of the last session. He also allows time at the end of each session to review what has just happened. As Susan H. is having difficulty remembering appointment times and other responsibilities, he helps her devise a system of reminders in big letters on her refrigerator.

Facilitate Client Participation in Mutual Self-Help Groups

Just as the strategies discussed in this chapter have proven helpful both to clients who have only substance use disorders as well as to those with COD, so the use of mutual self-help groups is a key tool for the clinician in assisting both categories of clients. In addition to traditional 12-Step groups, dual recovery mutual self-help approaches are becoming increasingly common in most large communities. The clinician plays an important role in helping clients with COD access appropriate mutual self-help resources and benefit from them. (See chapter 7 for an extended presentation of Dual Recovery Mutual Self-Help approaches tailored to meet the needs of persons with COD.) Groups for those who do not speak English may not be available, and the clinician is advised to seek resources in other counties or, if the number of clients warrants it, to initiate organization of a group for those who speak the same non-English language.

The clinician can assist the client by:

- ***Helping the client locate an appropriate group***. The clinician should strive to be aware not only of what local 12-Step and other dual recovery mutual self-help groups meet in the community, but also which 12-Step groups are known to be friendly to clients with COD, have other members with COD, or are designed specifically for people with COD. Clinicians do this by visiting groups to see how they are conducted, collaborating with colleagues to discuss groups in the area, updating their own lists of groups periodically, and gathering information from clients. The clinician should ensure that the group the client attends is a good fit for the client in terms of the age, gender, and cultural factors of the other members. In some communities, alternatives to 12-Step groups are available, such as Secular Organizations for Sobriety.
- ***Helping the client find a sponsor, ideally one who also has COD and is at a later stage of recovery***. Knowing that he or she has a sponsor who truly understands the impact of two or more disorders will be encouraging for the client. Also, some clients may "put people off" in a group and have particular difficulty finding a sponsor without the clinician's support.
- ***Helping the client prepare to participate appropriately in the group***. Some clients, particularly those with serious mental illness or anxiety about group participation, may

need to have the group process explained ahead of time. Clients should be told the structure of a meeting, expectations of sharing, and how to participate in the closing exercises, which may include holding hands and repeating sayings or prayers. They may need to rehearse the kinds of things that are and are not appropriate to share at such meetings. Clients also should be taught how to "pass" and when this would be appropriate. The counselor should be familiar enough with group function and dynamics to actually "walk the client" through the meeting before attending.

➡***Helping overcome barriers to group participation.*** The clinician should be aware of the genuine difficulties a client may have in connecting with a group. While clients with COD, like any others, may have some resistance to change, they also may have legitimate barriers they cannot remove alone. For example, a client with cognitive difficulties may need help working out how he or she can physically get to the meeting. The counselor may need to write down very detailed instructions for this person that another client would not need (e.g., "Catch the number 9 bus on the other side of the street from the treatment center, get off at Main Street, and walk three blocks to the left to the white church. Walk in at the basement entrance and go to Room 5.")

Case Study: **Helping a Client Find a Sponsor**

Linda C. had attended her 12-Step group for about 3 months, and although she knew she should ask someone to sponsor her, she was shy and afraid of rejection. She had identified a few women who might be good sponsors, but each week in therapy she stated that she was afraid to reach out, and no one had approached her, although the group members seemed "friendly enough." The therapist suggested that Linda C. "share" at a meeting, simply stating that she'd like a sponsor but was feeling shy and didn't want to be rejected. The therapist and Linda C. role-played together in a session, and the therapist reminded Linda C. that it was okay to feel afraid and if she couldn't share at the next meeting, they would talk about what stopped her.

After the next meeting, Linda C. related that she almost "shared" but got scared at the last minute, and was feeling bad that she had missed an opportunity. They talked about getting it over with, and Linda C. resolved to reach out, starting her sharing statement with, "It's hard for me to talk in public, but I want to work this program, so I'm going to tell you all that I know it's time to get a sponsor." This therapy work helped Linda C. to put her need out to the group, and the response from group members was helpful to Linda C., with several women offering to meet with her to talk about sponsorship. This experience also helped Linda C. to become more attached to the group and to learn a new skill for seeking help. While Linda C. was helped by counseling strategies alone, others with "social phobia" also may need antidepressant medications in addition to counseling.

➡***Debriefing with the client after he or she has attended a meeting to help process his or her reactions and prepare for future attendance***. The clinician's work does not end with referral to a mutual self-help group. The clinician must be prepared to help the client overcome any obstacles after attending the first group to ensure engagement in the group. Often this involves a discussion of the client's reaction to the group and a clarification of how he or she can participate in future groups.

8. Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

Suicide is a serious public health problem that ranks as the tenth leading cause of death in the United States (Centers for Disease Control and Prevention, 2020). Death by suicide is tragic, and has lasting harmful effects on families, friends, neighbors, colleagues, and communities (Substance Abuse and Mental Health Services Administration (SAMHSA), 2020). Among adults aged 18 or older in 2019, 4.8 percent (12 million people) had serious thoughts of suicide; 1.4 percent (3.5 million people) had made a suicide plan; and 0.6 percent (1.4 million people) had attempted suicide (SAMHSA, 2020). Below are some key terms used when referring to suicide.

Substance use disorders (SUDs) are associated with an increase in the likelihood and severity of suicidal thoughts and behaviors, as well as suicide attempts and deaths. To improve outcomes of SUD treatment, co-occurring mental disorders associated with suicidal thoughts and behaviors should be assessed and treated when appropriate. SAMHSA identifies the following co-occurring mental disorders as risk factors for suicidal thoughts and behaviors:

➡Depression (including substance-induced depression)
➡Anxiety disorders (especially post-traumatic stress disorder [PTSD])
➡Severe mental illness (schizophrenia, bipolar disorder)
➡Personality disorders (borderline and antisocial personality disorders)
➡Anorexia nervosa

Considerations for Clinicians

Attitudes toward suicide

Attitudes toward suicide vary widely. Before working with clients with suicidal thoughts and behaviors, clinicians are advised to conduct their own suicidal attitude inventory. Some of the items to consider in an inventory may include:

✓What is my personal and family history with suicidal thoughts and behaviors?
✓What personal experiences do I have with suicide or suicide attempts, and how do they affect my work with clients who have suicidal thoughts or behaviors?

Key Terms

- **Suicidal ideation** refers to thinking about, considering, or planning suicide (National Institute of Mental Health, 2021).
- **Self-injury** (also called non-suicidal self-injury [NSSI] or self-harm) is the act of deliberately harming one's own body. It does not involve intent to die (Mayo Clinic).
- **Suicide attempt** is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury.
- **Suicide** is death caused by self-directed injurious behavior with intent to die as a result of the behavior (National Institute of Mental Health, 2021).

✓What is my emotional reaction to clients who exhibit signs of suicidal ideation, self-harm, or attempts?
✓How do I feel when talking to clients about their suicidal thoughts and behaviors?
✓What did I learn about suicide in my formative years?

Three elements that are key to identifying and addressing suicidal thoughts and behaviors among individuals in substance use treatment are:
➡Screening and assessment
➡Safety planning, including lethal means counseling (i.e., assessing the individual's access to firearms, medications, or other potentially fatal substances or objects)
➡Linkage to care

Each of these three elements has been carefully incorporated into the Zero Suicide framework, a key component of the U.S. Surgeon General's and the National Action Alliance for Suicide Prevention's National Strategy for Suicide Prevention.

Warning signs

According to SAMHSA's Suicide Prevention Resource Center (https://www.sprc.org/), some behaviors that might indicate a person is at immediate risk for suicide include:
✦Talking about wanting to die or to kill oneself
✦Looking for a way to kill oneself, such as searching online or obtaining a gun
✦Talking about feeling hopeless or having no reason to live

Other behaviors or warning signs that may indicate a serious imminent risk include:
✦Talking about feeling trapped or in unbearable pain
✦Talking about being a burden to others
✦Increasing use of alcohol or drugs
✦Acting anxious or agitated or behaving recklessly
✦Sleeping too little or too much
✦Giving away important/meaningful possessions
✦Withdrawing or feeling isolated
✦Showing rage or talking about seeking revenge
✦Displaying extreme mood swings

General risk factors that can increase an individual's likelihood of attempting or dying by suicide include:
➡Previous suicide attempt(s)
➡Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
➡Alcohol and other substance use disorders
➡Family history of suicide
➡Hopelessness
➡Deliberate self-harm
➡Impulsive and/or aggressive tendencies
➡History of trauma or abuse
➡Major physical illnesses
➡Loss of relationship(s)
➡Easy access to lethal means
➡Local clusters of suicide
➡Lack of social support and sense of isolation
➡Stigma associated with asking for help
➡Lack of healthcare, especially mental health and substance use disorder treatment
➡Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
➡Exposure to others who have died by suicide (in real life or via the media and Internet)

If clinicians need assistance in working with a client who exhibits suicidal thoughts and behaviors, SAMHSA's Suicide Prevention Resource Center operates the National Suicide Prevention Lifeline, a 24-hour toll-free phone line for people in suicidal or emotional distress: 1-800-273-TALK (8255). An online chat option is also available.
Beginning July 16, 2022, individuals in crisis will be able to access the National Suicide Prevention Lifeline by calling **988**, which will become the '911' for suicide prevention

Key Messages

Key Messages for Clinicians

- ➡ Acquiring basic knowledge about the role of warning signs, risk factors, and protective factors as they relate to suicide risk.
- ➡ Understanding the impact of their own attitudes and experiences with suicidal thoughts and behaviors on their work with clients.
- ➡ Screening clients in substance use treatment for suicidal thoughts and behaviors at intake and routinely throughout treatment.
- ➡ Providing empathic and nonjudgmental support to people who experience suicidal thoughts and behaviors.
- ➡ Developing safety plans with individuals who are at increased risk for a suicide attempt.
- ➡ Implementing the Zero Suicide framework, which incorporates key screening and assessment, safety planning, and linkage to care considerations for counselors to use as suicide prevention strategies.
- ➡ Understanding available resources for the management of suicidal ideation and suicidal behaviors.
- ➡ Understanding the crisis care system to provide navigation and handoff, as needed, and to facilitate care coordination.
- ➡ Accessing supervision to address knowledge deficits, emotional reactions, and secondary trauma.

Key Messages for Substance Use Administrators and Leadership

- ✓ Raising awareness about the importance of addressing suicidal thoughts and behaviors in substance use treatment programs.
- ✓ Advancing their roles, and the roles of staff, in providing care for clients with suicidal thoughts and behaviors.
- ✓ Maintaining knowledge about the different levels of program involvement in addressing the needs of clients with SUD who are experiencing suicidal thoughts and behaviors.
- ✓ Implementing the Zero Suicide framework at all levels of the organization.
- ✓ Considering legal and ethical issues in managing and providing treatment to clients with suicidal thoughts and behaviors.
- ✓ Supporting training and IT (information technology) development to identify and treat individuals at risk for suicide.
- ✓ Using data to evaluate processes and promote continuous quality improvement.

and mental health crisis services. This easy-to-remember, 3-digit number will make it easier for individuals to access the help they need and reduce stigma related to suicide, suicidal ideation, and mental health issues.

Protective factors

Protective factors are buffers that lower long-term risk for suicide. Known and likely protective factors include:

➡Identifying reasons for living
➡Being substance-free
➡Attending 12-step support groups
➡Internalizing religious and/or spiritual teachings against suicide
➡Having a child in the home and/or childrearing responsibilities
➡Having supportive relationships with significant others
➡Establishing a trusting relationship with a counselor, physician, or other service provider
➡Obtaining and maintaining employment
➡Demonstrating trait optimism (a tendency to look at the positive side of life)

A caution about protective factors: If acute suicide warning signs and/or multiple risk factors are present, protective factors will not change the current assessment that preventive actions are necessary. Although protective factors may sustain someone showing ongoing signs of risk (e.g., due to chronic depression), they do not prevent clients from having suicidal thoughts or behaviors and afford no protection in acute crises.

Protective factors also vary with cultural values. For example, in cultures where extended families are closely knit, family support can act as a protective factor. Faith in and reliance on traditional healing methods among those individuals with a strong affiliation with a clan, tribe, or ethnic community may also serve as a protective factor.

Screening and Assessment

Evidence-based screening tools for suicide risk include:

➡The Columbia-Suicide Severity Rating Scale (C-SSRS)
➡Suicide Behaviors Questionnaire-Revised (SBQ-R)
➡Patient Health Questionnaire-9 (PHQ-9) and others.

Zero Suicide

Zero Suicide is a transformational framework for health and behavioral health care systems and provides a comprehensive approach to suicide prevention. To be successful, this framework requires commitment from counselors and other clinicians, program

administrators, and other stakeholders within the health system. Zero Suicide was developed by clinicians and practitioners to transform systemic approaches to suicide prevention. Zero Suicide calls on healthcare settings to set an explicit goal of full success in preventing suicide among the patients in their care; a toolkit is available that outlines this framework in detail.

Foundational principles of Zero Suicide

The core values of Zero Suicide include the belief and commitment that suicide can be eliminated in a population under care by improving service access and quality and through practicing continuous quality improvement.

Zero Suicide manages systems by systematic steps across systems of care to create a culture that no longer finds suicide acceptable, setting aggressive but achievable goals to eliminate suicide attempts and deaths, and organizing service delivery and support accordingly.

Finally, Zero Suicide uses evidence-based clinical care practices, adopting interventions that research shows reduce suicide behaviors and deaths, that are delivered through the entire system of care, and that emphasize productive patient-staff interactions. The seven elements of Zero Suicide, described below, represent what experts in the field of suicide prevention have identified as the core components of safe care for individuals with suicidal thoughts and urges. They represent a holistic approach to suicide prevention within health and behavioral health care systems.

Core Components of the Zero Suicide Framework

- ✓ Lead system-wide culture change committed to reducing suicides
- ✓ Train a competent, confident, and caring workforce
- ✓ Identify individuals with suicide risk via comprehensive screening and assessment
- ✓ Engage all individuals at-risk for suicide using a suicide care management plan
- ✓ Treat suicidal thoughts and behaviors directly using evidence-based treatments
- ✓ Transition individuals through care with warm hand-offs and supportive contacts
- ✓ Improve policies and procedures through continuous quality improvement

Addressing Suicidal Thoughts and Behaviors in SUD Treatment Programs: Levels of Program Involvement and Core Components

SAMHSA's TIP 50, *Suicidal Thoughts and Behaviors in Substance Abuse Treatment*, identifies three levels of program involvement in suicide prevention and intervention. **Level 1 programs** have the capacity to identify clients at risk and to identify warning signs of suicide as they emerge. All programs providing substance use treatment to clients should be Level 1. In a Level 1 program, all clinical staff recognize that clients in substance use treatment are at increased risk for suicidal thoughts and behaviors. All clinical staff have had basic classroom education in risk factors, warning signs, and protective factors for suicide. They have also received basic classroom education in recognizing misconceptions about suicide, have had an opportunity to replace them with accurate and contemporary information, and have explored their own attitudes toward suicide and suicidal behavior. Finally, all clinical staff have had basic classroom education and clinical supervision in recognizing clients' direct and indirect expressions of suicidal thoughts.

In addition to classroom education, all clinical staff have the skills to talk with clients about suicidal thoughts and behaviors and collect basic screening information. The Level 1 substance use treatment program has basic protocols for responding to clients with suicidal thoughts and behaviors. The program has formalized referral relationships with programs capable of addressing the needs of clients with suicidal thoughts and behaviors, as well as specific protocols available to all staff for how a referral is made and managing suicidal crises.

Level 2 programs have the capacity to provide integrated care to clients with suicidal thoughts and behaviors. In a Level 2 program, there is at least one staff member with an advanced mental health degree (e.g., licensed Ph.D. psychologist, licensed clinical social worker) who is specifically skilled in providing suicide prevention and intervention services and in providing clinical supervision to other program staff working with clients with suicidal thoughts and behaviors. The program has the capability to continue substance use treatment services for clients with suicidal thoughts and behaviors while monitoring those clients for suicidal symptoms and an exacerbation of psychiatric symptoms of depression, anxiety, or other co-occurring disorders. The program has formalized ongoing relationships (within the agency or in the community) with mental health professionals trained in suicide intervention to address emergency needs. Finally, the Level 2 program can offer consultation services to Level 1 programs on an as needed basis.

Level 3 programs have the capacity to provide integrated care to clients in acute suicidal crisis. Level 3 programs are linked to a mental health or hospital setting that provides

care for people with acute suicide-related needs and who are at high risk for a suicide attempt. Program staff have frequent, regular contact with the client, and the program has crisis beds or an area designated for close/regular observation. Clinical staff can perform comprehensive suicide assessments in-house that determine level of risk, treatment needs, and necessity for legal commitment of the client. Finally, the treatment agency has the appropriate certifications to legally commit clients who are deemed a danger to themselves or others. Such certifications are more commonly held by mental health rather than substance use treatment facilities.

Ethical and Legal Issues

Clients with suicidal thoughts and behaviors raise unique ethical and legal issues, which must be considered for clinicians, substance use counselors and SUD treatment program administrators. Ethical issues are often gray areas without defined proscriptions for counselor behavior, and ethical issues often overlap with legal issues. The legal issues regarding suicide prevention for SUD programs are primarily related to standards of care, maintaining appropriate confidentiality, and obtaining informed consent. It is the clinician's responsibility to determine what services are legally and ethically appropriate to provide within the scope of practice. While ethics is often thought of as an issue for frontline staff, including counselors, physicians, nurses, psychologists, and social workers, it also pertains to clinical supervisors regarding:

- Standards of care, including malpractice and additional training
- Confidentiality during admission, transfer, and treatment termination
- Informed consent

Standards of care

Ethical concerns relate to professional standards of care and the moral issues that arise in the conduct of professional services. Each profession concerned with substance use treatment (e.g., SUD counselors, social workers, professional counselors, psychologists, physicians) has a different set of professional standards. Additionally, each professional association, such as the Association for Addiction Professionals, the National Association of Social Workers, the American Counseling Association, the American Psychological Association, and the American Psychiatric Association, has a set of ethical standards to which their membership agrees to adhere. Finally, in states where these professional groups are licensed, the state licensing board may have an additional set of ethical standards to which persons licensed by that group must adhere. For example:

Both the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) provide standards of care for clients at risk of suicide that programs must consider for accreditation.

The American Psychiatric Association and other professional organizations offer practice guidelines for the clinician that set appropriate and reasonable standards of care.

While many of these guidelines are for professional activities beyond the scope of SUD counselors, they offer a resource for issues such as confidentiality, informed consent, referral procedures, treatment planning, and malpractice liability that have relevance to counselors working in SUD treatment agencies.

Maintaining appropriate confidentiality

Administrators should understand existing ethical and legal principles and potential areas of conflict. For example, safety and protection of the client supersedes confidentiality in certain crisis situations. When clients first enter the SUD treatment program, and as appropriate during the course of treatment, administrators and clinicians should explain that, in the event of suicide risk, they may take steps to promote the client's safety (including the potential for breaking confidentiality, arranging for an emergency evaluation over the client's objections, and involving emergency personnel). Clients should not be given the false impression that everything is confidential or that all types of treatment are always voluntary. Furthermore, when working with family members, administrators and clinicians should honor ethical and legal constraints on confidentiality and obtain appropriate consents for release of information from the client.

Obtaining informed consent

Informed consent should be part of collaboration with the client. Informed consent documentation should include an explanation of the limits of confidentiality (e.g., the duty to warn in specific situations). In addition, administrators should implement a policy and procedure for obtaining a release from clients who are at significant risk or have warning signs of suicidal thoughts and behavior to contact a family member or significant other if the counselor, with appropriate clinical supervision, feels the client may be at significant risk of attempting suicide. In order to contact family members during a crisis, counselors and administrators need to have access to the appropriate phone numbers and know which family members offer healthy, supportive relationships. This requires careful planning early in the treatment process. However, clients, in most cases, must still have the right to revoke the consent if they desire.

Suicide Resources

Substance Abuse and Mental Health Services Administration A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors: After an Attempt

EPLC: Suicidal Behaviors in Clinical High Risk Populations (New England Mental Health Technology Transfer Center Network)

National Suicide Prevention Lifeline 1-288-273-8255 National Suicide Prevention Lifeline Wallet Card: Having Trouble Coping?

National Suicide Prevention Lifeline Wallet Card*:* Suicide Prevention: Learning the Warning Signs

We Can All Prevent Suicide

Navigating Risk of Suicide in the Context of Substance Misuse: Best Practices for Supporting Youth and Young Adults *(Pacific Southwest Mental Health Technology Transfer Center Network)*

Preventing and Responding to Suicide Clusters in American Indian and Alaska Native Communities Report

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities (SPARK Kit)

SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians Suicide Prevention Resource Center

Suicide Risk Assessment & Crisis Response Planning (Southeast Mental Health Technology Transfer Center Network)

Suicide Safe Mobile App

TIP 50, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment Treatment for Suicidal Ideation, Self-harm, and Suicide Attempts Among Youth

American Association of Suicidology

American Foundation for Suicide Prevention

Centers for Disease Control and Prevention Preventing Suicide: A Technical Package of Policy, Programs, and Practices

Commission on Accreditation of Rehabilitation Facilities Quality Practice Notice on Suicide Prevention

Federal Communications Commission Fact Sheet: 988 and Suicide Prevention Hotline

The Joint Commission Suicide Prevention

National Action Alliance for Suicide Prevention Zero Suicide in Health and Behavioral Health Care
2012 National Strategy for Suicide Prevention

Zero Suicide Zero Suicide Toolkit

9. Engaging Adolescents in Treatment

To successfully identify and treat adolescents with traumatic stress and substance abuse, clinicians must continually explore better ways to encourage their participation in treatment. This is particularly important in mental health service systems and substance abuse service systems, as these teens present a unique set of challenges to any service system.

Adolescents with both traumatic stress and substance abuse problems often have complex histories and numerous additional problems that make this population particularly difficult to treat. Empirically based treatment interventions offer adolescents a good chance of success in overcoming a variety of psychological problems; however, many youth fail to obtain treatment, and those who enter treatment of ten terminate prematurely. Clinicians who work with adolescents encounter a series of challenges when trying to engage youth who have histories of traumatic stress and substance abuse. Most adolescents do not enter treatment voluntarily and are often apprehensive about the process. Furthermore, substance abusing adolescents, much like their adult counterparts, often have a hard time making positive changes in their use patterns. To provide effective services, these challenges and barriers must be addressed.
The following includes many important issues regarding engaging adolescents in treatment that providers must consider when treating adolescents with symptoms of both traumatic stress and substance use. Topics include:
➡Identifying and encouraging youth to seek help
➡Getting adolescents into initial treatment sessions
➡Addressing practical barriers to care
➡Getting families involved
➡Building alliances
➡Enhancing community awareness.

As you read through the pages that follow, consider the following questions:

- What are some specific challenges related to Brenda's history that might make engaging her in treatment difficult?
- How can we identify youth in need early?
- Are there ways to encourage adolescents to seek help?
- How can we get youth to give therapy a chance?
- What are the practical barriers that might keep adolescents out of treatment?
- How can we best get families and other caregivers involved in treatment?
- What are some ways to build alliances with these youth and their families?
- What steps can we take to educate the greater community about the link between substance abuse and traumatic stress?

Case Study: Brenda

Brenda, a 16-year-old mother of a 10-month-old boy, was mandated to treatment after a marijuana-related arrest. Born into a chaotic family, Brenda has lived, at various times, with her mother, her father, and other family members; she now spends most of her time with the father of her son at his parents' home. Brenda began drinking and smoking marijuana when she was 10. At age 12, she began selling marijuana and other drugs and became involved in a loosely organized gang. She has attended school only sporadically since she was 14 years old.

Illegal substances were common in the environment where Brenda was raised. Both of Brenda's parents have been intermittent users of heroin and other drugs, and her father spent a significant amount of time in jail during Brenda's childhood. Brenda was sexually assaulted by an adult friend of her father's at age nine. Brenda prided herself on never using heroin, and on "just" using marijuana and alcohol. Even the occasional use of cocaine was of very little concern to her and to most of the important figures in her personal life.

Brenda is a watchful, cautious, strong-willed, and outwardly confident girl. She speaks quietly about feeling old, feeling responsible for her younger siblings and her son, and about feeling disillusioned by the world, particularly by her father. Attending school, following the rules, and meeting the expectations that are typical for girls her age hold little meaning for her, and she has few dreams for her future. She is highly suspect of other people's intentions and experiences a sense of profound interpersonal distance. It is not likely that Brenda would have entered treatment without having been mandated by the court.

Identifying & Encouraging Youth to Seek Help

Teens tend not to seek out professional help for a variety of reasons. They may not believe they need help. They often are not aware of the range of services available. They may be concerned about the stigma of obtaining mental health services or hesitant to seek out an adult for assistance. Researchers and clinicians have developed a variety of ways to overcome these initial hurdles.

Offer multiple types of assistance

Teens are far more likely to seek assistance with issues concerning employment, relationships, and family than they are for mental health or emotional issues like posttraumatic stress or substance abuse. An agency that can act as a resource center and can offer the variety of services that might be sought by teens themselves, is more likely to be in a position to help an adolescent with multiple problems including those related to trauma and/or substance abuse.

Identify youth in schools

The school is a key access point for early identification of at-risk youth (See section 4: e.g., CBITS; SAPS). Two of the successful methods are:

1) Via peer networks: School-based support programs offer a promising pathway to reach at-risk youth. Programs that identify and train student leaders to provide peer assistance can help clinicians recognize at-risk students and provide needed support and referrals. By utilizing in-school student support resources, clinicians are more likely to be able to identify youth who would otherwise not have approached an adult for treatment. Programs that employ peer support networks to identify youth at risk should provide close adult supervision to peer supporters and have counselors readily available to provide assistance to the youth identified by the peer supporters.
2) Via standardized screening: Youth at risk can be identified by screenings and evaluations conducted in school or after-school settings. Clinicians administering annual or semiannual mental health or substance abuse screenings at a school can help identify youth who would not have sought treatment or otherwise been identified, thus facilitating youths' engagement in treatment or services. Multiple schools have screened their adolescent students for substance abuse problems using the CRAFFT (C*hildren's Hospital Boston*), a brief and adolescent-appropriate instrument. Programs that employ the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), Stein

et al., have successfully screened large numbers of students for traumatic stress within high-school populations. (See also Section 4: CBITS).*Getting Adolescents in the Door*

No-show rates for initial sessions at substance abuse clinics are reported at about 50% *(Source: Lerman and Pottick)*. Factors associated with missed appointments include active substance abuse, young age, and antisocial behavior. Listed below are some of the ways clinicians can increase the likelihood that an adolescent will attend the first session and continue coming thereafter:

- ✤ Make reminder calls
- ✤ Call the adolescent's home prior to the appointment and speak with both the youth and a parent. Tell them that you look forward to meeting them. Discuss the importance of arriving to the sessions on time; mention a couple of success stories of previous clients; and ask about any obstacles they anticipate to attendance.
- ✤ Be especially welcoming at the first session
- ✤ Praise the teen and family for just making it to the first session — let them know that you're glad to see them.

When engaging youths—and especially their caregivers—from diverse backgrounds, it is essential to use what you know about the cultural values and expectations that guide social interaction, mental health/substance abuse treatment, and salient themes in their communities. Establishing the trust of youths and families from diverse backgrounds is an important factor in determining whether they will continue to show up for appointments; and the quality of the initial interaction will greatly influence this decision. Remember that one's cultural community extends far beyond their racial/ethnic groups, and can also be defined by sexual orientation, homelessness, disabilities, socioeconomic status, and immigrant/refugee status, to name a few. If any staff use your cultural knowledge (Discussed in section IV: e.g., Considering culture and context; TST) of diverse youths and families to better relate members are unaware of the cultural backgrounds of the youths and families they are likely to assist, make sure they receive training in cultural competence; this will greatly contribute to successful treatment engagement and delivery.

Reach out to the family

Make an intense outreach effort starting with the very first session. Obtain several ways to get in touch with the youth and family and get contact information for those involved in their care. Make follow-up phone calls, letting them know that you care and that you want to continue to see them. This is particularly important for adolescents who are mandated for treatment.

Engaging Homeless Youth

Drug use by homeless youth is reported to be double that of youth in school (Forst & Crim). Furthermore, homeless adolescents who abuse substances engage in more high risk behaviors, are more resistant to treatment, and have higher rates of psychopathology and family problems than substance-using adolescents who are not homeless. While engaging this overlooked population in treatment is particularly important, it is also an especially challenging endeavor. Homeless youth are very unlikely to self-refer to treatment and, as they are frequently not in touch with caregivers, are rarely referred by motivated family members who may have otherwise initiated treatment. Although shelters are the primary intervention for these adolescents, many are not equipped to provide treatment for the multiple areas of need and various co-occurring conditions often characterizing this population. *(Slesnick, Meyers, Meade, & Segelken).*

Strategies to engage substance-abusing homeless adolescents and their families in treatment *(Slesnick, Meyers, Meade, & Segelken)* include:

- Meeting youth "at their level" when making the first contact. The therapist can facilitate engagement by showing the adolescent that he or she understands the youth's language and culture.
- Presenting the treatment in a non-threatening, appealing manner. For example, the therapist should avoid asking personal questions, convey the message that youth similar to the client have participated in and benefited from the program, and appear knowledgeable about the issues faced by many homeless adolescents, such as a history of abuse.
- Avoiding blaming the adolescent. Reframe current situations (e.g. drug behavior, living in shelter) in terms of relational factors rather than personal failure.
- Conveying hope throughout the engagement process that change is possible as well as a sense of control over their participation in treatment.
- Respecting the client's concerns, such as those surrounding confidentiality or engaging primary caregivers, and being open to negotiation.

Addressing Practical Barriers to Care

Many adolescents encounter real barriers to accessing treatment. Parents, caregivers, and adolescents need help to overcome them. Specific barriers and ways to assist include:

- **Transportation:** Discuss with the youth and family potential obstacles to getting to appointments regularly. Whenever possible, offer to provide bus or transit passes if your center is near public transportation.
- **Scheduling:** Both parents and adolescents may have difficulty with scheduling appointments. If a family is working with other treatment team members, try to coordinate with these members to schedule as many appointments as possible on the

same day, so that the family has to make only one trip to your location. Discuss the possibility of holding sessions before or after usual business hours to enable families to schedule appointments around work and school commitments.

- ➡ **Address child care limitations:** Families may have young children to care for and may not be able to afford child care during family sessions or parent sessions. If your agency has access to volunteers, ask them to assist with child care while parents are in session.
- ➡ **Address caregivers' treatment issues:** Caregivers may need referrals for treatment themselves. Providing independent referrals for caregiver treatment may help to alleviate stress on a family.

Getting Families Involved

Adolescents whose caregivers are involved and engaged in treatment are more likely to have better outcomes than those whose caregivers do not believe that treatment will help and/or are unwilling to work with treatment providers (Dakof, Tejeda, & Liddle). Specific strategies for family involvement in treatment include:

- ✤ Fostering family motivation: Determine what changes each family member would most like to see and incorporate those changes into treatment goals to increase the family's motivation and engagement.
- ✤ Validating parents: Validate parents' past and ongoing efforts to help their adolescent.
- ✤ Acknowledging parental stress: Acknowledge parents' stress and sense of burden (as both a parent and an individual).
- ✤ Being an ally for parent: In addition to trying to manage their teen's emotional and behavioral problems, parents are often overwhelmed by difficulties in their own lives. Be sure to provide active support and guidance.
- ✤ Providing education about the nature of mental health problems: Families may prefer to see their adolescent's symptoms solely as a medical and/or behavioral problem, and not as a mental health problem, and thus treat it with medical and/or behavioral solutions. In the case of substance abuse, for example, families may believe that once the adolescent is sober, all emotional and/or behavioral problems will disappear. Psycho-education (See section IV) regarding the nature of substance abuse and emotional problems may help family members better understand their adolescent's issues.
- ✤ Addressing complex family dynamics (See section 2: Complex Trauma; section IV: Treatment Options): Adolescents often come to treatment with complex family backgrounds, It is important to identify the family members and/or caretakers who have legal custody and practical influence over treatment-related decisions. It is also important to identify others who are most likely to be involved in an adolescent's care day to day including close friends and mentors who might support the adolescent's

successful engagement in treatment. Be particularly sensitive to situations in which an adolescent does not live with a biological parent.

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- ✤ Providing education about the nature of mental health problems: Families may prefer to see their adolescent's symptoms solely as a medical and/or behavioral problem, and not as a mental health problem, and thus treat it with medical and/or behavioral solutions. In the case of substance abuse, for example, families may believe that once the adolescent is sober, all emotional and/or behavioral problems will disappear. Psycho-education (See section IV) regarding the nature of substance abuse and emotional problems may help family members better understand their adolescent's issues.
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Building Alliances

As with any treatment, it is important that youth and caregivers feel that their clinician is an ally. This includes having a set of common goals. The entire family must believe that their work with the clinician and participation in treatment will lead to improvement in issues that are important to them. This kind of alliance can be fostered by doing the following:

- ✓ Establishing rapport, setting clear boundaries, and allowing for autonomy: Many adolescents do not respond to an intervention that they perceive as being imposed upon them, whether by a clinician, parents, or other authority figures. Regardless of the specific treatment approach, it is essential that clinicians get to know an adolescent in the beginning of treatment and develop a solid working relationship. It is also essential that clinicians outline a framework for the therapeutic relationship that establishes clear boundaries but allows for the adolescent to make autonomous decisions.
- ✓ Finding out what the adolescent wants to talk about: Although adolescents may be reluctant to disclose details about their risky behavior, there are several ways to

encourage meaningful conversations that will lead to open discussion about what is going on in their lives. These strategies include the following.

- Discovering and displaying both genuine interest in and respect for his/her unique interests, concerns, and worldview
- Showing some understanding of the culture the adolescent is surrounded by.
- Offering wisdom and guidance that can help the adolescent solve his/her life problems as he/she sees them.
- Informing youth about normal behavior

Teenagers benefit from contrasting their behavior to that of the average person their age. Although they might believe that "everyone smokes or drinks," they will be surprised to know, for example, that in a study only 6.7% of 8th-graders reported having been drunk in the 30 days preceding the study *(Johnston, O'Malley, & Bachman)*.

Using appropriate assessment tools

Administer assessment instruments that aren't face-to-face in order to encourage more disclosure. Adolescents tend to disclose more about topics such as substance abuse and suicidal ideation when they aren't talking to a clinician. For example, clinicians can use the Adolescent Questionnaire (Adquest), an 80-item self-report measure that includes questions about health, sexuality, safety, substance abuse, and friends, designed to open up many areas of interest and engage the adolescent in conversations involving these topics.

Discussing the limits of confidentiality thoroughly

To build trust with an adolescent, discuss the limits of confidentiality at the start of treatment and plan with the adolescent specifically how information will be communicated to parents and other authority figures. Stick to your agreement! There is no surer way to lose the trust of an adolescent than by sharing information without the adolescent's awareness. Reassure the adolescent that if you must disclose information (e.g., if someone's life is in danger), you will make every effort to tell him/her before you do it.

Employing Motivational Interviewing

Motivational interviewing *(MI; Miller & Rollnick)* has been shown to be effective at reducing alcohol and substance use in adolescents with an initial low motivation to change. The scope of this fact sheet cannot address the complexity of MI, but listed below are some of the main principles:

- Taking an empathic, nonjudgmental stance and listening reflectively. This involves attempting to understand the teenager's perspective and helping them feel understood, so that they can be more open and honest with others.

- Identifying how the adolescent's current behavior may affect their goals. This involves working with adolescents to identify personally meaningful goals, and helping youth evaluate whether what they are doing now will interfere with where they want to be in the future.
- Rolling with resistance. Rather than arguing with youth when they hit a roadblock, help them develop their own solutions to the problems that they have identified. Thus, youth are not reinforced when being a devil's advocate for the clinician's suggestions or recommendations about discontinuing use.
- Supporting self-efficacy for change. The belief that change is possible is an important motivator for successful change. Help adolescents be hopeful and confident about their ability to impact their own future in a positive way.
- Leaving the door open :When an adolescent wants to terminate treatment, make sure you leave the door open for them
- Rolling with resistance. Rather than arguing with youth when they hit a roadblock, help them develop their own solutions to the problems that they have identified. Thus, youth are not reinforced when being a devil's advocate for the clinician's suggestions or recommendations about discontinuing use.
- Supporting self-efficacy for change. The belief that change is possible is an important motivator for successful change. Help adolescents be hopeful and confident about their ability to impact their own future in a positive way.

Leaving the door open

When an adolescent wants to terminate treatment, make sure you leave the door open for them so they know that they can come back at any time. Treatment providers note that often it takes awhile for an adolescent to start coming in regularly.

Provide information about symptoms of substance abuse

In addition to understanding the negative health effects of substance use, community members should be able to recognize the signs and symptoms associated with abuse and dependence.

Provide information about risk and protective factors

Arming the community with this knowledge will be useful in identifying and treating youth in need, as well as in preventing future difficulties. Provide links to help. This includes information regarding hotlines to call when a person suspects that a child or adolescent is being abused, contacts for guidance during a crisis, and referrals for meeting additional youth and family needs.

Community Awareness

Community members often interact with teens, but they often do not have the training to identify and understand youth at risk. To improve community awareness, providers can: Provide information about symptoms associated with traumatic stress. For example, help parents, providers and community members understand the effects of traumatic experiences on youth functioning.

Adequate care begins with the recognition and accurate identification of the problems these adolescents experience—regardless of whether they present to a mental health professional or substance abuse specialist. Rather than referring a multi-problem teenager to another provider, clinicians willing to address co-occurring disorders can develop the skills necessary for providing such adolescents with hope of recovery.

Therapists and counselors can develop skills to provide a comprehensive and integrated treatment approach. In order to maximize an adolescent's chances of success, this approach should address the adolescent's concerns broadly and take into account the functional relationship between traumatic stress and substance abuse problems. When developing an individualized treatment plan, special attention should be given to the signs and symptoms of post-traumatic stress, substance abuse, and the relationship between the two.

Adolescents with trauma and substance abuse are often challenging to treat. Consider the case of Raphael below, as told by his therapist:

Case Study: Raphael

Raphael was a 15-year-old boy who lived in a group home. I am a clinician in the community mental health clinic that he came to for group and individual psychotherapy. Raphael had been raised by his mother and stepfather, but the courts decided to place him in a group home after Child Protective Service involvement with his family due to his ongoing truancy, being caught several times using marijuana and selling drugs, and being deemed unmanageable by his parents.

During my initial review of Raphael's case file, I also learned of an informed suspicion of past physical and sexual abuse. Before I met Raphael face-to-face, I was warned by other staff members about his anger, his resistance to cooperate during group activities, and his generally threatening demeanor.

Raphael was very disruptive during his group therapy sessions and initially did not say much during his individual treatment sessions with me. But as I developed enough patience, openness, and willingness to explore Raphael's interest in developing spontaneous rhymes or rap-style lyrics, Raphael started to engage increasingly in treatment. The road to recovery for Raphael was not an easy one, and I knew that I needed to be better prepared to help him with his multiple areas of difficulty and his aggressive interpersonal style. Eventually, Raphael spoke during our sessions about his difficult relationship with his mother, being frequently locked in a dark closet by his stepfather, and his conflictual relationship with his younger sister. He also began to speak about his frequent, almost daily, use of marijuana and alcohol. After learning more about his patterns of use, I began to understand how his substance use was a tool with which he numbed his feelings and which enabled him to be more dominant in social situations. Once Raphael began to actively use therapy to address his trauma and substance abuse histories, he began to work on developing better tools for coping with the intense feelings and impulses that contributed to his most pressing problems.

As you read the pages that follow, think about cases like Raphael's and consider the following questions:

- What are the challenges involved in engaging an adolescent in treatment who has a history of both trauma and substance abuse?
- What are the challenges associated with being able to accurately identify histories of trauma and/or substance use among adolescents?
- Do you feel proficient in assessing and treating youth with the different types of problems associated with trauma and substance abuse among adolescents?
- How can treatment and counseling centers promote and support an increase in providers' ability to assess and treat this population?

➡ How might therapists be supported in dealing with their own reactions to the often-difficult work with traumatized and substance-abusing adolescents?

The Co-Occurrence of Trauma and Substance Use Among Adolescents

Numerous studies have documented a strong link between trauma exposure and substance abuse in adolescents. This overlap is a result of high rates of substance abuse among youth who have experienced trauma as well as high rates of trauma or PTSD among substance-abusing youth. Multiple pathways have been identified in the connection between trauma and substance abuse including:

✓ Experiencing a traumatic event increases the risk of developing a substance abuse problem. Trauma—in the form of physical or sexual abuse, domestic violence, natural disasters, car accidents, traumatic loss, war, or other calamity—may lead to substance abuse and addiction. Adolescents experiencing posttraumatic stress may drink or take drugs in an attempt to manage or self-medicate their feelings of anxiety, physiological arousal, depression, hopelessness, and/or grief. Teens may abuse substances to fit in with peers, to combat feelings of isolation, or to try to become numb when they face triggers and trauma reminders.

✓ Adolescents who abuse substances are more likely to experience traumatic events, presumably because they are more likely to engage in risky activities. Traumas such as physical and sexual assaults, domestic violence, accidents, and serious injuries are more common in substance-abusing teens than in their nonsubstance-abusing peers.

✓ Youth who are already abusing substances may be less able to cope with a traumatic event as a result of the functional impairments associated with problematic use.

Below are just a few examples of studies that have documented the co-occurrence of trauma and substance abuse among adolescents:

➡ In an epidemiological study, researchers found a moderate overall co-occurrence of PTSD and substance abuse, with rates ranging from 13.5% to 29.7% *(Kilpatrick, Ruggiero, Acierno, Saunders, Resnick, & Best).* In this sample: — 29.7% of males and 24.4% of females who met diagnostic criteria for PTSD also met diagnostic criteria for either substance abuse or dependence — 13.5% of males and 24.8% of females who met criteria for a substance use disorder also met diagnostic criteria for PTSD

➡ In a sample of New Zealand teens *(Fergusson & Horwood),* rates of substance use disorders were: — 17 - 35% among teens who witnessed domestic violence — 10 - 15% among those who did not witness domestic violence

➡ Another study *(Funk, McDermeit, Godley, & Adams)* found 71% of teenagers in treatment for substance abuse reported a history of trauma exposure.

➡ In a study *(Deykin & Buke)* of chemically dependent adolescents in treatment for substance abuse: — lifetime prevalence rates of PTSD: 29.6% (24.3% for males and

45.3% for females) — current prevalence rates of PTSD: 19.2% (12.2% for males and 40.0% for females) — lifetime prevalence of trauma exposure: 73% of males and 80%

➡ In a study of adolescents seeking outpatient services for marijuana abuse or dependency, 14% of adolescents presenting for treatment met criteria for PTSD (Diamond, Panichelli-Mindel, Shera, Dennis, Tims, & Ungemack).

Attending to the Needs of Youth

Teenagers may find that alcohol and/or drugs initially seem to alleviate distress, either through the increased pleasurable sensations or through the avoidance of intense emotions that may follow stressful experiences. In the long run, however, substance use perpetuates a cycle of problem behaviors that can make it more difficult to recover after a traumatic event. When teenagers are struggling with both substance abuse and traumatic stress, the effects and negative consequences of one compounds the problems of the other.

Although such teenagers need help, often desperately, they frequently have difficulty entering or staying involved in treatment services. Usually teenagers attend such facilities against their will—either mandated to attend treatment (i.e., by the courts), referred by teachers, or brought by their parents. Because the service systems targeting substance abuse and mental health problems have traditionally been fragmented, few teenagers with both traumatic stress and substance abuse problems receive integrated treatment services. Compounding the problem is that there are few facilities offering integrated services, primarily because few professional training programs in substance abuse or mental health provide clinicians the education necessary to develop expertise in both trauma and substance abuse treatment; and few professionals often have training and experience across both fields. Given the strong link between trauma and substance abuse among adolescents, however, most substance abuse and mental health professionals have encountered this population.

Addressing traumatic stress in substance abuse treatment settings

Certain commonalities exist between the ways in which youth respond to substance abuse triggers and the ways in which they respond to reminders of loss and trauma. When compiling a list of triggers that may lead to emotional dysregulation and substance use, incorporating possible reminders of previous trauma and loss can be helpful. This requires substance use providers to look beyond the circumstances of the youth's use and pay attention to his/her past distressing events and present emotional difficulties surrounding problematic coping patterns (including substance use).

Addressing substance abuse problems in mental health settings

Mental health providers are often unfamiliar with the patterns of addiction associated with substances of abuse. It is important to recognize that there are similar processes at work in emotional and behavioral dysregulation, which are expressed in multiple types of symptoms and behaviors including classic post-traumatic stress symptoms, substance abuse, and other risky behaviors.

Exploring the Myths about Providing Treatment for Youth with Trauma and Substance Abuse Problems

There are several myths associated with the treatment of adolescent trauma and substance abuse. Below are some of the myths commonly held by substance use and mental health clinicians and other healthcare administrators and providers.

Myth: Almost every adolescent who uses drugs and/or alcohol has experienced some kind of trauma. Therefore, the effects of traumatic experiences do not need to be addressed by clinicians any differently from the ways they treat other problems that such adolescents experience.

- ✓ **Fact**: Trauma, as defined in psychological terms, involves experiencing or witnessing a situation that poses a threat to one's own or another person's life or bodily integrity —often resulting in post-traumatic stress symptoms. These symptoms can be alleviated by using specialized treatment approaches and interventions. Although not all youth who experience traumatic events develop post-traumatic stress symptoms, it is important to be prepared to attend to the multiple ways in which youth respond to distressing situations.
- ○ **Myth**: By assuming that adolescents use substances of abuse to cope with emotional distress, we relieve them from taking responsibility for their actions.
- ✓ **Fact**: Being aware of this self-medication hypothesis can be extremely helpful to both clinicians and youth while they attempt to make sense of the origins and perpetuation of a youth's substance use. Given that many adolescents are reluctant to acknowledge that their substance use is a "problem," maintaining a neutral stance in trying to understand the functional relationship between emotional problems and substance use can promote a youth's ability to take responsibility for his/her actions.
- ○ **Myth**: A. When dealing with an adolescent who has problems with substance abuse as well as a traumatic event history, it is imperative to: treat the substance abuse symptoms first before attempting to address trauma-related symptoms. B. Treat the trauma-related symptoms first before attempting to treat the substance abuse symptoms.
- ✓ **Fact**: Some adolescents with co-occurring traumatic stress and substance abuse problems are denied entry into substance abuse treatment programs until their emotional distress is sufficiently addressed; others are denied entry into mental health treatment centers until they gain sobriety. As the research suggests, symptoms

associated with traumatic stress and substance abuse are strongly linked. The decision about which symptoms and behaviors to address first depends on many factors including the relative threat to a youth's safety, health, and immediate well-being that those particular symptoms and behaviors pose.

- ○ **Myth:** Most evidence-based assessment tools for trauma or substance abuse are too long and complicated to be implemented in real clinical practice settings.
- ✓ **Fact:** Many of the older evidence-based assessment instruments do have a reputation for being long and complicated, as well as expensive. However, the assessment field has, over the past decade, produced many more assessment tools that are accessible and clinician-friendly in terms of both degree of complexity and length.
- ○ **Myth:** Manualized interventions are too rigid and simplistic to accommodate the complex needs of adolescents who have co-occurring post-traumatic stress and substance abuse problems.
- ✓ **Fact:** Today's evidence-based interventions are often manual-guided rather than manualized. This distinction reflects a movement away from promoting scripted and inflexible session content and structure and toward adherence to a clear therapeutic model with increasingly flexible session content and structure.

Common Challenges to Care

Clinicians, administrators, and other healthcare providers in the substance abuse and mental health fields often face major challenges in providing care to youth with traumatic stress and substance abuse problems. For example, the fragmentation that has traditionally existed between mental health and substance abuse systems often limits the types of services that youth are eligible to receive. Additionally, service centers may lack the resources or support necessary to provide comprehensive services. Although it may not be possible to find solutions to many of these challenges, below are some solutions to common treatment problems.

10. Brief Strategic Family Therapy for Adolescent Drug Abuse

Brief Strategic Family Therapy: An Overview

Brief Strategic Family Therapy (BSFT) is a brief intervention used to treat adolescent drug use that occurs with other problem behaviors. These co-occurring problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior *(Jessor and Jessor ; Newcomb and Bentler; Perrino et al.)*.

BSFT is based on three basic principles. The first is that BSFT is a family systems approach. Family systems means that family members are interdependent: What affects one family member affects other family members. According to family systems theory,

the drug-using adolescent is a family member who displays symptoms, including drug use and related co-occurring problem behaviors. These symptoms are indicative, at least in part, of what else is going on in the family system (Szapocznik and Kurtines). Just as important, research shows that families are the strongest and most enduring force in the development of children and adolescents (Szapocznik and Coatsworth). For this reason, family-based interventions have been studied as treatments for drug-abusing adolescents and have been found to be efficacious in treating both the drug abuse and related co-occurring problem behaviors *(for reviews, see Liddle and Dakof; Robbins et al; Ozechowski and Liddle)*.

The second BSFT principle is that the patterns of interaction in the family influence the behavior of each family member. Patterns of interaction are defined as the sequential behaviors among family members that become habitual and repeat over time (Minuchin et al.). An example of this is an adolescent who attracts attention to herself when her two caregivers (e.g., her mother and grandmother) are fighting as a way to disrupt the fight. In extreme cases, the adolescent may suffer a drug overdose or get arrested to attract attention to herself when her mother and grandmother are having a very serious fight.

The role of the BSFT clinician is to identify the patterns of family interaction that are associated with the adolescent's behavior problems. For example, a mother and grandmother who are arguing about establishing rules and consequences for a problem adolescent never reach an agreement because the adolescent disrupts their arguments with self-destructive attempts to get attention.

Therefore, the third principle of BSFT is to plan interventions that carefully target and provide practical ways to change those patterns of interaction (e.g., the way in which mother and grandmother attempt but fail to establish rules and consequences) that are directly linked to the adolescent's drug use and other problem behaviors.

Basic Concepts of Brief Strategic Family Therapy

The previous section introduced the underlying philosophy of BSFT: to help families help themselves and to preserve the family unit, whenever possible. The remainder of this manual focuses more directly on BSFT as a strategy to treat adolescent drug abuse and its associated behavior problems. This chapter presents the most basic concepts of the BSFT approach. It begins with a discussion of five theoretical concepts that comprise the basic foundation of BSFT. Some of these concepts may be new for drug abuse counselors. The five concepts discussed in this chapter are:

- ✓ Context
- ✓ Systems
- ✓ Structure
- ✓ Strategy

✓ Content versus process

Context

The social influences an individual encounters have an important impact on his or her behavior. Such influences are particularly powerful during the critical years of childhood and adolescence. The BSFT approach asserts that the counselor will not be able to understand the adolescent's drug-abusing behavior without understanding what is going on in the various contexts in which he or she lives. Drug-abusing behavior does not happen in a vacuum; it exists within an environment that includes family, peers, neighborhood, and the cultures that define the rules, values, and behaviors of the adolescent.

Family as Context

Context, as defined by *Urie Bronfenbrenner*, includes a number of social contexts. The most immediate are those that include the youth, such as family, peers, and neighborhoods. Bronfenbrenner recognized the enormous influence the family has, and he suggested that the family is the primary context in which the child learns and develops. More recent research has supported Bronfenbrenner's contention that the family is the primary context for socializing children and adolescents.

Peers as Context

Considerable research has demonstrated the influences that friends' attitudes, norms, and behaviors have on adolescent drug abuse. Moreover, drug-using adolescents often introduce their peers to and supply them with drugs *(Bush et al.)*. In the face of such powerful peer influences, it may seem that parents can do little to help their adolescents.

However, recent research suggests that, even in the presence of drug using *(Steinberg et al.)* or delinquent *(Mason et al.)* peers, parents can wield considerable influence over their adolescents. Most of the critical family issues (e.g., involvement, control, communication, rules and consequences, monitoring and supervision, bonding, family cohesion, and family negativity) have an impact on how much influence parents can have in countering the negative impact peers have on their adolescents' drug use.

Neighborhood as Context

The interactions between the family and the context in which the family lives may also be important to consider. A family functions within a neighborhood context, family members live in a particular neighborhood, and the children in the family are students at a particular school. For instance, to effectively manage a troubled 15- year-old's behavioral problems in a particular neighborhood, families may have to work against high drug availability, crime, and social isolation. In contrast, a small town in a semi-rural

community may have a community network that includes parents, teachers, grandparents, and civic leaders, all of whom collaborate in raising the town's children. Neighborhood context, then, can introduce additional challenges to parenting or resources that should be considered when working with families.

Culture as Context

Bronfenbrenner also suggested that families, peers, and neighborhoods exist within a wider cultural context that influences the family and its individual members. Extensive research on culture and the family has demonstrated that the family and the child are influenced by their cultural contexts *(Santisteban et al.)*. Much of the researchers' work has examined the ways in which minority families' values and behaviors have an impact on the relationship between parents and children and affect adolescents' involvement with drug abuse and its associated problems *(Santisteban et al.)*.

Counseling as Context

The counseling situation itself is a context that is associated with a set of rules, expectations, and experiences. The cultures of the client (i.e., the family), the counselor, the agency, and the funding source can all affect the nature of counseling as can the client's feelings about how responsive the "system" is to his or her needs.

Systems

Systems are a special case of context. A system is made up of parts that are interdependent and interrelated. Families are systems that are made up of individuals (parts) who are responsive (interrelated) to each other's behaviors.

A Whole Organism

"Systems" implies that the family must be viewed as a whole organism. In other words, it is much more than merely the sum of the individuals or groups that it comprises. During the many years that a family is together, family members develop habitual patterns of behavior after having repeated them thousands of times. In this way, each individual member has become accustomed to act, react, and respond in a specific manner within the family. Each member's actions elicit a certain reaction from another family member over and over again over time. These repetitive sequences give the family its own form and style.

The patterns that develop in a family actually shape the behaviors and styles of each of its members. Each family member has become accustomed to behaving in certain ways in the family. Basically, as one family member develops certain behaviors, such as a responsible, take-control style, this shapes other family members' behaviors. For example, family members may allow the responsible member to handle logistics. At the same time, the rest of the family members may become less responsible. In this fashion,

family members complement rather than compete with one another. These behaviors have occurred so many times, often without being thought about, that they have shaped the members to fit together like pieces of a puzzle--a perfect, predictable fit.

Family Systemic Influences

Family influences may be experienced as an "invisible force." Family members' behavior can vary considerably. They may act much differently when they are with other family members than when they are with people outside the family. By its very presence, the family system shapes the behaviors of its members. The invisible forces (i.e., systemic influences) that govern the behaviors of family members are at work every time the family is together. These "forces" include such things as spoken or unspoken expectations, alliances, rules for managing conflicts, and implicitly or explicitly assigned roles.

In the case of an adolescent with behavior problems, the family's lack of skills to manage a misbehaving youth can create a force (or pattern of interaction) that makes the adolescent inappropriately powerful in the family. For example, when the adolescent dismisses repeated attempts by the parents to discipline him or her, family members learn that the adolescent generally wins arguments, and they change their behavior accordingly. Once a situation like this arises in which family expectations, alliances, rules, and so on have been reinforced repeatedly, family members may be unable to change these patterns without outside help.

The Principle of Complementarity

The idea that family members are interdependent, influencing and being influenced by each other, is not unique to BSFT. Using different terminology, the theoretical approach underlying behaviorally oriented family treatments might explain these mutual influences as family members both serving as stimuli for and eliciting responses from one another *(Hayes et al)*. The theoretical approach underlying existential family treatments might describe this influence as family members either supporting or constraining the growth of other family members *(Lantz and Gregoire)*. What distinguishes BSFT from behaviorally oriented and existential family treatments is its focus on the family system rather than on individual functioning.

BSFT assumes that a drug-abusing adolescent will improve his or her behavior when the family learns how to behave adaptively. This will happen because family members, who are "linked" emotionally, are behaviorally responsive to each other's actions and reactions. In BSFT, the Principle of Complementarity holds that for every action by a family member there is a corresponding reaction from the rest of the family. For instance, often children may have learned to coerce parents into reinforcing their negative behavior--for example, by throwing a temper tantrum and stopping only when the parents

give in. Only when the parents change their behavior and stop reinforcing or "complementing" negative behavior will the child change.

Structure: Patterns of Family Interaction

An exchange among family members, either through actions or conversations, is called an interaction. In time, interactions become habitual and repetitive, and thus are referred to as patterns of interaction *(source: Minuchin)*. Patterns of family interaction are the habitual and repeated behaviors family members engage in with each other. More specifically, the patterns of family interaction are comprised of linked chains of behavior that occur among family members. A simple example can be illustrated by observing that family members choose to sit at the same place at the dinner table every day. Where people sit may make it easier for them to speak with each other and not with others. Consequently, a repetitive pattern of interaction reflected in a "sitting" pattern is likely to predict the "talking" pattern. A large number of these patterns of interaction will develop in any system. In families, this constellation of repetitive patterns of interaction is called the family "structure."

The repetitive patterns of interaction that make up a family's structure function like a script for a play that the actors have read, memorized, and re-enact constantly. When one actor says a certain line from the script or performs a certain action, which is the cue for other actors to recite their particular lines or perform their particular actions. The family's structure is the script for the family play.

Families of drug-abusing adolescents tend to have problems precisely because they continue to interact in ways that allow the youths to misbehave. BSFT counselors see the interactions between family members as maintaining or failing to correct problems, and so they make these interactions the targets of change in therapy. The adaptiveness of an interaction is defined in terms of the degree to which it permits the family to respond effectively to changing circumstances.

Strategy

The Three Ps of Effective Strategy

As its second word suggests, a fundamental concept of Brief Strategic Family Therapy is strategy. BSFT interventions are strategic in that they are practical, problem-focused, and planned.

Practical

BSFT uses strategies that work quickly and effectively, even though they might seem unconventional. BSFT may use any technique, approach, or strategy that will help change the maladaptive interactions that contribute to or maintain the family's presenting problem. Some interventions used in BSFT may seem "outside the theory" because they may be borrowed from other treatment modalities, such as behavior modification. For

example, behavioral contracting, in which patients sign a contract agreeing to do or not to do certain things, is used frequently as part of BSFT because it is one way to re-establish the parent figures as the family leaders. Frequently, the counselor's greatest challenge is to get the parent(s) to behave in a measured and predictable fashion. Behavioral contracting may be an ideal tool to use to accomplish this. The BSFT counselor uses whatever strategies are most likely to achieve the desired structural (i.e., interactional) changes with maximum speed, effectiveness, and permanence. Often, rather than trying to capture every problematic aspect of a family, the BSFT counselor might emphasize one aspect because it serves to move the counseling in a particular direction. For example, a counselor might emphasize a mother's permissiveness because it is related to her daughter's drug abuse and not emphasize the mother's relationship with her own parents, which may also be problematic.

Problem-Focused

The BSFT counselor works to change maladaptive interactions or to augment existing adaptive interactions (i.e., when family members interact effectively with one another) that are directly related to the presenting problem (e.g., adolescent drug use). This is a way of limiting the scope of treatment to those family dynamics that directly influence the adolescent's symptoms. The counselor may realize that the family has other problems. However, if they do not directly affect the adolescent's problem behaviors, these other family problems may not become a part of the BSFT treatment. It is not that BSFT cannot focus on these other problems. Rather, the counselor makes a choice about what problems to focus on as part of a time-limited counseling program. For example, the absence of clear family rules about appropriate and inappropriate behavior may directly affect the adolescent's drug-using behavior, but marital problems might not need to be modified to help the parents increase their involvement, control, monitoring and supervision, rule setting, and enforcement of rules in the adolescent's life.

Most families of drug-abusing adolescents are likely to experience multiple problems in addition to the adolescent's symptoms. Frequently, counselors complain that "this family has so many problems that I don't know where to start." In these cases, it is important for the counselor to carefully observe the distinction between "content" and "process". Normally, families with many different problems (a multitude of contents) are unable to tackle one problem at a time and keep working on it until it has been resolved (process). These families move (process) from one problem to another (content) without being able to focus on a single problem long enough to resolve it. This is precisely how they become overwhelmed with a large number of unresolved problems. It is their process, or how they resolve problems, that is faulty. The counselor's job is to help the family keep working on (process) a single problem (content) long enough to resolve it. In turn, the experience of resolving the problem may help change the family's process so that family members can apply their newly acquired resolution skills to other problems they are

facing. If the counselor gets lost in the family's process of shifting from one content/ problem to another, he or she may feel overwhelmed and, thus, be less likely to help the family resolve its conflicts.

Planned

In BSFT, the counselor plans the overall counseling strategy and the strategy for each session. "Planned" means that after the counselor determines what problematic interactions in the family are contributing to the problem, he or she then makes a clear and well-organized plan to correct them.

Content versus Process: A Critical Distinction

In BSFT, the "content" of therapy refers to what family members talk about, including their explanations for family problems, beliefs about how problems should be managed, perspectives about who or what causes the problems, and other topics. In contrast, the "process" of therapy refers to how family members interact, including the degree to which family members listen to, support, interrupt, undermine, and express emotion to one another, as well as other ways of interacting. The distinction between content and process is absolutely critical to BSFT. To be able to identify repetitive patterns of interaction, it is essential that the BSFT counselor focus on the process rather than the content of therapy.

Process is identified by the behaviors that are involved in a family interaction. Nonverbal behavior is usually indicative of process as is the manner in which family members speak to one another.

Process and content can send contradictory messages. For example, while an adolescent may say, "Sure Mom, I'll come home early," her sarcastic gesture and intonation may indicate that she has no intention of following her mother's request that she be home early. Generally, the process is more reliable than the content because behaviors or interactions (e.g., disobeying family rules) tend to repeat over time, while the specific topic involved may change from interaction to interaction (e.g., coming home late, not doing chores, etc.).

The focus of BSFT is to change the nature of those interactions that constitute the family's process. The counselor who listens to the content and loses sight of the process won't be able to make the kinds of changes in the family that are essential to BSFT work. Frequently, a family member will want to tell the counselor a story about something that happened with another family member. Whenever the counselor hears a story about another family member, the counselor is allowing the family to trap him or her in content. If the counselor wants to refocus the session from content to process, when Mom says, "Let me tell you what my son did...," the counselor would say: "Please tell your son directly so that I can hear how you talk about this." When Mom talks to her son directly, the therapist can observe the process rather than just hear the content when Mom tells the

therapist what her son did. Observations like these will help the therapist characterize the problematic interactions in the family.

Diagnosing Family System Problems

The BSFT approach to assessing and diagnosing family system problems differs drastically from that used by other kinds of psychotherapies. Unlike other psychotherapies that assess and diagnose by focusing on content, such as talking about a family's history, BSFT assesses and diagnoses by identifying the current family process. BSFT focuses on the nature and characteristics of the interactions that occur in the family and either help or hinder the family's attempts to get rid of the adolescent's problem behaviors.

The following six elements of the family's interactions are examined in detail:

- Organization
- Resonance
- Developmental stages
- Life context
- Identified patient
- Conflict resolution

Organization

As repetitive patterns of interaction in a family occur over time, they give the family a specific form, or "organization." Three aspects of this organization are examined below: leadership, subsystem organization, and communication flow.

Leadership

Leadership is defined as the distribution of authority and responsibility within the family. In functional two-parent families, leadership is in the hands of the parents. In modern societies, both parents usually share authority and decision-making. Frequently, in one-parent families, the parent shares some of the leadership with an older child. The latter situation has the potential for creating problems. In the case of a single parent living within an extended family framework, leadership may be shared with an uncle, aunt, or grandparent. In assessing whether leadership is adaptive, BSFT counselors look at hierarchy, behavior control, and guidance.

Counselors look at the hierarchy, or the way a family is ranked, to see who is in charge of leading the family and who holds the family's positions of authority. BSFT assumes that the leadership should be with the parent figures, with supporting roles assigned to older family members. Some leadership responsibilities can be delegated to older children, as long as those responsibilities are not overly burdensome, are age-appropriate, and are delegated by parent figures rather than usurped by the children. BSFT counselors look at

behavior control in the family to see who, if anyone, keeps order and doles out discipline in the family. Effective behavior control typically means that the parents are in charge and the children are acting in accordance with parental rules. Guidance refers to the teaching and mentoring functions in the family. BSFT assesses whether these roles are filled by appropriate family members and whether the youngsters' needs for guidance are being met.

Subsystem Organization

Families have both formal subsystems (e.g., spouses, siblings, grandparents, etc.) and informal subsystems (e.g., the older women, the people who manage the money, the people who do the housekeeping, the people who play chess). Important subsystems must have a certain degree of privacy and independence. BSFT looks at issues such as the adequacy or appropriateness of the subsystems in a family. It also assesses the nature of the relationships that give rise to these subsystems and especially looks at subsystem membership, triangulation, and communication flow, which are discussed below.

Subsystem Membership

BSFT identifies the family's subsystems, which are small groups within the family that are composed of family members with shared characteristics, such as age, gender, role, interests, or abilities. BSFT counselors pay particular attention to the appropriateness of each subsystem's membership and to the boundaries between subsystems. For example, parent figures should form a subsystem, while siblings of similar ages should also form a subsystem, and each of these subsystems should be separate from the others.

Subsystems that cross generations (e.g., between a parent and one child) cause trouble because such relationships blur hierarchical lines and undermine a parent's ability to control behavior. Relationships in which one parent figure and a child unite against another parent figure are called "coalitions." Coalitions are destructive to family functioning and are very frequently seen in families of drug-abusing adolescents. In these cases, the adolescent has gained so much power through this relationship that he or she dares to constantly challenge authority and gets away with it. The adolescent has this power to be rebellious, disobedient, and out of control by having gained the support of one parent who, to disqualify the other parent, enables the adolescent's inappropriate behavior.

Triangulation

Sometimes when two parental authority figures have a disagreement, rather than resolving the disagreement between themselves, they involve a third, less powerful person to diffuse the conflict. This process is called "triangulation." Invariably this triangulated third party, usually a child or an adolescent, experiences stress and develops symptoms of this stress, such as behavior problems. Triangles always spell trouble

because they prevent the resolution of a conflict between two authority figures. The triangulated child typically receives the brunt of much of his or her parents' unhappiness and begins to develop behavior problems that should be understood as a call for help.

Communication Flow

The final category of organization looks at the nature of communication. In functional families, communication flow is characterized by directness and specificity. Good communication flow is the ability of two family members to directly and specifically tell each other what they want to say. For example, a declaration such as, "I don't like it when you yell at me," is a sign of good communication because it is specific and direct. Indirect communications are problematic. Take, for example, a father who says to his son, "You tell your mother that she better get here right away," or the mother who tells the father, "You better do something about Johnny because he won't listen to me." In these two examples, the communication is conducted through a third person. Nonspecific communications are also troublesome, as in the case of the father who tells his son, "You are always in trouble." The communication would be more constructive if the father would explain very clearly what the problem is. For example: "I get angry when you come home late."

Resonance

"Resonance" defines the emotional and psychological accessibility or distance between family members. A 6-year-old son who hangs onto his mother's skirt at his birthday party may be said to be overly close to her. A mother who cries when her daughter hurts is emotionally very close. A father who does not care that his son is in trouble with the law may be described as psychologically and emotionally distant.

One of the key concepts related to resonance is boundaries. An interpersonal boundary, just as the words imply, is a way of denoting where one person or group of people ends and where the next one begins. People set their own boundaries when they let others know which behaviors entering their personal space they will allow and which ones they will not allow. In families, resonance refers to the psychological and emotional closeness or distance between any two family members. This psychological and emotional distance is established and maintained by the boundaries that exist between family members. In particular, the boundaries between two family members determine how much affect, or emotion, can get through from one person to the other. If the boundaries between two people are very permeable, then a lot gets through, and there is high resonance-- great psychological and emotional closeness--between them. One's happiness becomes the other's happiness. If the boundaries between two people are overly rigid, then each person may not even know what the other is feeling.

Enmeshment and Disengagement

The firmness and clarity of boundaries reflect the degree of differentiation within a family system. At one extreme, boundaries can be extremely impermeable. If this is the case, the emotional and psychological distance between family members is too large, and these family members are said to be "disengaged" from each other. At the other extreme, boundaries can be far too permeable or almost nonexistent. When boundaries are that permeable, the emotional and psychological closeness between people is too great, and these family members are said to be "enmeshed." Each of these extremes is problematic and becomes a target for intervention.

Interactions that are either enmeshed or disengaged can cause problems. When these interactions cause problems, they need to be altered to establish a better balance between the closeness and distance that exists between different family members. For each family, there is an ideal balance between closeness and distance that allows cooperation and separation.

Resonance and Culture

Resonance needs to be assessed in the context of culture. This is important because some cultures encourage family members to be very close with each other, while other cultures encourage greater distance. One important aspect of culture involves the racial or ethnic groups with which families identify themselves. For example, Hispanics are more likely than white Americans to be close and, thus, appear more enmeshed (have higher resonance). Similarly, an Asian father may be quite distant or disengaged from the women in his family, which is considered natural in his culture. However, whether the culture dictates the distance between family members, it is important for counselors to question if a particular way of interacting is causing problems for the family. In other words, even if an interaction is typical of a culture, if it is causing symptoms, then it may need to be changed. This type of situation must be handled with great knowledge and sensitivity to demonstrate respect for the culture and to allow family members to risk making a change that is foreign to their culture.

Enmeshment (high resonance) and Disengagement (low resonance)

Sometimes "enmeshment" (excessive closeness) and "disengagement" (excessive distance) can occur at the same time within a single family. This happens frequently in families of drug-abusing youths, when one parent is sometimes very protective and is closely allied with the youth (i.e., enabling), while the other parent may be somewhat disinterested and distant.

BSFT counselors look for certain behaviors in a family that are telltale signs of either enmeshment or disengagement. Obviously, some of these behaviors may happen in any family. However, when a large number of these behaviors occur or when some occur in an extreme form, they are likely to reflect problems in the family's patterns of interaction.

Easily observable symptoms of enmeshment include one person answering for another, one person finishing another's statements, and people interrupting each other. Observable symptoms of disengagement include one family member who wants to be separated from another or a family member who rarely speaks or is spoken about.

Developmental Stages

Individuals go through a series of developmental stages, ranging from infancy to old age. Certain conditions, roles, and responsibilities typically occur at each stage. Families also go through a series of developmental stages. For family members to continue to function adaptively at each developmental stage, they need to behave in ways that are appropriate for the family's developmental level.

Each time a developmental transition is reached, the family is confronted by a new set of circumstances. As the family attempts to adapt to the new circumstances, it experiences stress. Failure to adapt, to make the transition, to give up behaviors that were used successfully at a previous developmental stage, and to establish new behaviors that are adaptive to the new stage will cause some family members to develop new behavior problems. Perhaps one of the most stressful developmental changes occurs when children reach adolescence. This is the stage at which a large number of families are not able to adapt to developmental changes (e.g., from direct guidance to leadership and negotiation). Parents must be able to continue to be involved and monitor their adolescent's life, but now they must do it from a distinctly different perspective that allows their daughter or son to gain autonomy.

At each developmental stage, certain roles and tasks are expected of different family members. One way to determine whether the family has successfully overcome the various developmental challenges that it has confronted is to assess the appropriateness of the roles and tasks that have been assigned to each family member, considering the age and position of each person within the family. When a family's developmental stage is analyzed, four major sets of tasks and roles must be assessed: (1) Parenting tasks and roles are concerned with the parent figures' ability to act as parents at a level consistent with the age of the children; (2) Marital tasks and roles assess how well spouses cooperate and share parenting functions; (3) Sibling tasks and roles assess whether the children and adolescents are behaving in an age-appropriate fashion; and (4) Extended family's tasks and roles target the support for and intrusion into parenting functions from, for example, grandparents, aunts, and uncles, if extended family members are part of the household or share in parenting responsibilities.

Developmental transitions may be stressful. They are likely to cause family shake-ups because families may continue to approach new situations in old ways, thus making it possible for conflict to develop. Most often, families come to the attention of counselors precisely at these times. Of all of these developmental milestones, reaching adolescence

appears to be one of the most risky and critical stages in which drug abuse can occur in most ethnic groups *(Vega and Gil)*. Although the adolescent is the family member who is most likely to behave in problematic ways, often other members of the family, such as parents, also exhibit signs of troublesome or maladaptive behaviors and feelings *(Silverberg)*.

Assessing Appropriate Developmental Functioning

Careful judgments are needed to determine what is developmentally appropriate and/or inappropriate for each family member. It is particularly difficult to make these judgments when assessing the tasks and roles of children and extended family members. In every instance, the BSFT counselor should take into account the family's cultural heritage when making these judgments. For example, it is useful to know that some traditional African-American and Hispanic families tend to protect their children longer than non-Hispanic whites do. Thus, it would not be unusual for children to have a longer period of dependence among traditional Hispanic groups than among non-Hispanic white families. Similarly, it would not be unusual for the African-American caretaker of a 12-year-old to continue to behave in an authoritarian manner without the child rebelling or considering it odd. In fact, researchers have suggested that African-American inner city youths experience an authoritarian command as caring, while a child from another cultural group might experience it as rejecting. However, as suggested earlier, as an adolescent in the United States grows older, his or her parent, who may be from any culture and in any setting, may have to moderate his or her level of control and increase his or her authoritative parenting, or the youth may rebel.

Common Problems in Assessing Appropriateness of Developmental Stage

It is often difficult for parents to determine what is developmentally appropriate for children of different ages; for example, how much or how little responsibility should a child 6, 10, or 16 years old have in a household? In families of drug-abusing and conduct-disordered adolescents, parents and their children often have a difficult time determining what is developmentally appropriate for a child's age.

One of the main problems family members encounter is how to determine the degree of supervision and autonomy that children should have at each age level. This is a highly complex and conflictive area, even for the best of parents, because as children grow older, they experience considerable pressure from their peers to demonstrate increasing independence. It is also complex because many parents are not aware of what might be the norm in today's society. Therefore, they may allow too little or too much autonomy, based either on their own comfort or discomfort level, their own experience, and/or their culture. Moreover, children's peer groups may vary considerably in the level of autonomy they expect from parents. In working with the notion of "developmental appropriateness," a BSFT counselor needs to examine issues such as roles and functions, rights and

responsibilities, limits and consequences, as they are applied to the adolescents in the family. Examples of these standards are available from adolescent development research.

Life Context

While the dimensions of family functioning discussed up to now are all within the family, life context refers to what happens in the family's relationship to its social context. The life context of the family includes the extended family, the community, the work situation, adolescent peers, schools, courts, and other groups that may have an impact on the family, either as stressors or as support systems.

Antisocial Peers

A careful analysis of the life context is useful in many situations involving the treatment of substance abuse. For example, a youngster who uses drugs may be involved with a deviant or antisocial peer group. These friendships affect the youth and family in an adverse way and will certainly need to be modified to successfully eliminate the youth's drug use. Parents need help to identify less acceptable and more acceptable adolescent peers so that they can encourage their teens to associate with more desirable peers and discourage them from associating with less desirable peers.

Parent Support Systems and Social Resources

Parenting is a difficult task. Parents often lack adequate support systems for parenting. Parents need support from friends, extended family members, and other parents *(Henricson and Roker)*. The availability of support systems needs to be assessed, particularly in the case of single-parent families. The availability of social resources needs to be assessed, both in terms of what is already being used or what could potentially be used.

Juvenile Justice System

Increasingly, probation officers and the courts have become critical players in the families of drug-abusing adolescents. It is the BSFT counselor's job to assess how juvenile justice representatives such as probation officers interact with the family to determine whether they are supporting or undermining the family. One way to assess the probation officer's role, for example, is to invite him or her to participate in a family therapy session.

Identified Patient

The "identified patient" is the family member who has been branded by the family as the problem. The family blames this person, usually the drug-abusing adolescent, for much of its troubles. However, as discussed earlier, the BSFT view of the family is that the symptom is only that: a symptom of the family's problems. The more that family members insist that their entire problem is embodied in a single person, the more difficult it will be for them to accept that it is the entire family that needs to change. On the other

hand, the family that recognizes that several of its members may have problems is far healthier and more flexible and will have a relatively easier time of making changes through BSFT. The BSFT counselor believes that the problem is in the family's repetitive (habitual, rigid) patterns of interaction. Thus, the counselor not only will try to change the person who exhibits the problem but also to change the way all members of the family behave with each other.

The other aspect to understanding a family's identified patient is that usually families with problematic behaviors identify only one aspect of the identified patient as the source of all the pain and worry. For example, families of drug-abusing youths tend to focus only on the drug use and possibly on accompanying school and legal troubles that are directly and overtly related to the drug abuse. These families usually overlook the fact that the youngster may have other symptoms or problems, such as depression, attention deficit disorder, and learning deficits.

Conflict Resolution

While solving differences of opinion is always challenging, it is much more challenging when it is done in the context of a conflictive relationship that is high in negativity. The following are five different ways in which families can approach or manage conflicts. Some are adaptive and some are not. In the case of drug-abusing adolescents, with few exceptions, the first four tend to be ineffective, whereas the fifth tends to be effective in most situations:

- Denial
- Avoidance
- Diffusion
- Conflict emergence without resolution
- Conflict emergence with resolution

Denial

"Denial" refers to a situation in which conflict is not allowed to emerge. Sometimes this is done by adopting the attitude that everything is all right. At other times, conflict is denied by arranging situations to avoid confrontation or establishing unwritten rules with which no one dares to disagree outwardly, regardless of how they feel. The classic denial case is the one in which the family says: "We have no problems."

Avoidance

"Avoidance" refers to a situation in which conflict begins to emerge but is stopped, covered up, or inhibited in some way that prevents it from emerging. Examples of avoidance include postponing ("Let's not have a fight now."), humor ("You're so cute

when you're mad."), minimizing ("That's not really important."), and inhibiting ("Let's not argue; you know what can happen.").

Diffusion

"Diffusion" refers to situations in which conflict begins to emerge, but discussion about the conflict is diverted in another direction. This diversion prevents conflict resolution by distracting the family's attention away from the original conflict. This change of subject is often framed as a personal attack against the person who raised the original issue. For example, a mother says to her husband, "I don't like it when you get home late," but the husband changes the topic by responding: "What kind of mother are you anyway, letting your son stay home from school today when he is not even sick!"

Conflict Emergence without Resolution

"Conflict emergence" without resolution occurs when different opinions are clearly expressed, but no final solution is accepted. Everyone knows exactly where everyone else stands, but little is done to reach a negotiated agreement. Sometimes this occurs because the family, while willing to discuss the problem, simply does not know how to negotiate a compromise.

Conflict Emergence with Resolution

Emergence of the conflict and its resolution is generally considered to be the best outcome. Separate accounts and opinions regarding a particular conflict are clearly expressed and confronted. Then, the family is able to negotiate a solution that is acceptable to all family members involved.

A Caveat

In some cases, conflicts need to be postponed for more appropriate times. For example, if a family member is very angry, tired, or sick, it may be reasonable to table the conflict until he or she is ready to have a meaningful discussion. However, in such instances, it is critical that the family set a specific time to address the conflict. Indefinitely postponing conflict resolution is a sign of avoidance. A postponement for a definite amount of time is adaptive.

In other instances, a person may decide that the issue at hand is not worth having an argument about. For example, one person may want to stay home while his or her partner wants to go dancing. Either partner may opt to compromise by agreeing to the other's preference. So long as partners take turns compromising, this is adaptive and balanced. However, if the same person is always the one to give in, this may reflect the use of denial by one partner to avoid conflict with the other.

Orchestrating Change

This chapter describes the BSFT approach to orchestrating change in the family. The first section describes how BSFT counselors establish a therapeutic relationship, including the

importance of joining with the family, the role of tracking family interactions, and what is involved in building a treatment plan. The second section describes strategies for producing change in the family, including focusing on the present, reframing negativity in the family, shifting patterns of interaction through reversals of usual behavior, changing family boundaries and alliances, "detriangulating" family members caught in the middle of others' conflicts, and opening up closed family systems or subsystems by directing new interactions.

Establishing a Therapeutic Relationship

The counselor's first step in working with a family is to establish a therapeutic relationship with the family, beginning with the very first contact with family members. The quality of the relationship between the counselor and the family is a strong predictor of whether families will come to, stay in, and improve in treatment *(Robbins et al.)*. In general, studies have found that the therapeutic relationship is a strong predictor of success in many forms of therapy. Validating and supporting the family as a system and attending to each individual family member's experience are particularly important aspects of developing and maintaining a good therapeutic relationship *(Diamond et al)*

Establishing a therapeutic relationship means that the BSFT counselor needs to form a new system--a therapeutic system--made up of the counselor and the family. In this therapeutic system, the counselor is both a member and its leader. One challenge for the BSFT counselor is to establish relationships with all family members, some of whom are likely to be in conflict with each other. For example, drug-abusing adolescents generally begin treatment in conflict with their parent(s) or guardian(s). Both parties approach counseling needing support from the counselor. The counselor's job is to find ways to support the individuals on either side of the conflict. For example, the counselor might say to the adolescent, "I am here to help you explain to your something he or she would like to achieve, the counselor is able to establish a therapeutic alliance with the whole family.

The BSFT approach is based on the view that building a good therapeutic relationship is necessary to bring about change in the family. Several strategies for building a therapeutic relationship, joining, tracking, and building a treatment plan, are discussed below.

Joining

A number of techniques can be used to establish a therapeutic relationship. Some of these techniques fall into the category of "joining," or becoming a temporary member of the family.

Definition of Joining

In BSFT, joining has two aspects. Joining it is the steps a counselor takes to prepare the family for change. Joining also occurs when a therapist gains a position of leadership within the family. Counselors use a number of techniques to prepare the family to accept therapy and to accept the therapist as a leader of change. Some techniques that the therapist can use to facilitate the family's readiness for therapy include presenting oneself as an ally, appealing to family members with the greatest dominance over the family unit, and attempting to fit in with the family by adopting the family's manner of speaking and behaving. A counselor has joined a family when he or she has been accepted as a "special temporary member" of the family for the purpose of treatment. Joining occurs when the therapist has gained the family's trust and has blended with family members. To prepare the family for change and earn a position of leadership, the counselor must show respect and support for each family member and, in turn, earn each one's trust.

One of the most useful strategies a counselor can employ in joining is to support the existing family power structure. The BSFT counselor supports those family members who are in power by showing respect for them. This is done because they are the ones with the power to accept the counselor into the family; they have the power to place the counselor in a leadership role, and they have the power to take the family out of counseling. In most families, the most powerful member needs to agree to a change in the family, including changing himself or herself. For that reason, the counselor's strongest alliance must initially be with the most powerful family member. BSFT counselors must be careful not to defy those in power too early in the process of establishing a therapeutic relationship. Inexperienced family counselors often take the side of one family member against another, behaving as though one were right and the other were obviously wrong. In establishing relationships with the family, the counselor must join all family members, not just those with whom he or she agrees. In fact, frequently, the person with whom it is most critical to establish an alliance or bond is the most powerful and unlikable family member.

Many counselors in the drug abuse field feel somewhat hopeless about helping the families of drug-abusing youths because these families have many serious problems. Counselors who feel this way may find a discussion about becoming a member of the family unhelpful because their previous efforts to change families have been unsuccessful. BSFT teaches counselors how to succeed by approaching families as insiders, not as outsiders. As outsiders, counselors typically attempt to force change on the family, often through confrontation. However, the counselor who has learned how to become part of the system and to work with families from the inside should seldom need to be confrontational. Confrontation erodes the rapport and trust that the counselor has worked hard to earn. Confrontation can change the family's perception of the counselor as being an integral part of the therapeutic system to being an outsider.

The Price of Failed Joining

An example may help illustrate what is meant by powerful family members. The court system referred a family to counseling because its oldest child had behavior problems. The mother was willing to come to counseling with her son, but the mother's live-in boyfriend did not want the family to be in counseling. The counselor advised the mother to come to therapy with the adolescent anyway. The boyfriend felt that his position of power had been threatened by the potential alliance between the mother and the counselor. As a result, the boyfriend reasserted himself, demanding that she stop participating in counseling. She then dropped out of counseling. This is clearly a case in which the counselor's early challenge of the family's way of "operating" caused the entire family to drop out of treatment. The counselor could and should have been more aware and respectful of the family's existing power structure. Respect, in this case, does not mean that the counselor approves of or agrees with the boyfriend's behavior. Rather, it means that the counselor understands how this family is organized and works his or her way into the family through the existing structure.

A more adaptive counseling strategy might be to call the mother's boyfriend, with the mother's permission, to recognize his position of power in the family and request his help with his girlfriend's son.

A Cautionary Note: Family Secrets

As was already stated, joining is about establishing a relationship with every member of the family. Sometimes a family member will try to sabotage the joining process by using family secrets. Some secrets can cause the counselor such serious problems that he or she is forced to refer the family he or she had intended to help to another counselor. Secrets are best dealt with up front. The counselor should not allow himself or herself to get trapped in a special relationship with one family member that is based on sharing a secret that the other family members do not know. A counselor who keeps a secret is caught between family members. The counselor has formed an alliance with one family member to the exclusion of others. In some cases, it is not just an alliance with one family member but also an alliance with one family member against another family member. It means that the family member with the secret can blackmail the counselor with the threat of revealing that the counselor knows this secret and didn't address it with the family. Consequently, a family secret is a very effective strategy that family members can use to sabotage the treatment, if counselors let them.

For these reasons, counselors should make it a rule to announce to each family at the onset of counseling that he or she will not keep secrets. The counselor should also say that if anyone shares special information with the counselor, the counselor will help them share it with the appropriate people in the family. For example, if a wife calls and tells the counselor that she is having an affair, her spouse will need to know, although the children

do not need to know the parents' marital issues. In this case, the counselor would say, "This affair is indicative of a problem in your marriage. Let me help you share it with your husband." The counselor must do whatever is needed to continue to help the wife see that affairs are symptoms of marital problems. The affair can be reframed as a cry for help, a call for action, or a basic discontent. If so, these marital issues or problems need to be discussed.

It is possible that despite all the counselor's efforts, the wife will respond with an absolute, "No, I don't want to tell him. He would leave me. Besides, this affair doesn't mean all that much." Typically BSFT therapy only gets into marital issues to the extent that the marital problems are interfering with the parents' abilities to function effectively as parents. However, the counselor has no choice but to help the wife tell her husband about the affair. If the wife absolutely refuses, then the counselor has lost his or her bid for leadership in the counseling process. The wife now has control over the counseling process. For that reason, the counselor must refer the family to another counselor.

Tracking

In the example about the mother's powerful boyfriend, it was recommended that the counselor use the way in which the family is organized, or interacts, with the father figure in a position of power, as a vehicle for getting the family into treatment. This strategy in which the counselor learns how the family interacts and then uses this information to establish a therapeutic plan of action is called "tracking." Tracking is a technique in which the counselor respects how the family interacts but, at the same time, takes advantage of those family interactions for therapeutic purposes. Sometimes families interact spontaneously, permitting the counselor to observe the family dynamics. When this does not happen spontaneously, the counselor must encourage the family to interact.

Encouraging the Family to Interact

When a family is in counseling, family members like to tell the counselor stories about each other. For example, a mother might say to the counselor, "My son did so and so." In contrast to the way in which the counselor functions in other therapy models, the BSFT counselor is not interested in the content of the family members' stories. Instead, the counselor is interested in observing (and correcting) problematic interactions. To observe the family's patterns of interaction, the counselor must ask family members to talk directly to each other about the problem. When this occurs, the counselor can observe or track what happens when the family members discuss the issue. The counselor can then watch the family's interactions: fighting, disagreeing, and struggling with their issues. By tracking, the counselor will not only be able to identify the interactive patterns in the family, but also will be able to determine which of these patterns may be causing the family's problems or symptoms. The added benefit of this kind of tracking is that the counselor shows respect for the family's ways of interacting.

Tracking Content and Process

The difference between "content" and "process" was discussed in Chapter 2 (see p. 13). Content is the subject matter that is being discussed. Process refers to the interactions that underlie the communication. By observing the process, the counselor learns who is dominant, who is submissive, what emotions are expressed in the interaction, and the unwritten rules that appear to guide the family's communication and organization. For example, a mother may mention that her son's drug problem is a concern. The grandmother responds by shouting that the mother is overreacting and needs to back off. The content of the interaction--the son's drug problem--is not nearly as important as the process being displayed--the grandmother undermining the mother and shutting her down. Often the counselor will track or use the family's content because it represents a topic that is important to the family. In this example, the counselor might keep the focus of the counseling session on the son's drug problem because it is an important topic in this family. However, the focus of BSFT is entirely on changing process. What needs to be changed here, as a first step, is the parent figures' inability to agree on the existence of a problem, and, more generally, the grandmother's tendency to invalidate the mother's concerns.

Mimesis

"Mimesis" is a form of tracking for the purpose of joining. It refers to mimicking the family's behavior in an effort to join with the family. Mimesis can be used to join with the whole family. For example, a counselor can act jovial with a jovial family. Mimesis also can be used to join with one family member. Mimesis is used in everyday social situations. For example, by attending to how others dress for a particular activity so that one can dress appropriately, one is attempting to gain and demonstrate acceptance by mimicking the type of dress that is worn by others (e.g., casual). People mimic other people's moods when they act like the other people do in certain situations. For example, at a funeral they would act sad as others do and at a celebration they would act joyful. When the counselor validates a family by mimicking its behavior, family members are more likely to accept the counselor as one of their own.

Mimesis also refers to using a family's own ways of speaking to join with the family. Each family and each family member has its, his, or her own vocabulary and perspective. For instance, if a family member is a carpenter, it might be useful to use the language of carpentry. The therapist might say, "Dealing with your son requires lots of different tools, just like jobs at work do. Sometimes you need to use a hammer and use a lot of force, and sometimes you need to use a soft cloth for a more gentle job." If a family member is an accountant, it may be helpful to speak in terms of assets and liabilities. If a person is religious, it may be helpful to speak of God's will.

Whatever language a family uses should be the language the counselor uses to converse with that family. The counselor should not talk to a family using vocabulary that is found in this manual--words such as "interactions," "restructuring," and "systems." Instead, the BSFT counselor should use the "pots and pans" language that each of the family members uses in his or her everyday life. For example, if families are uncomfortable with the term "counseling," the term "meetings" might be used.

Much of the work the counselor does to establish the therapeutic relationship involves learning how the family interacts to better blend with the family. However, the counselor cannot learn the ways in which the family interacts unless he or she sees family members interacting as they would when the counselor is not present. Getting family members to interact can be difficult because families often come into counseling thinking that their job is to tell the counselor what happened. Therefore, it is essential that counselors decentralize themselves by discouraging communications that are directed at them, and instead encouraging family members to interact so that they can be observed behaving in their usual way.

Building a Treatment Plan

BSFT diagnoses are made to identify adaptive and maladaptive patterns of family interaction so that the counselor can plan practical, strategically efficient interventions. The purpose of the intervention is to improve the family interactions most closely linked to the adolescent's symptoms. This, in turn, will help the family to manage those symptoms.

Enactment: Identifying Maladaptive Interactions

In BSFT, the counselor assesses and diagnoses the family's interactions by allowing the family to interact in the counseling session as it normally does at home. To begin, the counselor asks the family to discuss something. When a family member speaks to the counselor about another family member who is present, the counselor asks the family member who is speaking to repeat what was said directly to the family member about whom it was said. Family interactions that occur as they would at home and that show the family's typical interactional patterns are called "enactments." An enactment can either occur spontaneously, or the counselor can initiate it by asking family members to discuss something among themselves. Creating enactments of family interactions is like placing the counselor on the viewing side of a one-way mirror and letting the family "do its thing" while the counselor observes.

Different therapy models have different explanations for why a family or adolescent is having difficulty, and so they have different targets of intervention. BSFT targets interactional patterns. Because BSFT is a problem-focused therapy approach, it targets those interactional patterns that are most directly related to the symptom for which the family is seeking treatment. Targeting patterns most directly related to the symptom

allows BSFT to be brief and strengthens a therapist's relationship with a family by demonstrating that the therapist will help the family solve the problems family members have identified.

Families that develop symptoms tend to be organized or to function around those symptoms. That's because a symptom works like a magnet, organizing the family around it. This is especially true if the symptom is a serious, life-threatening one, such as drug abuse. Therefore, it is most efficient to work with the family by focusing on the symptom around which the family has already organized itself.

Family Crises as Enactments

Enactments are used to observe family interactions in the present and to identify family interactional problems. Family crises are particularly opportune types of enactments because they are highly charged, and family members are emotionally available to try new behaviors. Therefore, families in crisis should be seen immediately. In addition to gaining valuable information about problematic family interactions, the counselor gains considerable rapport with families because he or she is willing to be of service at a time of great need.

A Cautionary Note: Adolescents Attending Therapy Sessions on Drugs

Counselors usually refuse to work with a client who comes into the therapy session on drugs because the client is viewed as "not being all there" to do the treatment work. However, in the case of a family therapy such as BSFT, determining whether to conduct the session is a strategic decision the counselor must make. One possibility in BSFT is to view the adolescent on drugs as an enactment of what the family confronts at home all the time. Thus, when an adolescent comes to therapy on drugs, it can be viewed as an opportunity for the counselor to teach the family how to respond to the adolescent when he or she takes drugs. The BSFT counselor can see how each family member responds to this situation and look for the maladaptive interactions that allow the adolescent to continue this behavior. The counselor can then work with the non-drug-using family members to change their usual way of responding to the adolescent on drugs. Hence, the work in this session is not with the adolescent but with the other family members.

From Diagnosis to Planning

Once a therapeutic relationship has been established and a diagnosis has been formulated, the counselor is ready to develop a treatment plan. The treatment plan lays out the interventions that will be necessary to change those family maladaptive interactional patterns that have been identified as related to the presenting symptom. Problematic patterns of family interaction are diagnosed using the six dimensions of family interaction discussed in Chapter 3 (organization, resonance, developmental stages, life context, identified patient, and conflict resolution). Often some dimensions are more problematic

than others. The interventions need to focus more on the most problematic interactions than on the others.

The six dimensions of the family's interactions operate in an interdependent fashion. For this reason, it may not be necessary to plan a separate intervention to address each problem that has been diagnosed. For example, addressing a family's tendency to blame its problems on the adolescent (i.e., the identified patient) may bring the family's ineffective conflict resolution strategies to light. In a similar fashion, addressing a son's role as his mother's confidant (i.e., inappropriate developmental stage) may bring out the rigid and inflexible boundary between the parent figures.

Producing Change

As was stated earlier, the focus of BSFT is to shift the family from maladaptive patterns of interaction to adaptive ones. Counselors can use a number of techniques to facilitate this shift. These techniques, all of which are used to encourage family members to behave differently, fall under the heading of "restructuring." In restructuring, the counselor orchestrates and directs change in the family's patterns of interaction (i.e., structure). Some of the most frequently used restructuring techniques are described in this chapter.

When the family's structure has been shifted from maladaptive toward adaptive, the family develops a mastery of communication and management skills. In turn, this mastery will help them solve both present and future problems. To help family members master these skills, the BSFT counselor works with them to develop new behaviors and use these new behaviors to interact more constructively with one another. After these more adaptive behaviors and interactions occur, the BSFT counselor validates them with positive reinforcements. Subsequently, the counselor gives the family the task of practicing these new behaviors/interactions in naturally occurring situations (e.g., when setting a curfew or when eating meals together) so that family members can practice mastering these skills at home.

Mastering more adaptive interactions provides families with the tools they need to manage the adolescent's drug abuse and related problem behaviors. Some adaptive behaviors/interactions that validate individual family members are self-reinforcing. However, the counselor needs to reinforce those behaviors/interactions that initially are not strongly self-reinforcing (i.e., validated) to better ensure their sustainability. As family members reinforce each other's more adaptive skills, they master the skills needed to behave in adaptive ways. It is very important to note that mastery of adaptive skills is not achieved by criticizing, interpreting, or belittling the individual. Rather, it is achieved by incrementally shaping positive behavior.

The rest of this chapter describes seven frequently used restructuring techniques (i.e., to change families' patterns of interaction). These techniques will give a counselor the basic

tools needed to help a family change its patterns of interaction. The seven restructuring techniques are:

- ➢ Working in the present
- ➢ Reframing negativity
- ➢ Reversals
- ➢ Working with boundaries and alliances
- ➢ Detriangulation
- ➢ Opening up closed systems
- ➢ Tasks

Working in the Present

Although some types of counseling focus on the past (Bergin and Garfield 1994), BSFT focuses strictly on the present. In BSFT, families do not simply talk about their problems, because talking about problems usually involves telling a story about the past. Working in the present with family interactional processes that are maintaining the family's symptoms is necessary to bring about change in BSFT. Consequently, the BSFT counselor wants the family to engage in interactions within the therapy session--in the same way that it would at home. When this happens and family members enact the way in which they interact routinely, the counselor can respond to help the family members reshape their behavior. Several techniques that require working in the present with family processes are found in subsequent sections within this chapter.

Does BSFT Ever Work in the Past?

Counselors work with the past less than 5 percent of the counseling time. One important example of working in the past can be illustrated by an early counseling session in which the parent and adolescent are in adversarial roles. The parent may be angry or deeply hurt by the youth's behavior. One strategy to overcome this impasse in which neither family member is willing to bend is to ask the parent, "Can you remember when Felix was born? How did you feel?" The parent may say nostalgically: "He was such a beautiful child. The minute I saw him, I was enchanted. I loved him so much I thought my heart would burst."

This kind of intervention is called "reconnection" *(cf. Liddle)*. When the parent is hardened by the very difficult experiences he or she has had with a troublesome adolescent, counselors sometimes use the strategy of reconnection to overcome the impasse in which neither the parent nor the youth is willing to bend first. Reconnection is an intervention that helps the parent recall the positive feeling (love) that he or she once had for the child. After the parent expresses his or her early love for the child, the

counselor turns to the youth and says: "Did you know your mother loves you so very much? Look at the expression of bliss on her face."

As can be seen, the counseling session digressed into the past for a very short time to reconnect the parent. This was necessary to change the here-and-now interaction between two family members. The reconnection allowed the counselor to transform an interaction characterized by resentment into an interaction characterized by affection. Because the feelings of affection and bonding do not last long, the counselor must move quickly to use reconnection as a bridge that moves the counseling to a more positive interactional terrain.

Reframing: Systemic Cognitive Restructuring

To "reframe," a counselor creates a different perspective or "frame" of reality than the one within which the family has been operating. He or she presents this new frame to the family in a convincing manner --that is, "selling" it to the family and then using this new frame to facilitate change. The purpose of systems-oriented, cognitive restructuring (reframing) is to change perceptions and/or meaning in ways that will enable family members to change their interactions. Most of the time, in families of adolescent drug abusers, negativity needs to be reframed. Negativity is usually exhibited as blaming, pejorative, and invalidating statements ("You are no good." "I can't trust you."), and, in general, "angry fighting." Reframing negativity might involve describing a mother's criticism of her teenage son as her desire that he be successful, or reframing fighting as an attempt to have some sort of connection with another family member.

It has been suggested that "... high levels of negativity interfere with effective problem-solving and communication within the family" *(Robbins et al.)*. Robbins and colleagues report that negativity in family therapy sessions is linked to dropping out of family therapy. For those who remain in therapy, negativity is linked to poor family therapy outcomes. Because negativity is bad for the family and for the therapy, most contemporary family therapies target negativity. The best-known strategy for transforming negative interactions into positive ones is reframing *(Robbins et al)*.

While the counselor is encouraged to permit family members to interact with each other in their usual way and to join before orchestrating change, a caveat is necessary when intense negative feelings accompany conflictive interactions. If the family is to remain in counseling, family members must experience some relief from the negative feelings soon after counseling begins. Therefore, counselors are encouraged to use reframing abundantly, if necessary, in the first and perhaps the first few sessions to alleviate the family's intensive negative feelings. Such reframes also may allow family members to discuss their pain and grievances in a meaningful way.

An example will help illustrate the use of reframing negative feelings to create more positive feelings among family members. Anger is a fairly common emotion among

families with an adolescent who is involved in antisocial activities. The parents may feel angry that their attempts to guide their child down the "right" path have failed and that the child disrespects their guidance. The adolescent is likely to interpret this anger as uncaring and rejecting. Both parties may feel that the other is an adversary, which severely diminishes the possibility that they can have a genuine dialogue.

The particular reframe that needs to be used is one that changes the emotions from anger, hurt, and fighting (negative) to caring and concern (positive). The counselor must create a more positive reality or frame. The counselor, for example, might say to the parent, "I can see how terribly worried you are about your son. I know you care an awful lot about him, and that is why you are so frustrated about what he is doing to himself."

With this intervention, the counselor helps move both the parent's and the child's perceptions from anger to concern. Typically, most parents would respond by saying, "I am very worried. I want my child to do well and to be successful in life." When the youth hears the parent's concern, he or she may begin to feel less rejected. Instead of rejecting, the parent is now communicating concern, care, and support for the child. Hence, by creating a more positive sense of reality, the counselor transforms an adversarial relationship between the parent(s) and the adolescent, orchestrating opportunities for new channels of communication to emerge and for new interactions to take place between them.

Reframing is among the safest interventions in BSFT, and, consequently, the beginning counselor is encouraged to use it abundantly. Reframing is an intervention that usually does not cause the counselor any loss of rapport. For that reason, the counselor should feel free to use it abundantly, particularly in the most explosive situations.

Affect: Creating Opportunities for New Ways of Behaving

In BSFT, counselors are interested in affect (a feeling or an emotion) as it is reflected in interactions. In BSFT, the counseling strategy is to use emotion as an opportunity to "move" the family to a new, more adaptive set of interactions. One of many possible ways of working with emotion is found in the following example. When a mother cries, the counselor might suggest to the drug-abusing youngster, "Ask your mom to tell you about her tears." An alternative would be, "What do you think your mom's tears are trying to say?" If the youth responds, "I think it is...," the counselor would follow with a directive to the youth, "Ask your mother if what you think her tears mean is why she is crying." In this way, the crying is used to initiate an interaction among family members that acknowledges not only the emotion in crying but also the experience underlying the crying. In other words, the crying is used to promote interactions that show respect for the emotion as well as promote a deeper level of understanding among family members.

In another example, a drug-abusing adolescent and her family come to their first BSFT counseling session. The parents proceed to describe their daughter as disobedient,

rebellious, and disrespectful-- a girl who is ruining her life and going nowhere. They are angry and reject this young girl, and they blame her for all the pain in the family. In this instance, the BSFT counselor recognizes that the family is "stuck" about what to do with this girl and that their inability to decide what to do is based on the view they have developed about her and her behavior. To "open up" the family to try new ways to reach the youngster, the BSFT counselor must present a new "frame" or perspective that will enable the family to react differently toward the girl. The BSFT counselor might tell the family that, although she realizes how frustrated and exasperated they must feel about their daughter's behavior, "it is my professional opinion that the main problem with this girl is that she is very depressed and is in a lot of pain that she does not know how to handle." Reframing is a practical tool used to stimulate a change in family interactions. With this new frame, the family may now be able to behave in new ways toward the adolescent, which can include communicating in a caring and nurturing manner. A more collaborative set of relationships within the family will make it easier for the parents to discuss the daughter's drug abuse, to address the issues that may be driving her to abuse drugs, and to develop a family strategy to help the adolescent reduce her drug use.

Reversals

When using the technique called "reversal," the counselor changes a habitual pattern of interacting by coaching one member of the family to do or say the opposite of what he or she usually would. Reversing the established interactional pattern breaks up previously rigid patterns of interacting that give rise to and maintain symptoms, while allowing alternatives to emerge. If an adolescent gets angry because her father nagged her, she yells at her father, and the father and daughter begin to fight, a reversal would entail coaching the father to respond differently to his daughter by saying, "Rachel, I love you when you get angry like that," or "Rachel, I get very frightened when you get angry like that." Reversals make family members interact differently than they did when the family got into trouble.

Working With Boundaries and Alliances

Certain alliances are likely to be adaptive. For example, when the authority or parent figures in the family are allied with each other, they will be in a better position to manage the adolescent's problem behaviors. However, when an alliance forms between a parent figure and one of the children against another parent figure, the family is likely to experience trouble, especially with antisocial adolescent behavior. An adolescent who is allied with an authority figure has a great deal of power and authority within the family system. Therefore, it would be difficult to place limits on this adolescent's problem behavior. One goal of BSFT is to realign maladaptive alliances.

One important determinant of alliances between family members is the psychological barrier between them, or the metaphorical fence that distinguishes one member from

another. BSFT counselors call this barrier or fence a "boundary." Counselors aim to have clear boundaries between family members so that there is some privacy and some independence from other family members. However, these should not be rigid boundaries, with which family members would have few shared experiences. By shifting boundaries, BSFT counselors change maladaptive alliances across the generations (e.g., between parent figures and child). For example, in a family in which the mother and the daughter are allied and support each other on almost all issues while excluding the father, the mother may no longer be powerful enough to control her daughter when she becomes an adolescent and may need help. In this case, an alliance between the mother and the father needs to be re-established, while the cross-generational coalition between mother and daughter needs to be eliminated.

It is the BSFT counselor's job to shift the alliances that exist in the family. This means restoring the balance of power to the parents or parent figures so that they can effectively exercise their leadership in the family and control their daughter's behavior. The counselor attempts to achieve these alliance shifts in a very smooth, subtle, and perhaps even sly fashion. Rather than directly confronting the alliance of the mother and daughter, for example, the counselor may begin by encouraging the father to establish some form of interaction with his daughter.

Boundary shifting is accomplished in two ways. Some boundaries need to be loosened, while others need to be strengthened. Loosening boundaries brings disengaged family members (e.g., father and daughter) closer together. This may involve finding areas of common interest between them and encouraging them to pursue these interests together. For instance, in the case of a teenage son enmeshed with his mother and disengaged from his father, the counselor may direct the father to involve his son in a project or to take his son on regular outings. The counselor also may arrange the seating in counseling sessions to help strengthen some alliances and loosen others.

In addition to bringing family members closer together, the counselor may need to strengthen the boundaries between enmeshed family members to create more separation. One example is the mother grandmother parenting system in which the grandmother enables her grandson's drug use by protecting him from his mother's attempts to set limits. Rather than confronting the grandmother-adolescent alliance directly, the counselor may first encourage the mother and grandmother to sit down together and design a set of rules and responsibilities for the adolescent. This process of designing rules often requires the parent figures to work out some of the unresolved conflict(s) in their relationship, without the counselor having to address that relationship directly. This brings the mother closer to the grandmother and distances the grandmother from the adolescent, thereby rearranging the family's maladaptive hierarchy and subsystem composition.

It should be noted that, in this case, the counselor tracks the family's content (grandmother hiding adolescent's drug use from mother) as a maneuver to change the nature of the interaction between the mother and the grandmother from an adversarial relationship to one in which they agree on something. The adolescent's drug use provides the content necessary to strengthen the boundaries between the generations and to loosen the boundaries between the parent figures.

Clearly, bringing the mother and grandmother together to the negotiating table is only an intermediate step. After that, the tough work of helping mother and grandmother negotiate their deep-seated resentments and grievances against each other begins. Because the counselor follows a problem-focused approach, he or she does not attempt to resolve all of the problems the parent figures encounter. Instead, the counselor tries to resolve only those aspects of their difficulties with each other that interfere with their ability to resolve the problems they have with the adolescent in the family.

Behavioral Contracting as a Strategy for Setting Limits for Both Parent and Adolescent

From a process perspective, setting clear rules and consequences helps develop the demarcation of boundaries between parent(s) and child(ren). Sometimes when a parent and an adolescent have a very intense conflictive relationship in which there is a constant battle over the violation of rules, the rules and their consequences are vague, and there is considerable lack of consistency in their application. In these cases, it is recommended that the counselor use behavioral contracting to help the parent(s) and the adolescent agree on a set of rules and the resulting consequences if he or she fails to follow these rules. The counselor encourages the parent(s) and the adolescent to negotiate a set of clearly stated and enforceable rules, and encourages both parties to commit to maintaining and following these rules.

Helping parents use behavioral contracting to establish boundaries for themselves in relationship to their adolescent is of tremendous therapeutic value. Parents who have established boundaries can no longer respond to the adolescent's behavior/misbehavior according to how they feel at the time (lax, tired, frustrated, angry). The parents have committed themselves to respond according to agreed-upon rules. From a BSFT point of view, it is very important for the counselor to begin to help the parents develop adequate boundaries with their adolescent children who have behavior problems.

In families that have problems with boundaries, the counselor's most difficult task is to get the parents to stick to their part of the contract. Counselors expect that the adolescent will not keep his or her part of the contract and instead will try to test whether his or her parents will try to stick to their part of the contract. When the adolescent misbehaves, parents tend to behave in their usual way, which may be a reaction to the way they feel at the moment. The counselor's job is to make the parents uphold their side of the

agreement. Once parents have set effective boundaries with their adolescent children, most misbehavior quickly diminishes. (Of course, sometimes rules and consequences need to be renegotiated as parents and adolescents begin to acquire experience with the notion of enforceable rules and consequences.)

Boundaries Between the Family and the Outside World

It is important not only to understand the nature of the alliances and boundaries that occur within the family but also to understand the boundaries that exist between the family and the outside world.

Some families have very rigid boundaries around themselves, prohibiting their members from interacting with the outside world. Other families have very weak boundaries around themselves that allow outsiders to have an undue influence on family members. Either of these extremes can be problematic and is fair ground for BSFT intervention. For example, if parents are uninvolved with their children's school or friends (rigid boundaries), the BSFT counselor works to get the parents to participate more fully in their child's school life and to interact more with their child's friends.

Detriangulation

As was said earlier, triangles occur when a third, usually less powerful, person gets involved in a conflict between two others. It is a basic assumption of BSFT that the only way conflict between two people (called a "dyad") can be resolved is by keeping the conflict between them. Bringing in a third person and forming a triangle becomes an obstacle to resolving the conflict. The third person usually is drawn into a coalition with one of the parties in conflict and against the other. This coalition results in an imbalance within the original dyad. The issues involved in the conflict are detoured through the third person rather than dealt with directly. For example, when parent A has a fight with parent B, parent B may attack the adolescent in retaliation for parent A's behavior (or attempt to enlist the youth's support for his or her side of the argument) rather than expressing his or her anger directly to parent A. Such triangulated adolescents are often blamed for the family's problems, and they may become identified patients and develop symptoms such as drug abuse.

Because triangulation prevents the involved parties from resolving their conflicts, the goal of counseling is to break up the triangle. Detriangulation permits the parents in conflict to discuss issues and feelings directly and more effectively. Detriangulation also frees the third party, the adolescent, from being used as the escape valve for the parents' problems.

One of the ways in which a BSFT counselor achieves detriangulation is by keeping the third party (i.e., the adolescent) from participating in the discussions between the dyad. Another way to set boundaries to detriangulate is to ask the third party not to attend a therapy session so that the two conflicting parties can work on their issues directly. For

example, when working with a family in which the son begins to act disrespectfully whenever his parents begin to argue, the counselor might instruct the parents to ignore the son and continue their discussion. If the son's misbehavior becomes unmanageable, the counselor may ask the son to leave the room so that the parents can argue without the son's interference. Eventually, the counselor will ask the parents to collaborate in controlling the son.

Attempts by the Family to Triangulate the Clinician

Triangulation does not necessarily have to involve only family members. Sometimes a clinician can become part of a triangle as well. One of the most common strategies used by family members is to attempt to get the counselor to ally himself or herself with one family member against another. For example, one family member might say to the counselor, "Isn't it true that I am right and he is wrong?" "You know best, you tell him." "We were having this argument last night, and I told her that you had said that...."

Triangulation is always a form of conflict avoidance. Regardless of whether it is the counselor or a family member who is being triangulated, triangulation prevents two family members in conflict from reaching a resolution. The only way two family members can resolve their conflicts is on a one-to-one basis.

An important reason why the counselor does not want to be triangulated is that the person in the middle of a triangle is either rendered powerless or symptomatic. In the case of the counselor, the "symptom" he or she would develop would be ineffectiveness as a therapist, that is an inability to do his or her job well because his or her freedom of movement (e.g., changing alliances, choosing whom to address, etc.) has been restricted. A triangulated counselor is defeated. If the clinician is unable to get out of the triangle, he or she has no hope of being effective, regardless of what else he or she does or says.

When a family member attempts to triangulate the counselor, the counselor has to bring the conflict back to the people who are involved in it. For example, the counselor might say, "Ultimately, it doesn't matter what I think. What matters is what the two of you agree to, together. I am here to help you talk, negotiate, hear each other clearly, and come to an agreement." In this way, the counselor places the focus of the interaction back on the family. The counselor also might respond, "I understand how difficult this is for you, but this is your son, and you have to come to terms with each other, not with me."

Opening up Closed Systems

Families in which conflicts are not openly expressed need help in discussing the conflict so that it can be a target for change. Sometimes a counselor can work with a family member who has an unexpressed or implicit conflict and help that person discuss the problem so that it can be resolved. This brings conflicts out into the open and facilitates their resolution by intensifying and focusing on covert emotional issues. In families of drug-abusing adolescents, a typical example of unexpressed or suppressed conflict

involves disengaged fathers who tend to deny or avoid any discussion of the youth's problems. Asking a surly or sulking adolescent to express what is on his or her mind whenever the father is addressed may help the father break through his denial.

Tasks

Central Role

The use of "tasks" or assignments is central to all work with families. The counselor uses tasks both inside and outside the counseling sessions as the basic tool for orchestrating change. Because the emphasis in BSFT is in promoting new skills among family members, at both the level of individual behaviors and in family interactional relations, tasks serve as the vehicle through which counselors choreograph opportunities for the family to behave differently.

In the example in which mother and son were initially allied and the father was left outside of this alliance, father and son were first assigned the task of doing something together that would interest them both. Later on, the mother and father were assigned the collaborative task of working together to define rules regarding the types of behaviors they would permit in their son and the consequences that they would assign to their son's behavior and misbehavior.

General Rule

It is a general rule that the BSFT counselor must first assign a task for the family to perform in the therapy session so that the counselor has an opportunity to observe and help the family successfully carry out the task. Only after a task has been accomplished successfully in the therapy session can a similar follow up task be assigned to the family to be completed outside of therapy.

Moreover, the counselor's aim is to provide the family with a successful experience. Thus, the counselor should try to assign tasks that are sufficiently doable at each step of the counseling process. The counselor should start with easy tasks and work up to more difficult ones, slowly building a foundation of successes with the family before attempting truly difficult restructuring moves.

Hope for the Best; Be Prepared for the Worst

Clinicians should never expect the family to accomplish the assigned tasks flawlessly. In fact, if family members were skillful enough to accomplish all assigned tasks successfully, they would not need to be in counseling. When tasks are assigned, counselors should always hope for the best but be prepared for the worst. After all, a task represents a new way of behaving for the family and one that may be difficult given that they have had years of practice engaging in the old ways of behaving.

As the family attempts to carry out a task, the counselor should help the family overcome obstacles it may encounter. However, in spite of the counselor's best efforts, the task is

not always accomplished. The counselor's job is to observe and/or uncover what happened and identify the obstacles that prevented the family from achieving the task. When a task fails, the counselor starts over and works to overcome the newly identified obstacles. Unsuccessful attempts to complete tasks are a great source of new and important information regarding the interactions that prevent a family from functioning optimally.

The first task that family clinicians give to all of their cases is to bring everyone into the counseling session. Every counselor who works with problem youths and their families knows very well that most of the families who need counseling never reach the first counseling session. Therefore, these families can be described as having failed the first task given them, to come in for counseling. This task, called engagement, is so important that we have devoted the next chapter to it.

Engaging the Family into Treatment

This section defines, in systems terms, the nature of the problem of resistance to treatment and redefines the nature of BSFT joining, diagnosing, and restructuring interventions in ways that take into account those patterns of interaction that prevent families from entering treatment.

The Problem

Regardless of their professional orientation and where or how they practice, all clinicians have had the disappointing and frustrating experience of encountering "resistance to counseling" in the form of missed or cancelled first appointments. For BSFT counselors, this becomes an even more common and complex issue because more than one individual needs to be engaged to come to treatment.

Unfortunately, some clinicians handle engagement problems by accepting the resistance of some family members. In effect, the counselor agrees with the family's assessment that only one member is sick and needs treatment. Consequently, the initially well-intentioned counselor agrees to see only one or two family members for treatment. This usually results in the adolescent and an overburdened mother following through with counseling visits. Therefore, the counselor has been co-opted into the family's dysfunctional process.

Not only has the counselor "bought" the family's definition of the problem, but he or she also has accepted the family's ideas about who is the identified patient. When the counselor agrees to see only one or two family members, instead of challenging the maladaptive family interaction patterns that kept the other members away, he or she is reinforcing those family patterns. In the example in which a mother and son are allied against the father, if the counselor accepts the mother and son into counseling, he or she is reinforcing the father figure's disengagement.

At a more complex level, there are serious clinical implications for the counselor who accepts the family's version of the problem. In doing this, the counselor surrenders his or her position as the expert and leader. If the counselor agrees with the family's assessment of "who's got the problem," the family will perceive his or her expertise and ability to understand the issues as no greater than its own. The counselor's credibility as a helper and the family's perception of his or her competence will be at stake. Some family members may perceive the counselor as unable to challenge the status quo in the family because, in fact, he or she has failed to achieve the first and defining reframe of the problem.

When the counselor agrees to see only part of the family, he or she may have surrendered his or her authority too early and may be unable to direct change and to move freely from one family member to another. Thus, by beginning counseling with only part of the family, excluded family members may see the counselor as being in a coalition with the family members who originally participated in therapy. Therefore, the family members who didn't attend the initial sessions may never come to trust the counselor. This means that the counselor will not be able to observe the system as a whole as it usually operates at home because the family members who were not involved in therapy from the beginning will not trust the counselor sufficiently to behave as they would at home. The counselor, then, will be working with the family knowing only one aspect of how the family typically interacts.

Some counselors respond to the resistance of some family members to attend counseling by agreeing to see only those who wish to come. Other family counselors have resolved the dilemma of what to do when only some family members want to go to counseling by taking a more alienated stance saying: "There are too many motivated families waiting for help; the resistant families will call back when they finally feel the need; there is no need to get involved in a power struggle." The reality is that these resistant families will most likely never come to counseling by themselves. Ironically, the families who most need counseling are those families whose patterns and habits interfere with their ability to get help for themselves.

Dealing With Resistance to Engagement

When some family members do not want to participate in treatment, has called the counselor asking for help, that parent is not powerful enough to bring the adolescent into counseling. If the counselor wants the family to be in counseling, he or she will have to recognize that the youth (or a noncooperative parent figure) is the most powerful person in the family. Once the reason the family is not in treatment is understood, the counselor can draw upon the concept of tracking to find a way to reach this powerful person directly and negotiate a treatment contract to which the person will agree.

Counselors should not become discouraged at this stage. Their mission now is to identify the obstacles the family faces and help it surmount them. It is essential to keep in mind that a family seeks counseling because it is unable to overcome an obstacle without help. Failed tasks, such as not getting the family to come in for treatment, tend to be a great source of new and important information regarding the reasons why a family cannot do what is best for them. The most important question in counseling is, "What has happened that will not allow some families to do what may be best for them?"

In trying to engage the family in treatment, the counselor should apply the concept of repetitive patterns of maladaptive interaction, which give rise to and maintain symptoms, to the problem of resistance to entering treatment. The very same principles that apply to understanding family functioning and treatment also apply to understanding and treating the family's resistance to entering counseling. When the family wishes to get rid of the youth's drug abuse symptom by seeking professional help, the same interactive patterns that prevented it from getting rid of the adolescent's symptom also prevent the family from getting help. The term "resistance" is used to refer to the maladaptive interactive patterns that keep families from entering treatment. From a family-systems perspective, resistance is nothing more than the family's display of its inability to adapt effectively to the situation at hand and to collaborate with one another to seek help. Thus, the key to eliminating the resistance to counseling lies within the family's patterns of interaction; overcome the resistance in the interactional patterns and the family will come to counseling.

In working to overcome resistant patterns of family interaction, tasks play a particularly vital role because they are the only BSFT intervention used outside the therapy session. For this reason, tasks are particularly well-suited for use during the engagement period, when crucial aspects of the family's work in overcoming resistance to counseling need to take place outside the office--obviously--because the family has not yet come in.

The central task around which engagement is organized is getting the family to come to therapy together. Thus, in engagement, the counselor assigns tasks that involve doing whatever is needed to get the family into treatment. For example, a father calls a BSFT counselor and asks for help with his drug-abusing son. The counselor responds by suggesting that the father bring his entire family to a session so that he or she can involve the whole family in fixing the problem. The father responds that his son would never come to treatment and that he doesn't know what to do. The first task that the counselor might assign the father is to talk with his wife and involve her in the effort to bring their son into treatment.

The Task of Coming to Treatment

The simple case. The counselor gives the task of bringing the whole family into counseling to the family member who calls for help. The counselor explains why this task

is a good idea and promises to support the family as it works at this task. Occasionally, this is all that is needed. Often people do not request family counseling simply because family counseling is not well known, and thus it does not occur to them to take such action.

Fear, an obstacle that might easily be overcome. Sometimes, family members are afraid of what will happen in family therapy. Some of these fears may be real; others may be simply imagined. In some instances, families just need some reassuring advice to overcome their fears. Such fears might include, "They are going to gang up on me," or "Everyone will know what a failure I am." Once these family members have been helped to overcome their fears, they will be ready to enter counseling.

Tasks to change how family members act with each other. Very often, however, simple clarification and reassurance is not sufficient to mobilize a family. It is at this point that tasks that apply joining, diagnostic, and restructuring strategies are useful in engaging the family. The counselor needs to prescribe tasks for the family members who are willing to come to therapy. These need to be tasks that attempt to change the ways in which family members interact when discussing coming to therapy. In the process of carrying out these tasks, the family's resistance will come to light. When that happens, the counselor will have the diagnostic information needed to get around the family's patterns of interaction that are maintaining the symptom of resistance. Once these patterns are changed, the family will come to therapy.

It should not be a surprise that families fail to accomplish the task of getting all of their members to counseling. In fact, the therapist's job is to help the families accomplish tasks that they are not able to accomplish on their own. As discussed earlier, when assigning any task, the counselor must expect that the task may not be performed as requested. This is certainly the case when the family is asked to perform the task of coming together to counseling.

The application of joining, diagnosing, and restructuring techniques to the engagement of resistant families is discussed separately below. However, these techniques are used simultaneously during engagement, as they are during counseling.

Joining

Joining the resistant family begins with the first contact with the family member who calls for help and continues throughout the entire relationship with the family.

With resistant families, the joining techniques described earlier have to be adapted to match the goal of this phase of therapy. For example, in tracking the resistant family members to engage them, it is necessary to track through the caller or initial help seeker and any other family members who may be involved in the process of bringing the family to counseling. The counselor tracks by "following" from the first family member to the next available family member to the next one and so on. This following, or tracking, is

done without challenging the family patterns of interaction. Rather, tracking is accomplished by gaining the permission of one family member to reach the others.

Establishing a Therapeutic Alliance

An effective way for the counselor to establish a therapeutic alliance they want to solve their problems and that the counselor wants the same thing. It must be recognized, however, that each family member may view the problem differently. For example, the mother may want to get her son to quit using drugs, while the son may want peace at home.

A therapeutic alliance is built around individual goals that family members can reach in therapy. Ideally, the counselor and the family members agree on a goal, and therapy is offered in the framework of achieving that goal. However, in families in which members are in conflict over their goals, it is necessary to find something for each of them to achieve in therapy. For example, the counselor can say to the mother that therapy can help her son stop using drugs, to the son that therapy can help him get his mother off his back and stop her nagging, and to the father that therapy can help stop his being called in constantly to play the "bad guy." In each case, the counselor can offer counseling as a means for each family member to achieve his or her own personal goal.

In engaging resistant families, the counselor initially works with and through only one or a few family members. Because the entire family is not initially available, the counselor will need to form a bond with the person who called for help and any other family members that make themselves available. However, the focus of this early engagement phase is strictly to work with these people to bring about the changes necessary to engage the entire family in counseling. The focus is not to talk about the problem but rather to talk about getting everyone to help solve the problem by coming to therapy. By using the contact person as a vehicle (via tracking) for joining with other members of the family, the counselor can eventually establish a therapeutic alliance with each family member and thereby elicit the cooperation of the entire family in the engagement effort.

Diagnosing the Interactions That Keep the Family from Coming Into Treatment

In engagement, the purpose of diagnosis is to identify those particular patterns of interaction that permit the resistant behavior to continue. However, because it isn't possible to observe the entire family, the BSFT counselor works with limited information to diagnose those patterns of interaction that are supporting the resistance.

To identify the maladaptive patterns responsible for the resistance, diagnosis begins prior to therapy, when a family member first calls the counselor. Because it is not possible to encourage and observe enactments of family members interacting before they enter counseling, engagement diagnosis has been modified so that it can be used during engagement to collect the diagnostic information in other ways.

First, the counselor asks the contact person interpersonal systems questions that allow him or her to infer what the family's interactional patterns may be. For example, the counselor may ask, "How do you ask your husband to come to treatment?" "What happens when you ask your husband to come to treatment?" "When he gets angry at you for asking him to come to treatment, what do you do next?" Through these questions, the counselor tries to identify the interplay between these spouses that contributes to the resistance. For example, is it possible that the wife is asking the husband to come to treatment in an accusatory way, which causes him to get angry? An example might be, "It is your fault that your son is in trouble because you are sick. You have to go to treatment."

As was indicated earlier, counselors do not like to rely on what family members tell them because each family member is very invested in his or her own viewpoints and probably cannot provide a systemic or objective account of family functioning. However, when counselors have access to only one person, they work with the person they have, strictly for the purpose of engaging that person in treatment.

Second, counselors explore the family system for resistances to the task of coming to therapy. This is done by assigning exploratory tasks to uncover resistances that cause the family to fail at the task of coming to therapy. For example, in the case above, the counselor might suggest to the wife that she ask her husband to come for her sake and not because there is anything wrong with him. At that point, the wife may say to the counselor, "I can't really ask him for my sake because I know he's too busy to come to the family meetings." This statement suggests that the wife is not completely committed to getting the husband to come to treatment. On the one hand, she claims to want him to come to treatment, but on the other, she gives excuses for why he cannot. The purpose of exploring the resistance, beginning with the first phone call, is to identify as early as possible the obstacles that may prevent the family from coming to therapy, with the aim of intervening in a way that gets around these obstacles.

Complementarity: Understanding How the Family "Pieces" Fit Together to Create Resistance

What makes this type of early diagnostic work possible is an understanding of the Principle of Complementarity. As noted earlier, for a family to work as a unit (even maladaptively), the behaviors of each family member must "fit with" the behaviors of every other family member. Thus, for each action within the family, there is a complementary action or reaction. For example, in the case of resistance, the husband doesn't want to come to treatment (the action), and the wife excuses him for not coming to treatment (the complementary action). Similarly, a caller tells the counselor that whenever she says anything to her husband about counseling (the action), he becomes angry (the complementary reaction). The counselor needs to know exactly what the wife's

contribution is to this circular transaction, that is, what her part is in maintaining this pattern of resistance.

Restructuring the Resistance

In the process of engaging resistant families, the counselor initially sees only one or a few of the family members. It is still possible, through these individuals, to bring about short-term changes in interactional patterns that will allow the family to come for therapy. A variety of change-producing interventions have already been described in Chapter 4: reframing, reversals, detriangulation, opening up closed systems, shifting alliances, and task setting. The counselor can use all of these techniques to overcome the family's resistance to counseling. In the process of engaging resistant families, task setting is particularly useful in restructuring.

The next section discusses the types of resistant families that have been identified, the process of getting the family into counseling, and the central role that tasks may play in achieving this goal. Much of counseling work with resistant families has been done with families in which the parents knew or believed the adolescent was using drugs and engaging in associated problem behaviors such as truancy, delinquency, fighting, and breaking curfew. These types of families are typically difficult to engage in therapy. However, the examples are not intended to represent all possible types of configurations of family patterns of interaction that work to resist counseling. Counselors working with other types of problems and families are encouraged to review their caseload of difficult-to-engage families and to carefully diagnose the systemic resistances to therapy. Some counselors may find that the resistant families they work with are similar to those described here, and some may find different patterns of resistance. In any case, counselors will be better equipped to work with these families if they have some understanding of the more common types of resistances in families of adolescent drug abusers.

Types of Resistant Families

There are four general types of family patterns of interaction that emerge repeatedly in work with families of drug-abusing adolescents who resist engagement to therapy. These four patterns are discussed below in terms of how the resistant patterns of interaction are manifested, how they come to the attention of the counselor, and how the resistance can be restructured to get the family into therapy.

Powerful Identified Patient

The most frequently observed type of family resistance to entering treatment is characterized by an identified patient who has a powerful position in the family and whose parents are unable to influence him or her. This is a problem, particularly in cases that are not court referred and in which the adolescent identified patient is not required to

engage in counseling. Very often, the parent of a powerful identified patient will admit that he or she is weak or ineffective and will say that his or her son or daughter flatly refuses to come to counseling. Counselors can assume that the identified patient resists counseling for two reasons: It threatens his or her position of power, and counseling is on the parent's agenda and compliance would strengthen the parent's power.

As a first step in joining and tracking the rules of the family, the counselor shows respect for and allies with the adolescent. The counselor contacts the drug-abusing adolescent by phone or in person (perhaps on his or her own turf, such as after school at the park). The counselor listens to the powerful adolescent's complaints about his or her parents and then offers to help the youth change the situation at home so that the parents will stop harassing him or her. This does not threaten the adolescent's power within the family and, thus, is likely to be accepted. The counselor offers respect and concern for the youth and brings an agenda of change that the adolescent will share by virtue of the alliance.

To bring these families who resist entering treatment into treatment, the counselor does not directly challenge the youth's power in the family. Instead, the counselor accepts and tracks the adolescent's power. The counselor allies himself or herself with the adolescent so that he or she may later be in a position to influence the adolescent to change his or her behavior. Initially, in forming an alliance with the powerful adolescent, the counselor reframes the need for counseling in a manner that strengthens the powerful adolescent in a positive way. This is an example of tracking--using the power of the adolescent to bring him or her into therapy. The kind of reframing that is most useful with powerful adolescents is one that transfers the symptom from the powerful adolescent/identified patient to the family. For example, the counselor may say, "I want you to come into counseling to help me change some of the things that are going on in your family." Later, once the adolescent is in counseling, the counselor will challenge the adolescent's position of power.

It should be noted that in cases in which powerful adolescents have less powerful parents, forming the initial alliance with the parents is likely to be ineffective because the parents are not strong enough to bring their adolescent into counseling. Their failed attempts to bring the adolescent into counseling would render the parents even weaker, and the family would fail to enter counseling. Furthermore, the youth is likely to perceive the counselor as being the parents' ally, which would immediately make the adolescent distrust the weak counselor.

Contact Person Protecting Structure

The second most common type of resistance to entering treatment is characterized by a parent who protects the family's maladaptive patterns of interaction. In these families, the person (usually the mother) who contacts the counselor to request help is also the person who is-- without realizing it--maintaining the resistance in the family. The way in which

the identified patient is maintained in the family is also the way in which counseling is resisted. The mother, for example, might give conflicting messages to the counselor, such as, "I want to take my family to counseling, but my son couldn't come to the session because he forgot and fell asleep, and my husband has so much work he doesn't have the time."

The mother is expressing a desire for the counselor's help while protecting and allying herself with the family's resistance to being involved in solving the problem. The mother protects this resistance by agreeing that the excuses for noninvolvement are valid. In other words, she is supporting the arguments the other family members are using to maintain the status quo. It is worthwhile to note that ordinarily this same conflicting message that occurs in the family maintains the symptomatic structure. In other words, someone complains about the problem behavior, yet supports the maintenance of the behaviors that nurture the problem. This pattern is typical of families in which the caller (e.g., the mother) and the identified patient are enmeshed.

To bring these families into treatment, the counselor must first form an alliance with the mother by acknowledging her frustration in wanting to get help and not getting any cooperation from the other family members to get it. Through this alliance, the counselor asks the mother's permission to contact the other family members "even though they are busy and the counselor recognizes how difficult it is for them to become involved." With the mother's permission, the counselor calls the other family members and separates them from the mother in regard to the issue of coming to counseling. The counselor develops his or her own relationship with other family members in discussing the importance of coming to counseling. In doing so, he or she circumvents the mother's protective behaviors. Once the family is in counseling, the mother's overprotection of the adolescent's misbehavior and of the father's uninvolvement (and the adolescent's and father's eagerness that she continue to protect them) will be addressed because it also may be related to the adolescent's problem behaviors.

Disengaged Parent

These family structures in which one parent protects the family's maladaptive patterns of behavior are characterized by little or no cohesiveness and lack of an alliance between the parents or parent figures as a subsystem. One of the parents, usually the father, refuses to come into therapy. This is typically a father who has remained disengaged from the problems at home. The father's disengagement not only protects him from having to address his adolescent's problems but also protects him from having to deal with the marital relationship, which is most likely the more troublesome of the two relationships he is avoiding. Typically, the mother is over-involved (enmeshed) with the identified patient and either lacks the skills to manage the youth or is supporting the identified patient in a covert fashion.

For example, if the father tries to control the adolescent's behavior, the mother complains that he is too tough or makes her afraid that he may become violent.2 The father does not challenge this portrayal of himself. He is then rendered useless and again distances himself, re-establishing the disengagement between husband and son and between husband and wife. In this family, the dimension of resonance is of foremost importance in planning how to change the family and bring it into therapy. The counselor must use tasks to bring the mother closer to the father and distance her from the son. That is, the boundary between the parents needs to be loosened to bring them closer together, and the boundary between mother and son needs to be strengthened to create distance between them.

To engage these families into treatment, the counselor must form an alliance with the person who called for help (usually the mother). The counselor then must begin to direct the mother to change her patterns of interaction with the father to improve their cooperation, at least temporarily, in bringing the family into treatment. The counselor should give the mother tasks to do with her husband that pertain only to getting the family into treatment and taking care of their son's problems. The counselor should assign tasks in a way that is least likely to spark the broader marital conflict. To set up the task, the counselor may ask the mother what she believes is the real reason her husband does not want to come to counseling. Once this reason is ascertained, the counselor coaches the mother to present the issue of coming to treatment in a way that the husband can accept. For example, if he doesn't want to come because he has given up on his son, she may be coached to suggest to him that coming to treatment will help her cope with the situation.

Although the pattern of resistance is similar to that of the contact person protecting the structure, in this instance, the resistance emerges differently. In this case, the mother does not excuse the father's distance. To the contrary, she complains about her spouse's disinterest; this mother is usually eager to do something to involve her husband; she just needs some direction to be able to do it.

Families with Secrets

Sometimes counseling is threatening to one or more individuals in the family. Sometimes the person who resists coming to counseling is either afraid of being made a scapegoat or afraid that dangerous secrets (e.g., infidelity) will be revealed. These individuals' beliefs or frames about counseling are usually an extension of the frame within which the family is functioning. That is, it is a family of secrets. The counselor must reframe the idea or goal of counseling in a way that eliminates its potential negative consequences and replaces them with positive aims. One example of how to do this is to meet with the person who rejects counseling the most and assure him or her that counseling does not have to go where he or she does not want it to go. The counselor needs to make it clear that he or she will make every effort to focus on the adolescent's problems instead of the

issues that might concern the unwilling family member. The counselor also should assure this individual that in the counseling session, "We will deal only with those issues that you want to deal with. You'll be the boss. I am here only to help you to the extent that you say."

Clinical Research Supporting Brief Strategic Family Therapy

This chapter describes past research on the effectiveness of BSFT with drug-abusing adolescents with behavioral problems. BSFT has been found to be effective in reducing adolescents' conduct problems, drug use, and association with antisocial peers and in improving family functioning. In addition, BSFT engagement has been found to increase engagement and retention in therapy. Additional studies testing an ecological version of BSFT with this population are currently underway.

As presented in this manual, BSFT's primary emphasis is on identifying and modifying maladaptive patterns of family interaction that are linked to the adolescent's symptoms. The ecological version of BSFT, BSFT-ecological (Robbins et al. in press) applies this principle of identifying and modifying maladaptive patterns of interaction to the multiple social contexts in which the adolescent is embedded (cf. Bronfenbrenner). The principal social contexts that are targeted in BSFT-ecological are family, family-peer relations, family-school relations, family-juvenile justice relations, and parent support systems. Joining, diagnosing, and restructuring, as developed in BSFT to use within the family system, are applied to these other social contexts or systems that influence the adolescent's behaviors. For instance, the BSFT counselor assesses the maladaptive, repetitive patterns of interaction that occur in each of these systems or domains. As an example, the BSFT counselor would diagnose the family-school system in the same way that he or she would diagnose the family system. In diagnosing structure, the counselor would ask, "Do parents provide effective leadership in their relationship with their child's teachers?" In diagnosing resonance, the counselor would ask, "Are parents and teachers disengaged?" In diagnosing conflict resolution, the counselor's questions would be, "What is the conflict resolution style in the parent teacher relationship? Might parents and teachers avoid conflict with each other (by remaining disengaged) or diffuse conflicts by blaming each other?" In BSFT-ecological, joining the teacher in the parent teacher relationship employs the same joining techniques developed for BSFT. Similarly, in BSFT-ecological, BSFT restructuring techniques are used to modify the nature of the relationship between a parent and his or her child's teacher.

Outpatient Brief Strategic Family Therapy versus Outpatient Group Counseling

A recent study (Santisteban et al. in press) examined the efficacy of BSFT in reducing an adolescent's behavioral problems, association with antisocial peers, and marijuana use, and in improving family functioning. In this study, outpatient BSFT was compared to an outpatient group counseling control treatment. Participants were 79 Hispanic families

with a 12- to 18-year-old adolescent who was referred to counseling for conduct and antisocial problems by either a school counselor or a parent. Families were randomly assigned to either BSFT or group counseling. Analyses of treatment integrity revealed that interventions in both therapies adhered to treatment guidelines and that the two therapies were clearly distinguishable.

Conduct disorder and association with antisocial peers were assessed using the Revised Behavior Problem Checklist (RBPC) (*Quay and Peterson*), which is a measure of adolescent behavior problems reported by parents. Conduct disorder was measured using 22 items, and association with antisocial peers was measured using 17 items. Each item asks the parent(s) to rate whether a specific aspect of the adolescent's behavior (e.g., fighting, spending time with "bad" friends) is no problem (0), a mild problem (1), or a severe problem (2). Ratings for all items on each scale are then added together to derive a total score.

The effects of BSFT on conduct disorder, association with antisocial peers, and marijuana use were evaluated in two ways. First, analyses of variance were conducted to examine whether BSFT reduced conduct disorder, association with antisocial peers, and marijuana use to a significantly greater extent than did group counseling. Second, exploratory analyses were conducted on clinically significant changes in conduct problems and association with antisocial peers. These exploratory analyses used the twofold clinical significance criteria recommended by Jacobson and Truax, et al. To be able to classify a change in symptoms for a given participant as clinically significant, two conditions have to occur. First, the magnitude of the change must be large enough to be reliable--that is, to rule out random fluctuation as a plausible explanation. Second, the participant must "recover" from clinical to nonclinical levels, i.e., cross the diagnostic threshold.

Conduct Disorder

Analyses of variance indicated that conduct disorder scores for adolescents in BSFT compared to those for adolescents in group counseling were significantly reduced between pre- and post treatment. In the clinical significance analyses, a substantially larger proportion of adolescents in BSFT than in group counseling demonstrated clinically significant improvement. At intake, 70 percent of adolescents in BSFT had conduct disorder scores that were above clinical cutoffs. That is, they scored above the empirically established threshold for clinical diagnoses of conduct disorder. At the end of treatment, 46 percent of these adolescents showed reliable improvement, and 5 percent showed reliable deterioration. Among the 46 percent who showed reliable improvement, 59 percent recovered to nonclinical levels of conduct disorder. In contrast, at intake, 64 percent of adolescents in group counseling had conduct disorder scores above the clinical cutoff. Of these, none showed reliable improvement, and 11 percent showed reliable deterioration. Therefore, while adolescents in BSFT who entered treatment at clinical

levels of conduct disorder had a 66 percent likelihood of improving, none of the adolescents in group counseling reliably improved.

Association with Antisocial Peers

Analyses of variance indicated that, for adolescents in BSFT, scores for association with antisocial peers were significantly reduced between pre- and post-treatment, compared to those for adolescents in group counseling. In the clinical significance analyses, 79 percent of adolescents in BSFT were above clinical cutoffs for association with antisocial peers at intake. Among adolescents in BSFT meeting clinical criteria for association with antisocial peers, 36 percent showed reliable improvement, and 2 percent showed reliable deterioration. Of the 36 percent of adolescents in BSFT with reliable improvement, 50 percent were classified as recovered. Among adolescents in group counseling, 64 percent were above clinical cutoffs for association with antisocial peers at intake. Among adolescents in group counseling meeting these clinical criteria at intake, 11 percent reliably improved, and none reliably deteriorated. Of the 11 percent of adolescents in group counseling evidencing reliable improvement in association with antisocial peers, 50 percent recovered to nonclinical levels. Hence, adolescents in BSFT who entered treatment at clinical levels of association with antisocial peers were 2.5 times more likely to reliable improve than were adolescents in group treatment.

Marijuana Use

Analyses of variance revealed that BSFT was associated with significantly greater reductions in self-reported marijuana use than was group counseling. To investigate whether clinically meaningful 3 changes in marijuana use occurred, four use categories from the substance use literature (e.g., Brooks et al.1998) were employed. These categories are based on the number of days an individual uses marijuana in the 30 days before the intake and termination assessments:

- ✤ Abstainer - 0 days
- ✤ Weekly user - 1 to 8 days
- ✤ Frequent user - 9 to 16 days
- ✤ Daily user - 17 or more days

In BSFT, 40 percent of participants reported using marijuana at intake and/or termination. Of these, 25 percent did not show change, 60 percent showed improvement in drug use, and 15 percent showed deterioration. Of the individuals in BSFT who shifted into less severe categories, 75 percent were no longer using marijuana at termination. In group counseling, 26 percent of participants reported using marijuana at intake and/or termination. Of these, 33 percent showed no change, 17 percent showed improvement, and 50 percent deteriorated. The 17 percent of adolescents in group counseling cases that showed improvement were no longer using marijuana at termination. Hence, adolescents

in BSFT were 3.5 times more likely than were adolescents in group counseling to show improvement in marijuana use.

Treatments also were compared in terms of their influence on family functioning. Family functioning was measured using the Structural Family Systems Ratings *(Szapocznik et al)*. This measure was constructed to assess family functioning. Based on their scores when they entered therapy, families were separated by a median split into those who had good and those who had poor family functioning. Within each group (i.e., those with good and those with poor family functioning), a statistical test that compares group means (analysis of variance) tested changes in family functioning from before to after the intervention.

Among families who were admitted with poor family functioning, the results showed that those assigned to BSFT had a significant improvement in family functioning, while those families assigned to group counseling did not improve significantly.

Among families who were admitted with good family functioning, the results showed that those assigned to BSFT retained their good levels of family functioning, while families assigned to group counseling showed significant deterioration. These findings suggest that not all families of drug-abusing youths begin counseling with poor family functioning, but if the family is not given adequate help to cope with the youth's problems, the family's functioning may deteriorate.

One Person Brief Strategic Family Therapy

With the advent of the adolescent drug epidemic of the 1970s, the vast majority of counselors who worked with drug-using youths reported that, although they preferred to use family therapy, they were not able to bring whole families into treatment. In response, a procedure was developed that would achieve the goals of BSFT (to change maladaptive family interactions and symptomatic adolescent behavior) without requiring the whole family to attend treatment sessions. The procedure is an adaptation of BSFT called "One Person" BSFT. One Person BSFT capitalizes on the systemic concept of complementarity, which suggests that when one family member changes, the rest of the system responds by either restoring the family process to its old ways or adapting to the new changes *(Minuchin and Fishman)*. The goal of One Person BSFT is to change the drug-abusing adolescent's participation in maladaptive family interactions that include him or her. Occasionally, these changes create a family crisis as the family attempts to return to its old ways. The counselor uses the opportunity created by these crises to engage reluctant family members.

A clinical trial was conducted to compare the efficacy of One Person BSFT to Conjoint (full family) BSFT. Hispanic families with a drug-abusing 12- to 17-year-old adolescent were randomly assigned to the One Person or Conjoint BSFT modalities. Both therapies were designed to use exactly the same BSFT theory so that only one variable (one person

vs. conjoint meetings) would differ between the treatments. Analyses of treatment integrity revealed that interventions in both therapies adhered to guidelines and that the two therapies were clearly distinguishable. The results showed that One Person was as efficacious as Conjoint BSFT in significantly reducing adolescent drug use and behavior problems as well as in improving family functioning at the end of therapy. These results were maintained at the 6-month follow up.

One Person BSFT is not discussed in this manual because it is considered a very advanced clinical technique. More information on One Person BSFT is available in Szapocznik and Kurtines.

Brief Strategic Family Therapy Engagement

As discussed in Chapter 5, in response to the problem of engaging resistant families, a set of engagement procedures based on BSFT principles was developed. These procedures are based on the premise that resistance to entering treatment can be understood in family interactional terms.

One Person BSFT techniques are useful in this initial phase. That's because the person who contacts the counselor to request help may become the one person through whom work is initially done to restructure the maladaptive family interactions that are maintaining the symptom of resistance. The success of the engagement process is measured by the family's and the symptomatic youth's attendance in family therapy. In part, success in engagement permits the counselor to redefine the problem as a family problem in which all family members have something to gain. Once the family is engaged in treatment, the focus of the intervention is shifted from engagement to removing the adolescent's presenting symptoms.

The efficacy of BSFT engagement has been tested in three studies with Hispanic youths *(Coatsworth et al.)*. The first study included mostly Cuban families with adolescents who had behavior problems and who were suspected of or observed using drugs by their parents or school counselors. Of those engaged, 93 percent actually reported drug use. Families were randomly assigned to one of two therapies: BSFT engagement or engagement as usual (the control therapy). The engagement-as-usual therapy consisted of the typical engagement methods used by community treatment agencies, which were identified prior to the study using a community survey of outpatient agencies serving drug-abusing adolescents. All families who were successfully engaged received BSFT. In the experimental therapy, families were engaged and retained using BSFT engagement techniques. Successful engagement was defined as the conjoint family (minimally the identified patient and his or her parents and siblings living in the same household) attending the first BSFT session, which was usually to assess the drug-using adolescent and his or her family. Treatment integrity analyses revealed that interventions in both engagement therapies adhered to prescribed guidelines using six levels of engagement

effort that were operationally defined and that the therapies were clearly distinguishable by level of engagement effort applied.

The six levels of engagement effort, as enumerated in *Szapocznik et al*. are:

- ➢Level 0 - expressing polite concern, scheduling an intake appointment, establishing that cases met criteria for inclusion in the study, and making clear who must attend the intake assessment;
- ➢Level 1 - attempting minimal joining, encouraging the caller to involve the family, asking about the depth and breadth of adolescent problems, and asking about family members;
- ➢Level 2 - attempting more thorough joining; asking about family interactions; seeking information about the problems, values, and interests of family members; supporting and establishing an alliance with the caller; beginning to establish leadership; and asking whether all family members would be willing to attend the intake appointment;
- ➢Level 3 - restructuring for engagement through the caller, advising the caller about negotiating and reframing, and following up with family members (either over the phone or personally with the caller at the therapist's office) to be sure that intake appointments would be kept;
- ➢Level 4 - conducting lower level ecological engagement interventions, joining family members or conducting intrapersonal restructuring (with family members other than the original caller) over the phone or in the therapist's office, and contacting significant others (by phone) to gather more information; and
- ➢Level 5 - conducting higher level ecological interventions, making out-of-office visits to family members or significant others, and using significant others to help conduct restructuring.

Level 0-1 behaviors were permitted for both the BSFT engagement and engagement-as-usual conditions. Level 2-5 behaviors were permitted only for the BSFT engagement condition. Efficacy was measured in rates of both family treatment entry as well as retention to treatment completion.

The efficacy of the two methods of engagement was measured by the percentage of families who entered treatment and the percentage of families who completed the treatment. The results revealed that 42 percent of the families in the engagement-as-usual therapy and 93 percent of the families in the BSFT engagement therapy were successfully engaged. In addition, 25 percent of engaged cases in the engagement-as-usual treatment and 77 percent of engaged cases in the BSFT engagement treatment successfully completed treatment. These differences in engagement and retention between the two methods of engagement were both statistically significant. Improvements in adolescent symptoms occurred but were not significantly different between the two methods of

engagement. Thus, the critical distinction between the treatments was in their different rates of engagement and retention. Therefore, BSFT engagement had a positive impact on more families than did engagement as usual.

In addition to replicating the previous engagement study, the second study also explored factors that might moderate the efficacy of the engagement interventions. In contrast to the previous engagement study, Santisteban et al. more stringently defined the success of engagement as a minimum of two office visits: the intake session and the first therapy session. The researchers randomly assigned 193 Hispanic families to one experimental and two control treatments. The experimental therapy was BSFT plus BSFT engagement. The first control therapy was BSFT plus engagement as usual, and the second was group counseling plus engagement as usual. In both control treatments, engagement as usual involved no specialized engagement strategies.

Results showed that 81 percent of families were successfully engaged in the BSFT plus BSFT engagement experimental treatment. In contrast, 60 percent of the families in the two control therapies were successfully engaged. These differences in engagement were statistically significant. However, the efficacy of the experimental therapy procedures was moderated by the cultural/ethnic identity of the Hispanic families in the study. Among families assigned to BSFT engagement, 93 percent of the non-Cuban Hispanics (composed primarily of Nicaraguan, Colombian, Puerto Rican, Peruvian, and Mexican families) and 64 percent of the Cuban Hispanics were engaged. These findings have led to further study of the mechanism by which culture/ethnicity and other contextual factors may influence clinical processes related to engagement *(Santisteban et al.; Santisteban et al. in press)*. The results of the Szapocznik et al. and Santisteban et al. studies strongly support the efficacy of BSFT engagement. Further, the second study with its focus on cultural/ethnic identity supports the widely held belief that therapeutic interactions must be responsive to contextual changes in the treatment population *(Sue et al; Szapocznik and Kurtines)*.

A third study *(Coatsworth et al.)* compared BSFT to a community control intervention in terms of its ability to engage and retain adolescents and their families in treatment. An important aspect of this study was that an outside treatment agency administered the control intervention. Because of that, the control intervention (e.g., usual engagement strategies) was less subject to the influence of the investigators. Findings in this study, as in previous studies, showed that BSFT was significantly more successful, at 81 percent, in engaging adolescents and their families in treatment than was the community control treatment, at 61 percent. Likewise, among those engaged in treatment, a higher percentage of adolescents and their families in BSFT, at 71 percent, were retained in treatment compared to those in the community control intervention, at 42 percent. In BSFT, 58 percent of adolescents and their families completed treatment compared to 25 percent of those in the community control intervention. Families in BSFT were 2.3 times

more likely both to be engaged and retained in treatment than were families randomized to the community control treatment.

An additional finding of the *Coatsworth et al.* study warrants special mention. In BSFT, families of adolescents with more severe conduct problem symptoms were more likely to remain in treatment than were families of adolescents whose conduct problem symptoms were less severe. The opposite pattern was evident in the community control intervention, with families that were retained in treatment showing lower intake levels of conduct problems than did families who dropped out. These findings are particularly important because they suggest that adolescents who are most in need of services are more likely to stay in BSFT than in traditional community treatments.

11. Group Therapy in Substance Use Treatment

Group therapy is a therapy modality wherein clients learn and practice recovery strategies, build interpersonal skills, and reinforce and develop social support networks. It typically involves a group of 6 to 12 clients who meet on a regular basis with one or two group therapists. The most recent National Survey of Substance Abuse Treatment Services reports that 93 percent of substance use disorder (SUD) treatment facilities, across different settings, provide group therapy (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). The popularity of this type of group therapy has been shaped by the influence of mutual-support groups, the potential for cost containment, and its efficiency in delivering psychoeducation while teaching coping skills to many individuals at once.

Based on SAMHSA's Treatment Improvement Protocol (TIP) 41, *Substance Abuse Treatment: Group Therapy*, this section provides an overview of goals, processes, group-specific approaches, resources, and common elements that support favorable outcomes in group therapy. It does not address non-treatment groups, specifically peer and mutual-support groups. Nonetheless, these groups can also support recovery and add significant value to the treatment process (e.g., reinforcing coping strategies, modeling recovery behavior, providing hope, and minimizing the stigma often associated with SUDs).

Group therapy has therapeutic advantages. It provides potential benefits in promoting social support, reducing isolation and stigma, developing effective communication and interpersonal skills, and practicing recovery-oriented coping strategies with group members (Wendt & Gone; Wenzel et al.). There is a growing body of evidence that group therapy is cost effective and produces client outcomes comparable to individual therapy

Key Points

- Group therapy, used extensively in SUD treatment, consists of individual theoretical approaches adapted to the development of specialized manual-based group treatments.
- Several core processes predict outcomes in many SUD group therapy settings, including therapeutic alliance, group affiliation, and culturally responsive practices.
- Across the continuum of care, group therapy can be an effective and efficient modality for improving treatment engagement, developing and practicing coping skills, and supporting recovery.
- Group therapy is one of the most common approaches in SUD treatment settings. There is broad need for clinical supervision and formal training in specific group processes and dynamics, as well as evidence-based SUD group therapies.

in SUD treatment acceptance, retention, reductions in frequency of use, abstinence rates, and psychological symptoms and distress (Burlingame et al.; Lo Coco et al.; Olmstead et al.; Sobell & Sobell; Sobell et al.). Adding group therapy as a component to individually oriented SUD treatment approaches improves treatment engagement, abstinence rates, and perceived peer support (de Moura et al.).

Groups in SUD Treatment: An Overview

Group therapy is a common way to deliver SUD treatment interventions in various types of treatment settings. Group therapy is used in hospital-based units providing medically supervised withdrawal, outpatient and intensive outpatient programs, non-hospital residential treatment centers, halfway houses, continuing care groups, and outpatient groups for those engaged in medication-assisted treatment (Pugatch et al; Sokol et al.).

Groups differ in their overall purpose and goals. Some groups address a specific point in recovery, such as early recovery and relapse prevention. Other groups provide psychoeducation on various topics, including the consequences of SUDs, family impact, and the use of support systems. Other groups focus on managing specific co-occurring health conditions (e.g., HIV/AIDS), psychological symptoms (e.g., anger management), and mental disorders (e.g., social anxiety, mood disorders). Groups may focus on populations (e.g., gender-and age-specific and criminal justice groups). There are

culturally specific groups that integrate cultural practices and values into treatment and others that provide an affirming space for recovery (e.g., for LGBTQ+ individuals).

Many SUD treatment programs use individual theoretical approaches and rework them into group therapy (Wendt & Gone). Groups often use a combination of strategies, such as motivational interviewing, stages-of-change interventions, psychoeducation, supportive approaches, and skill development. In the past decade, evidence-based group therapies for SUDs have evolved using motivational and cognitive–behavioral approaches or a combination of both (Sobell & Sobell).

Group member selection

Matching clients with the appropriate group is vital to successful treatment. In addition to admission criteria and the group's purpose, a client's needs, current goals, and ability to participate determine appropriateness. For example, a female client who presents with an SUD and trauma history may be better served

Percentage of SUD Treatment Facilities Offering Special Program or Group

Special Program or Group	***Percentage***
Adolescents	24
Adult men	47
Adult women	49
Clients with co-occurring disorders	53
Criminal justice clients (not including DUI/DWI offenders)	36
DUI/DWI offenders	24
Lesbian, gay, bisexual, or transgender (LGBT)	23
Older adults	23
People with HIV/AIDS	20

Pregnant or postpartum women	24
Veterans	22
Source: SAMHSA, 2020.	

in a women-only group. Clients who are not suited for group therapy should be reevaluated if conditions change. The following list describes client circumstances that may justify ruling out group therapy at a particular point in time (American Group Psychotherapy Association; Greenfield et al.):

- Inability to attend group therapy regularly
- Currently misusing substances
- Intellectual disability or a neurocognitive disorder that prevents the client from communicating with other group members, understanding or attending to the group process, or following through with group tasks
- Current psychosis, mania, or other symptoms that would hamper participation Inability to follow group rules established by the treatment program and group members

Elements that enhance outcomes: Group cohesion and therapeutic alliance

Group cohesion and therapeutic alliance improve outcomes for individuals who participate in group therapy for SUDs. Favorable outcomes include treatment acceptance, engagement, and retention in group therapy, as well as enhanced abstinence rates or reduction in substance misuse frequency.

Group cohesion refers to the quality of relationships among group members, including the client–therapist connection. It includes the perception of interpersonal and emotional support and affiliation in the group (Burlingame et al; Dolgin et al., 2020; Sugarman et al.; Yalom & Leszcz). Group cohesion is associated with positive outcomes across treatment settings, theoretical

Enhancing Group Cohesion

- Ask members to share if they ever experienced a similar circumstance, feeling, or thought as expressed by a specific group member.
- Ask the group to provide feedback to another group member on what they see as working well and what is not working so well regarding self-care.
- Brainstorm with the group about how to manage a specific high-risk situation using a concrete example from a group member.
- Use role-plays to practice coping or refusal skills, then reverse roles so that another member can experience and empathize with the group member's situation while learning recovery skills.

Enhancing Therapeutic Alliance

Prior to participation, walk through an example of a typical group session. Talk about how group sessions begin and end. Discuss normal experiences in group sessions, such as being anxious about giving feedback to another member or sharing an experience or emotions with the entire group, hearing a painful story from another participant, or learning about a member leaving the group. A key ingredient in building alliance is using reflective listening and periodic check-ins, (e.g., "Is it okay with you if I share what I just heard and observed?").

approaches, and client populations. Group therapists should encourage member–member interactions rather than conducting individual therapy in a group format, model how members can give balanced positive and negative feedback, and highlight commonalities and foster similar experiences among group members (Burlingame et al.; Kivlighan et al., 2020; Sobell & Sobell; Valeri et al.).

Therapeutic alliance is the development of a working relationship and bond between a group member and therapist. It includes an agreement on goals and tasks to address the presenting problems (Ardito & Rabellino; Bordin; Martin & Garske). Group therapists begin to foster therapeutic alliance with the first interaction with a client. Group therapists should prepare clients to join the group by explaining the group process, treatment expectations, and group rules prior to participation. Furthermore, they should develop shared goals for group therapy. In group sessions, therapists adopt culturally responsive practices to build alliance and show support and empathy as the client negotiates recovery challenges. Therapeutic alliance is associated with positive group treatment outcomes across theoretical approaches and client populations (Crits-Christoph et al.; Davis et al.; Flückiger et al.; Meier et al.; Sobell & Sobell; von Greiff & Skogens).

Group preparation from initiation to termination

Group therapists should be mindful that new clients are typically in unfamiliar territory, unacquainted with clinical and recovery language, group processes, and treatment procedures. Treatment engagement and outcomes are fortified when client preparation occurs prior to group attendance. The preparation should address when the client will end group therapy and the process of termination, including available continuing care services and the process of referring clients, which may be handled by a case manager or aftercare coordinator (Sobell & Sobell).

Group Structure and Development

Group structure and formats

Most studies evaluating group SUD treatments use a fixed number of sessions, closed-group format, and manual-based approaches. Less is known about SUD treatment groups

Open and Closed Groups

Open groups accept group members on a rolling basis with no end date. Clients can enter group at any time. Closed groups have a specific start and end date and typically accept clients only at the beginning of the process (Sobell & Sobell).

with open formats, varied session lengths, and those that use non-manualized approaches. Factors to consider include the following:

➡Closed groups offer advantages in evaluating treatment effectiveness using a specific approach or strategy.

➡Closed groups are more likely to build group cohesiveness and support among members, resulting in less client turnover, which is associated with better outcomes (Pavia et al.; Sobell & Sobell; Wendt & Gone).

➡Group therapists in SUD treatment may transition in and out of group due to staffing demands. This may disrupt group cohesiveness, trust, and the level of self-disclosure. Treatment providers should avoid this practice whenever possible (Morgan-Lopez & Fals-Stewart).

Therapists' ability to use and adapt specific techniques as situations in the group dictate (as opposed to using predetermined exercises and content) is associated with better outcomes in general. There is some evidence that clients become dissatisfied within open group formats when the same content is reintroduced to new members. Consequently, less time is devoted to group interaction and there are fewer opportunities to build on content and group processes from previous sessions. Client satisfaction is not only tied to treatment engagement but also to outcomes (Owen & Hilsenroth).

Agenda setting

To effectively facilitate an SUD group, therapists need to prepare and set an agenda for each session, because predictability helps create a safe and therapeutic working environment (Sobell & Sobell). However, counselors should remain flexible and open to changing the agenda as needed. Agendas should emphasize elements of the group that will be consistent across all sessions. This means that therapists need to mark the opening and closing of sessions in the same way each time. Agendas used in early sessions might also cover the reinforcement of group rules and how group members share or provide feedback. If needed, the counselor can add these items to later agendas as reminders. In addition to group processes, agendas can also cover session content, like planned exercises, educational material, and content to address individual and group-specific concerns and needs.

Group size

There is no consensus on the most effective group size in SUD treatment. Literature suggests that group size should range from 6 to 12 individuals to effectively address

Stigma

Stigma is a process in which people with SUDs are devalued, labeled, and excluded in society. It fosters health inequalities and is associated with negative outcomes for those with SUDs. Stigma is linked to premature discontinuation of treatment, increased risky behavior, and delayed recovery. Stigma can be self-imposed or imposed by others, including other group members, family, staff, and society. Person-first language, positive recovery stories, acceptance, and commitment to group therapy may help address stigma and its far-reaching effects (Livingston et al.; Luoma et al.). In addition, community-based approaches may decrease stigma through social media messaging and education about SUDs and their contributing factors. Stigma can be reduced by community recovery activities and advocacy groups (e.g., recovery runs/walks, public policy forums, the use of recovery ambassadors) (National Academies of Sciences, Engineering, and Medicine).

of maximum group size; group size restrictions vary across states, counties, and healthcare delivery systems and insurance plans.

Culturally responsive practices

Although there is recognition of the importance of developing cultural competence in SUD treatment, little research is available on culturally responsive practices in group therapy. One study of 13 SUD treatment providers found that racial, ethnic, and cultural considerations were not regularly integrated into the group process (Wendt & Gone).

Developing cultural competence is an ongoing learning process. It involves the following components across modalities and settings (Sue et al.):

clients' needs and to enable all members to participate (Sobell & Sobell; Velasquez et al.). Group size also depends on the purpose of group therapy. For example, groups that focus on education with some processing and sharing may effectively accommodate larger groups (e.g., psychoeducational multifamily group sessions). Groups with fewer than six members are less likely to survive as a result of attrition and absenteeism, whereas larger groups are likely to have fewer member–member interactions (Wendt & Gone; Yalom & Leszcz). There is no scientific determination

Culture

Culture includes race, ethnicity, gender, age, religion, sexual orientation, ability, geographic region, and class. Culture involves shared beliefs, values, and practices. In group therapy, culture not only shapes help-seeking behaviors and beliefs about illness and treatment, but also communication patterns within the group (Cohen, Sue et al.).

Cultural awareness: The willingness and ability to recognize and self-reflect on the importance of race, ethnicity, and culture—that not everyone shares the same beliefs, values, practices, or experiences. Cultural awareness is the recognition that these attributes play a significant role in all group interactions and in the interpretation of communication and actions of others in the group. Cultural humility is also part of cultural awareness—the commitment to lifelong learning, self-reflection, showing interest in others, and understanding that imbalances in power and privilege exist among clients, co-workers, and administrative staff (Tervalon & Murray-Garcia).

Cultural knowledge: A commitment to learning about other cultures by researching, using a cultural guide or mentor from the group population, attending culturally specific events, and asking group members about their culture with a welcoming and inquisitive attitude. Being culturally responsive means addressing how group dynamics may produce further burden on clients at a time when they need services. It involves the recognition of how culture, racism, discrimination, and microaggressions affect individual group members, group processes, and communication, regardless of the group therapy approach (Harris; Kivlighan et al.).

Microaggressions

Microaggressions are derogatory comments, insults, or nonverbal behaviors, whether intentional or unintentional, that reflect prejudice, hostility, stereotypes, and generalizations toward a person based solely on their membership in a marginalized group (such as gender identity, ethnicity, race, sexual orientation, socioeconomic status). The effects of microaggressions can be cumulative and affect mental and physical health (Nadal et al.; Sue; Wang et al.).

Cultural knowledge of behavioral health: Learning about healing practices, help-seeking preferences, and acceptable treatments reflected in the group composition. For example, some cultures have specific names for emotional and behavioral problems and cultural explanations for their cause. Other cultures are more likely to distrust behavioral healthcare services and institutions. Group members from some cultures may be more likely to express mental distress through physical symptoms. All cultures have prescribed ways of viewing emotional issues and drug and alcohol misuse.

Cultural skills: Anticipating culturally specific needs of group members: An essential cultural skill in group therapy is effective, appropriate, and respectful communication, including knowledge about body language, attention to gestures and touch, and vigilance about microaggressions that might occur in group process. Other skills include securing translation services, surmounting language barriers, anticipating need for accessibility services, and using

culturally specific community resources. Being responsive to cultural diversities can make the difference in how group members respond to services and in treatment outcomes (Gainsbury; Kivlighan et al.).

Groups across the continuum of care

Across the continuum of care, SUD treatment groups use support, psychoeducation, skill development, and interpersonal processes to assist clients in addressing their emotions, thoughts, and behavior in recovery. Irrespective of setting, population, and the clients' phase of recovery, most SUD treatment groups use a combination of motivational interviewing, cognitive–behavioral, and stages-of-change strategies. Early recovery groups are more likely to focus on psychoeducation, support, and skill development, while late recovery groups tend to emphasize relapse prevention, social skills, and relationship concerns.

Group Approaches in SUD Treatment

Group-specific SUD treatment approaches are divided into three areas: theoretical models, populations, and clinical issues. The following reference lists reflect a sample of some current approaches:

Groups using specific theoretical approaches

Group Cognitive Therapy for Addictions (Wenzel et al.)
Group Therapy for Substance Use Disorders: A Motivational Cognitive-Behavioral Approach (Sobell & Sobell).

Groups focusing on specific populations and clinical issues

Anger Management for Substance Use Disorder and Mental Health Clients: A Cognitive–Behavioral Therapy Manual (Reilly & Shopshire)
Building Recovery by Improving Goals, Habits, and Thoughts (BRIGHT): A Group Cognitive Behavioral Therapy for Depression in Clients With Co-Occurring Alcohol and Drug Use Problems—Group Leader's Manual (Hepner et al.)
Integrated Group Therapy for Bipolar Disorder and Substance Abuse (Weiss & Connery)
Seeking Safety: A Treatment Manual for PTSD and Substance Abuse (Najavits)
Treating Women With Substance Use Disorders: The Women's Recovery Group Manual (Greenfield)

Group Facilitation and Professional Development

SUD group therapists' credentials

Foremost, the therapist needs to abide by the ethical and professional standards of their credentialing and governing bodies. Each state has its own licensing, certification, and

supervision requirements that enable SUD counselors to provide services. Those services include, but are not limited to, both individual and group therapy (National Association of State Alcohol and Drug Abuse Directors). There is no specific SUD group therapy license or certification designation.

Fundamental skills of a group therapist

In addition to helping clients integrate into a new group, reinforcing group rules, and facilitating the group process during sessions, the therapist needs to promote emotional safety. Safety involves setting limits, redirecting topics, and helping group members process difficult exchanges, behaviors, and feelings.

Clients need to feel support and compassion from the group therapist. The therapist must build an alliance with each member and facilitate and promote communication among members so that they share with and learn from each other. The therapist maintains the focus on individual and group goals throughout the process. Though many SUD treatment therapists use primarily psychoeducation in groups (Wendt & Gone), group facilitation should include a combination of supportive, skill building, and relational strategies to capitalize on the benefits of group therapy.

Common challenges in providing group therapy

Despite the fact that group therapy is a main modality in SUD treatment, there is little research that addresses group-specific interventions and formats. This disparity between practice and supporting research results in several challenges:

- ➡ Providers rely on individual approaches in group therapy.
- ➡ Evidence-based group-specific treatments are often thought to be inflexible.
- ➡ Training in how to facilitate group therapy, including group dynamics, is not widely available.

For providers, studies support the benefits of early training in group skills and principles, culturally responsive group practices, and management of group dynamics. Therapists need support and training in how to use group-specific resources, and when and how to deviate from session agendas to maintain flexible clinical strategies (Flückiger et al.; Wendt & Gone).

Professional development

Even though state requirements differ and there is no specific SUD group therapy license or certification, therapists who provide group therapy in SUD treatment need to commit to professional development in group-specific skills and competencies. These activities include training opportunities in general group therapy, adopting guidelines for best and evidence-based practices designed specifically for SUD treatment, and engaging in supervision. Supervision specific to group practice should include establishing

professional development plans; providing support and guidance in group dynamics, strategies, and modalities; and engaging in evaluative processes to support adoption of group-specific competencies.

12. Resources

1) **SAMHSA Behavioral Health Treatment Services Locator**

2) **Administration for Children and Families (ACF)** — The Administration for Children and Families (ACF) is a division of the Department of Health & Human Services. We promote the economic and social well-being of families, children, individuals and communities.

3) **Alcohol Policy Information System (APIS)** The Alcohol Policy Information System (APIS) provides detailed information on a wide variety of alcohol-related policies in the United States at both the State and Federal levels. Detailed, state-by-state, information is available for 33 policies. APIS also provides a variety of informational resources of interest to alcohol policy researchers and others involved with alcohol policy issues.

4) **Brandeis University PDMP Center of Excellence** — Funded by grants from the U.S. Department of Justice, Bureau of Justice Assistance, the Prescription Drug Monitoring Program (PDMP) Center of Excellence was founded in 2010 at the Schneider Institutes for Health Policy, Brandeis University. The Center partners with the PDMP Training and Technical Assistance Center at Brandeis to combat the prescription drug abuse epidemic. The Center collaborates with a wide variety of PDMP stakeholders, including federal and state governments and agencies, universities, health departments, and medical and pharmacy boards.

5) **Community Anti-Drug Coalitions of America (CADCA)** CADCA is the premier membership organization representing those working to make their communities safe, healthy and drug-free. CADCA has members in every U.S. state and territory and working in 18 countries around the world.

6) **Center for the Application of Prevention Technologies** SAMHSA's Center for the Application of Prevention Technologies (CAPT) is a national substance abuse

prevention training and technical assistance (T/TA) system dedicated to strengthening prevention systems and the nation's behavioral health workforce.

7) **Centers for Disease Control Tobacco Information and Prevention Source Page** The premiere source for tobacco information and prevention, featuring the Smoking and Health Database. The Database covers more than 30 years of information, and is a comprehensive online resource covering the scientific, technical, social science, policy, legal, and historical literature related to smoking and tobacco use.

8) **Injury Prevention & Control: Prescription Drug Overdose** – The CDC remains committed to advancing a public health approach to preventing drug overdose death and applies its scientific expertise to help curb the epidemic

9) **Center for Substance Abuse Prevention (CSAP)** The Center for Substance Abuse Prevention (CSAP) works with federal, state, public, and private organizations to develop comprehensive prevention systems by:

- ➡ Providing national leadership in the development of policies, programs, and services to prevent the onset of illegal drug use, prescription drug misuse and abuse, alcohol misuse and abuse, and underage alcohol and tobacco use;
- ➡ Providing the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds and discretionary grants;
- ➡ Promoting effective substance abuse prevention practices that enable states, communities, and other organizations to apply prevention knowledge effectively.

10) **International Certification and Reciprocity Consortium, Inc. (IC&RC)** IC&RC is the global leader in the credentialing of prevention, addiction treatment, and recovery professionals. Organized in 1981, it provides standards and examinations to certification and licensing boards in 25 countries, 47 states and territories, five Native American regions, and all branches of the U.S. military.

11) **National Governor's Association** –The abuse of prescription drugs is the fastest growing drug problem in the United States, and is the most common type of drug abuse after marijuana use among teens between the ages of 12 and 17. To combat the growing problem, the National Governors Association (NGA) is hosting a year-

long project led by Alabama Gov. Robert Bentley and Colorado Gov. John Hickenlooper.

12) **National Highway Traffic Safety Administration (NHTSA) Impaired Driving** –NHTSA was established by the Highway Safety Act of 1970 and is dedicated to achieving the highest standards of excellence in motor vehicle and highway safety. It works daily to help prevent crashes and their attendant costs, both human and financial.

13) **National Institute on Alcohol Abuse and Alcoholism** NIAAA supports and conducts research on the impact of alcohol use on human health and well-being. It is the largest funder of alcohol research in the world.

14) **National Institute on Drug Abuse** NIDA's mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction.

15) **Edinburgh Rehab Centre** A highly experienced and proficient rehabilitation center than works arduously everyday to help people overcome the harmful effects of addiction that can prevent a person from reaching their goal of stopping consumption of alcohol or other substances they abuse.

16) **National Organization of Fetal Alcohol Syndrome** NOFAS is a 501 (c)(3) nonprofit organization founded in 1990 dedicated to eliminating birth defects caused by alcohol consumption during pregnancy and improving the quality of life for those individuals and families affected. NOFAS is the only national organization focusing solely on FAS, the leading known cause of mental retardation.

17) **Office of National Drug Control Policy (ONDCP)** As part of the Executive Office of the President, the Office of National Drug Control Policy (ONDCP) places an emphasis on community-based prevention programs, early intervention programs in healthcare settings, aligning criminal justice policies and public health systems to divert non-violent drug offenders into treatment instead of jail, funding scientific research on drug use, and, through the Affordable Care Act, expanding access to substance abuse treatment.

18) **Partnership for Drug-Free Kids** The Partnership for Drug-Free Kids translates the science of teen drug use and addiction for families, providing parents with direct support to prevent and cope with teen drug and alcohol abuse.

19) **Society for Prevention Research (SPR)** The Society for Prevention Research is an organization dedicated to advancing scientific investigation on the etiology and prevention of social, physical and mental health, and academic problems and on the translation of that information to promote health and well being. The multi-disciplinary membership of SPR is international and includes scientists, practitioners, advocates, administrators, and policy makers who value the conduct and dissemination of prevention science worldwide.

20) **Substance Abuse and Mental Health Services Administration (SAMHSA)** SAMHSA is the lead federal agency on substance abuse treatment and prevention. Includes the Centers for Substance Abuse Treatment (CSAT), Prevention (CSAP), and Mental Health Services (CMHS).

21) **Substance Abuse Prevention and Treatment Block Grant** The Substance Abuse Prevention and Treatment Block Grant program provides funds to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, 6 Pacific jurisdictions, and 1 tribal entity to prevention and treat substance abuse**.**

22) **Center for Substance Abuse Treatment (CSAT)** The mission of the Center for Substance Abuse Treatment is to promote community-based substance abuse treatment and recovery services for individuals and families in every community. CSAT provides national leadership to improve access, reduce barriers, and promote high quality, effective treatment and recovery services.

23) **Center for Mental Health Services (CMHS)** – The Center for Mental Health Services leads federal efforts to promote the prevention and treatment of mental disorders. Congress created CMHS to bring new hope to adults who have serious mental illness and children with emotional disorders.

24) **National Registry of Evidence-based Programs and Practices (NREPP)** The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online database of mental health and substance abuse interventions. All interventions in the registry have met NREPP's minimum requirements for review and have been independently assessed and rated for Quality of Research and Readiness for Dissemination. The purpose of NREPP is to help the public learn

more about available evidence-based programs and practices and determine which of these may best meet their needs. NREPP is one way that SAMHSA is working to improve access to information on evaluated interventions and reduce the lag time between the creation of scientific knowledge and its practical application in the field.

25) **U.S. Department of Justice** – The mission of the U.S. Department of Justice is to enforce the law and defend the interests of the United States according to the law; to ensure public safety against threats foreign and domestic; to provide federal leadership in preventing and controlling crime; to seek just punishment for those guilty of unlawful behavior; and to ensure fair and impartial administration of justice for all Americans.

26) **Drug Enforcement Administration** — The mission of the Drug Enforcement Administration (DEA) is to enforce the controlled substances laws and regulations of the United States and bring to the criminal and civil justice system of the United States, or any other competent jurisdiction, those organizations and principal members of organizations, involved in the growing, manufacture, or distribution of controlled substances appearing in or destined for illicit traffic in the United States; and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances.

27) **Underage Drinking Enforcement Training Center** The Office of Juvenile Justice and Delinquency Prevention (OJJDP) established the Underage Drinking Enforcement Training Center (UDETC) to support its Enforcing Underage Drinking Laws program. The UDETC provides a variety of science-based, practical, effective training and technical assistance services to support, enhance, and build leadership capacity and increase state and local community effectiveness in their efforts to enforce underage drinking laws, prevent underage drinking, and eliminate the devastating consequences associated with alcohol use by underage youth.

28) **U.S. Department of Education** The Safe Students-Healthy Schools Initiative supports local educational agencies (LEAs) in the development of community-wide approaches to creating safe and drug-free schools and promoting healthy childhood development. Programs are intended to prevent violence and the illegal use of drugs and to promote safety and discipline. Coordination with other community-based organizations (CBOs) is required. This program is jointly funded

and administered by the departments of Education, Justice, and Health and Human Services.

29) **U.S Department of Labor, Working Partners for an Alcohol and Drug-Free Workplace** Working Partners provides businesses and communities with tools and information to effectively address drug and alcohol problems. More specifically, the initiative raises awareness about the impact drugs and alcohol have on the workplace and helps employers and employees work together to ensure their workplaces are free of the hazards of alcohol and drug abuse.

Additional Resources

YOUTH FRIENDLY SUBSTANCE USE ONLINE RESOURCES

- **Kelty Mental Health Resource Centre**: Resources are available on this website for youth and teens about substance use, including in-depth information on various substances and concurrent disorders, as well as steps to seek help. http://keltymentalhealth.ca/substance-use
- **Partnership for Drug-Free Kids**: This website works to reduce substance abuse among adolescents by supporting families and engaging with teens. http://www.drugfree.org/
- **Truth Campaign**: This campaign provides information and uses videos and social media to engage youth in taking action against tobacco and tobacco companies. http://www.thetruth.com/
- **Your Room**: This website offers information about alcohol and a wide range of drugs, their effects, withdrawal, and how to get help for yourself or for anyone else who needs it. http://yourroom.com.au/

SUBSTANCE USE RESOURCE INSTITUTES

- **National Council on Alcohol and Drug Dependence**: This informational website provides support to those who need assistance confronting the diseases of alcoholism and drug dependence. http://ncaddms.org/
- **National Institute of Alcohol Abuse and Alcoholism**: NIAAA supports and conducts research on the impact of alcohol use on human health and wellbeing. They provide resources directed toward young people to evaluate your drinking and tools to stay in control. http://rethinkingdrinking.niaaa.nih.gov/

- **NIDA for Teens**: NIDA provides a wealth of knowledge and resources including easy-to-read guides about various drugs. Their website for adolescents includes videos, blog posts, and drug facts. http://teens.drugabuse.gov/

TREATMENT SERVICE LOCATORS

- **Behavioral Health Treatment Services Locator:** Find treatment facilities for substance abuse/addiction and/or mental health problems. https://findtreatment.samhsa.gov/
- **Buprenorphine Treatment Physician Locator:** Find physicians authorized to treat opioid dependency with buprenorphine by state. http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
- **Opioid Treatment Program Directory:** Search opioid treatment programs by state. http://dpt2.samhsa.gov/treatment/directory.aspx
- **Sober Nation Treatment Locator:** An extensive directory of recovery centers http://www.sobernation.com/

SUPPORT GROUPS

- **Al-Anon Family for Teens**: A group for problem drinkers who can find understanding and support through group meetings, podcasts, and other resources. http://www.al-anon.alateen.org/for-alateen
- **Alcohol Anonymous**: The AA website can help young people find AA meetings near them and has brochures directed at young people. http://www.aa.org/pages/en_US
- **Narcotics Anonymous**: The NA website can help young people find NA meetings near them and has resources including brochures for young addicts. http://www.na.org/
- **Smart Recovery**: SMART Recovery is a leading self-empowering addiction recovery support group. The website provides resources for teens and youth support programs, meeting locations, and an online community. http://www.smartrecovery.org/teens/

HELPLINES

- **Crisis Call Center**: Visit http://crisiscallcenter.org/, call 1-800-273-8255, or text "ANSWER" to 839863
- **Crisis Text Line:** Visit www.crisistextline.org/ or text "START" to 741-741

- **National Suicide Prevention Lifeline:** Visit www.suicidepreventionlifeline.org/ or call 1-800-273-TALK (8255)
- **SAMHSA's Helpline**: Visit www.samhsa.gov/find-help/national-helpline or call 1-800-662-HELP (4357)

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